The California Commission on Health and Safety and Workers’ Compensation

CHSWC 2009 Annual Report

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ABOUT CHSWC

The Commission on Health and Safety and Workers’ Compensation (CHSWC) examines the health and safety and workers’ compensation systems in California and makes recommendations to improve their operation.

Established in 1994, CHSWC has directed its efforts toward projects and studies to identify opportunities for improvement and to provide an empirical basis for recommendations and/or further investigations. CHSWC utilizes its own staff expertise combined with independent researchers with broad experience and highly respected qualifications.

At the request of the Executive Branch, the Legislature and the Commission, CHSWC conducts research, releases public reports, presents findings, and provides information on the health and safety and workers’ compensation systems.

CHSWC activities involve the entire health, safety and workers’ compensation community. Many individuals and organizations participate in CHSWC meetings and fact-finding roundtables and serve on advisory committees to assist CHSWC on projects and studies.

CHSWC projects address several major areas, including permanent disability (PD) ratings and related benefits, State Disability Insurance (SDI), return to work, carve-outs and medical fee schedules. Additional projects address benefits, medical costs and quality, fraud and abuse, streamlining of administrative functions, informational services to injured workers, alternative workers’ compensation systems, and injury and illness prevention. CHSWC also continually examines the impact of workers’ compensation reforms.

The most extensive and potentially far-reaching project undertaken by CHSWC is the ongoing study of workers’ compensation PD ratings. Incorporating public fact-finding hearings with studies by RAND, the CHSWC PD project analyzes major policy issues regarding the way that California workers are compensated for PD incurred on the job.

CHSWC engages in a number of studies and projects in partnership with other state agencies and the workers’ compensation community including: the Labor and Workforce Development Agency (LWDA); the Department of Industrial Relations (DIR); the Division of Workers’ Compensation (DWC); the California Department of Insurance (CDI); the Fraud Assessment Commission (FAC); the Governor’s Office of Homeland Security (OHS); the Bureau of Labor Statistics (BLS); the Department of Fair Employment and Housing (DFEH); the California HealthCare Foundation (CHCF); RAND; the National Academy of Social Insurance (NASI); and the International Association of Industrial Accident Boards and Commissions (IAIABC). CHSWC projects and studies are described in this report.
CHSWC Members Representing Employers

Catherine Aguilar

Catherine (Cathy) Aguilar is Workers’ Compensation Claims Manager for the San Francisco Unified School District. She has been active in the workers’ compensation industry for over 25 years, working her way up from the mail room to claims examiner, supervisor, manager, director and vice president of claims for a national third-party administrator (TPA). In addition, Ms. Aguilar worked for Costco Wholesale as regional director for the East Coast workers' compensation program and managed the workers' compensation program for the San Diego Schools Joint Powers Association.

Ms. Aguilar has been an active member of the California Coalition on Workers’ Compensation and is currently an active member of the San Diego Chapter of Risk Insurance Managers Association. She is also a member of the San Diego Public Agencies Risk Management Association (PARMA). Over the years, she has taught various courses for the Insurance Education Association.

Appointed by: Governor

Sean McNally

Sean McNally is the vice president of Corporate and Government Affairs for Grimmway Farms in Bakersfield, California. He is certified by the State Bar of California as a specialist in workers’ compensation law. He is a licensed general contractor and serves as a trustee for the Self Insurer’s Security Fund. His community activities include serving on the Kern Adult Literacy Council Board of Directors as the president, and as a member of the Board of Directors of the Golden Empire Gleaners and the Board of Trustees for Garces Memorial High School.

Mr. McNally is a graduate of the University of the Pacific, McGeorge School of Law and was a partner at the law firm of Hanna, Brophy, MacLean, McAleer and Jensen. He graduated from the University of San Francisco with Bachelor of Arts degrees in English and Theology. Following that, he did graduate studies at Hebrew University in Jerusalem, Israel.

Appointed by: Governor
### Kristen Schwenkmeyer

Kristen Schwenkmeyer is secretary-treasurer of Gordon & Schwenkmeyer, a telemarketing firm she started with Mike Gordon in March of 1985. Her primary responsibilities include overall administration of operations, budgeting and personnel for a staff of over 700.

Previously, Ms. Schwenkmeyer served as staff aide to Supervisor Ralph Clark of the Orange County Board of Supervisors and Senator John Glenn in Washington, D.C.

Ms. Schwenkmeyer received a Bachelor of Arts degree in Political Science from the University of California, Santa Barbara.

Appointed by: Senate Rules Committee

### Robert B. Steinberg

Robert B. Steinberg is a partner in the law offices of Rose, Klein & Marias and specializes in employee injury, third-party civil damage construction, product liability, asbestos and toxic exposure litigation. He is a fellow of the American College of Trial Lawyers (ACTL), a member of the Board of Governors of the Association of Trial Lawyers of America (ATLA), an advocate of the American Board of Trial Advocates (ABOTA), and a trustee of the Asbestos Litigation Group (ALG). He is a past president of the California Trial Lawyers (CTLA) (1985) and a past trustee of the Los Angeles County Bar Association (1987).

Mr. Steinberg received Law and Bachelor of Science degrees from the University of California, Los Angeles.

Appointed by: Speaker of the Assembly
CHSWC Members Representing Labor

**Faith Culbreath**

Faith Culbreath was asked in April 2009 by the Trustees of SEIU United Healthcare Workers West (UHW), a 150,000-member statewide local union, to head its External Affairs Department which includes building and promoting the Local’s Political Power and Community Strength program. Ms. Culbreath has been President of Security Officers United in Los Angeles (SOULA), Local 2006, of the Service Employees International Union (SEIU) since 2007.

Previously, Ms. Culbreath was a Field Campaign Coordinator for the Property Services Division of SEIU and worked on various national and global campaigns. She also played a key role during the 2002 “Justice for Janitors” contract strike in Boston and was prominent in the development of the new SEIU Property and Service Local 3 in Ohio, Michigan, Pennsylvania and Indiana. She served dual roles as Secretary-Treasurer as well as Detroit City Director.

Appointed by: Speaker of the Assembly

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**Darrel “Shorty” Thacker**

Darrel “Shorty” Thacker is the central district manager for the Northern California Carpenters’ Regional Council. Mr. Thacker also served as the director of field support operations for the Bay Counties District Council of Carpenters and as the senior business representative of Local 22, Carpenters.

Mr. Thacker joined the Millwrights in 1973, where he worked in construction as a journeyman, foreman, general foreman and superintendent from 1973 to 1978. He also worked as a Millwright business agent from 1978 to 1983.

Following his service as a United States Marine in the Vietnam War, Mr. Thacker earned an Associate of Arts degree in Mathematics from Fresno City College in 1970.

Appointed by: Governor
Angie Wei

Angie Wei is the legislative director of the California Labor Federation, the state AFL-CIO Federation. The state Federation represents 1,200 affiliated unions and over two million workers covered by collective bargaining agreements. Previously, Ms. Wei was a program associate for PolicyLine of Oakland, California, and advocated for the California Immigrant Welfare Collaborative, a coalition of four immigrant rights organizations that came together to respond to cuts in public benefits for immigrants as a result of the 1996 federal welfare reform law.

Ms. Wei holds a Bachelor of Arts degree in Political Science and Asian American Studies from the University of California, Berkeley and a Master of Arts degree in Public Policy from the Kennedy School of Government at Harvard University.

Appointed by: Senate Rules Committee
In the interest of California’s workers and employers, the Commission on Health and Safety and Workers’ Compensation (CHSWC) recommends ensuring the adequate and timely delivery of indemnity and medical benefits and eliminating unnecessary costs.

In addition, CHSWC strongly recommends that the State of California move toward developing an overall “culture of safety” in the workplace.

INDEMNITY BENEFITS

Past reforms made significant changes in indemnity benefit delivery, including temporary disability (TD) and permanent disability (PD) benefits and apportionment of PD.

Permanent Disability

An increase in PD compensation is expected for a number of reasons, including the fact that benefits were reduced more than anticipated at the time Senate Bill (SB) 899 was enacted, workers and their representatives have been advocating for a benefit increase, and the Division of Workers’ Compensation (DWC) has contemplated a 16 percent benefit increase in its 2008 proposal for revision of the permanent disability rating schedule (PDRS).

Research has demonstrated that benefits are not uniformly proportional to earnings losses either across the range of severity of disability ratings or across the range of pre-injury earnings. Benefits are disproportional to losses across the range of severity because benefits increase almost geometrically with increasing PD ratings, while average earnings losses increase in a more constant relation to increasing disability ratings. Benefits are disproportional to losses across the range of pre-injury earnings because the weekly maximum payment is so low that it usually does not reflect differences in the dollar amounts of losses for workers who may have the same percentage loss of earnings but who have different pre-injury earnings.

The distribution of PD benefits would be more equitable if, when a PD benefit increase is adopted, the increase is directed to cases with lower ratings and to workers with moderate or higher pre-injury earnings.

Recommendation

CHSWC recommends that, when PD compensation is increased, the distribution of the increased benefits should be determined in light of evidence of the distribution of the wage losses associated with permanent disabilities.

Temporary Disability

CHSWC recommends no change in TD statutes at this time. Weekly compensation is now two-thirds of pre-injury earnings, or approximately full replacement of lost net earnings loss, for 97 percent of all injured workers. The weekly rate is indexed for inflation without need for periodic legislative action. The maximum duration of benefits, formerly unlimited, has been reduced to two years for most injuries. Most cases require far less than the maximum duration, and some exceptions are provided by statute. Unless there is evidence that the limit is insufficient and that the limit can be amended without unintended consequences, there is no immediate reason to consider changing the duration of TD eligibility.

RETURN TO WORK

Research supports the observation that return to work (RTW) at the earliest appropriate time reduces the long-term wage loss of an injured worker and the costs borne by employers. CHSWC studies by RAND
found that California consistently had poor RTW rates for permanent workplace injuries when compared to other states. California's injured workers are far more likely to be out of work after their injury, and in the long run, the benefits do not compensate for the resulting lower earnings.

The 2003 and 2004 reforms contained three major provisions aimed at improving RTW: tiered PD benefits, the supplemental job displacement benefit (SJDB); and the RTW Reimbursement Program for smaller employers.

An updated study of RTW is being conducted by RAND under contract with CHSWC. Preliminary findings indicate that RTW has improved in recent years. The gains in RTW, however, started prior to 2003. The gains in RTW may have coincided with the first cases coming out of the 2001 expansion of the Fair Employment and Housing Act (FEHA). If the final report confirms that the 2003 and 2004 provisions to improve RTW have been ineffective, they should be repealed for the sake of simplicity and economy. The following recommendations are all made pending the publication of the research report, which is expected in 2010.

**Recommendations**

- Continue to promote a system that effectively and safely integrates injured workers back into the workplace at the earliest possible opportunity so that economic losses resulting from injuries may be reduced for both employers and employees. Coordinate workers' compensation with other programs that support RTW such as FEHA.

- Continue to evaluate and measure RTW.

- Review programs and improve or eliminate those that are ineffective. When programs are not achieving their purposes, consider whether to terminate them or revise them to make them effective. Specifically, if the tiered PD, SJDB, and RTW Reimbursement programs are shown to be ineffective when the current research is completed, then they should be eliminated.

- If the SJDB program and the Tiered Permanent Disability Benefit program ("bump-up/bump-down") are allowed to continue, consider recommendations from the CHSWC Report of the November 17, 2006 Return-to-Work Roundtable and the 2008 Administrative Director’s (AD’s) Return-to-Work Advisory Group, including the following changes to the RTW incentives that were adopted in the 2003 and 2004 reforms:
  - Make technical changes regarding the SJDB and tiered PD benefits, including coordinating the timelines for eligibility determinations and the timing of notices.
  - Explore specific requirements involving seasonal and temporary employment, as well as general and special employment.

**MEDICAL ISSUES**

Many reform provisions have already addressed medical and medical-legal issues. These included establishing medical networks, revising fee schedules, using medical treatment utilization guidelines, using a single qualified medical evaluator (QME) or agreed medical evaluator (AME) for medical-legal reports in each case, and requiring medical treatment to be provided while waiting for acceptance or rejection of a claim of occupational injury or illness. Despite those efforts, medical costs are again rising.
Medical Treatment Guidelines

The AD was required by statute enacted in 2003 to adopt a medical treatment utilization schedule (MTUS) in consultation with CHSWC. With participation by DWC, CHSWC conducted a study by RAND to evaluate treatment guidelines. As a result of that study and consistent with the subsequent report,\(^1\) CHSWC recommended that the MTUS should be initially based on the ACOEM Guidelines, 2nd edition, and augmented by additional topic-specific guidelines with continual review and updating. CHSWC also recommended that standards be adopted to determine appropriate treatment in situations where no guidelines are directly applicable. DWC adopted an MTUS on June 15, 2007, based on ACOEM Guidelines. DWC also added acupuncture guidelines effective June 15, 2007.

DWC is continuing to augment and update the MTUS. Effective July 18, 2009, DWC added new sections for chronic pain and for postsurgical physical medicine, updated the ACOEM Guidelines chapter on elbow disorders, and restructured the MTUS to facilitate future updates.

Recommendations

- Use stakeholder discussions and research to identify reasons for deviations from the guidelines so that inappropriate deviations can be prevented.
- Continue to evaluate the effect of the MTUS and identify its gaps or weaknesses so that it may be appropriately augmented and updated.
- Examine quality-management tools that may enhance quality of care and avoid unnecessary care while reducing the need for medical review of individual treatment recommendations.

Managing Medical Quality and Costs

California historically had higher-than-average medical costs with poorer-than-average outcomes, leading to the conclusion that medical costs were unnecessarily high. This general conclusion was supported by numerous more specific analyses. The 2003 and 2004 reforms produced an immediate reduction in medical expenses, but expenses have bottomed out and are again rising, according to data from the Workers’ Compensation Insurance Rating Bureau (WCIRB) and the California Workers’ Compensation Institute (CWCI). Throughout these changes, there have been concerns about the quality of medical care being provided to California’s injured workers, timely and expedient access to medical care, restraints on unnecessary care, and understanding of medical errors in the provision of care. Studies have shown that the quality of medical care in the United States is not high and that reporting quality-of-care information, either back to the providers or to consumers, can motivate providers to improve.

According to WCIRB, medical costs have increased significantly. In its January 2010 pure premium filing, WCIRB notes that since the full implementation of reforms in 2005, the average cost of the medical losses per claim have increased at a rate of 15 percent per year.

Recommendations

- Conduct further studies which are needed to determine what is driving medical costs.
- The AD should review the Official Medical Fee Schedule (OMFS) provision for pass-through of the cost of implantable spinal hardware payable in addition to the OMFS facility fee which already includes a component for hardware costs. Alternatives for consideration are:
  - Eliminate the pass-through or duplicate payment for spinal surgical hardware.
  - Reduce the pass-through to the estimated cost in excess of the allowance included in the OMFS rate.

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Reduce the OMFS multiplier to exclude the amounts implicit for hardware in Medicare’s payments rates in continuing to allow a pass-through or a fixed allowance for spinal hardware.

- The AD should review adopting a Medicare-based fee schedule for specialty hospitals. Modifications of the Medicare methodologies for the workers’ compensation patient populations may be needed, particularly with respect to workers’ compensation stays in rehabilitation and long-term care facilities.

- The AD should consider adopting a new Medicare-based fee schedule for ambulatory surgery center (ASC) services because ASC services are paid under a system that parallels the payment system for hospital outpatient services but at a lower rate (about 67 percent of the hospital rate). The AD has broad authority to establish different multipliers or conversion factors within the 120 percent aggregate cap. The AD should consider defining ASCs eligible for payment of facility fees to be more similar to the requirements of Medicare or other payors.

- The AD has already established the Medicare rate as a floor on evaluation and management (E/M) visits; further rate increases are appropriate for these services under a resource-based relative value fee schedule, but they should be accompanied by the adoption of Medicare’s documentation requirement for E/M visits.

- The OMFS should be modified to include explicit fees for activities that are unique to work-related injuries.

- Continue to evaluate costs, access and quality of care provided by medical provider networks (MPNs). Areas for consideration for improving the MPN process include:
  - Allow DWC to approve the medical provider entity instead of requiring each insurance carrier or self-insured employer to file an application to establish an MPN.
  - Provide increased monitoring of quality and access to medical care.
  - Implement an independent audit process to confirm representations made by MPN applicants.
  - Implement a periodic recertification process to assure continued compliance with requirements.

- Upon completion of the quality-of-care measurement demonstration project now underway, consider ways to translate the results of the project into an ongoing quality monitoring system for broader use. The demonstration project is being conducted by RAND and UCLA and funded by a partnership of CHSWC and Zenith Insurance Company. Results are expected in 2010.

**Improving the Quality of the QME System**

Existing law provides that medical issues of compensable injury, nature and extent of injury, capacity for RTW, permanent impairment, and apportionment are all addressed by medical-legal evaluations. Issues of appropriateness of particular medical treatments are addressed first by utilization review (UR), with recourse to medical-legal evaluation if the worker disputes a UR decision to delay, modify, or deny authorization for treatment. A medical-legal evaluation is performed by an AME if the worker is represented and the parties agree, otherwise by a QME selected from a panel of three assigned by DWC.

Problems exist due to delays in selecting evaluators, obtaining examinations, and producing the evaluation reports. Problems also exist with deficiencies in the content of reports that fail to comply with the legal standards or omit necessary components and thus necessitate supplemental reports. All of these problems contribute to increased frictional costs and delays in resolving disputes and delivering benefits to injured workers.
Recommendation

Seek ways to improve the medical-legal evaluation process:

- Invite stakeholder discussion of the causes of delays and the causes of inconsistencies and deficiencies in medical-legal reports.
- Consider research to identify the causes of delays and the causes of inconsistencies and deficiencies in medical-legal reports.

REDUCTIONS IN ADMINISTRATIVE COSTS

Liens

The number of lien filings increased by 190 percent from 248,602 in 2005, to 721,220 in 2007. Over 80 percent of the liens filed are for medical issues, such as medical necessity or billing disputes. This increase has resulted in expenditure of DWC staff resources on the resolution of those liens. Filing, processing, and adjudicating liens place an enormous burden on the already strained workers’ compensation courts and an administrative burden on the parties.

Recommendation

Invite stakeholder discussion and conduct data analysis where relevant to identify ways to reduce the need for liens and to reduce the filing of unnecessary liens.

Repeal of Ineffective RTW Programs

In another recommendation, it is suggested that programs intended to improve RTW should be repealed if they are ineffective. According to WCIRB data, elimination of the tiered PD benefit would save $192 million a year. Besides the cost for direct payments, each of the three RTW programs has its own administrative costs, such as the cost of staffing to adjudicate disputes over whether an RTW offer complies with the requirements of the tiered PD benefit or the slightly different requirements of the SJDB program.

Most strikingly, the RTW Reimbursement program, at an annual operating cost of $0.8 million, distributed only $8,744.44 in reimbursements over the two-year period from January 2, 2007, through December 15, 2003. Unless this program subsequently demonstrates its cost-effectiveness, the repeal of this program alone would save approximately $800,000 per year in administrative costs.

Recommendation

Review programs and improve or eliminate those that are ineffective. Specifically, if the tiered PD, SJDB, and RTW Reimbursement programs are shown to be ineffective when the current RTW research is completed, then they should be eliminated.

ANTI-FRAUD EFFORTS

Insurance fraud, including failure to carry workers’ compensation insurance, is a growing problem in our society, representing over $15 billion in losses each year in California alone, according to the Department of Insurance (CDI). Most people believe that insurance fraud is a victimless crime that does not affect them. In fact, it is a crime that costs lives and also funds criminal enterprises. Ultimately, fraud contributes to higher premium costs for everyone. Cutting the cost of fraud makes economic sense for
California. Nevertheless, fraud is elusive and increasingly difficult to detect as criminals become more sophisticated in their practices.

Ultimately, fraud must be prosecuted in the criminal justice system; however, there are many opportunities to detect potential fraud through various indicators. CHSWC participates in research and activities that identify and measure potential fraud by working closely with the Fraud Assessment Commission (FAC) and CDI to examine the extent of potential fraud in the workers’ compensation system and continue to make recommendations. Further information about anti-fraud efforts is available in the “Special Report: Fraud” and in the “Projects and Studies” sections of this report.

Workers’ Compensation Payroll Reporting by Employers

The cost of workers’ compensation insurance premium is based on the amount of an employer’s payroll. By misreporting payroll costs, some employers avoid the higher premiums they would incur with full reporting of payroll. Employers can also misreport total payroll or the number of workers in specific high-risk, high-premium occupation classifications by simply reporting them in lower-risk, lower-premium occupations. A CHSWC study found that as much as $60 billion in payroll were under-reported in 2004. A related study on split class codes found that 25 percent to 30 percent of low-wage payroll is under-reported or misreported.

Recommendations

- Focus more FAC funding on premium fraud enforcement.
- Raise the civil penalties for premium fraud.
- Develop a more systematic approach to detecting premium fraud.

Accuracy of Workers’ Compensation Insurance Coverage Information

Two previous CHSWC recommendations have been enacted to help enforce the requirement for all employers to secure the payment of compensation. Both programs require accurate data.

Pursuant to CHSWC recommendations, Senate Bill (SB) 869 was enacted in 2007, amending Labor Code Section 90.3 to establish a records matching program in the Division of Labor Standards Enforcement (DLSE) to identify employers who do not have a record of workers’ compensation coverage. Initial reports from that program show considerable success in indentifying uninsured employers and targeting them for enforcement actions. There are a number of errors, however, where insured employers are mistakenly identified as having no record of coverage.

Pursuant to CHSWC recommendations, Assembly Bill (AB) 483 was enacted in 2009 to establish an Internet site where viewers can determine if an employer has insurance. One of the concerns about this proposal has been the possibility of an employer being mistakenly reported as uninsured.

To optimize both of these programs and to facilitate enforcement of the requirement for all employers to secure the payment of compensation, the reasons for missing or mismatched information should be examined and processes should be adopted to assure the timeliness and accuracy of coverage data.

Recommendation

CHSWC recommends continuing examination of data quality problems and improvement of the reporting of employers’ coverage for workers’ compensation.
The Accuracy of Workers’ Compensation Injury Reporting by Claims Administrators, Employers and Insurers

Injury reporting is used by state and federal agencies to accurately calculate workers’ compensation insurance premiums, as well as to address injury and illness prevention efforts and related inspection activities. A CHSWC study of a large sample of Workers’ Compensation Information System (WCIS) data and Bureau of Labor Statistics (BLS) data found that 21 percent to 25 percent of lost-time injuries go unreported. Inaccurate injury reporting distorts the insurance premium calculations for employers and distorts systemwide and individual workplace risk assessments. Cost shifts may occur, attention to safety conditions may be misdirected, and policymakers may make misinformed resource decisions about workplace injury and illness prevention.

Recommendations

- Convene a task force to develop methods, procedures or incentives to improve injury reporting.
- Periodically monitor the magnitude of under-reporting by claims administrators, employers and insurers that must report to the agencies that collect the data.

INFORMATION FOR INJURED WORKERS AND EMPLOYERS

Injured workers, employers, and the public need up-to-date and easily accessible information about the workers’ compensation system.

Recommendations

- Update informational publications as needed.
- Improve benefit notices process.
- Continue to provide easily accessible and updated information on the CHSWC website.
- Make information available in several languages in addition to English and Spanish, such as Chinese, Vietnamese, Tagalog and Korean.

CALIFORNIA INSURANCE INDUSTRY

Workers’ compensation premiums fell after the early 1990s reforms, only to rise sharply, almost tripling by the second half of 2003, before dropping back by early 2009 to match the 1999 low. As prices were climbing, however, more than two dozen insurers became insolvent. AB 316, enacted in 2007, mandates CHSWC to conduct a study of the causes of those insolvencies. In June 2008, CHSWC awarded a contract to RAND to conduct the study. The final report of the study is expected in December 2009.

Recommendation

CHSWC defers recommendations on the California Insurance Industry until the final report of the research project, currently underway, examining insurance market volatility and the causes of a rash of insolvencies, is issued.
UNINSURED EMPLOYERS BENEFITS TRUST FUND

All employers in California are required to provide workers’ compensation coverage for their employees through the purchase of workers’ compensation insurance or by being certified by the State as permissibly self-insured.

Since not all employers comply with the law to obtain workers’ compensation coverage for their employees, the Uninsured Employers Benefits Trust Fund (UEBTF) was established to provide for the payment of workers' compensation benefits to injured employees of illegally uninsured employers. As of 2004, Fund losses previously incurred by the State's General Fund are now incurred by the UEBTF and are now funded by a surcharge on all insured employers and self-insured employers, by penalties to non-compliant employers, and by recoveries from uninsured employers for actual worker injuries.

The workers’ compensation community has expressed concern with several aspects of UEBTF. Employers are concerned about the cost of UEBTF and the distribution of that cost among law-abiding employers. Workers, along with the attorneys and medical providers to whom they turn for help, are concerned about the difficulties of obtaining benefits from UEBTF. Chief among those difficulties is the need to accurately identify the employer and serve the employer.

Recommendations

- Continue to improve methods to help workers access benefits from UEBTF:
  - Develop a simplified guide on the UEBTF claims process for injured workers.
  - Educate Information and Assistance (I&A) Officers on UEBTF procedures to improve access for injured workers.

- Encourage reporting of suspected illegally-uninsured employers:
  - Facilitate prompt referral of uninsured employers to appropriate enforcement agencies through mechanisms such as mandatory reporting. For example, require medical providers to report suspected uninsured employers to CDI on the FD-1 fraud form.
  - Develop a standard form and a “hotline” for whistleblowers to report to Division of Labor Standards Enforcement (DLSE) employers who are uninsured or committing other labor law violations.

- Improve reporting. Continue to improve the data matching program authorized by SB 869 to systematically identify unlawfully insured employers by providing a more detailed explanation of the methodology and more clearly reporting annual findings.

WORKERS’ COMPENSATION ADMINISTRATION

DWC administers the workers’ compensation system in California. It is responsible for adopting regulations pursuant to delegations of legislative power. DWC is also responsible for enforcement, adjudication and data collection. CHSWC has collaborated with DWC on numerous studies and projects. To further DWC’s mission to minimize the adverse impact of work-related injuries on California employees and employers, CHSWC recommends strengthening and streamlining DWC’s oversight role.

Recommendations

- DWC should resume publishing the promptness of first payment reports on insurance carriers. This was a simple way to motivate carriers to improve their compliance with legal requirements.

- DWC should require electronic filing, rather than paper filing, with the Department of Industrial Relations (DIR) Division of Labor Statistics and Research (DLSR), the Employer’s Report of Occupational Injury or Illness (DLSR Form 5020) and the Doctor’s First Report of Occupational Injury or Illness (DLSR Form 5021). This will save money on paper, postage and manual processing.
CHSWC RECOMMENDATIONS

- DWC should implement expeditiously the following regulations:
  - Update medical cost reporting.
  - Implement electronic billing.
  - Update coding for doctor’s payments by converting from the current physician fee schedule to Medicare’s Resource Based Relative Value Scale (RBRVS) system.
  - Adopt regulations to implement pharmacy networks pursuant to Labor Code Section 4600.2.
- Conduct a review of WCIS to ensure that it captures the relevant data elements for measurement and analysis of the California workers’ compensation system. Confining the elements to the International Association of Industrial Accident Boards and Commissions (IAIABC) specification may be limiting the ability to analyze unique features of the California system.
- Develop and adopt penalty regulations for failure to report data to WCIS after getting legislative authority, if necessary.
- Conduct a comprehensive review of the statutory requirements for benefit notices to ensure consistency, coordination, streamlining and improved customer service.

HEALTH AND SAFETY

CHSWC recognizes that injury and illness prevention is the best way to preserve workers’ earnings and to limit increases in workers’ compensation costs to employers.

One of the most proactive efforts undertaken by CHSWC is the Worker Occupational Safety and Health Training and Education Program (WOSHTEP) which trains and educates workers, including young workers, in the fields and in a wide range of workplaces on proven injury and illness prevention measures. WOSHTEP has recently expanded its presence into Central California and is now a statewide program that deserves continued support by employers and the state university systems.

CHSWC also recognizes that there will always be more that can be done to improve the injury and illness prevention culture and understand safety and health behaviors, especially in traditionally or emerging high-risk environments/occupations. As a result of CHSWC convening health and safety experts in 2008 to develop a safety and health research agenda, California is one step closer to understanding obstacles and opportunities in improved safety and health.

In 2009-2010, the following projects and studies by leading researchers in the country will be underway:

- The Impact of Worker’s Compensation Experience Modification Rating (Ex-mod) and Firm Age on Safety Behavior and Risk.
- Evaluation of the Effectiveness of California’s Injury and Illness Prevention Program and Compliance Officers’ Inspections.
- Experimental Evidence on the Causal Effect of Cal/OSHA Inspections on Workplace Employees and Employers.
- Firefighters Musculoskeletal Injuries.
- Schools Injury and Illness Prevention Program Project.
CHSWC RECOMMENDATIONS


CHSWC expects that the results of these projects and studies will yield important recommendations which may be adopted in full or in part to inform future research and action, leading to policy or administrative change to improve the health and safety and workers’ compensation systems in California.

Recommendation

CHSWC defers recommendations on improving workplace health and safety until results of these projects and studies are available.

INTEGRATION OF GROUP HEALTH AND WORKERS’ COMPENSATION MEDICAL CARE

Group health costs have been rising much more quickly than inflation and wages. Worker’s compensation medical costs have been rising even more quickly. These costs create financial challenges for employers, especially those in industries with already high workers’ compensation costs. Furthermore, group health care and workers’ compensation medical care are typically delivered through separate provider systems, resulting in unnecessary, duplicative and contraindicated treatment, and inefficient administration.

Suggestions have been made to integrate workers’ compensation medical care with the general medical care provided to patients by group health insurers in order to improve the quality and coordination of care, lower overall medical expenditure, reduce administrative costs, and derive other efficiencies in care. Research also supports the contention that an integrated 24-hour care system could potentially provide medical cost savings, as well as shorten the duration of disability for workers.

Recommendations

- Evaluate the results of a pilot which integrated occupational and non-occupational treatment in a carve-out agreement between DMS Facility Services and the Service Employees International Union (SEIU) Local 1877.
- Evaluate the administrative and overhead cost of delivering occupational medical care under workers’ compensation insurance.
- Disseminate the results of the evaluation and the opportunities and challenges of implementing an integrated occupational and non-occupational medical treatment and insurance product.
- Develop and provide specific details and resources on integrated care for unions and employers interested in carve-out programs.
HEALTH AND SAFETY

Health and Safety Legislation

The following describes the only health and safety bill that was signed into law in 2009.

**SB 478 - Senator Wolk**
**Amends Section 7311.1 of, and adds Section 7311.25 to, the Labor Code**
**Employment safety: manlifts**
**Status: Enrolled 9/4/09 and Signed 10/11/09.**

Existing law requires that a conveyance, as specified, be erected, constructed, installed, altered, tested, maintained, serviced, and repaired by a person certified by the Division of Occupational Safety and Health as a certified competent conveyance mechanic.

This bill requires that an elevator company disclose its status as a certified qualified conveyance company prior to bidding on a project or contracting for services. The bill authorizes the owner or operator of agricultural production, processing, and handling facilities, as defined, to designate a competent employee who is not required to be a certified competent conveyance mechanic to maintain and test, as specified, the manlifts used at the facilities.

Health and Safety Regulations

The regulatory activities of Department of Occupational Safety and Health (DOSH) are outlined below. Formal rulemaking is preceded by a notice, the release of a draft rule and an announcement for a public hearing. This update covers only recent administrative regulations. Regulations in Title 8 of the California Code of Regulations (CCR) can be found online at:

http://www.dir.ca.gov/samples/search/query.htm

Occupational Safety and Health Standards Board approved standards are at:

http://www.dir.ca.gov/OSHSB/apprvd.html

The latest formal rulemaking updates are available at:

http://www.dir.ca.gov/OSHSB/proposedregulations.html

NOTE: CHSWC does not list all the Standards Board regulations from the past year, only new Division of Occupational Safety and Health administrative regulations. In 2009, there were no changes to Chapter 3.2. California Occupational Safety and Health Regulations, subchapter 2 at:

https://www.dir.ca.gov/title8/ch3_2sb2.html
WORKERS’ COMPENSATION

Workers’ Compensation Legislation

The following describes the workers’ compensation bills that were signed into law in 2009.

ABX 412 - Assembly Member Evans
Amend Sections 62.5 and 4352 of the Labor Code (among other codes)
State government (various statutory changes related to the budget)
Status: Enrolled 7/24/09 and Chaptered 7/28/09.

Existing law establishes the Division of Labor Standards Enforcement within the Department of Industrial Relations. Under existing law, the division enforces specified provisions of law relating to private employment.

This bill creates the Labor Enforcement and Compliance Fund as a special account in the State Treasury. Monies in the fund may be expended by the department, upon appropriation by the Legislature, for the support of the activities that the Division of Labor Standards Enforcement performs pursuant to this division and Division 2 (commencing with Section 200), Division 3 (commencing with Section 2700), and Division 4 (commencing with Section 3200). The fund will rely on separate surcharges levied by the director upon all employers. The total amount of the surcharges will be allocated between employers in proportion to payroll respectively paid in the most recent year for which payroll information is available. The director is to adopt regulations governing the manner of collection of the surcharges. The total amount of the surcharges paid by employers may not exceed the amounts necessary to carry out the purposes of section 62.5 and will adjust to reconcile any over/under assessments from previous fiscal years along with inflation adjustments.

This bill also amends the surcharge limits on the Occupational Safety and Health Fund which was created the previous year in section 62.5 and adjusts surcharges to reconcile any over/under assessments from previous fiscal years along with inflation adjustments through fiscal year 2013-14.

Under existing law in section 4352, workers' compensation is the exclusive remedy of a disaster service worker, or his or her dependents, for injury or death arising out of, and in the course of, his or her activities as a disaster service worker. Under that law, no compensation may be paid or furnished to a disaster service worker or the worker's dependent except from money appropriated for the purpose of furnishing compensation to disaster service workers and their dependents. Liability for the payment or furnishing of compensation is dependent upon and limited to the availability of money so appropriated.

This bill instead provides that workers' compensation may not be paid or furnished to a disaster service worker absent an initial appropriation of funds for that purpose, and that if appropriated funds are not available, the State Compensation Insurance Fund may provide compensation to an eligible claimant whose injuries have previously either been accepted or found to be compensable by the Workers' Compensation Appeals Board. The bill requires the California Emergency Management Agency to reimburse the fund when an appropriation becomes available.

AB 48 - Assembly Member Portantino
Amends Sections 27, 101, 146, 149, and 473.1 of the Business and Professions Code, adds Chapter 8.5 (commencing with Section 95000) to, and adds and repeals Chapter 8 (commencing with Section 94800) of the Education Code
Private postsecondary education: related to workers’ compensation programs (among other educational programs)

The former Private Postsecondary and Vocational Education Reform Act of 1989 had been repealed.
This bill creates a new successor agency charged with certifying vocational training entities and will also confirm which ones qualify for Supplemental Job Disability Benefit reimbursement.

**AB 361 - Assembly Member Bonnie Lowenthal (Coauthors: Assembly Members Ammiano, Coto, and Torlakson)**

*Adds Section 4610.3 to the Labor Code*

**Workers' compensation: treatment authorization**

**Status:** Enrolled 9/9/09 and Signed 10/01/09.

Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services.

Existing law authorizes an employer or insurer to establish or modify a medical provider network for the provision of medical treatment to injured employees, and to submit a medical provider network plan to the administrative director for approval. Existing law permits employers to enter into contracts for the provision of medical services to injured employees with a health care organization that has been certified by the administrative director for this purpose.

This bill provides that, regardless of whether an employer has established a medical provider network or entered into a contract with a health care organization, an employer that authorizes medical treatment shall not rescind or modify the authorization for the portion of the medical treatment that has been provided after that treatment has been provided for any reason, including, but not limited to, the employer's subsequent determination that the physician who treated the employee was not eligible to treat that injured employee. This bill provides that its provisions shall not be construed to expand or alter the benefits available under, or the terms and conditions of, any contract, including, but not limited to, existing medical provider network and health care organization contracts. The bill also provides that its provisions shall not be construed to impact the ability of the employer to transfer treatment of an injured employee into a medical provider network or health care organization.

The bill further provides that its provisions shall not be construed to establish that a provider of authorized medical treatment is the primary care physician for specified purposes.

**AB 409 - Assembly Member Garrick**

*Amends Section 1063.5 of the Insurance Code*

**California Insurance Guarantee Association (CIGA) and premium payment collections**

**Status:** Enrolled 7/30/09 and Signed and Chaptered on 8/6/09.

Existing law requires the California Insurance Guarantee Association (CIGA) to collect premium payments from member insurers sufficient to cover the obligations of an insurer that has become insolvent.

Under existing law, the rate of premium charged a member insurer is a uniform percentage of the net direct written premium of the insurer in the preceding calendar year. Existing law provides that the initial premium charge shall be adjusted by applying the same rate of premium charge as initially used to each insurer's written premium as shown on the annual statement for the 2nd year following the year in which the initial premium charge is made.

This bill instead provides that the initial premium charge shall be adjusted by applying the same rate of premium charge as initially used to each insurer's written premium as shown on the annual statement for the 2nd year following the year on which the initial premium charge was based.
AB 470 – Assembly Member Niello
Amends Section 791.13 of the Insurance Code
Insurance information: confidentiality.
Status: Enrolled on 7/30/09 and Signed and Chaptered on 8/6/09.

Existing law prohibits insurance institutions, agents, or insurance-support organizations from disclosing
personal or privileged information collected in connection with an insurance transaction unless a specified
exception applies.

This bill would authorize the disclosure of information from an accident report, supplemental report, or
investigative report to an insured's lawyer if the insured is otherwise entitled to obtain the report, as
specified.

AB 483 - Assembly Member Buchanan (Coauthors: Assembly Members De La Torre, De Leon,
Jones, Lieu, and Portantino)
Adds Section 11752.75 to the Insurance Code
Workers’ compensation: Internet web sites

Existing law provides that a licensed rating organization shall make available specified policy information
relating to workers' compensation insurance, as specified.

This bill provides that a licensed rating organization shall, pursuant to regulations adopted by the
Insurance Commissioner after notice and hearing, establish and maintain an Internet Web site, as
specified, for the purposes of assisting any person to determine whether an employer is insured for
workers' compensation.

This bill specifies who may submit an inquiry and for what purpose, what information shall be available on
the Internet Web site, and provides that a rating organization is not required to disclose, on the Internet
Web site, certain specified information or confidential information, as specified.

This bill requires that the Internet Web site be operational within one year after adoption of regulations by
the commissioner, and be updated as specified. This bill requires the Insurance Commissioner to adopt
regulations to implement this act and provide for dispute resolution regarding the accuracy of the
information displayed on the Internet Web site.

This bill requires the Insurance Commissioner to conduct a review, evaluation, and assessment of the
Internet Web site, as specified, to provide a written report no later than July 1, 2013, of his or her findings
to various state legislative and executive entities, and to make the report available on its own Internet
Web site.

AB 1093 - Assembly Member Yamada
Amends Section 3600 of the Labor Code
Workers’ compensation: personal characteristics of employees and injuries incurred by
employees that arise out of, and in the course of, employment

Existing workers’ compensation law generally requires employers to secure the payment of workers’
compensation, including medical treatment, for injuries incurred by their employees that arise out of, and
in the course of, employment.

This bill provides that for purposes of determining whether to grant or deny a workers' compensation
claim, if an employee is injured or killed by a 3rd party in the course of the employee’s employment, no
personal relationship or personal connection shall be deemed to exist between the employee and the 3rd
party based only on a determination that the 3rd party injured or killed the employee solely because of the
3rd party's personal beliefs relating to his or her perception of the employee's race, religious creed, color, national origin, age, gender, disability, sex, or sexual orientation.

**AB 1117 - Assembly Member Fuentes**  
Amends Section 11770 of the Insurance Code  
State Compensation Insurance Fund Board and conflict of interest  
Status: Chaptered on August 6, 2009.

Existing law establishes the State Compensation Insurance Fund (State Fund) to be administered by a board of directors for the purpose of transacting workers' compensation insurance and other public employment-related insurances, as specified. Under existing law, the members of the board are prohibited from having a financial conflict of interest, as defined.

This bill provides that, for purposes of board actions affecting generally applicable rates, a member of the board of directors shall not be deemed to have a financial interest, as defined in the Political Reform Act of 1974 and pursuant to specified government contracting conflict of interest provisions, in a contract of insurance between the State Compensation Insurance Fund and an organization of which any member of the board of directors is an owner, officer, or employee.

This bill declares that it is to take effect immediately as an urgency statute.

**AB 1227 - Assembly Member Feuer**  
Amends Section 4850 of the Labor Code  
Workers' compensation: public employees: leaves of absence.  

Existing workers' compensation law requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, and in the course of, employment.

Existing law generally provides that whenever certain public employees who are members of the Public Employees' Retirement System or the Los Angeles City Employees' Retirement System or subject to the County Employees Retirement Law of 1937 are disabled, whether temporarily or permanently, by injury or illness arising out of, and in the course of, their duties, they are required to become entitled, regardless of their period of service with the public employer, to a leave of absence while so disabled without loss of salary in lieu of temporary disability payments or maintenance allowance payments, if any, that would be payable for the period of disability, but not exceeding one year, or until that earlier date as he or she is retired on permanent disability pension, and is actually receiving disability pension payment, or certain advanced disability pension payment.

This bill, for purposes of these provisions, requires that these employees be employed on a regular, full-time basis, but eliminates the requirement that these employees be members of the Public Employees' Retirement System or the Los Angeles City Employees' Retirement System or subject to the County Employees Retirement Law of 1937. The bill provides that the provisions pertaining to a leave of absence shall not apply to certain public safety personnel who are employees of the City and County of San Francisco.

**AB 1499 - Assembly Member Evans**  
Adds and Repeals Section 19605.78 of the Business and Professions Code  
Horse racing and workers' compensation  
Status: Chaptered on August 6, 2009.

Existing law, until January 1, 2014, authorizes a quarter horse racing association to deduct an additional 0.5 percent of the total amount handled in its exotic parimutuel pools and a harness racing association to deduct an additional 1 percent of the total amount handled in conventional parimutuel pools of harness races, under certain conditions, for workers' compensation insurance costs of trainers and owners, as
specified, with any funds not expended for this purpose in the year in which they are collected to either be used for the following year's workers' compensation costs or to benefit the purse pool, as specified. If the racing association and the organization representing horsemen and horsewomen cannot agree on the manner of distribution of these funds to defray the costs of workers' compensation insurance, the matter is required to be submitted to the California Horse Racing Board for a decision.

This bill also authorizes a fair to deduct an additional 0.5 percent of the total amount handled in exotic parimutuel pools of races for any breed, other than races solely for thoroughbreds. This deduction also is to be for similar purposes and subject to similar conditions as the quarter horse racing association and harness racing association authorizations discussed above. This authorization also expires on January 1, 2014.

This bill declares that it is to take effect immediately as an urgency statute.

**SB 186 - Senator DeSaulnier**
Amends, repeals, and adds Section 4600 of the Labor Code  
Workers' compensation: medical treatment: predesignation of physician  

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment. Existing law, until December 31, 2009, provides an employee with the right to be treated by his or her personal physician from the date of injury if specified requirements are met, including a requirement that the physician agrees to be predesignated.

This bill deletes the December 31, 2009, repeal date for those provisions pertaining to an employee's predesignation of a personal physician.

**SB 313 – Senator DeSaulnier**
Amends Section 3722 of the Labor Code  
Workers' compensation: penalty assessments.  
Status: Enrolled 10/13/09 and Signed 11/2/09.

Existing law requires the Director of Industrial Relations to issue and serve on any employer that has failed to secure the payment of workers' compensation a stop order prohibiting the use of employee labor.

Under existing law, at the time the stop order is issued and served, the director is required to issue and serve a penalty assessment order requiring the uninsured employer to pay to the director, for deposit into the State Treasury to the credit of the continuously appropriated Uninsured Employers Benefits Trust Fund, the sum of $1,000 per employee employed at the time the order is issued and served. Existing law provides that in lieu of the aforementioned penalty assessment, at any time that the director determines that an employer has been uninsured for a period in excess of one week during the calendar year preceding the director's determination, the director may issue and serve a penalty assessment order that requires the uninsured employer to pay to the director, for deposit into the State Treasury to the credit of the Uninsured Employers Benefits Trust Fund, the greater of (1) twice the amount the employer would have paid in workers' compensation premiums during the period the employer was uninsured or (2) the sum of $1,000 per employee employed during the period the employer was uninsured.

This bill increases the penalty assessment to $1,500 per employee employed during the period the employer was uninsured. Because the money from the increased penalty assessment is deposited into the continuously appropriated Uninsured Employers Fund, this bill makes an appropriation.

The bill clarifies that the director is required to issue and serve either of the above-mentioned penalty assessments.
This bill also provides that if the employer is uninsured at the time the above penalty is being determined, the amount an employer would have paid in workers’ compensation premiums shall be the product of the employer's payroll for all periods of time the employer was uninsured within the three-year period immediately prior to the date the above penalty assessment is issued multiplied by a rate determined in accordance with regulations that may be adopted by the director or, if none have been adopted, the manual rate or rates of the State Compensation Insurance Fund for the employer's governing classification, as determined by the director, pursuant to the standard classification system approved by the Insurance Commissioner. This bill provides that, unless the amount of the employer's payroll for all periods during which the employer was uninsured within the three-year period is otherwise proven by a preponderance of evidence, the employer's payroll for each week the employer was uninsured shall be presumed to be the state average weekly wage, as defined, multiplied by the number of persons employed by the employer at the time the penalty assessment is issued.

Workers' Compensation Regulations

The regulatory activities of the Division of Workers' Compensation (DWC) to implement the provisions of the recent workers' compensation reform legislation are outlined below. Formal rulemaking is often preceded by the release of a draft rule and the opening of an online forum for interested parties to post comments. This update covers only recent regulations. Older regulations can be found in previous Commission on Health and Safety and Workers' Compensation (CHSWC) annual reports which are available online at http://www.dir.ca.gov/chswc.

Information about these preliminary activities is available at http://www.dir.ca.gov/Wcjudicial.htm.

The latest formal rulemaking updates are available at www.dir.ca.gov/DWC/DWCrulemaking.htm.
### Assembly Bill 1073

<table>
<thead>
<tr>
<th>AB 1073 Mandates/Tasks</th>
<th>Status of Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Labor Code Sections (LC§§) 5307.27, 4604.5</strong></td>
<td><em>Status</em>: Regulations completed. Filed with Secretary of State June 18, 2009. Effective July 18, 2009.</td>
</tr>
<tr>
<td><strong>Medical Treatment Utilization Schedule – Chronic pain medical treatment guidelines, postsurgical treatment guidelines evidence-based reviews, chronic pain medical treatment guidelines DWC’s and ODG’s references, and postsurgical treatment guidelines ODG’s references</strong></td>
<td><a href="http://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS_Regulations/MTUS_Regulations.htm">http://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS_Regulations/MTUS_Regulations.htm</a></td>
</tr>
<tr>
<td></td>
<td>8 CCR Sections 9792.20 - 9792.26</td>
</tr>
<tr>
<td></td>
<td>The Medical Treatment Utilization Schedule (MTUS) was amended and definitions were updated.</td>
</tr>
<tr>
<td></td>
<td>The postsurgical treatment guidelines provide that the 24-visit cap on physical medicine services shall not apply to visits for postsurgical physical medicine and rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the Administrative Director (AD).</td>
</tr>
<tr>
<td></td>
<td>The postsurgical treatment guidelines define key terms commonly used in the regulations, address the application of the postsurgical treatment guidelines, address postsurgical patient management, set forth the postsurgical patient treatment approach, and describe the indications, frequency and duration of postsurgical treatment, and chronic pain guidelines are similarly defined and addressed for chronic pain management and treatment.</td>
</tr>
</tbody>
</table>

### Senate Bill 899

<table>
<thead>
<tr>
<th>SB 899 Mandates/Tasks</th>
<th>Status of Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LC §§4600.3 et seq., 4600.5, 4600.6 and 4600.7</strong></td>
<td><em>Status</em>: Regulations in process. A public hearing was held on July 27, 2009. Expected effective date 1/1/10.</td>
</tr>
<tr>
<td><strong>Health Care Organizations (HCOs)</strong></td>
<td><a href="http://www.dir.ca.gov/dwc/DWCPPropRegs/hco/HCO_Regulations.htm">http://www.dir.ca.gov/dwc/DWCPPropRegs/hco/HCO_Regulations.htm</a></td>
</tr>
<tr>
<td></td>
<td>8 CCR Sections 9771, 9778, 9779, 9779.5, and 9779.9</td>
</tr>
<tr>
<td></td>
<td>To reduce the certification application fee and recertification fee and remove redundant data collection requirements.</td>
</tr>
<tr>
<td>SB 899 Mandates/Tasks</td>
<td>Status of Regulations</td>
</tr>
<tr>
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</tbody>
</table>
| **Medical Provider Network (MPNs)** | Status: Regulations in process. A public hearing was held on October 8, 2009.  
8 CCR Sections 9767.3, 9767.6, 9767.8, 9767.12, 9767.16, 9880, 9881, 9881.1, 10139  
Proposes amendments to medical provider network (MPN) regulations. The proposed amendments will streamline the existing MPN notification process primarily by shortening required notices, allowing flexibility in distribution of notices, and by reducing filings with the division.  
The regulations also propose amending the employee information form, and Workers’ Compensation Claim Form (DWC 1) and notice of potential eligibility (NOPE) regulations. The proposed amendments also clarify other filing requirements and update the DWC workers’ compensation poster, the initial employee notice, and the NOPE form to reflect changes to benefits and to include MPN information. |
http://www.dir.ca.gov/dwc/DWCPPropRegs/qme_regulations/qme_regulations.htm  
8 CCR Sections 1 - 159  
Qualified Medical Evaluator (QME) definitions and procedures were updated.  
Qualified Medical Evaluator (QME) Forms 105 (Request for QME Panel – Unrepresented) and 106 (Request for QME Panel – Represented) and the Attachments to Form 105 (How to Request a QME if You Do Not Have an Attorney) and to Form 106 (How to Request a QME in a Represented Case) are revised.  
QME Form 121 (Declaration Regarding Protection of Mental Health Record) and QME Form 122 [Agreed Medical Evaluator (AME) or QME Declaration of Service of Medical-Legal Report] are created. |
<table>
<thead>
<tr>
<th>SB 899 Mandates/Tasks</th>
<th>Status of Regulations</th>
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</thead>
</table>
| Sunsets: December 31, 2009 | **8 CCR Sections 9780 through 9783.1**  
An employee may pre-designate his or her personal physician if the employee notifies the employer prior to the date of injury that he or she has a personal physician and if the employer offers non-occupational group health coverage.  
If the worker fails to properly pre-designate a personal physician prior to injury, he or she will not be able to do so after the injury occurs.  
If an injured worker does not properly pre-designate his or her personal physician, the employer will have the control over the employee’s medical treatment for the first 30 days from the date the injury is reported.  
Alternatively, if the employee whose employer has a medical provider network (MPN) fails to properly designate his or her personal physician, the employee will be required to get treatment within the MPN for the course of the injury.  
If the employee has properly pre-designated a personal physician, referrals made by that physician need not be within an MPN. |
<table>
<thead>
<tr>
<th>SB 899 Mandates/Tasks</th>
<th>Status of Regulations</th>
</tr>
</thead>
</table>
| LC §4616 Medical Provider Networks | **Status:** Regulations completed. Emergency regulations effective November 1, 2004. Permanent regulations effective September 15, 2005.  

http://www.dir.ca.gov/dwc/dwcpregmpreg.htm  

8 CCR Sections 9767.1 et seq.  

Regulations specify the requirements for a medical provider network (MPN), the MPN application process, access standards, the second-and third-opinion process, the procedure to modify an MPN, the process to transfer ongoing care into and within the MPN, the employer-notification requirements, and the procedures concerning the denial of an MPN plan or the suspension or revocation of an MPN plan.  

**Effective April 9, 2008:**  

A new definition of the term “cessation of use” was added as subdivision (a)(2). The added definition states that “cessation of use” means the discontinued use of an implemented MPN that continues to do business.  

A new definition of the term “termination” was added as subdivision (a)(25). The added definition states that the term “termination” means the discontinued use of an implemented MPN that ceases to do business.  

The other subdivisions were re-lettered to accommodate these additions. These amendments were necessary to provide definitions for the regulated public and to differentiate between the terms “cessation of use” and “termination.” |
<table>
<thead>
<tr>
<th>SB 899 Mandates/Tasks</th>
<th>Status of Regulations</th>
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<tbody>
<tr>
<td><strong>LC §4660</strong></td>
<td><strong>Status:</strong> Revised regulations in progress. Public hearings on 7/21/08 and 7/22/08. Time for completion of regulations elapsed. <strong>Status:</strong> Regulations Completed. Emergency regulations effective January 1, 2005. Permanent regulations effective June 10, 2005. <a href="http://www.dir.ca.gov/dwc/dwcpregs/PDRSRegs.htm">http://www.dir.ca.gov/dwc/dwcpregs/PDRSRegs.htm</a> <strong>8 CCR Section 9725 et seq.</strong> The Permanent Disability Rating Schedule (PDRS) adopts and incorporates the American Medical Association (AMA) <em>Guides to the Evaluation of Permanent Impairment, 5th Edition</em>. The PDRS includes multipliers ranging from 1.1 to 1.4, depending on type of injury, to adjust AMA impairment to reflect diminished future earning capacity. The PDRS is effective for dates of injury on or after January 1, 2005, and for dates of injury prior to January 1, 2005, in accordance with subdivision (d) of Labor Code §4660. The PDRS shall be amended at least once every five years. The Administrative Director (AD) shall (1) collect 2005 PDRS ratings for 18 months, (2) evaluate the data to determine the aggregate effect of the diminished future earning capacity adjustment on the permanent partial disability ratings under the 2005 PDRS, and (3) revise, if necessary, the diminished future earning capacity adjustment to reflect consideration of an employee's diminished future earning capacity for injuries based on the data collected.</td>
</tr>
<tr>
<td><strong>Permanent Disability Rating Schedule Revision</strong> (continued)</td>
<td><strong>Effective May 2008:</strong> Regulations in process. Time for completion of regulations elapsed. Notice of Rulemaking issued and public hearings were held on July 21 and 22, 2008. Following adoption of the 2005 PDRS, DWC gathered 18 months of data on return to work and wage loss and conducted a comprehensive study. The rulemaking proposes to amend the current future earning capacity adjustment and the current age adjustment in the PDRS to reflect empirical data on wage loss.</td>
</tr>
</tbody>
</table>
## SB 899 Mandates/Tasks

<table>
<thead>
<tr>
<th>SB 899 Mandates/Tasks</th>
<th>Status of Regulations</th>
</tr>
</thead>
</table>
| **LC §5814.6**<br>Penalty for Business Practice of Unreasonable Delay in Payment of Compensation | **Status:** Regulations completed. Final regulations effective May 26, 2007.  
http://www.dir.ca.gov/DWC/DWCPropRegs/AdminPenalties_LC5814_6Regulations/LC5814_6Regulations.htm  
**8 CCR Sections 10225 – 10225.2**  
Penalties are specified for the following particular violations of Labor Code §5814:  
1. $100,000 for a finding of knowing violation with a frequency indicating a general business practice;  
2. $30,000 for each finding by a workers' compensation judge of failure to comply with an existing award;  
3. $5,000 to $15,000, depending on duration, for delay in payment of temporary disability benefits;  
4. $1,000 to $15,000, depending on severity, for each penalty award by a workers' compensation judge for unreasonably denying authorization for treatment or failing to reimburse an employee for self-procured treatment;  
5. $2,500 for each penalty award by a workers' compensation judge for failure to provide a notice or training voucher regarding a supplemental job displacement benefit (SJDB) in a timely manner;  
6. $2,500 for each penalty award by a workers' compensation judge for failure to reimburse an injured worker for supplemental job displacement services, or where a failure to pay the training provided results in an interruption of training;  
7. $1,000 to $15,000, depending on duration, for each penalty award by a workers' compensation judge for failure to make timely payment of permanent disability benefits;  
8. $2,500 for each penalty award by a workers' compensation judge for any other violation of Labor Code §5814. |
| **LC §5814.6**<br>Penalty for Business Practice of Unreasonable Delay in Payment of Compensation (continued) | The Administrative Director (AD) may charge penalties under both Labor Code §129.5 (including failure to pay undisputed portion of indemnity or medical treatment) and §5814 (unreasonable delay in payment of compensation); however, only one penalty may be imposed following the hearing on such charges.  
The AD may mitigate a penalty based on consideration of specified equitable factors. Each administrative penalty shall be doubled upon a second finding and tripled upon a third finding under Labor Code §5814.6 within a five-year period. |
### AB 227 & SB 228 OMFS Mandates/Tasks

<table>
<thead>
<tr>
<th>LC §5307.1</th>
<th>Status: Regulations revised effective February 15, 2007.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Fee Schedule</strong></td>
<td></td>
</tr>
<tr>
<td>Provides that the existing Official Medical Fee Schedule (OMFS) for physician services will remain in effect in 2004 and 2005, but fees will be reduced by 5 percent.</td>
<td></td>
</tr>
<tr>
<td>As of January 1, 2006, the Administrative Director (AD) will have the authority to adopt an OMFS for physician services.</td>
<td></td>
</tr>
<tr>
<td>8 CCR Section 9789.11</td>
<td>For physician services rendered on or after January 1, 2004, the maximum allowable reimbursement amount set forth in the Official Medical Fee Schedule (OMFS) 2003 is reduced by five (5) percent, except that the reimbursement will not fall below the Medicare rate.</td>
</tr>
<tr>
<td></td>
<td>The Administrative Director (AD) has not yet adopted the Medicare-based schedule for physicians. On October 1, 2007, pursuant to contract, the Lewin Group began preparing its study regarding recommendations for a physician fee schedule. After the consultant’s report is completed, the division will draft regulations.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LC §5307.1</th>
<th>Status: Regulations complete. Effective March 1, 2007.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy Fee Schedule</strong></td>
<td></td>
</tr>
<tr>
<td>Administrative Director (AD) to adopt a new fee schedule for pharmaceuticals based on the Medi-Cal fee schedule.</td>
<td></td>
</tr>
<tr>
<td>8 CCR Section 9789.40</td>
<td>Regulation reflects the statutory mandate that pharmacy services rendered on or after January 1, 2004, must be paid at 100 percent of the current Medi-Cal rates.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LC §5307.1</th>
<th>Status: Statutes specify that changes can be implemented without regulations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Official Medical Fee Schedule Shall Be Adjusted</strong> to conform to relevant Medicare/Medi-Cal changes within 60 days of changes (except specified inpatient changes)</td>
<td></td>
</tr>
<tr>
<td>Updates to Medicare and Medi-Cal changes are implemented by an “Order of the Administrative Director of the Division of Workers’ Compensation.”</td>
<td></td>
</tr>
<tr>
<td>Update orders issued periodically as needed. The most recent orders issued are as follows:</td>
<td></td>
</tr>
<tr>
<td>- Inpatient – update to conform to Medicare changes was adopted by Order, effective December 1, 2008.</td>
<td></td>
</tr>
<tr>
<td>- Outpatient – update to conform to Medicare changes was adopted by Order, effective March 1, 2009.</td>
<td></td>
</tr>
<tr>
<td>- Ambulance fees – update to conform to Medicare changes was adopted by Order, effective January 1, 2009.</td>
<td></td>
</tr>
<tr>
<td>- Pathology and Clinical Laboratory – update to conform to Medicare changes was adopted by Order, effective January 1, 2009.</td>
<td></td>
</tr>
<tr>
<td>AB 227 &amp; SB 228 OMFS Mandates/Tasks</td>
<td>Status of Regulations</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LC §5307.1 (continued)</td>
<td>- Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEPOS) – update to conform to Medicare changes was adopted by Order, effective July 1, 2009.</td>
</tr>
<tr>
<td>Official Medical Fee Schedule Shall Be Adjusted to conform to relevant Medicare/Medi-Cal changes within 60 days of changes (except specified inpatient changes)</td>
<td><a href="http://www.dir.ca.gov/DWC/OMFS9904.htm">http://www.dir.ca.gov/DWC/OMFS9904.htm</a></td>
</tr>
<tr>
<td>LC §5307.1</td>
<td>Status: In process.</td>
</tr>
<tr>
<td>Specified Schedules (Not in Fee Schedule until January 1, 2005)</td>
<td></td>
</tr>
<tr>
<td>(Skilled nursing facility, home health agency, inpatient for hospitals exempt from Medicare Prospective Payment System, outpatient renal dialysis)</td>
<td>Expect to move forward on these in 2010. Division of Workers’ Compensation (DWC) is in the process of prioritizing the work.</td>
</tr>
</tbody>
</table>
### Special Report: 2009 Legislation and Regulations

#### Other Mandates of Assembly Bill 227 and Senate Bill 228

<table>
<thead>
<tr>
<th>AB 227 &amp; SB 228 Other Mandates/Tasks</th>
<th>Status of Regulations</th>
</tr>
</thead>
</table>
| **LC §4603.4** Electronic Bill Payment Regulations | **Status:** In process.  
Pre-rulemaking advisory committee meetings have been held from June 2004 to the present. A draft of the regulations was posted on the DWC forum from August 10 to September 10, 2007. Notice of Rulemaking will be issued in Fall 2009. 
Proposed regulations will require standardized forms for medical bills and will require claims administrators to accept electronic claims for payment of medical services. |
| **LC §4610.1** Utilization Review Enforcement | **Status:** Regulations completed. Final regulations effective June 7, 2007.  
http://www.dir.ca.gov/DWC/DWCPropRegs/UREnforcementRegulations/UR_EnforcementRegulations.htm  
8 CCR Sections 9792.11 – 9792.15  
Regulations provide for:  
- Investigations of the utilization review process.  
- A series of penalties on claims administrators from $50.00-$50,000 for failure to have a utilization review plan or provide treatment according to the regulations.  
- Procedures include Notice of Administrative Penalty Assessment, Appeal Hearing, and Review Procedure. |
| **LC §5318** Spinal Surgery Implantables/Hardware Reimbursement | **Status:** In process.  
The Division of Workers’ Compensation (DWC) is seeking assistance from RAND to develop possible approaches to refine reimbursement methodology. 
Notice of proposed rulemaking expected in 2010. |
<table>
<thead>
<tr>
<th>AB 227 &amp; SB 228 Other Mandates/Tasks</th>
<th>Status of Regulations</th>
</tr>
</thead>
</table>
| **LC §5307.27 Medical Treatment Utilization Schedule** | **Status:** Regulations completed. Final regulations effective June 15, 2007.  
http://www.dir.ca.gov/DWC/DWCPropRegs/MedicalTreatmentUtilizationSchedule/MTUS_regulations.htm  
8 CCR Sections 9792.20 – 9792.23  
The American College of Occupational and Environmental Medicine’s (ACOEM) Practice Guidelines, Second Edition (2004), are presumed correct for both treatment and diagnostic services addressed in those guidelines, both for acute and for chronic conditions. For conditions and injuries not addressed by ACOEM Practice Guidelines, treatment shall be in accordance with other scientifically and evidence-based treatment guidelines that are generally recognized by the national medical community. Key terms are defined.  
A hierarchy of evidence is established to govern circumstances not covered by ACOEM Practice Guidelines, variances from the guidelines, and conflicts among other guidelines. The hierarchy ranges from strong to moderate to limited research-based evidence, with a minimum of one randomized controlled study to constitute limited research-based evidence.  
Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the ACOEM Practice Guidelines. In this situation, the claims administrator shall authorize treatment if such treatment is in accordance with other scientifically and evidence-based medical treatment guidelines that are generally recognized by the national medical community.  
A Medical Evidence Evaluation Advisory Committee is established and its composition is specified.  
**Status of Follow-up Regulations:** Regulations completed. Filed with Secretary of State June 18, 2009. Effective July 18, 2009.  
http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_Regulations.htm  
The Division of Workers’ Compensation (DWC) has updated the Medical Treatment Utilization Schedule (MTUS), including adoption of new chronic pain and elbow guidelines. This rulemaking action was combined with the postsurgical treatment guidelines rulemaking to carry out Assembly Bill (AB) 1073. |
### Assembly Bill 749

<table>
<thead>
<tr>
<th>AB 749 Other Mandates/Tasks</th>
<th>Status of Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LC §138.4</strong> Benefit Notices to Employees from Claims Administrators</td>
<td>Status: Regulations completed. Effective April 9, 2008.</td>
</tr>
<tr>
<td>Regulations are revised to reflect changes in this statute.</td>
<td><a href="http://www.dir.ca.gov/dwc/DWCPropRegs/BenefitNoticeRegulations/BenefitNotice_regulations.htm">http://www.dir.ca.gov/dwc/DWCPropRegs/BenefitNoticeRegulations/BenefitNotice_regulations.htm</a></td>
</tr>
<tr>
<td>8 CCR Sections 9767.16, 9810, 9811, 9812, 9813, 9813.1, and 9813.2</td>
<td>Updates notices dealing with payment, nonpayment, or delay in payment of temporary disability, permanent disability, return to work and the provision of vocational rehabilitation services, notices of any change in the amount or type of benefits being provided, the termination of benefits, the rejection of any liability for compensation, and an accounting of benefits paid.</td>
</tr>
<tr>
<td><strong>LC §§139.48 and 139.49</strong> Return-to-Work Reimbursement Program/Study</td>
<td>Status: Regulations completed. Effective August 18, 2006.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.dir.ca.gov/dwc/DWCPropRegs/ReturnToWork_regulations/ReturnToWork_regulations.htm">http://www.dir.ca.gov/dwc/DWCPropRegs/ReturnToWork_regulations/ReturnToWork_regulations.htm</a></td>
</tr>
<tr>
<td>8 CCR Sections 10004-10005</td>
<td>During 2009, the Division of Workers’ Compensation has been actively publicizing the Return-to-Work Reimbursement Program. The Return to Work Study was completed May 2009.</td>
</tr>
<tr>
<td>(Annually to every employer, claims adjuster, third-party administrator, physician and attorney participating in workers’ compensation)</td>
<td></td>
</tr>
<tr>
<td><strong>LC §4062.8</strong> Develop and Revise Educational Materials for Primary Treating Physicians and Chiropractors</td>
<td>Status: Project in process.</td>
</tr>
<tr>
<td></td>
<td>The Division of Workers’ Compensation (DWC) is in the process of developing an Internet-based series of educational materials for treating physicians and qualified medical evaluators.</td>
</tr>
</tbody>
</table>
### AB 749 Other Mandates/Tasks

<table>
<thead>
<tr>
<th>Status of Regulations</th>
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</table>
| **LC §4600.2** Pharmacy Contract Standards | Status: In process.  
DWC contracted with the University of California, San Francisco (UCSF) Pharmacy School to provide study and recommendations for contract standards. Report received at the end of March 2004. Rulemaking will commence in winter 2009. |
| **LC §4603.4** Electronic Bill Payment Regulations | Status: Pre-rulemaking advisory committees have been ongoing. Notice of Rulemaking will be issued in Fall 2009. |

### Other Regulations

<table>
<thead>
<tr>
<th>Other Mandates/Tasks</th>
<th>Status of Regulations</th>
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</table>
The proposed regulations update the two Workers’ Compensation Information System (WCIS) implementation guides, refine the list of required data elements, and establish reporting procedures for medical bills paid by a lump sum following the filing of a lien with the Workers’ Compensation Appeals Board (WCAB). |
| **LC §138.6 (continued)** Workers’ Compensation Information System | Status: Regulations provide that medical bill payment data reporting became mandatory on September 22, 2006.  
To implement the Legislature’s amendment of Labor Code §138.7, the regulations allow access to this information by researchers employed or under contract to the Commission on Health and Safety and Workers’ Compensation (CHSWC). |
| **LC §§129, 129.5** Audit Program Regulations | Status: Regulations completed. Filed with Secretary of State Apr. 20, 2009. Effective May 20, 2009.  
8 CCR Sections 10100.2 – 10115.2  
Updates definitions and procedures for adjusting locations, the annual Report of Inventory, routine and targeted audits, and audit compliance penalties. |
<table>
<thead>
<tr>
<th>Other Mandates/Tasks</th>
<th>Status of Regulations</th>
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<tbody>
<tr>
<td>LC §123.6 Ethical Standards for Workers' Compensation Administrative Law Judges</td>
<td>Status: Regulations completed. Filed with Secretary of State August 25, 2008. Effective September 24, 2008. 8 CCR §§9720.1 et seq.</td>
</tr>
<tr>
<td>LC §§127.5, 5300, 5307 Workers' Compensation Appeals Board/Division of Workers' Compensation (WCAB/DWC) District Offices Regulations and Forms</td>
<td>Status: Regulations became effective November 17, 2008. 8 CCR §§ 10210 et seq. <a href="http://www.dir.ca.gov/dwc/DWCPropRegs/EAMS_regulations/EAMS_regulations.htm">http://www.dir.ca.gov/dwc/DWCPropRegs/EAMS_regulations/EAMS_regulations.htm</a></td>
</tr>
<tr>
<td>LC §§4061.5, 4603.4, and 4610 PR-2 Form - Primary Treating Physician's Progress Report, Functional Improvement Report, Request for Authorization Form</td>
<td>Status: Regulations in process. Draft regulations were posted on the Division of Workers' Compensation (DWC) online Forum through May 18, 2008. Formal rulemaking will commence shortly. 8 CCR Sections 9785, 9785.2</td>
</tr>
<tr>
<td>LC §127 Fees for Copies of Documents</td>
<td>Status: Revisions anticipated in 2010. 8 CCR Section 9990</td>
</tr>
<tr>
<td>LC §4659 Commutation Tables for Permanent Disability</td>
<td>Status: Need to hire actuary. 8 CCR §§ 10169, 10169.1</td>
</tr>
</tbody>
</table>
The California workers' compensation system covers 15,395,000 employees working for over 850,000 employers in the State. These employees and employers generated a gross domestic product of $1,846,757,000,000 ($1.85 trillion) for 2008. A total of 613,800 occupational injuries and illnesses were reported for 2008, ranging from minor medical treatment cases up to catastrophic injuries and deaths. The total paid cost to employers for workers' compensation in 2008 was $15.3 billion.

Employers range from small businesses with just one or two employees to multinational corporations doing business in the State and the state government itself. Every employer in California must secure its liability for payment of compensation, either by obtaining insurance from an insurer licensed by the Department of Insurance (CDI) or by obtaining a certificate of consent to self-insure from the Department of Industrial Relations (DIR). The only lawful exception is the State, which is legally uninsured. Based on the claim counts reported to the Workers' Compensation Information System (WCIS) (see the chart below), 70 percent of injuries occur to employees of insured employers, 26 percent of injuries occur to employees of self-insured employers, and 4 percent of injuries occur to employees of the State of California.

### A Claim Counts-based Estimate of Workers' Compensation System Size

Measurements of the California workers' compensation system have long been plagued by incomplete data. The Workers' Compensation Insurance Rating Bureau (WCIRB) collects detailed data from insurers to enable the Insurance Commissioner and the companies to determine reasonable prices for coverage. These data are also used for many measurements of the system. Comparable data are not collected on self-insured employers, so researchers relied on estimates. It was estimated that 20% of the market was self-insured, so systemwide measurements were often obtained by multiplying the WCIRB figures by 1.25.

It is now possible to improve that estimate by using Workers’ Compensation Information System (WCIS) data on the number of claims filed by employees of insured employers, self-insured employers, and the legally uninsured state agencies. The claims are:

- 70% with insured employers
- 26% with self-insured employers
- 4% with the State as the employer

Assuming that other characteristics are proportional to the number of claims, the new multiplier to estimate systemwide performance based on insurer data is:

\[
\frac{100\%}{70\%} = 1.43
\]

For example, if insurers’ paid losses and expenses are $10.7 billion, then the systemwide paid losses and expenses are estimated as:

\[
$10.7\text{ billion} \times 1.43 = $15.3\text{ billion}.
\]

The Commission on Health and Safety and Workers’ Compensation (CHSWC) obtained WCIS data and began using the new method for estimating system size in 2008. This method produces a larger estimate than the old method. Comparisons to previous years must be recalculated using the new method for consistency.
Workers’ compensation is generally a no-fault system that provides statutory benefits for occupational injuries or illnesses. Benefits consist of medical treatment, temporary disability (TD) payments, permanent disability (PD) payments, return-to-work assistance, and death benefits. The overall amounts paid in each of these categories systemwide are shown in the following chart. These figures are based on insurer-paid amounts multiplied by 1.43 to include estimated amounts paid by self-insured employers and the State.

Systemwide Cost: Paid Dollars for 2008 Calendar Year

<table>
<thead>
<tr>
<th>A Claim Counts-based Estimate of Workers’ Compensation System Size (Million $)</th>
<th>Insured</th>
<th>Self-Insured and the State*</th>
<th>All Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity*</td>
<td>$2,986</td>
<td>$1,284</td>
<td>$4,270</td>
</tr>
<tr>
<td>Medical*</td>
<td>$4,130</td>
<td>$1,776</td>
<td>$5,906</td>
</tr>
<tr>
<td>Changes to Total Reserves</td>
<td>$35</td>
<td>$15</td>
<td>$50</td>
</tr>
<tr>
<td>Insurer Pre-Tax Underwriting Profit/Loss</td>
<td>-$84</td>
<td>X</td>
<td>-$84</td>
</tr>
<tr>
<td>Expenses (See Table below: Breakdown of Expenses)</td>
<td>$4,053</td>
<td>$1,081</td>
<td>$5,134</td>
</tr>
<tr>
<td><strong>TOTAL for 2008</strong></td>
<td><strong>$11,120</strong></td>
<td><strong>$4,156</strong></td>
<td><strong>$15,276</strong></td>
</tr>
</tbody>
</table>

*Include CIGA payments

Source for Insured figures above is WCIRB Losses and Expenses report June 2009. Other figures are calculated by CHSWC using 0.43 multiplier for equivalent cost components. The equivalent expense components are estimated as follows:

<table>
<thead>
<tr>
<th>Breakdown of Expenses (Million $)</th>
<th>Insured</th>
<th>Self-Insured and State*</th>
<th>All Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss Adjustment Expense</td>
<td>$1,824</td>
<td>$784</td>
<td>$2,608</td>
</tr>
<tr>
<td>Commissions and Brokerage</td>
<td>$853</td>
<td>X</td>
<td>$853</td>
</tr>
<tr>
<td>Other Acquisition Expenses</td>
<td>$468</td>
<td>X</td>
<td>$468</td>
</tr>
<tr>
<td>General Expenses</td>
<td>$689</td>
<td>$296</td>
<td>$985</td>
</tr>
<tr>
<td>Premium and Other Taxes</td>
<td>$219</td>
<td>X</td>
<td>$219</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$4,053</strong></td>
<td><strong>$1,081</strong></td>
<td><strong>$5,134</strong></td>
</tr>
</tbody>
</table>

Estimate of Workers’ Compensation System Size Based on Written Premium

Another way to calculate systemwide costs for employers is by using written premium. Written premium for insured employers = $10.7 billion in accident year 2008.²

$10.7 billion * 1.43 = $15.3 billion systemwide costs for employers.

Costs Reached a Crisis in 2003

Both the increases in the costs of workers’ compensation benefits and changes in the workers’ compensation insurance industry were factors contributing to a workers’ compensation crisis that peaked in 2003. The crisis propelled reforms enacted in 2003 and 2004 that reduced the cost of benefits. Within five years, the average rate for workers’ compensation insurance fell by more than 60 percent. The impact on injured workers’ benefits is the subject of continuing study.

Increasing Cost of Benefits

The costs of workers’ compensation benefits increased greatly between 1997 and 2003. The total costs of the California workers’ compensation system more than tripled, growing from $8.0 billion in 1997 to $29.3 billion in 2003. 3

Medical Costs

Medical costs, which are the largest single category of worker’s compensation costs, rose most sharply, from $2.9 billion in 1997 to $7.0 billion in 2003. The rate of increase in medical cost per workers’ compensation claim far exceeded the rate of increase in the consumer price index for medical care. The cost increase is driven partly by the availability of new medical technologies and drugs that are

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3 The total cost of the workers’ compensation figures consists of medical care payments and wage replacement benefits to injured workers, along with administrative expenses and adjustments to reserves, as calculated by CHSWC based on insurer data from WCIRB. *Annual Reports*, San Francisco: *WCIRB*, 1998, 2004.
increasingly costly. Furthermore, the rate of utilization of medical goods and services was higher in workers’ compensation than in other insurance systems, as well as higher in California workers’ compensation than in other states. The high rates of utilization did not produce superior health outcomes.

**Weekly Benefits**

Other contributing factors to the increases in costs were the increases to the TD and PD benefits that began phasing into effect in 2003 following Assembly Bill (AB) 749. Benefits prior to AB 749 had not kept up with inflation:

- AB 749 brought weekly TD benefits up to two-thirds of the State’s average weekly wage by 2005. This is the standard set by the National Commission on State Workers’ Compensation Laws. AB 749 also indexed TD benefits to inflation in the State average weekly wage beginning in 2006, much like in other states.

- After AB 749, weekly PD benefits for 2006 were increased by about 40 percent over 2002 weekly rates, bringing the weekly rates to approximately equal the rates in 1984 after adjusting for inflation.

**Expansion of Liability**

Another factor contributing to the increase in workers’ compensation costs for employers was the expansion of workers’ compensation liability. Through most of the history of the workers’ compensation system, the courts have expanded the boundaries of compensability. Partially counteracting this broad trend, there have been legislative restrictions from time to time, such as those imposing new conditions to compensability for psychiatric claims or post-termination claims. Although the system was originally seen as primarily dealing with traumatic injuries and accidents, it has come to be dominated by cumulative injuries and illnesses that may interact with the diseases and disorders of an aging population, the epidemic of obesity, and other public health issues outside the strictly occupational sphere.

**Instability in Insurance Industry**

When the workers’ compensation insurance industry was deregulated beginning in 1995, insurers competed by lowering premium rates, in many instances below their actual costs. Many insurers drew on their reserves or other sources of capital or relied on investment profits during bull market years. Investment income dropped with the return of a bear market. Between 2000 and 2003, 27 workers’ compensation insurers went into liquidation. Subsequently, the surviving insurers charged higher premium rates to meet costs and begin to replenish reserves. A study to obtain a more thorough analysis of the causes of the market instability is due to be published by the end of 2009.

**Impact on Employer**

Costs for insurance peaked at an average of $6.45 per $100 of payroll in the latter half of 2003, making California the most expensive state in the U.S. for workers’ compensation insurance. However, the average rate has dropped every year since that time. In the first three quarters of 2009, the average premium rate per $100 of payroll was $2.33 which is equal to what it was in 1998 and only $0.03 higher than in 1999, which was the lowest rate in the past 15 years.

**Workers’ Compensation Reforms: Recent Changes to the California System**

**Key Legislative Changes**

California made significant legislative reforms in the workers’ compensation system in 2002, 2003 and 2004. The reforms of 2002, 2003 and 2004 included provisions that, at least initially, accomplished the following:
• Control of medical costs:
  o Evidence-based medical treatment guidelines (e.g., ACOEM Guidelines).
  o Utilization review of medical treatment, systematically applying the guidelines.
  o A revised dispute resolution system using a qualified medical evaluator (QME) selected from a panel whenever an agreed medical evaluator (AME) is not used.
  o Standardized and transparent medical fee schedules.
  o New fee schedule for inpatient hospital, hospital out-patient departments, and ambulatory surgery centers based on the Medicare fee plus 20 percent.
  o A new fee schedule for pharmaceuticals based on the Medi-Cal Fee Schedule.
  o Caps on the number of chiropractic, physical therapy and occupational therapy visits per claim.
  o Employer control of medical care through medical provider networks (MPNs).

• Changes to indemnity benefits:
  o Indemnity benefit weekly rate increases enacted in 2002 legislation catching up for inflation and indexing weekly TD benefits to maintain the target levels recommended by the 1972 National Commission on State Workers’ Compensation Laws.
  o Increase in number of weeks of PD benefits enacted in 2002, adding 19.75 weeks for all awards of 20 percent disability or greater, phased in at 1 week for every percentage point for awards below 20 percent.
  o Decrease in number of weeks of PD benefits enacted in 2004, reducing 14.75 weeks from awards of 15 percent disability or greater, phasing in the reduction at 1 week for every percentage point for awards below 15 percent. For awards of 70 percent to 99.75 percent, 7 weeks of benefits were added for every percentage above 69.75 percent.
  o Duration of TD benefits, formerly limited only by the evidence in each case, was restricted by the 2004 legislation to 104 weeks of benefits within 2 years of first payment, amended in 2007 to 104 weeks within 5 years of date of injury.

• Changes in PD compensation:
  o PD rating based on American Medical Association (AMA) Guides prescribed by 2004 legislation, implemented by Permanent Disability Rating Schedule (PDRS) revision effective 1/1/2005.
  o Apportionment to causation, the conclusive presumption that previously awarded disability, continues to exist for the purpose of apportionment from a subsequent award.
  o Incentives for employers to offer return to work (RTW), with a change of + or – 15 percent in weekly PD benefits depending on whether an appropriate and timely offer is made.

These legislative changes will be described in greater detail in the following pages.

Reform Results

• The cost of workers’ compensation insurance has dropped over 60 percent for insured employers.⁴

• Medical paid costs are down since their peak in 2003.

SYSTEM COSTS AND BENEFITS OVERVIEW

- PD benefits incurred are down by at least two-thirds.\(^5\)
- TD has declined, even before the two-year cap took effect, without any direct cut in benefits.
- WCIRB estimates that indemnity claim frequency for the first three quarters of 2009 is 11.2 percent less than the first three quarters of 2008. The claim frequency declined especially rapidly by over 30 percent just in the two years immediately after the enactment of the 2003-2004 reforms.\(^6\)

Savings from the workers’ compensation reforms have been estimated at $13.7 billion per year for insurers.\(^7\) Extending the estimates to include self-insured employers and the State, the reforms have reduced the direct cost of paying benefits plus loss adjustment expenses by a total of $19.6 billion per year. Insurance rates continued to decline into 2009, but reported medical costs began to rise again, and in July 2009, insurance rates began to trend upward again.

**Descriptions of Major Legislative Changes, 2002-2004**

**Medical Reforms**

California’s workers’ compensation medical costs grew by over 120 percent from 1997 to 2004. Prior to the reforms enacted in 2003 and 2004, overall costs for workers’ compensation medical treatment were estimated to be 50 percent to 100 percent higher than group health for similar conditions. Reforms were intended to control medical costs by means of including utilization controls, control over choice of providers, and fee schedules.

**Utilization**

According to the Workers’ Compensation Research Institute (WCRI), the utilization of workers’ compensation medical services in California was over 70 percent greater than other states. Several utilization measures were adopted to control this including:

- Caps on chiropractic, physical therapy, and occupational therapy visits, limiting each type of therapy to 24 visits per claim. According to WCIRB, following the enactment of workers’ compensation reforms of SB 228, physical therapy utilization has been reduced by approximately 61 percent and chiropractic utilization by approximately 77 percent.
- Evidence-based guidelines for treatment of common occupational injuries and illnesses. Scientifically based treatment guidelines were adopted to replace the nearly unlimited discretion of the treating physician.
- Elimination of the treating physician presumption of correctness on medical treatment issues for all dates of injury. Previously, an employer’s or insurer’s ability to restrain excessive or inappropriate treatment was readily thwarted by the presumption in favor of the treating physician’s opinions.

Despite these utilization controls, increasing medical costs in 2009 are attributed to an increase in average number of visits per claim, the average number of procedures per visit, and an average amount paid per procedure, as well as the growing role of medical cost containment programs.\(^8\) Research is underway to attempt to identify specific cost drivers.

\(^7\) CHSWC Calculations based on WCIRB Report “WCIRB Legislative Cost Monitoring Report, October 9, 2008.”
\(^8\) CWCI “Analysis of Post-Reform Outcomes: Medical Benefit Payments and Medical Treatment in the California Workers’ Compensation System,” 2009.
**Choice of Medical Providers**

By default, injured workers must receive treatment from physicians designated by the employer or insurer for the first 30 days after reporting an injury. After 30 days, they have free choice of physicians. These choices may be altered by the employee, employer or insurer exercising various rights:

- If an employee has designated a personal physician prior to an injury, the employee has the right to be treated by that physician instead of a physician of the employer’s choosing. Only employees for whom the employer provides group health coverage are eligible to predesignate, and the personal physician must meet requirements specified in Section 4600(d) of the Labor Code.

  Predesignation has been available but largely ignored for many years. However, significant conditions and restrictions were adopted in 2004 concurrently with the enactment of statutes authorizing MPNs (see below). The section was further amended in 2006, and it is scheduled to sunset on December 31, 2009. A valid predesignation takes precedence over the other provisions for choice of medical providers.

- If an employer has contracted with an approved workers’ compensation managed health care organization (HCO), an employee injured while that contract is in force is required to receive treatment for the injury only in accordance with the HCO contract for the first 90 or 180 days after the report of the injury, depending on whether the employer also provides group health coverage. Statutes authorizing HCOs were enacted in the 1990s and remained unchanged by the 2003 and 2004 reforms. The emergence of MPNs (see below) with no time limits on medical control, however, has reduced the level of employer interest in HCOs.

- If a self-insured employer or the insurer of an insured employer has established an MPN approved by the Division of Workers' Compensation (DWC), an injured worker is required to receive all treatment within the MPN. There are provisions for transitioning patients into an MPN if treatment began outside the MPN for any reason. The employee has free choice of physicians within the MPN after the first visit, but the employee has very limited rights to treatment outside the MPN. Unlike the choice of providers in HCOs or the default 30-day control, an employee covered by an MPN must choose from network providers indefinitely. MPNs were authorized by Senate Bill (SB) 899 enacted in 2004, with the first MPNs beginning operations in 2005. As of September 2008, DWC lists 1,281 approved MPNs.

**Fee Schedules**

CHSWC/RAND studies found that the lack of fee schedules regarding certain medical services and the delays in updating existing fee schedules created administrative inefficiency and therefore higher costs.

CHSWC studies found that the California workers’ compensation system had high pharmaceutical reimbursement rates relative to other systems, such as Medicaid and employer health benefits, and that when compared with other workers’ compensation systems, California’s pharmaceutical reimbursement rates were near the highest among the various states reviewed. Workers’ compensation reforms accomplished the following:

- Created a new fee schedule for hospital inpatient and out-patient departments and ambulatory surgery centers (ASCs) based on Medicare fees plus 20 percent. (SB 228)
- Created a new schedule for pharmaceuticals based on 100 percent of Medi-Cal. (SB 228)
- Required pharmacies and other providers of medical supplies and medicines to dispense a generic drug equivalent unless the prescribing doctor states otherwise in writing. (AB 749)
- Authorized employers and insurers to contract with pharmacies or pharmacy benefit networks pursuant to standards adopted by the DWC Administrative Director (AD). [Assembly Bill (AB) 749]
After the adoption of the new pharmaceutical fee schedule, it became apparent that the Medi-Cal pharmaceutical fee schedule did not cover repackaged drugs dispensed by physicians, so they were still payable according to the old formula based on list price. CHSWC studies in collaboration with RAND, UC Berkeley, and the California Workers’ Compensation Institute (CWCI) found that on average, physician-dispensed drugs cost 490 percent of what was paid to pharmacies for the same drugs. In some cases, including the most commonly prescribed drug dispensed by physicians, the mark-up exceeded 1,000 percent. The AD adopted regulations effective March 2007 restricting costs of repackaged drugs that are dispensed by physicians to be more in line with the Medi-Cal pharmacy fee schedule and what pharmacies are allowed to charge. Had this change been in effect in 2006, it would have saved about $263 million in paid costs that year.

Although the loophole for repackaged drugs was closed, other gaps remain in the fee schedules. Attention has recently shifted from repackaged drugs to compound drugs and medical foods as potentially costly products that are poorly managed under existing laws and regulations.

Recent CHSWC/RAND studies on the inpatient hospital fee schedule and the outpatient facility fee services pointed out several problems that still exist with fee schedules. One of the fee schedule problems is the Labor Code provision that arguably requires the payment of ASC fees at the same rates as hospital outpatient surgical departments, even though the ASCs have lower costs and are paid less than the hospitals under Medicare. The second fee schedule problem is the duplicate payment of spinal surgical implant hardware, because the full cost of the hardware is separately reimbursable even though the average cost of the hardware is already included in the global reimbursement for these procedures. CHSWC/RAND studies make recommendations for legislative and regulatory actions to correct these problems.

**Immediate Medical Care**

For claims reported after April 19, 2004, SB 899 requires that within one day of receiving an employee claim form, the employer will authorize the provision of medical treatment and will continue to provide such treatment until such time as the claim is accepted or denied. The employer’s liability for medical treatment prior to the time the claim is accepted or denied is limited to $10,000 (Labor Code Section 5402).

DWC provided information on claims denial rates for 2002 through 2008 to assess if any significant increases in denied claims have occurred beginning in 2004 as a result of the SB 899 provisions related to immediate medical care. As shown in the following table, information from DWC indicates that the rates of claims denied in calendar years 2004 through 2006 are generally comparable to that at the 2003 level. From 2006 through 2008, the data show a slight increase in claim denial rate.

<table>
<thead>
<tr>
<th>Accident Year</th>
<th>Total Reported Claims</th>
<th>Claims Denied</th>
<th>Claim Denial Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>889,016</td>
<td>49,723</td>
<td>5.6%</td>
</tr>
<tr>
<td>2003</td>
<td>848,143</td>
<td>53,161</td>
<td>6.3%</td>
</tr>
<tr>
<td>2004</td>
<td>802,144</td>
<td>49,828</td>
<td>6.2%</td>
</tr>
<tr>
<td>2005</td>
<td>755,656</td>
<td>47,845</td>
<td>6.3%</td>
</tr>
<tr>
<td>2006</td>
<td>731,447</td>
<td>48,074</td>
<td>6.6%</td>
</tr>
<tr>
<td>2007</td>
<td>691,431</td>
<td>50,018</td>
<td>7.2%</td>
</tr>
<tr>
<td>2008</td>
<td>625,769</td>
<td>44,658</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Source: WCIRB

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Indemnity Benefits

Permanent Disability Compensation

Changes to the Permanent Disability Rating Schedule

PD benefits are meant to compensate workers for their remaining disability after they have reached maximum medical improvement from their injuries. However, a CHSWC study by RAND found that the PD rating system in California prior to 2005 was procedurally complicated, expensive to administer and inconsistent:

- Earnings losses for similarly rated disabilities for different body parts varied dramatically.
- PD ratings varied among doctors evaluating the same or similar injuries, due in part to significant reliance on subjective criteria.

SB 899 revised the rating methodology for PD:

- One of the basic principles of a PD rating, “diminished ability to compete,” was replaced by “diminished future earning capacity,” which is defined as “a numeric formula based on empirical data and findings that aggregate the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees.”
- The new PD rating schedule (PDRS), adopted January 1, 2005, was required to incorporate the American Medical Association (AMA) Guides for both descriptions and measurements of impairments and for the corresponding percentages of impairment. Evaluations according to the AMA Guides are expected to be more predictable and consistent than evaluations under the more subjective rating system that was in place for almost a century.
- In a set of en banc decisions known as Almaraz/Guzman and Ogilvie in 2009, the Workers’ Compensation Appeals Board (WCAB) interpreted these changes in a way that has cast doubt on the success of the reforms in achieving consistency, uniformity and objectivity.

Changes to Permanent Disability Indemnity Payments

PD compensation is payable as a weekly benefit for a number of weeks:

- The number of weeks depends entirely on the PD rating. The number of weeks is cumulative and progressive:
  - The number is cumulative, meaning that across the range of ratings from 1 percent to 99 percent, each additional percentage point of disability adds a specified number of weeks of benefits to the award.
  - The number is progressive, meaning that the number of weeks added for each point in the upper ranges is larger than the number added for each point in the lower ranges.
  - SB 899 reduced the number of weeks of PD benefits by one week for each of the first 14.75 percentage points of every disability rating. For the percentage points under 10, SB 899 reduced the weeks of indemnity payments from 4 to 3 weeks per point. For the percentage points from 10 percent to 14.75 percent, SB 899 reduced the weeks of indemnity payments from 5 to 4 weeks per point. Because an indemnity award is cumulative, this means that every award from 15 percent up to 69 percent is reduced by almost 15 weeks. Few awards reach 70 percent, but for those that do reach this range, SB 899 increased the number of weeks for each percentage point in the range of 70 percent to 99.75 percent from 9 weeks per point to 16 weeks per point.
The weekly benefit amount depends on the employee’s pre-injury earnings within a specified range. The range is low compared to most workers’ wages, however, so most workers receive a maximum weekly rate rather than a full two-thirds of their pre-injury earnings.

In a few cases, the weekly amount is affected by the PD rating. For most cases, the maximum weekly amount is $230 per week. For cases with ratings of 70 percent to 99 percent, the maximum weekly amount is $270. As noted above, most workers earn enough to qualify for the maximum weekly amount. These maximum amounts have not changed since 2006, when the last of the changes enacted in 2002 took effect.

Under SB 899, the weekly amount may be adjusted up or down by 15 percent depending on whether the employer offers the employee RTW.

Changes to Permanent Disability Intended to Encourage Return to Work

To encourage employers to offer an opportunity for disabled workers to return to work, the 2004 reforms introduced an adjustment of the weekly benefit amount. If the employer offers work according to statutory criteria, the employer pays the remaining weeks of benefits at a 15 percent lower weekly amount. Conversely, if the employer does not offer work according to statutory criteria, the employer pays the remaining weeks at a 15 percent higher weekly amount. This adjustment applies only to an employer of 50 or more employees.

Based on the greater number of workers who return to their at-injury employers than the number who do not, it was expected that this RTW incentive would save about 3 percent in overall PD costs while targeting the increased benefit to the workers who need it more.

Experience shows that the expected savings have not materialized. More cases are being paid at the bumped up rate than at the bumped down rate, implying that more workers are not receiving the appropriate RTW offers within the specified timeframes. This is contrary to previous evidence that more workers returned to their at-injury employers. To further confound expectations, nearly 70 percent of awards are paid without being adjusted either up or down, even though only 37 percent of employees work for businesses that are exempt from this bump-up/bump-down incentive. Anecdotal reports indicate that the statutory criteria are not practical. It appears that the statutory criteria for an RTW offer are unrealistic. In 2008, DWC convened multiple meetings of a Return-to-Work Advisory Committee in an attempt to identify appropriate revisions to this and other incentives and supports for returning injured workers to employment. As of late 2009, it is doubtful that the two-tiered PD system is an effective incentive to promote RTW.

Changes to Permanent Disability Apportionment

A permanent disability may be only partially attributable to an industrial injury and partially attributable to other factors such as prior injuries or other conditions. Apportionment is the process of determining the portion of PD which an employer is required to compensate. A simplified summary of the law prior to 2004 is that an employer was liable for all of the PD except that portion which the employer could prove would have existed even in the absence of the industrial injury.

SB 899 replaced the former statutes with new provisions, including the rule, “apportionment of PD shall be based on causation.” In some situations, this might be compared to weighing all the industrial and non-industrial factors and assigning liability in proportion to the industrial contribution to the PD award.

SB 899 adopted a presumption that any disability that has been previously awarded continues to exist. For example, if a worker with a previous disability award of 10 percent sustains an injury to the same part of the body and is then rated with a 15 percent disability, the 10 percent award may be subtracted from the award for the new injury. It is no longer necessary for the employer to prove that the worker still had the 10 percent disability immediately prior to the second injury.

The courts have resolved some of the disputes over interpretation of the new law of apportionment, but many questions remain to be resolved.
Combined Effects of Changes to Permanent Disability

The savings from the combined effects of changes to PD are approximately $3.5 billion per year. These savings resulted from:

- A substantial fraction of cases that would have received PD ratings under the former PDRS do not have any impairment according to the AMA Guides. It is difficult to quantify the share of these “zeros”; however, current evidence suggests that as many as 25 percent of cases may be dropping out of the PD ratings entirely.

- The reduction in weeks at the lower end of all awards cuts the overall cost of PD by 16 percent, according to University of California (UC), Berkeley analysis.

- Apportionment is reducing PD awards by an average of 6 percent, according to a UC Berkeley analysis of Disability Evaluation Unit (DEU) ratings.

- The 15 percent up or down adjustment of weekly benefits depending on an RTW offer appears to be increasing costs.

- Average ratings under the new PDRS are approximately 40 percent lower than average ratings under the pre-2005 rating schedule, reducing the overall cost of PD by about 30 percent.

The cumulative effect of all of these changes is to cut the systemwide cost of PD benefits by more than two-thirds, as depicted in the following chart.

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10 Based on WCIRB-projected pre-reform annual PD cost of $3.7 billion, extended to include self-insured and State ($3.7b * 1.43 = $5.3 billion). A two-thirds reduction is $3.5 billion.
**Temporary Disability Compensation**

*Temporary Disability Duration*

Until 1979, TD benefits were limited to no more than 240 weeks of disability within five years of the date of injury. In 1978, a bill was enacted to remove the limit because of the hardship in the occasional case that required hospitalization for additional surgery more than five years after the date of injury. The cost was expected to be insignificant. The limits on temporary total disability were removed in 1979.

As interpreted by the courts, the amended statute allowed an extension without limit, as long as it was uninterrupted. This was the exact opposite of the expected scenario where separate periods of TD might be needed in the event of additional hospitalizations.

The result was that a few workers managed to extend “temporary” disability indefinitely, creating a few egregious examples of abuse of a well-intended humanitarian amendment. Later research showed that prior to the 2004 reforms, only about 8 percent of workers’ compensation TD claims involved payments exceeding 104 weeks. These claims often extended much longer, and the payments beyond 104 weeks represented approximately 34 percent of all TD payments.

SB 899 enacted in 2004 limited TD to 104 weeks of benefits within two years after the first payment. The reform raised concerns that the new limit was too restrictive. The commonly cited reason is that the two-year clock is running while a worker returns to work so that if more time is needed later, the worker is no longer eligible for TD benefits. In 2007, the Legislature passed and the Governor signed AB 338. The bill allows an injured worker to receive up to 104 weeks of aggregate disability payments within five years of the date of injury.

*Temporary Disability Benefit Amount*

The weekly amount of the TD benefit is set at two-thirds of the worker’s average weekly wage, within an upper and a lower boundary. The upper boundary remained unchanged from 1996 until 2003, while inflation pushed wages up. TD benefits lagged farther and farther behind the target of two-thirds replacement of lost wages for many workers. The maximum amount was raised beginning in 2003, and now it is indexed for inflation so that the maximum recognized earnings are approximately 1.5 times the statewide average weekly wage. This means that the maximum TD rate is approximately equal to the statewide average weekly wage.

A California Workers’ Compensation Institute (CWCI) report published January 23, 2006, found that more than 97 percent of TD recipients in California received two-thirds of their average weekly wage in TD payments.

**Return-to-Work Assistance and Incentives**

*Background*

The goals of improving the impact of injuries on workers, as well as reducing the cost to employers and the impact on the California economy, are best served when injured workers return to sustained employment:

- The CHSWC/RAND study of PD found that permanently disabled workers who return to work at the same employer have less wage loss.

- The CHSWC/RAND RTW studies found that California has the poorest rate of RTW compared with other states and recommended that RTW incentives be implemented.

Although California had high PD costs, the poor rate of RTW produced a high rate of uncompensated wage loss compared to other states. A vocational rehabilitation program enacted in the 1970s was intended to help workers return to suitable gainful employment. Many stakeholders in the workers’
compensation community reported dissatisfaction with the costs and outcomes of the vocational rehabilitation program. The proportion of rehabilitated injured workers working at the completion of their vocational rehabilitation plans declined during the 1990s.

In 2003, the Vocational Rehabilitation Program was repealed by AB 227 and replaced by a supplemental job displacement benefit (SJDB). SJDB is a voucher for education-related retraining or skills-enhancement for workers injured on or after January 1, 2004, who cannot return to their at-injury employers. In 2004, SB 899 provided that for workers injured before 2004, the vocational rehabilitation program would end January 1, 2009.

Return-to-Work Reforms

The reforms employed several approaches to improving RTW including:

- Tiered PD benefit depending on whether or not the employer offers RTW. The weekly PD benefit rate is increased by 15 percent if the employer does not make a timely RTW offer and is decreased by 15 percent if the employer does make the offer, providing an incentive for employers. This applies to employers of 50 or more employees.

- Worksite-modification reimbursements of up to $2,500 for employers to support accommodations by employers. This applies to employers of 50 or fewer employees.

- SJDB which helps pay for education for retraining or skills-enhancement for workers who could not return to work for the at-injury employer.

- Indirectly, but importantly, scientific standards for medical treatment which are expected to improve health outcomes and reduce the duration and severity of disability.

Evaluation of Return to Work After Reforms

It is doubtful that any of the direct approaches have improved California’s RTW rate.

In 2007, DWC conducted a study of RTW rates. For a summary of the DWC research, see “Special Report: Permanent Disability Rating Schedule” in this Annual Report. Although the study found an improved RTW rate, there are limitations to the analysis.

CHSWC has contracted with RAND to conduct a comprehensive study of the impact of recent RTW and vocational rehabilitation reform on employer costs and injured worker outcomes. Preliminary results from the CHSWC/RAND study indicate that the improvement in RTW began before the workers’ compensation reforms were enacted and was not obviously influenced by those reforms. For further information about this ongoing study, see the “Projects and Studies” section in this Annual Report.

Costs of Workers’ Compensation in California

Employers pay the cost of workers’ compensation either by paying premiums for workers’ compensation insurance or by self-insuring with the consent of the Department of Industrial Relations (DIR). Only the State of California can be legally uninsured as an employer. The cost to insured employers is measured in terms of premium. Premium is measured before discounts that are given for deductibles because there are no adequate data on amounts paid in deductibles by employers. The cost to self-insured employers is measured mostly by incurred claims, similar to the analysis of insurance company losses and expenses. These two aspects of employer cost will be discussed in the following pages, and the loss and expense analysis for insurers appears later in this section.
**SYSTEM COSTS AND BENEFITS OVERVIEW**

**Costs Paid by Insured Employers**

In 2008, workers’ compensation insurers earned $10.9 billion in premiums from California employers.  

The cost of workers’ compensation insurance in California has undergone dramatic changes in the past ten years due to a combination of factors.

When workers’ compensation premiums were deregulated beginning in 1995, insurers competed by lowering premium rates, in many instances lower than their actual costs. Costs also increased beyond the amounts that were foreseen when premiums were determined and collected. Many insurers drew on their reserves to make up the difference, and several insurers became insolvent. Subsequently, the surviving insurers charged higher premium rates to meet costs and began to replenish surplus.

The California workers’ compensation legislative reforms in the early 2000s, which were developed to control medical costs, update indemnity benefits and improve the assessment of PD, had significant impact on insurance costs.

As intended, these reforms reduced workers’ compensation costs in California. It appears that the savings have been fully realized and the system has returned to a trend of cost increases. The question now is whether the cost increases are merely the long-term trends of inflation and medical cost growth, or whether the savings accomplished by the reforms are being eroded by an inability to maintain the early savings. Insurers report broad-based growth in medical spending, and judicial interpretations of the PD rating system portend increased litigation and higher PD payments. The cost of insurance continued to drop through the latest period for which written premium data are available, but filed rates have begun to climb again.

**Workers’ Compensation Written Premium**

WCIRB defines written premium as the premium an insurer expects to earn over the policy period.

As shown in the following chart, workers’ compensation written premium has undergone dramatic changes since 1995. Written premium increased slightly in the latter part of the 1990s, more than tripled from 1999 through 2004, and experienced a significant decline of over 50 percent from 2004 to 2008.

**Workers’ Compensation Written Premium as of September 30, 2009**

(Billion $)

<table>
<thead>
<tr>
<th>Year</th>
<th>Written Premium - Gross of Deductible Credits</th>
<th>Written Premium - Net of Deductible Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>95</td>
<td>$5.7</td>
<td>$5.1</td>
</tr>
<tr>
<td>96</td>
<td>$5.9</td>
<td>$5.0</td>
</tr>
<tr>
<td>97</td>
<td>$6.4</td>
<td>$5.3</td>
</tr>
<tr>
<td>98</td>
<td>$6.6</td>
<td>$5.5</td>
</tr>
<tr>
<td>99</td>
<td>$7.1</td>
<td>$5.7</td>
</tr>
<tr>
<td>00</td>
<td>$9.1</td>
<td>$6.5</td>
</tr>
<tr>
<td>01</td>
<td>$12.0</td>
<td>$8.6</td>
</tr>
<tr>
<td>02</td>
<td>$15.6</td>
<td>$11.0</td>
</tr>
<tr>
<td>03</td>
<td>$21.5</td>
<td>$14.9</td>
</tr>
<tr>
<td>04</td>
<td>$23.5</td>
<td>$16.3</td>
</tr>
<tr>
<td>05</td>
<td>$21.3</td>
<td>$15.2</td>
</tr>
<tr>
<td>06</td>
<td>$16.3</td>
<td>$11.2</td>
</tr>
<tr>
<td>07</td>
<td>$13.0</td>
<td>$8.8</td>
</tr>
<tr>
<td>08</td>
<td>$10.7</td>
<td>$7.6</td>
</tr>
</tbody>
</table>

Data Source: WCIRB

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11 Source: “2008 California’s Workers’ Compensation Losses and Expenses.” WCIRB – June 25, 2009. Note that earned premium is not identical to written premium. The two measurements are related, and the choice of which measurement to use depends on the purpose.
SYSTEM COSTS AND BENEFITS OVERVIEW

Workers’ Compensation Average Premium Rate

The following chart shows the average workers’ compensation premium rate per $100 of payroll. The average dropped during the early-to-mid 1990s, stabilized during the mid-to-late 1990s, and then rose significantly beginning in 2000 up to the second half of 2003. However, the average rate has dropped every year since that time. In the first three quarters of 2009, the average premium rate per $100 of payroll was $2.33.

Average Workers’ Compensation Insurer Rate per $100 of Payroll as of September 30, 2009 (Dollar $)

Data Source: WCIRB

Workers Covered by Workers’ Compensation Insurance

The estimated number of California workers covered by workers’ compensation insurance grew by about 23 percent from 11.96 million in 1993 to 14.73 million in 2001. From 2001 through 2005, the number of covered workers in California stabilized, averaging about 14.7 million per year. The estimated number of California workers covered by workers’ compensation insurance grew by about 6 percent from 2003 to 2007.

Estimated Number of Workers Covered by Workers’ Compensation Insurance in California (Millions)

Data Source: National Academy of Social Insurance (NASI)
**Total Earned Premium**

**Workers' Compensation Earned Premium**

(Billion $)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>8.98</td>
<td>7.83</td>
<td>5.84</td>
<td>5.78</td>
<td>6.21</td>
<td>6.47</td>
<td>7.01</td>
<td>8.63</td>
<td>11.46</td>
<td>14.81</td>
<td>20.30</td>
<td>23.25</td>
<td>17.15</td>
<td>13.27</td>
<td>10.93</td>
<td></td>
</tr>
</tbody>
</table>

Source: WCIRB

**Average Earned Premium per Covered Worker**

As shown in the graph below, the average earned premium per covered worker dropped during the early-to-mid 1990s, leveled off for a few years, and more than tripled between 1999 and 2004. There was a 46 percent decrease in average earned premium per covered worker from 2004 to 2007.

**Average Premium per Covered Worker**

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>$751</td>
<td>$644</td>
<td>$469</td>
<td>$450</td>
<td>$468</td>
<td>$472</td>
<td>$496</td>
<td>$592</td>
<td>$778</td>
<td>$1,015</td>
<td>$1,395</td>
<td>$1,581</td>
<td>$1,433</td>
<td>$1,124</td>
<td>$862</td>
</tr>
</tbody>
</table>

Data Source: WCIRB and NASI  
Calculations: CHSWC
SYSTEM COSTS AND BENEFITS OVERVIEW

Costs Paid by Self-Insured Private and Public Employers

The permissible alternatives to insurance are private self-insurance, public self-insurance for governmental entities either individually or in joint power authorities (JPAs), and legally uninsured State government. Part of the cost of workers’ compensation for self-insured employers can be estimated by the amounts of benefits paid in a given year and by changes in reserves. This method is similar to an analysis done by WCIRB for the insurance industry, but the data for self-insured employers are less comprehensive than for insurers. The most complete estimate of the cost to self-insured employers is still obtained by taking some multiple of the cost to insured employers, excluding the cost elements that only apply to insurance. As described in the sidebars at the beginning of this section, that multiple is 0.43, and the estimated cost to self-insured employers and the State for 2008 is $4.156 billion.

Private Self-Insured Employers

Number of Employees

The following chart shows the number of employees working for private self-insured employers between 1992 and 2008. A number of factors may affect the year-to-year changes. One striking comparison is to the average cost of insurance per $100 of payroll for insured employers, as described earlier. When insurance is inexpensive, fewer employers may be attracted to self-insurance, but when insurance becomes more expensive, more employers move to self-insurance.

Indemnity Claims

The rate of indemnity claims per 100 employees of private self-insured employers reflects trends seen throughout the workers’ compensation system. Frequency has been declining steadily for years. In addition, the reforms of the early 1990s and the reforms of 2003-2004 each produced distinct drops in frequency. Smaller year-to-year variations, including a small upswing in 1998 and a two-year upward trend from 2000 through 2002, are not correlated with any short-term variations in the insured market.

---

12 Data for private self insured employers is from DIR’s Office of Self Insurance Plans correspondence received by CHSWC on 08/27/2009.
Number of Indemnity Claims Per 100 Employees of Private Self-Insured Employers

Data Source: DIR Self-Insurance Plans

Incurred Cost per Indemnity Claim

The following chart shows the incurred cost per indemnity claim for private self-insured employers, which has experienced changes similar to the changes for insurance companies. There has been a steady rise in the cost per indemnity claim until 2003, when the cost began to drop in response to the reforms of 2003 and 2004. The upward trend returned in 2006. Although the growth in cost per claim is back, the cost is now growing from a lower starting point than it would have been without the reforms.

Incurred Cost Per Indemnity Claim of Private Self-Insured Employers

Data Source: DIR Self-Insurance Plans
**Incurred Cost per Indemnity and Medical Claim**

The average cost of all claims, including both indemnity claims and medical-only claims is naturally lower than the average cost of indemnity claims. While lower, it shows a pattern similar to the trends for indemnity claims. The rate of growth since 2006 has been lower for the average of all claims than in indemnity claims.

![Incurred Cost Per Claim - Indemnity and Medical Private Self-Insurers](chart)

*Data Source: DIR Self-Insurance Plans*
**Public Self-Insured Employers**

*Number of Employees*


**Number of Employees of Public Self-Insured Employers (Millions)**

- Data Source: DIR Self-Insurance Plans

*Indemnity Claims*

The number of indemnity claims by employees working for public self-insured employers remained steady between 1996-1997 to 2000-2001. Between 2000-2001 and 2004-2005, the number of indemnity claims decreased steadily, increased slightly between 2004-2005 and 2005-2006, then decreased again between 2005-2006 and 2006-2007 to the lowest level in the past 14 years, and then increased by 8 percent from 2006-2007 to 2007-2008. The rate of claims in the public sector appears to be less sensitive to the reforms which produced the marked drops in frequency in the private sector.

**Number of Indemnity Claims per 100 Employees Public Self-Insured Employers**

- Data Source: DIR Self-Insurance Plans

---

13 Data for Public Self-Insured Employers is from DIR’s Office of Self Insurance Plans correspondence received by CHSWC on 09/23/2009.
**System Costs and Benefits Overview**

*Incurred Cost per Claim*

The following chart shows the incurred cost per indemnity claim for public self-insured employers. Between 1994-1995 and 2007-2008, the incurred cost per indemnity claim increased by about 73 percent from $9,860 to $17,084.

![Incurred Cost Per Indemnity Claim](chart)

*Incurred Cost per Indemnity and Medical Claim*


![Incurred Cost per Claim - Indemnity and Medical](chart)
Workers’ Compensation System Expenditures: Indemnity and Medical Benefits

Overall Costs

Methodology for Estimating

The estimated percentages of total system costs are based on insured employer costs provided by WCIRB. The assumption is that these data apply also to self-insureds. Since self-insured employers and the State are estimated to be 30 percent of total California workers’ compensation claims, the total system costs are calculated by increasing WCIRB data for insured employers to reflect that proportion.

Growth of Workers’ Compensation Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenses</th>
<th>Medical Paid</th>
<th>Indemnity Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>61%</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>1999</td>
<td>80%</td>
<td>24%</td>
<td>13%</td>
</tr>
<tr>
<td>2000</td>
<td>85%</td>
<td>45%</td>
<td>29%</td>
</tr>
<tr>
<td>2001</td>
<td>97%</td>
<td>57%</td>
<td>31%</td>
</tr>
<tr>
<td>2002</td>
<td>146%</td>
<td>100%</td>
<td>47%</td>
</tr>
<tr>
<td>2003</td>
<td>200%</td>
<td>138%</td>
<td>70%</td>
</tr>
<tr>
<td>2004</td>
<td>231%</td>
<td>124%</td>
<td>75%</td>
</tr>
<tr>
<td>2005</td>
<td>215%</td>
<td>87%</td>
<td>60%</td>
</tr>
<tr>
<td>2006</td>
<td>204%</td>
<td>84%</td>
<td>32%</td>
</tr>
<tr>
<td>2007</td>
<td>154%</td>
<td>84%</td>
<td>16%</td>
</tr>
<tr>
<td>2008</td>
<td>145%</td>
<td>101%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Workers’ Compensation Costs Percent Growth by Year Compared With 1997

Distribution of Workers’ Compensation Costs by Type

The following chart shows the distribution of workers’ compensation insurance premiums.

Estimated Distribution of Workers’ Compensation Insurance Premiums, 2008 (Million $)

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Medical</th>
<th>Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,134</td>
<td>$5,906</td>
<td>$4,270</td>
</tr>
</tbody>
</table>

Changes to Total Reserves

-50 0.3%

Insurer Pre-Tax Underwriting Profit/Loss

-$84

* The distribution shown in this chart includes both insured and self-insured employers’ costs. For insured costs, Expenses include allocated loss adjustment expenses, unallocated loss adjustment expenses, commissions and brokerage, other acquisition expenses, and premium taxes. Self-insured employers would not encounter some of those types of expenses. In addition, insurers’s pre-tax underwriting losses were $84 million in 2008.

Data Source: WCIRB
**Indemnity Benefits**

WCIRB provided data for the cost of indemnity benefits paid by insured employers. Assuming that insured employers comprise approximately 70 percent of total California workers’ compensation claims, estimated indemnity benefits are shown on the following chart for the total system, insured employers, self-insured employers, and the State of California.

### Systemwide Estimated Costs of Paid Indemnity Benefits

<table>
<thead>
<tr>
<th>Indemnity Benefits (Thousand $)</th>
<th>2007</th>
<th>2008</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Disability</td>
<td>$2,126,502</td>
<td>$2,075,473</td>
<td>-$51,029</td>
</tr>
<tr>
<td>Permanent Total Disability</td>
<td>$131,998</td>
<td>$146,811</td>
<td>$14,813</td>
</tr>
<tr>
<td>Permanent Partial Disability</td>
<td>$1,885,192</td>
<td>$1,704,986</td>
<td>-$180,206</td>
</tr>
<tr>
<td>Death</td>
<td>$97,400</td>
<td>$99,319</td>
<td>$1,919</td>
</tr>
<tr>
<td>Funeral Expenses</td>
<td>$1,909</td>
<td>$2,217</td>
<td>$308</td>
</tr>
<tr>
<td>Life Pensions</td>
<td>$71,923</td>
<td>$83,644</td>
<td>$11,721</td>
</tr>
<tr>
<td>Voc Rehab/Non-transferable Education Voucher</td>
<td>$217,067</td>
<td>$158,242</td>
<td>-$58,825</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$4,531,990</strong></td>
<td><strong>$4,270,692</strong></td>
<td><strong>-$261,298</strong></td>
</tr>
</tbody>
</table>

### Paid by Insured Employers

<table>
<thead>
<tr>
<th>Indemnity Benefits (Thousand $)</th>
<th>2007</th>
<th>2008</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Disability *</td>
<td>$1,487,064</td>
<td>$1,451,380</td>
<td>-$35,684</td>
</tr>
<tr>
<td>Permanent Total Disability *</td>
<td>$92,306</td>
<td>$102,665</td>
<td>$10,359</td>
</tr>
<tr>
<td>Permanent Partial Disability *</td>
<td>$1,318,316</td>
<td>$1,192,298</td>
<td>-$126,018</td>
</tr>
<tr>
<td>Death *</td>
<td>$68,112</td>
<td>$69,454</td>
<td>$1,342</td>
</tr>
<tr>
<td>Funeral Expenses</td>
<td>$1,335</td>
<td>$1,550</td>
<td>$215</td>
</tr>
<tr>
<td>Life Pensions</td>
<td>$50,296</td>
<td>$58,492</td>
<td>$8,196</td>
</tr>
<tr>
<td>Voc Rehab/Non-transferable Education Voucher *</td>
<td>$151,795</td>
<td>$110,659</td>
<td>-$41,136</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3,169,224</strong></td>
<td><strong>$2,986,498</strong></td>
<td><strong>-$182,726</strong></td>
</tr>
</tbody>
</table>

### Paid by Self-Insured Employers and the State**

<table>
<thead>
<tr>
<th>Indemnity Benefits (Thousand $)</th>
<th>2007</th>
<th>2008</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Disability</td>
<td>$639,438</td>
<td>$624,093</td>
<td>-$15,345</td>
</tr>
<tr>
<td>Permanent Total Disability</td>
<td>$39,692</td>
<td>$44,146</td>
<td>$4,454</td>
</tr>
<tr>
<td>Permanent Partial Disability</td>
<td>$566,876</td>
<td>$512,688</td>
<td>-$54,188</td>
</tr>
<tr>
<td>Death</td>
<td>$29,288</td>
<td>$29,865</td>
<td>$577</td>
</tr>
<tr>
<td>Funeral Expenses</td>
<td>$574</td>
<td>$667</td>
<td>$93</td>
</tr>
<tr>
<td>Life Pensions</td>
<td>$21,627</td>
<td>$25,152</td>
<td>$3,525</td>
</tr>
<tr>
<td>Voc Rehab/Non-transferable Education Voucher</td>
<td>$65,272</td>
<td>$47,583</td>
<td>-$17,689</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,362,766</strong></td>
<td><strong>$1,284,194</strong></td>
<td><strong>-$78,572</strong></td>
</tr>
</tbody>
</table>

* Single Sum Settlement and Other Indemnity payments have been allocated to the benefit categories.

** Figures estimated based on insured employers' costs. Self-insured employers and the State of California are estimated to comprise 30 percent of all California workers' compensation claims.
**Trends in Paid Indemnity Benefits**

The estimated systemwide paid indemnity benefits for the past several years are displayed in the chart below. After the reforms of 2003 and 2004, paid indemnity benefits dropped to below the 1999 levels. The permanent partial disability that peaked in 2004 saw one of the biggest declines after the reforms. The TD benefits began declining in 2004 despite the TD benefit increases of AB 749 and the impact of the two-year limit not taking effect until April, 2006.

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**Supplemental Job Displacement Benefits Costs**

The reforms of 2003 eliminated vocational rehabilitation for injuries arising on or after January 1, 2004, and replaced it with an SJDB. The vocational rehabilitation statutes are repealed entirely effective January 1, 2009. Consequently, the expenditures for vocational rehabilitation are dwindling rapidly as the remaining pre-2004 cases run off. SJDB expenditures are taking their place, but at a much lower level.

**Supplemental Job Displacement Benefit Vouchers**

AB 227 created a system of non-transferable educational vouchers effective for injuries occurring on or after January 1, 2004. WCIRB’s estimate of the cost of educational vouchers is based on information compiled from the most current WCIRB Permanent Disability Claim Survey. In total, 18.3 percent of accident year 2004 PD claims involved educational vouchers, and the average cost of the educational vouchers was approximately $5,900. For the 2005 accident year at first survey level, 20.7 percent of sampled PD claims were reported as involving educational vouchers with an estimated average cost of approximately $5,600.

**Vocational Rehabilitation and Supplemental Job Displacement Benefit Vouchers Incurred Costs**

WCIRB has summarized the vocational rehabilitation (VR) information reported on unit statistical reports. The table below shows a summary of VR information by accident year, with losses evaluated at a combination of second and third unit report levels, depending on which policy year the accident year claim
was reported. This unit statistical information suggests that the cost per claim for VR or SJDB vouchers has declined by approximately 80 percent as SJDB has replaced VR.

<table>
<thead>
<tr>
<th>Accident Year (AY)</th>
<th>Percent of Indemnity Claims with VR or SJDB Vouchers</th>
<th>Change from Average of AY 2001-03</th>
<th>VR and SJDB Vouchers Cost per VR &amp; SJDB Vouchers Claim</th>
<th>Change from Average of AY 2001-03</th>
<th>VR and SJDB Vouchers Cost per Indemnity Claim</th>
<th>VR and SJDB Cost Level Change from Average of AY 2001-03</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>25.1%</td>
<td>$9,525</td>
<td>-</td>
<td>$2,387</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>25.2%</td>
<td>$9,635</td>
<td>-</td>
<td>$2,426</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>24.0%</td>
<td>$8,987</td>
<td>-</td>
<td>$2,158</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>12.1%</td>
<td>$4,187</td>
<td>-51%</td>
<td>$505</td>
<td>-78%</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>11.2%</td>
<td>$3,923</td>
<td>-55%</td>
<td>$441</td>
<td>-81%</td>
<td></td>
</tr>
</tbody>
</table>

Source: WCIRB

AB 227, enacted in 2003, in combination with clean-up language in SB 899 enacted in 2004, repealed the workers’ compensation VR benefit for dates of injury on or after January 1, 2004. VR benefits are available only to eligible workers who were injured before 2004 and were available only through December 31, 2008. VR is essentially over, although some litigation continues over the wind-up of VR under particular circumstances. The chart below presents the most recent data available through 2006 on VR costs including SJDB vouchers (non-transferable educational vouchers) beginning from policy year 2003.
The following chart shows the amounts paid for each component of the VR benefit including newly introduced VR settlement and SJDB vouchers for the period from 2002 through 2008.

**Paid Vocational Rehabilitation Benefits and SJDB Vouchers**  
(Million $)

<table>
<thead>
<tr>
<th>Year</th>
<th>Education Vouchers</th>
<th>VR Settlement*</th>
<th>Education &amp; Training</th>
<th>Evaluation</th>
<th>Other Voc. Rehab</th>
<th>Maintenance Allowance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>N/A</td>
<td>N/A</td>
<td>0.028</td>
<td>3.398</td>
<td>N/A</td>
<td>239.310</td>
<td>531.736</td>
</tr>
<tr>
<td>2003</td>
<td>N/A</td>
<td>N/A</td>
<td>190.464</td>
<td>130.537</td>
<td>N/A</td>
<td>265.167</td>
<td>585.988</td>
</tr>
<tr>
<td>2004</td>
<td>N/A</td>
<td>12.232</td>
<td>190.394</td>
<td>126.562</td>
<td>N/A</td>
<td>256.572</td>
<td>586.260</td>
</tr>
<tr>
<td>2005</td>
<td>N/A</td>
<td>53.039</td>
<td>134.594</td>
<td>94.933</td>
<td>N/A</td>
<td>189.050</td>
<td>470.716</td>
</tr>
<tr>
<td>2006</td>
<td>8.004</td>
<td>37.014</td>
<td>62.789</td>
<td>40.282</td>
<td>0.612</td>
<td>94.025</td>
<td>242.726</td>
</tr>
<tr>
<td>2007</td>
<td>8.598</td>
<td>22.490</td>
<td>38.151</td>
<td>24.476</td>
<td>0.949</td>
<td>57.131</td>
<td>151.795</td>
</tr>
</tbody>
</table>

* Vocational Rehabilitation Settlements were allowed on injuries occurring on or after January 1, 2003, pursuant to Assembly Bill No.749

**Data Source:** WCIRB

**Medical Benefits**

**Workers’ Compensation Medical Costs vs. Medical Inflation**

The following chart compares the growth rates of California’s workers’ compensation medical costs paid by insurers and self-insured employers with the medical component of the Consumer Price Index (CPI), also known as the “Medical CPI,” a term used by economists to describe price increases in health care services.

**Growth of Workers’ Compensation Medical Costs Compared to Medical Inflation Rate-Percent Change since 1997**  
(1997=100)

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Cost Index</th>
<th>Medical CPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>1998</td>
<td>109.9</td>
<td>103.2</td>
</tr>
<tr>
<td>1999</td>
<td>123.7</td>
<td>106.8</td>
</tr>
<tr>
<td>2000</td>
<td>144.9</td>
<td>111.2</td>
</tr>
<tr>
<td>2001</td>
<td>156.8</td>
<td>116.3</td>
</tr>
<tr>
<td>2002</td>
<td>166.8</td>
<td>121.7</td>
</tr>
<tr>
<td>2003</td>
<td>200.0</td>
<td>126.6</td>
</tr>
<tr>
<td>2004</td>
<td>237.8</td>
<td>132.2</td>
</tr>
<tr>
<td>2005</td>
<td>241.8</td>
<td>137.8</td>
</tr>
<tr>
<td>2006</td>
<td>187.3</td>
<td>143.3</td>
</tr>
<tr>
<td>2007</td>
<td>184.0</td>
<td>149.6</td>
</tr>
<tr>
<td>2008</td>
<td>183.7</td>
<td>155.2</td>
</tr>
</tbody>
</table>

**Data Source:** WCIRB; Bureau of Labor Statistics
## Distribution of Medical Benefits: Where Does the Workers' Compensation Dollar Go?

### Systemwide Estimated Costs - Medical Benefits Paid

<table>
<thead>
<tr>
<th>Medical Benefits (Thousand $)</th>
<th>2007</th>
<th>2008</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>$2,209,782</td>
<td>$2,152,919</td>
<td>-$56,863</td>
</tr>
<tr>
<td>Capitated Medical</td>
<td>$11,559</td>
<td>$19,773</td>
<td>$8,214</td>
</tr>
<tr>
<td>Hospital</td>
<td>$1,381,931</td>
<td>$1,569,319</td>
<td>$187,388</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$497,144</td>
<td>$525,875</td>
<td>$28,731</td>
</tr>
<tr>
<td>Payments Made Directly to Patient</td>
<td>$803,903</td>
<td>$943,538</td>
<td>$139,635</td>
</tr>
<tr>
<td>Medical-Legal Evaluation</td>
<td>$213,832</td>
<td>$289,112</td>
<td>$75,280</td>
</tr>
<tr>
<td>Medical Cost-Containment Programs*</td>
<td>$267,676</td>
<td>$405,763</td>
<td>$138,087</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,385,826</td>
<td>$5,906,299</td>
<td>$520,473</td>
</tr>
</tbody>
</table>

**Paid by Insured Employers**

<table>
<thead>
<tr>
<th>Medical Benefits (Thousand $)</th>
<th>2007</th>
<th>2008</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>$1,545,302</td>
<td>$1,505,538</td>
<td>-$39,764</td>
</tr>
<tr>
<td>Capitated Medical</td>
<td>$8,083</td>
<td>$13,827</td>
<td>$5,744</td>
</tr>
<tr>
<td>Hospital</td>
<td>$966,385</td>
<td>$1,097,426</td>
<td>$131,041</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$347,653</td>
<td>$367,745</td>
<td>$20,092</td>
</tr>
<tr>
<td>Payments Made Directly to Patient</td>
<td>$562,170</td>
<td>$659,817</td>
<td>$97,647</td>
</tr>
<tr>
<td>Medical-Legal Evaluation</td>
<td>$149,533</td>
<td>$202,176</td>
<td>$52,643</td>
</tr>
<tr>
<td>Medical Cost-Containment Programs*</td>
<td>$187,186</td>
<td>$283,750</td>
<td>$96,564</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$3,766,312</td>
<td>$4,130,279</td>
<td>$363,967</td>
</tr>
</tbody>
</table>

**Paid by Self-Insured Employers**

<table>
<thead>
<tr>
<th>Medical Benefits (Thousand $)</th>
<th>2007</th>
<th>2008</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>$664,480</td>
<td>$647,381</td>
<td>-$17,099</td>
</tr>
<tr>
<td>Capitated Medical</td>
<td>$3,476</td>
<td>$5,946</td>
<td>$2,470</td>
</tr>
<tr>
<td>Hospital</td>
<td>$415,546</td>
<td>$471,893</td>
<td>$56,347</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$149,491</td>
<td>$158,130</td>
<td>$8,639</td>
</tr>
<tr>
<td>Payments Made Directly to Patient</td>
<td>$241,733</td>
<td>$283,721</td>
<td>$41,988</td>
</tr>
<tr>
<td>Medical-Legal Evaluation</td>
<td>$64,299</td>
<td>$86,936</td>
<td>$22,637</td>
</tr>
<tr>
<td>Medical Cost-Containment Programs*</td>
<td>$80,490</td>
<td>$122,013</td>
<td>$41,523</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,619,514</td>
<td>$1,776,020</td>
<td>$156,506</td>
</tr>
</tbody>
</table>

* Figures for medical cost-containment programs are based on a sample of insurers who reported medical cost containment expenses to the WCIRB.

** Figures estimated based on insured employers’ costs. Self-insured employers and the State of California are estimated to comprise 30 percent of all California workers’ compensation claims from 2007.
**Trends in Paid Medical Benefits**

The estimated systemwide paid medical costs for the past several years are displayed in the chart below. The following trends may result from the impact of recent workers’ compensation reforms. The cost of the total medical benefit increased by 65.4 percent from 1999 to 2003, then decreased by 15.3 percent from 2003 to 2008. Pharmacy costs increased by 132 percent from 1999 through 2004, before declining slightly from 2004 to 2008. Expenditures on medical cost-containment programs in 2005 were less than a third of what they were in 2002 and tripled again in 2008. Hospital costs increased by 78 percent from 1999 to 2003, then declined by 39 percent from 2003 to 2006, and increased by 34.4 percent from 2006 to 2008. Medical-legal evaluation costs decreased from 2000 to 2002, then more than doubled between 2002 and 2008, with a slight decrease from 2006 to 2007. Payments to physicians increased by 51 percent from 1999 to 2003, then dropped by 41.3 percent from 2003 to 2008.

**Workers' Compensation Paid Medical Benefits by Type**

*Systemwide Estimated Costs* (Million $)

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical-Legal Evaluation</th>
<th>Med Cost Cntnmnt Prgrms</th>
<th>Pharmacy</th>
<th>Capitated Medical</th>
<th>Direct Payments to Patient</th>
<th>Hospital</th>
<th>Physicians</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>$157.0</td>
<td>N/A</td>
<td>$294.9</td>
<td>$7.9</td>
<td>$241.5</td>
<td>$1,076.0</td>
<td>$2,437.2</td>
<td>$4,214.5</td>
</tr>
<tr>
<td>2000</td>
<td>$157.0</td>
<td>N/A</td>
<td>$294.9</td>
<td>$7.9</td>
<td>$241.5</td>
<td>$1,076.0</td>
<td>$2,437.2</td>
<td>$4,214.5</td>
</tr>
<tr>
<td>2001</td>
<td>$138.5</td>
<td>N/A</td>
<td>$320.8</td>
<td>$6.5</td>
<td>$329.8</td>
<td>$1,111.6</td>
<td>$2,630.1</td>
<td>$4,537.3</td>
</tr>
<tr>
<td>2002</td>
<td>$127.4</td>
<td>N/A</td>
<td>$424.2</td>
<td>$8.8</td>
<td>$340.2</td>
<td>$1,612.0</td>
<td>$2,943.4</td>
<td>$5,537.3</td>
</tr>
<tr>
<td>2003</td>
<td>$183.5</td>
<td>$408.2</td>
<td>$651.4</td>
<td>$13.0</td>
<td>$256.1</td>
<td>$1,917.8</td>
<td>$3,669.4</td>
<td>$6,864.3</td>
</tr>
<tr>
<td>2004</td>
<td>$229.4</td>
<td>$278.8</td>
<td>$683.5</td>
<td>$15.2</td>
<td>$207.8</td>
<td>$1,796.1</td>
<td>$3,414.8</td>
<td>$6,670.0</td>
</tr>
<tr>
<td>2005</td>
<td>$244.5</td>
<td>$222.8</td>
<td>$559.1</td>
<td>$32.6</td>
<td>$866.4</td>
<td>$1,374.2</td>
<td>$2,431.0</td>
<td>$5,571.5</td>
</tr>
<tr>
<td>2006</td>
<td>$231.8</td>
<td>$127.4</td>
<td>$545.0</td>
<td>$13.5</td>
<td>$899.6</td>
<td>$1,167.9</td>
<td>$2,285.0</td>
<td>$5,452.9</td>
</tr>
<tr>
<td>2007</td>
<td>$213.8</td>
<td>$250.2</td>
<td>$497.1</td>
<td>$11.6</td>
<td>$803.9</td>
<td>$1,381.9</td>
<td>$2,209.8</td>
<td>$5,396.4</td>
</tr>
<tr>
<td>2008</td>
<td>$289.1</td>
<td>$267.7</td>
<td>$525.9</td>
<td>$19.8</td>
<td>$943.5</td>
<td>$1,569.3</td>
<td>$2,152.9</td>
<td>$5,906.3</td>
</tr>
</tbody>
</table>

Source: WCIRB
Calculations: CHSWC
**Average Claim Costs**

At the same time that premiums and claim frequency were declining, the total amount insurers paid on indemnity claims jumped sharply.

The total average cost of indemnity claims decreased by 22 percent from 2001 to 2005, reflecting the impact of AB 227, SB 228 and SB 899. However, the total indemnity and medical average costs per claim increased by 47 percent between 2005 and 2008.

---

**Estimated Ultimate Total Loss* per Indemnity Claim**

*After Reflecting the Estimated Impact of the Ogilvie and Almaraz/Guzman Decisions as of September 30, 2009*

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* Excludes medical-only

** Loss severities prior to adjustment for the impact of the Ogilvie and Almaraz/Guzman decisions for accident years 2004 to 2008 are: $39,538, $38,295, $44,410, $49,697, and $55,292, respectively.

Source: WCIRB

Please note that WCIRB’s estimates of average indemnity claim costs have not been indexed to take into account wage increase and medical inflation.
**Average Cost per Claim by Type of Injury**

As shown in the following chart, from 1999 to 2004, back injuries increased by 46 percent and slip and fall injuries by 54 percent, followed by carpal tunnel/repetitive motion injuries (RMI) by 42 percent.

Average costs of psychiatric and mental stress claims increased by 23 percent between 1999 and 2003. Between 2002 and 2003, the average cost of psychiatric and mental stress claims decreased by 2 percent and then increased by 51 percent from 2003 through 2008.

From 2004 to 2006, the average costs for all of the types of injuries shown below, with the exception of psychiatric and mental stress, declined.

The average cost for all of the types of injuries shown below increased between 2006 and 2008.

---

**Average Cost per Claim by Type of Injury**

<table>
<thead>
<tr>
<th>Year</th>
<th>Slip and Fall</th>
<th>Back Injuries</th>
<th>Other Cumulative Injuries</th>
<th>Carpal Tunnel/RMI</th>
<th>Psychiatric and Mental Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>$41,200</td>
<td>$38,016</td>
<td>$39,008</td>
<td>$29,643</td>
<td>$22,177</td>
</tr>
<tr>
<td>2000</td>
<td>$44,689</td>
<td>$40,311</td>
<td>$38,543</td>
<td>$32,817</td>
<td>$23,082</td>
</tr>
<tr>
<td>2001</td>
<td>$47,316</td>
<td>$43,739</td>
<td>$38,721</td>
<td>$34,627</td>
<td>$23,505</td>
</tr>
<tr>
<td>2002</td>
<td>$53,576</td>
<td>$47,938</td>
<td>$38,494</td>
<td>$37,552</td>
<td>$27,278</td>
</tr>
<tr>
<td>2003</td>
<td>$58,869</td>
<td>$53,049</td>
<td>$43,507</td>
<td>$40,349</td>
<td>$26,706</td>
</tr>
<tr>
<td>2004</td>
<td>$63,581</td>
<td>$55,570</td>
<td>$51,867</td>
<td>$42,152</td>
<td>$26,855</td>
</tr>
<tr>
<td>2005</td>
<td>$61,266</td>
<td>$52,955</td>
<td>$49,773</td>
<td>$41,108</td>
<td>$27,427</td>
</tr>
<tr>
<td>2006</td>
<td>$53,121</td>
<td>$45,963</td>
<td>$42,975</td>
<td>$37,598</td>
<td>$29,499</td>
</tr>
<tr>
<td>2007</td>
<td>$55,738</td>
<td>$45,698</td>
<td>$39,880</td>
<td>$37,500</td>
<td>$29,798</td>
</tr>
<tr>
<td>2008</td>
<td>$62,004</td>
<td>$49,283</td>
<td>$43,417</td>
<td>$39,709</td>
<td>$40,385</td>
</tr>
</tbody>
</table>

Data Source: WCIRB
Changes in Average Medical and Indemnity Costs per Claim by Type of Injury

The chart below illustrates the impact of the reforms on selected types of injury. The long-term trend from 2000 to 2008 shows increases in medical costs for all these types of injury. The same trend for indemnity costs shows decreases for back injuries, carpal tunnel/RMI, and other cumulative injuries as the result of reduction in those indemnity costs for both the 2005-2006 and 2006-2007 periods, and increases for the psychiatric and mental stress and slips and falls after some decrease in indemnity costs for these two types of injury for the 2006-2007 period.

From 2006 to 2007, medical costs fell for every type of injury. In the same year, indemnity costs showed decreases for all types of injury as well.

From 2007 to 2008, medical costs increased for every type of injury, the largest being a 57 percent increase for psychiatric and mental stress. In the same year, indemnity costs increased for every type of injury, the largest being 18.6 percent for psychiatric and mental stress.

Data Source: WCIRB
Medical-Legal Expenses

Changes to the medical-legal process over the years have been intended to reduce both the cost and the frequency of litigation. Starting in 1989, legislative reforms restricted the number of medical-legal evaluations needed to determine the extent of PD. The qualified medical evaluator (QME) designation was intended to improve the quality of medical evaluations in cases where the parties did not select an agreed medical evaluator (AME). Legislation in 1993 attempted to limit workers’ compensation judges to approving the PD rating proposed by one side or the other (Labor Code Section 4065, known as “baseball arbitration”). In addition, the 1993 legislation established a presumption in favor of the evaluation by the treating physician (Labor Code Section 4602.9), which was expected to reduce litigation and reduce costs.

In 1995, CHSWC contracted with the Survey Research Center at the University of California (UC), Berkeley to assess the impact of workers’ compensation reform legislation on the workers’ compensation medical-legal evaluation process.

This ongoing study has determined that during the 1990s, the cost of medical-legal evaluations dramatically improved. As shown in the following discussion, this was due to reductions in all the factors that contribute to the total cost. However, baseball arbitration proved to be impractical and the treating physician’s presumption turned out to cost more than it saved. Assembly Bill (AB) 749, enacted in 2002, repealed baseball arbitration and partially repealed the primary treating physician’s presumption, except when the worker had pre-designated a personal physician or personal chiropractor for injuries occurring on or after January 1, 2003. This partial repeal was carried further by Senate Bill (SB) 228 enacted in 2003 to all dates of injury, except in cases where the employee has pre-designated a personal doctor or chiropractor. Finally, in 2004, SB 899 completely repealed the primary treating physician’s presumption.

The reforms of SB 899 also changed the medical dispute resolution process in the workers’ compensation system by eliminating the practice of each attorney obtaining a QME of his or her own choice. The new provisions required that the dispute resolution process through an AME or a single QME applies to all disputes including compensability of claim and PD evaluation.

In cases where attorneys do not agree on an AME, SB 899 limits the attorneys to one QME jointly selected by process of elimination from a state-assigned panel of three evaluators. In cases without attorneys, the injured worker selects the QME from the state-assigned panel, similar to the process established since 1989 for non-attorney cases.

After a significant decrease of medical-legal expenses starting in 1989 when legislative reforms restricted the number and lowered the cost of medical-legal evaluations, there was again a significant increase in average medical-legal costs beginning in the 2000 accident year. In 2006, the average cost of medical-legal evaluations was $1,505, or a 29.5 percent increase compared to the 2005 accident year, and the highest level since 1989. In the workers’ compensation system, the medical-legal cost is reported as a component of medical cost and beginning from 2002, represents its growing portion. A decline in medical costs shortly after passage of major reform measures in 2003 and 2004, followed by a sharp increase starting in 2006, raises the question of how much of the rise in medical costs is attributable to increasing medical-legal costs. The table below shows the share of medical-legal costs in workers’ compensation medical costs from 1997 to 2008.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Medical-Legal Evaluation Costs in Total Medical Costs</td>
<td>5.4</td>
<td>4.6</td>
<td>3.7</td>
<td>3.6</td>
<td>3.0</td>
<td>2.2</td>
<td>2.6</td>
<td>3.5</td>
<td>4.8</td>
<td>4.3</td>
<td>4.8</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Source: WCIRB Losses and Expenses report, Exhibit 1.4
Increases in both the number and cost of medical-legal evaluations are expected to result from two recent California Workers’ Compensation Appeals Board *en banc* decisions (described elsewhere in this Annual Report). The Almaraz/Guzman and Ogilvie decisions may require more reports and more complex reports for the assessment of permanent impairment and disability, and as result, an increase in litigation and medical-legal costs.

Throughout the discussion of the cost of medical-legal reports, it will be important to remember that the quality of medical-legal reports has an impact on the cost of the system and the timeliness of benefit delivery which may very well overshadow the direct cost of the medical-legal reports.

The medical-legal analysis that follows uses data from the WCIRB *Permanent Disability Survey*. Accident year 2006 is the latest year for which sufficiently mature data reports are available.

**Permanent Disability Claims**

The following chart displays the number of permanent partial disability (PPD) claims during each calendar year since 1989. Through 1993, WCIRB created these data series from Individual Case Report Records submitted as part of the Unit Statistical Report. Since that time, the series has been discontinued, and estimates for 1994 and subsequent years are based on policy year data adjusted to the calendar year and information on the frequency of all claims, including medical-only claims, that are still available on a calendar year basis.

The data presented in the medical-legal section of this report are current and based on the latest available data through accident year 2006.

**Medical-Legal Evaluations per Claim**

The following chart illustrates that the average number of medical-legal evaluations per claim declined from 2.53 evaluations in 1990 to 0.78 in 2001. This decline of 69 percent is attributed to a series of reforms since 1989 and the impact of efforts against medical mills.

Reforms instituted in 1993 that advanced the role of the treating physician in the medical-legal process and granted the opinions of the treating physician a presumption of correctness were expected to reduce the average number of evaluations even further. Earlier CHSWC reports evaluating the treating physician
presumption did not find that these reforms had significant effect on the average number of evaluations per claim. SB 899 enacted in 2004 completely repealed the primary treating physician’s presumption (Labor Code Section 4062.9).

The change in the average number of evaluations between 1993 and 1994 was almost entirely the result of improvements that occurred during the course of 1993 calendar year claims. These results were based on smaller surveys done by WCIRB when the claims were less mature. These later data involving a larger sample of surveyed claims suggest that the number of evaluations per claim continued to decline after leveling off between 1993 and 1995.

Between 2001 and 2004, the average number of medical-legal evaluations per claim increased by 29.5 percent. The increase from 2001 to 2004 could be driven by a number of factors, some of which are discussed in connection with the spike in early first medical-legal evaluations, discussed below. The average number of medical-legal evaluations per claim for accident year 2005 decreased by 24 percent compared to accident year 2004, went down to the level of 1997 and remained at that level for the 2006 accident year. The decrease in evaluations was likely due to the SB 899 provision requiring a single QME or AME even in represented cases for injuries beginning 1/1/2005.

Medical-Legal Reporting by California Region

The different regions of California are often thought to have different patterns of medical-legal reporting. The revisions to the WCIRB Permanent Disability Survey, undertaken at the recommendation of CHSWC and instituted for the 1997 accident year, explored new issues. A zip code field was added to analyze patterns in different regions.

The following chart demonstrates the frequency with which medical-legal evaluations were used between 1997 and 2006 in different regions. Accident years 1998 and 1999 did not indicate any significant difference in frequency across the State’s major regions. However, as the number of evaluations per claim continued to decline between 2000 and 2002, the differences between regions became more pronounced. Between 2002 and 2004, the average number of medical-legal evaluations per claim for each region increased and then decreased again from 2004 to 2005, with the lowest number of medical-legal evaluations per claim (0.67) in nine years for Southern California. In 2006, this pattern repeated as a slight decrease for Northern and Central regions, but there was a 13 percent increase in the number of evaluations per claim in the Southern region.
Different regions of California have different patterns of medical-legal reporting. Also, regions with a higher share of workers’ compensation claims in the system have a bigger impact on the average number of medical-legal evaluations per claim and average cost of medical-legal evaluations in the State. As the table below indicates, the Southern California region has the highest number of workers’ compensation claims in the system, followed by the Northern California region.

<table>
<thead>
<tr>
<th>Region</th>
<th>2004 1st level</th>
<th>2005 1st level</th>
<th>2006 1st level</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>58.1%</td>
<td>63.1%</td>
<td>61.8%</td>
</tr>
<tr>
<td>Central</td>
<td>16.3%</td>
<td>13.5%</td>
<td>13.6%</td>
</tr>
<tr>
<td>North</td>
<td>25.7%</td>
<td>23.4%</td>
<td>24.6%</td>
</tr>
</tbody>
</table>

Usually, the Southern California region has had higher numbers for both the average cost per evaluations and the average number of evaluations per claim than the Northern California region. However, starting with 2003, the number of medical-legal evaluations per claim in the Northern California region grew higher than in the Southern California region. The number of medical-legal evaluations per claim in the Central California region was the highest among all three regions in six out of the nine years.

**Average Cost per Medical-Legal Evaluation**

The average cost of a medical-legal evaluation per claim declined from 1990 to the mid-1990s and then increased from the mid-1990s to 2000 by 15 percent. Between 2000 and 2006, the average cost of a medical-legal evaluation doubled.

There are two reasons why the average cost per medical-legal evaluation declined from 1990 to 1995. First, substantial changes were made to the structure of the Medical-Legal Fee Schedule that reduced the rates at which medical-legal evaluations are reimbursed. These restrictions were introduced in early 1993 and enforced at the beginning of August 1993.

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14 Based on WCIRB’s PD Survey random sample.
Second, during this period, the average cost of a medical-legal evaluation was also being affected by the frequency of psychiatric evaluations. On average, psychiatric evaluations are the most expensive evaluations by specialty of provider. The relative portion of all evaluations that is made up of psychiatric evaluations has declined since hitting a high during 1990-1991, leading to a substantial improvement in the overall average cost per evaluation.

In 2006, the average cost of a medical-legal evaluation increased by 72.4 percent compared to 2004 medical-legal evaluations and reached its highest level since 1990.

Since the mid-1990s, the average cost of a medical-legal evaluation has increased, even though the reimbursement under the medical-legal fee schedule did not change from 1993 until 2006. The revised PD Survey by WCIRB includes additional questions that reveal some of the potential causes of this increase in costs. The changes indicate various types of fee schedule classifications as well as geography factors.

15 The new Medical-Legal Fee Schedule became effective for dates of service on or after July 1, 2006.
16 Issues for injury years before 1997 cannot be examined because the WCIRB survey revision of that year prevents comparisons.
SYSTEM COSTS AND BENEFITS OVERVIEW

The survey data show that, on average, evaluations done in the Southern California region have always been substantially more expensive. Increases in the average cost are being driven by claims in the Southern California region as can be seen from the table below.

Table: Regional Contributions to the Increase of the Average Medical-Legal Costs: 2000-2006

<table>
<thead>
<tr>
<th>Region</th>
<th>Distribution of Medical-Legal Evaluations by Region in 2000</th>
<th>Distribution of Medical-Legal Evaluations by Region in 2006</th>
<th>Change in Average Cost 2000-2006</th>
<th>Contribution of Each Region to the Average Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern California</td>
<td>58.6%</td>
<td>58.1%</td>
<td>$997</td>
<td>78%</td>
</tr>
<tr>
<td>Central California</td>
<td>16.5%</td>
<td>16.3%</td>
<td>$532</td>
<td>9%</td>
</tr>
<tr>
<td>Northern California</td>
<td>24.5%</td>
<td>25.7%</td>
<td>$395</td>
<td>12%</td>
</tr>
</tbody>
</table>

Cost Drivers

The primary cost driver for California and its Southern region is not the price paid for specific types of evaluations. Rather, the mix of codes under which the evaluations are billed has changed to include a higher percentage of the most complex and expensive evaluations and fewer of the least expensive type.¹⁷

The two tables below show the costs and description from the Medical-Legal Fee Schedule.

Table: Medical-Legal Evaluation Cost for Dates of Service before July 1, 2006

<table>
<thead>
<tr>
<th>Evaluation Type</th>
<th>Amount Presumed Reasonable</th>
</tr>
</thead>
<tbody>
<tr>
<td>ML-101 Follow-up/ Supplemental</td>
<td>$250</td>
</tr>
<tr>
<td>ML-102 Basic</td>
<td>$500</td>
</tr>
<tr>
<td>ML-103 Complex</td>
<td>$750</td>
</tr>
<tr>
<td>ML-104 Extraordinary</td>
<td>$200/hour</td>
</tr>
</tbody>
</table>

Table: Medical-Legal Evaluation Cost for Dates of Service on or after July 1, 2006

<table>
<thead>
<tr>
<th>Evaluation Type</th>
<th>Amount Presumed Reasonable</th>
</tr>
</thead>
<tbody>
<tr>
<td>ML-101 Follow-up/Supplemental</td>
<td>$62.50/15 minutes or $250/hr</td>
</tr>
<tr>
<td>ML-102 Basic</td>
<td>$625</td>
</tr>
<tr>
<td>ML-103 Complex</td>
<td>$937.50</td>
</tr>
<tr>
<td>ML-104 Extraordinary</td>
<td>$62.50/15 minutes or $250/hr</td>
</tr>
</tbody>
</table>

¹⁷ WCIRB also noted that much of the increase in the average cost of a medical-legal evaluation is attributable to increases in a proportion of more complex medical-legal evaluations. Claims Subcommittee meeting minutes for July 28, 2008.

¹⁸ Please note that Agreed Medical Evaluators receive 25 percent more than the rates shown in both of the tables.
The following two charts indicate that the distribution of evaluations both in the Southern California region and California as a whole has shifted away from ML-101 evaluations to include a higher percentage of ML-104 evaluations with "Extraordinary" complexity. Evaluations with "Extraordinary" complexity increased from 19 percent to 42.8 percent in the Southern California region and from 19 percent to 38.3 percent in all regions from 1998 to 2006.
Increases to the medical-legal fee schedules for dates of services on or after July 1, 2006, could have also contributed to the higher average cost per evaluation. The chart below shows that the average cost per evaluation in each type of evaluation is higher in the 2006 accident year sample compared to the 2001 accident year. The biggest increases are for the Complex and Extraordinary cases.

In addition, the medical-legal evaluations in 2006 accident year had both a higher average cost of Extraordinary evaluations ($1,126 and $2,143 respectively) and a higher share of Extraordinary evaluations (24 percent and 38.3 percent respectively) than in accident year 2001.

The chart below shows that the average cost of Extraordinary medical-legal evaluations increased by 40 percent after July 1, 2006, when the new Medical-Legal Fee Schedule became effective.
Psychiatric evaluations are nearly always billed under the ML-104 code that is the most expensive.

Another possible explanation for the differing trends in the average number of medical-legal evaluations per claim both in California and its regions and the increasing frequency of the most Complex evaluations in California is that psychiatric evaluations increased from 6.4 percent of total medical-legal evaluations in 2004 to 7.7 percent in 2005 and to 8.7 percent in 2006. The chart below indicates a 16.4 percent increase in psychiatric evaluations per report in the Southern California region and a 15.2 percent increase in psychiatric evaluations per report in the Northern California region from 2005 to 2006. From 2005 to 2006, there was a 10.6 percent decrease in psychiatric evaluations per claim in the Central California region.

At the same time, the average cost of a psychiatric evaluation increased by 8.3 percent, from $2,351 in 2005 to $2,545 in 2006, exacerbating the effect of the increase in psychiatric evaluations in the Southern California region.

**Average Number of Psychiatric Evaluations per PPD Claim by Region**

<table>
<thead>
<tr>
<th>Year</th>
<th>Northern California</th>
<th>Central California</th>
<th>Southern California</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>0.049</td>
<td>0.054</td>
<td>0.068</td>
</tr>
<tr>
<td>1999</td>
<td>0.033</td>
<td>0.025</td>
<td>0.075</td>
</tr>
<tr>
<td>2000</td>
<td>0.037</td>
<td>0.056</td>
<td>0.092</td>
</tr>
<tr>
<td>2001</td>
<td>0.019</td>
<td>0.034</td>
<td>0.106</td>
</tr>
<tr>
<td>2002</td>
<td>0.013</td>
<td>0.057</td>
<td>0.069</td>
</tr>
<tr>
<td>2003</td>
<td>0.027</td>
<td>0.057</td>
<td>0.062</td>
</tr>
<tr>
<td>2004</td>
<td>0.037</td>
<td>0.034</td>
<td>0.081</td>
</tr>
<tr>
<td>2005</td>
<td>0.046</td>
<td>0.022</td>
<td>0.061</td>
</tr>
<tr>
<td>2006</td>
<td>0.053</td>
<td>0.046</td>
<td>0.071</td>
</tr>
</tbody>
</table>

Data Source: WCIRB
Total Medical-Legal Cost Calculation

Total medical-legal costs are calculated by multiplying the number of permanent partial disability (PPD) claims by the average number of medical-legal evaluations per claim and by the average cost per medical-legal evaluation:

Total Medical-Legal Cost = Number of PPD Claims \times \text{Average Evaluations/Claim} \times \text{Average Cost/Evaluation}

Medical-Legal Costs

During the 1990s, the cost of medical-legal evaluation improved dramatically. For the insured community, the total cost of medical-legal evaluations performed on PPD claims by 40 months after the beginning of the accident year declined from a high of $419 million in 1990 to an estimated $56.3 million for injuries occurring in 2006. This is an 86.6 percent decline since 1990.

Medical-Legal Costs on PPD Claims at Insured Employers
(In Million $, 40 months after beginning of accident year)

| Data Source: WCIRB |

Sources of Improvement in Medical-Legal Costs

The decline in total medical-legal costs for insurers as shown below reflects improvements in all components of the cost structure during the 1990s. As discussed in the previous sections, this substantial decline in total medical-legal costs for insurers results from significant decreases in two components of the cost structure: the total number of PPD claims; and the number of medical-legal evaluations per PPD claims. The source of savings can be attributed in almost equal proportion to the reduction in the number of evaluations performed per claim and the decline in PPD claim frequency.

Table: Sources of Change in Medical-Legal Costs

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>2006</th>
<th>Change 1990-2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PPD Claims</td>
<td>167.7</td>
<td>45.6</td>
<td>-72.8%</td>
</tr>
<tr>
<td>Number of evaluations per PPD Claims</td>
<td>2.53</td>
<td>0.82</td>
<td>-67.6%</td>
</tr>
<tr>
<td>Average Cost of Evaluation</td>
<td>$986</td>
<td>$1,505</td>
<td>+52.6%</td>
</tr>
</tbody>
</table>
WORKERS’ COMPENSATION SYSTEM PERFORMANCE

INTRODUCTION

The Commission on Health and Safety and Workers’ Compensation (CHSWC) examines the overall performance of the health and safety and workers’ compensation systems to determine whether they meet the State’s constitutional objective to “accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character.”

In this section, CHSWC has attempted to provide performance measures to assist in evaluating the system impact on everyone, particularly workers and employers.

Through studies and comments from the community, as well as administrative data, CHSWC has compiled the following information pertaining to the performance of California’s systems for health and safety and workers’ compensation. Explanations of the data are included with the graphs.

Workers’ Compensation Appeals Board (WCAB) Workload
   DWC Opening Documents
   DWC Hearings
   DWC Decisions
   DWC Lien Decisions
   Vocational Rehabilitation/Supplemental Job Displacement Benefit (SJDB)
   DWC Audit and Enforcement Program
   Disability Evaluation Unit
   Medical Provider Networks and Healthcare Organizations
   Information and Assistance Unit
   Uninsured Employers Benefits Trust Fund

Adjudication Simplification Efforts
   DWC Information System
   Carve-outs – Alternative Workers’ Compensation Systems

Anti-Fraud Efforts

WCAB WORKLOAD

Division of Workers’ Compensation Opening Documents

Three types of documents open a Workers’ Compensation Appeals Board (WCAB) case. The following chart shows the numbers of Applications for Adjudication of Claim (Applications), Original Compromise and Releases (C&Rs), and Original Stipulations (Stips) received by the Division of Workers’ Compensation (DWC).

The number of documents filed with DWC to open a WCAB case on a workers’ compensation claim fluctuated during the early and mid-1990s, leveled off during the late 1990s, increased slightly between 2000 and 2003, and decreased between 2003 and 2007. Prior to August 9, 2008, DWC’s workload adjudication data were available from the legacy system. DWC transitioned to a new computer-based system, the Electronic Adjudication Management System (EAMS), at the end of August 2008. Therefore, data for 2008 are comprised of data both from the legacy and from the EAMS system and may not be directly comparable to previous years due to transition issues.
The period from 1993 to 1996 shows substantial increases in Applications, slight increases in Stips, and significant decreases in C&Rs during the period from 1993 to 1995. Through 2003, C&Rs continued to decline, while Applications increased. Between 2003 and 2007, Applications declined substantially, and C&Rs decreased slightly. 2007 was the lowest year since 1992 for all three documents combined, with C&Rs nearing a historic low in 2006 followed by a slight increase in 2007.

**DWC Opening Documents**

As shown in the following graph, the proportion or mix of the types of case-opening documents received by DWC varied during the 1990s. The proportion of Applications was rising from 1993 through 2003 and declining slightly from 2003 to 2007. The proportion of original (case-opening) Stips averaged 12 percent from 1993 to 2003 and then increased from 2003 to 2007. The proportion of original C&R’s declined from 1993 to 2003 and then increased from 2003 to 2007.
**Division of Workers’ Compensation Hearings**

**Numbers of Hearings**

The graph below indicates the numbers of different types of hearings held in DWC from 1997 through 2008. While the total number of hearings held increased by 52 percent from 1997 to 2007, the number of expedited hearings grew by about 162 percent during the same period.

Expedited hearings for certain cases, such as determination of medical necessity, may be requested pursuant to Labor Code Section 5502(b). Per Labor Code Section 5502(d), Initial 5502 Conferences are to be conducted in all other cases within 30 days of the receipt of a Declaration of Readiness (DR), and Initial 5502 Conference. Trials are to be held within 75 days of the receipt of a DR if the issues were not settled at the Initial 5502 Conference.

**Timeliness of Hearings**

California Labor Code Section 5502 specifies the time limits for various types of hearings conducted by DWC on WCAB cases. In general:

- A conference is required to be held within 30 days of the receipt of a request in the form of a DR.
- A trial must be held either within 60 days of the request or within 75 days if a settlement conference has not resolved the dispute.
- An expedited hearing must be held within 30 days of the receipt of the DR.

As the following chart shows, the average elapsed time from a request to a DWC hearing decreased in the mid-1990s to late-1990s and then remained fairly constant. From 2000 to 2004, all of the average elapsed times have increased from the previous year’s quarter and none were within the statutory requirements. However, between 2005 and 2007, the average elapsed time from the request to a trial
decreased by 46 percent. The average elapsed time for conferences decreased by 44 percent, while the average time for expedited hearings decreased by 15 percent.

### Elapsed Time in Days from Request to DWC Hearing (4th Quarter)

Please note: Data for 2008 are from the EAMS system. Data extracted from EAMS system do not count hearings in the same way as did the legacy system and therefore are not directly comparable to previous years' data.

<table>
<thead>
<tr>
<th>Year</th>
<th>First 5502 Conference</th>
<th>First 5502 Trial</th>
<th>Expedited Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>81</td>
<td>102</td>
<td>36</td>
</tr>
<tr>
<td>1996</td>
<td>78</td>
<td>116</td>
<td>32</td>
</tr>
<tr>
<td>1997</td>
<td>70</td>
<td>146</td>
<td>34</td>
</tr>
<tr>
<td>1998</td>
<td>62</td>
<td>121</td>
<td>31</td>
</tr>
<tr>
<td>1999</td>
<td>68</td>
<td>117</td>
<td>31</td>
</tr>
<tr>
<td>2000</td>
<td>62</td>
<td>144</td>
<td>35</td>
</tr>
<tr>
<td>2001</td>
<td>71</td>
<td>144</td>
<td>37</td>
</tr>
<tr>
<td>2002</td>
<td>79</td>
<td>125</td>
<td>40</td>
</tr>
<tr>
<td>2003</td>
<td>102</td>
<td>171</td>
<td>48</td>
</tr>
<tr>
<td>2004</td>
<td>118</td>
<td>211</td>
<td>57</td>
</tr>
<tr>
<td>2005</td>
<td>113</td>
<td>218</td>
<td>40</td>
</tr>
<tr>
<td>2006</td>
<td>67</td>
<td>163</td>
<td>41</td>
</tr>
<tr>
<td>2007</td>
<td>63</td>
<td>117</td>
<td>34</td>
</tr>
<tr>
<td>2008</td>
<td>70</td>
<td>130</td>
<td>49</td>
</tr>
</tbody>
</table>

Source: DWC

### Division of Workers’ Compensation Decisions

#### DWC Case-Closing Decisions

The number of decisions made by DWC that are considered to be case-closing declined overall during the 1990s, with a slight increase from 2000 to 2002, followed by a decrease in 2003, and then an increase between 2003 and 2005. In 2007, the total for case-closing decisions decreased by 18 percent compared to 2005.

### DWC Case-Closing Decisions

Please note: Prior to 8/9/2008, DWC’s workload adjudication data was available from the legacy system. DWC transitioned to a new computer-based system, the Electronic Adjudication Management System (EAMS), at the end of August 2008. Therefore, data for 2008 are comprised of data both from the legacy and from the EAMS system and may not be directly comparable to previous years due to transition issues.
The preceding chart shows the following:

- The numbers of Findings and Awards (F&As) have shown an overall decline of 10.5 percent from 1993 to 2007.
- Findings and Orders (F&Os) inconsistently changed between 1993 and 2007. From 1993 to 1994, F&Os declined by 9 percent, but between 1994 and 1996, they increased by 15 percent. For the next five years (1996 to 2001), F&Os declined by 34 percent, and this was followed by a 9 percent increase between 2001 and 2002 and then a 4 percent decrease from 2002 to 2003. From 2003 and 2007, F&Os increased by 35 percent.

**Mix of DWC Decisions**

As shown on the charts on the previous page and this page, again, the vast majority of the case-closing decisions rendered during the 1990s were in the form of a WCAB judge’s approval of Stips and C&Rs which were originally formulated by the case parties.

During the period from 1993 through the beginning of 2000 and beyond, the proportion of Stips rose, while the proportion of C&Rs declined. This reflects the large decrease in the issuance of C&Rs through the 1990s.

Only a small percentage of case-closing decisions evolved from an F&A or F&O issued by a WCAB judge after a hearing.

**DWC Decisions: Percentage Distribution by Type of Decisions**

Please note: Prior to 8/9/2008, DWC’s workload adjudication data was available from the legacy system. DWC transitioned to a new computer-based system, the Electronic Adjudication Management System (EAMS), at the end of August 2008. Therefore, data for 2008 are comprised of data both from the legacy and from the EAMS system and may not be directly comparable to previous years due to transition issues.
Division of Workers’ Compensation Lien Decisions

DWC has been dealing with a large backlog of liens filed on WCAB cases. The majority of the liens have been for medical treatment and medical-legal reports. However, liens are also filed to obtain reimbursement for other expenses:

- The Employment Development Department (EDD) files liens to recover disability insurance indemnity and unemployment benefits paid to industrially injured workers.
- Attorneys have an implied lien during representation of an injured worker. If an attorney is substituted out of a case and seeks a fee, the attorney has to file a lien.
- District Attorneys file liens to recover spousal and/or child support ordered in marital dissolution proceedings of the injured worker.
- Although relatively rare now, a private disability insurance policy holder will occasionally file a lien on workers’ compensation benefits on the theory that the proceeds from the benefits were used for living expenses of the injured worker.
- Some defendants will file liens in lieu of petitions for contribution where they have paid or are paying medical treatment costs to which another carrier’s injury allegedly contributed.
- Liens are sometimes used to document recoverable (non-medical) costs, e.g., photocopying of medical records, interpreters’ services and travel expenses.

Among medical liens, there are several reasons liens may be filed:

- In the past, some providers routinely filed liens when they submitted medical bills or medical-legal bills without waiting to see whether bills would be paid or disputed.
- In some cases, treatment is provided “on lien” because: the claims administrator has disputed liability for the injury; the claims administrator has failed or refused to provide the treatment; or treatment is provided “on lien” without first seeking authorization. In some cases, even for authorized treatment, the amount payable is in dispute.
- Of particular concern is the practice of using the lien process to seek additional payment after services have already been reimbursed pursuant to the applicable fee schedule and accepted by the provider without dispute. This practice is apparently driven by independent collection services that get a portion of whatever they can collect on these written-off balances.

A lien filing fee of $100 was enacted in an attempt to discourage the filing of premature or frivolous medical liens. Labor Code Section 4903.05 was enacted by Senate Bill (SB) 228 in 2003 and amended by SB 899 in 2004. The volume of lien filings was promptly cut in half, but DWC encountered difficulties in carrying out the filing fee program. Effective July 1, 2006, budget trailer bill language in Assembly Bill (AB) 1806 repealed the lien filing fee and added Section 4903.6 to forbid the premature filing of medical liens at DWC district offices. The volume of lien filings promptly doubled after the repeal of the filing fee.
As shown in two charts below, the number of liens has increased by more than 110 percent between 2000 and 2003, decreased by 66 percent between 2003 and 2005, increased by more than 190 percent between 2005 and 2007, and decreased by 17 percent from 2007 to 2008.

**Number of Liens Filed, 2000 - 2007**  
(Legacy System data)

Data Source: DIR

**Number of Liens Filed, 2000 - 2008**  
(EAMS)*

* Please Note that data from Electronic Adjudication Management System (EAMS) does not include informational liens

Data Source: DWC
The following chart shows a large growth in decisions regarding liens filed on WCAB cases and a concomitant expenditure of DWC staff resources on the resolution of those liens.

**DWC Lien Decisions**

(Thousands)

Please note: Prior to 8/9/2008, DWC's workload adjudication data was available from the legacy system. DWC transitioned to a new computer-based system, the Electronic Adjudication Management System (EAMS), at the end of August 2008. Therefore, data for 2008 are comprised of data both from the legacy and from the EAMS system and may not be directly comparable to previous years due to transition issues.
VOCATIONAL REHABILITATION/SUPPLEMENTAL JOB DISPLACEMENT BENEFIT (SJDB)\(^{19}\)

AB 227 enacted in 2003, in combination with clean-up language in SB 899 enacted in 2004, repealed the workers’ compensation vocational rehabilitation benefit for dates of injury on or after January 1, 2004. Vocational rehabilitation benefits are available only to eligible workers who were injured before 2004 and were available only through December 31, 2008. Vocational rehabilitation is essentially over, although some litigation continues over the wind-up of vocational rehabilitation under particular circumstances.

The vocational rehabilitation program was replaced by a supplemental job displacement benefit (SJDB) to provide a voucher for education-related retraining or skills-enhancement for workers injured on or after January 1, 2004, who cannot return to their at-injury employers. Several problems exist with the current SJDB benefit, including the fact that vouchers are frequently settled for cash, vouchers never expire, and the administrative process is complex.

The following is calendar year 2008 data for the vocational rehabilitation/SJDB program:

The number of:

- Opening documents by type and total – 2,080 and 12,785 reopened
- Plans (new) – 211
- Disputes (new) – 2,652
- Settlements (new) – 5,657

These numbers account for new and reopened cases:

- Plans approved for unrepresented employees = 65
- Plans approved for represented employees = 146

Closures by types and totals:

- Employee completed plan and returned to work = 1,322
- Employee completed plan and not working = 2,986
- Employee settled prospective vocational rehabilitation = 5,657

Dispute resolution & conferences = 3,817.

The Retraining & Return to Work Unit issued 7,198 determinations for calendar year 2008.

Appeals = 475 or a 6 percent of the decisions issued and less than 1 percent were overturned by the WCAB or higher court.

Open cases as of January 1, 2008 = 42,538 and on December 31, 2008, all cases were closed due to the repeal of vocational rehabilitation, effective January 1, 2009.

Return to work with the same employer in either a modified or alternative work position (pre-2004 date of injury) calendar year 2008 total = 137.

Return to work (post-2004 date of injury) in either a regular, modified or alternative job for calendar year 2008 total = 9,794.

SJDB disputes for calendar year 2008 = 346.

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\(^{19}\) Calendar year 2007 data were not available from DWC due to Electronic Adjudication Management System (EAMS) transition issues.
DIVISION OF WORKERS’ COMPENSATION AUDIT AND ENFORCEMENT PROGRAM

Background

The 1989 California workers’ compensation reform legislation established an audit function within DWC to monitor the performance of workers’ compensation insurers, self-insured employers, and third-party administrators to ensure that industrially injured workers are receiving proper benefits in a timely manner.

The purpose of the audit and enforcement function is to provide incentives for the prompt and accurate delivery of workers’ compensation benefits to industrially injured workers and to identify and bring into compliance those insurers, third-party administrators, and self-insured employers who do not deliver benefits in a timely and accurate manner.

Assembly Bill 749 Changes to the Audit Program

Assembly Bill (AB) 749, effective January 1, 2003, resulted in major changes to California workers’ compensation law and mandated significant changes to the methodologies for file selection and assessment of penalties in the audit program.

Labor Code Sections 129 and 129.5 were amended to ensure that each audit unit will be audited at least once every five years and that good performers will be rewarded. A profile audit review (PAR) of every audit subject will be done at least every five years. Any audit subject that fails to meet a profile audit standard established by the Administrative Director (AD) of the DWC will be given a full compliance audit (FCA). Any audit subject that fails to meet or exceed the FCA performance standard will be audited again within two years. Targeted PARs or FCAs may also be conducted at any time based on information indicating that an insurer, self-insured employer, or third-party administrator is failing to meet its obligations.

To reward good performers, profile audit subjects that meet or exceed the PAR performance standard will not be liable for any penalties but will be required to pay any unpaid compensation. FCA subjects that meet or exceed standards will only be required to pay penalties for unpaid or late paid compensation, as well as any unpaid compensation.

Labor Code Section 129.5(e) was amended to provide for civil penalties up to $100,000 if an employer, insurer, or third-party administrator has knowingly committed or (rather than “and”) has performed with sufficient frequency to indicate a general business-practice act discharging or administering its obligations in specified improper manners. Failure to meet the FCA performance standards in two consecutive FCAs will be rebuttably presumed to be engaging in a general business practice of discharging and administering compensation obligations in an improper manner.

Review of the civil penalties assessed is obtained by written request for a hearing before WCAB rather than by application for a writ of mandate in the Superior Court. Judicial review of the Board’s F&O is as provided in Sections 5950 et seq.

Penalties collected under Section 129.5 and unclaimed assessments for unpaid compensation under Section 129 are credited to the Workers’ Compensation Administration Revolving Fund (WCARF).

Audit and Enforcement Unit Data

The following charts and graphs depict workload data from 2000 through 2008. As noted on the charts, data before 2003 cannot be directly compared with similar data in 2003 and after because of the significant changes in the program effective January 1, 2003.
Overview of Audit Methodology

Selection of Audit Subjects

Audit subjects, including insurers, self-insured employers, and third-party administrators, are selected randomly for routine audits.

The bases for selecting audit subjects for targeted audits are specified in 8 California Code of Regulations (CCR) Section 10106.1(c), effective January 1, 2003:

- Complaints regarding claims handling received by DWC.
- Failure to meet or exceed FCA Performance Standards.
- High numbers of penalties awarded pursuant to Labor Code Section 5814.
- Information received from the Workers’ Compensation Information System (WCIS).
- Failure to provide a claim file for a PAR.
- Failure to pay or appeal a Notice of Compensation Due ordered by the Audit Unit.
Routine and Targeted Audits

The following chart shows the number of routine audits and targeted audits and the total number of audits conducted each year.

**Please Note:** Assembly Bill 749 resulted in major changes to California workers’ compensation law and mandated significant changes to the audit program beginning in 2003. Therefore, audit workload data from years prior to 2003 cannot directly be compared with data from 2003 and after.

**Note:** An additional target audit was conducted based on a return agreement in a previous stipulation of civil penalty in year 2000.

Audits by Type of Audit Subject

The following chart depicts the total number of audit subjects each year with a breakdown by whether the subject is an insurance company (insurer), a self-insured employer, or a third-party administrator.
Selection of Files to be Audited

The majority of claim files are selected for audit on a random basis, with the number of indemnity and denied cases being selected based on the numbers of claims in each of those populations of the audit subject:

- Targeted files are selected because they have attributes that the audits focus on.
- Additional files include claims chosen based on criteria relevant to a targeted audit but for which no specific complaints had been received.
- The number of claims audited is based upon the total number of claims at the adjusting location and the number of complaints received by DWC related to claims-handling practices. Types of claims include indemnity, medical-only, denied, complaint and additional.

The following chart shows the total number of files audited each year, broken down by the method used to select them.

Files Audited by Method of Selection

<table>
<thead>
<tr>
<th>Year</th>
<th>Target</th>
<th>Random</th>
<th>Total Files Audited</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>321</td>
<td>8,600</td>
<td>8,921</td>
</tr>
<tr>
<td>2001</td>
<td>644</td>
<td>8,105</td>
<td>8,749</td>
</tr>
<tr>
<td>2002</td>
<td>532</td>
<td>8,329</td>
<td>8,861</td>
</tr>
<tr>
<td>2003</td>
<td>262</td>
<td>3,163</td>
<td>3,425</td>
</tr>
<tr>
<td>2004</td>
<td>939</td>
<td>2,337</td>
<td>2,276</td>
</tr>
<tr>
<td>2005</td>
<td>228</td>
<td>4,538</td>
<td>4,766</td>
</tr>
<tr>
<td>2006</td>
<td>180</td>
<td>4,004</td>
<td>4,184</td>
</tr>
<tr>
<td>2007</td>
<td>191</td>
<td>4,195</td>
<td>4,386</td>
</tr>
<tr>
<td>2008</td>
<td>118</td>
<td>3,755</td>
<td>3,873</td>
</tr>
</tbody>
</table>

Please Note: Assembly Bill 749 resulted in major changes to California workers' compensation law and mandated significant changes to the audit program beginning in 2003. Therefore, audit workload data from years prior to 2003 cannot be directly compared with data from 2003 and after.

Data Source: DWC Audit and Enforcement Unit

Administrative Penalties

As shown in the following chart, the administrative penalties assessed have changed significantly since the reform legislation changes to the Audit and Enforcement Program beginning in 2003.

DWC Audit Unit - Administrative Penalties

<table>
<thead>
<tr>
<th>Year</th>
<th>Assessable penalties waived per LC§129.5(c) and regulatory authority</th>
<th>Total penalties Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>N/A</td>
<td>$1,524,470</td>
</tr>
<tr>
<td>2001</td>
<td>N/A</td>
<td>$1,793,065</td>
</tr>
<tr>
<td>2002</td>
<td>N/A</td>
<td>$2,004,890</td>
</tr>
<tr>
<td>2003</td>
<td>$624,835</td>
<td>$81,645</td>
</tr>
<tr>
<td>2004</td>
<td>$518,605</td>
<td>$835,988</td>
</tr>
<tr>
<td>2005</td>
<td>$606,125</td>
<td>$1,252,153</td>
</tr>
<tr>
<td>2006</td>
<td>$1,200,800</td>
<td>$811,146</td>
</tr>
<tr>
<td>2007</td>
<td>$1,254,320</td>
<td>$649,840</td>
</tr>
<tr>
<td>2008</td>
<td>$1,210,176</td>
<td>$703,295</td>
</tr>
</tbody>
</table>

Source: DWC Audit and Enforcement Unit
The following chart shows the average number of penalty citations per audit subject each year and the average dollar amount per penalty citation.

**Average Number of Penalty Citations per Audit Subject and Average Amount per Penalty Citation**

*Please Note:* Assembly Bill 749 resulted in major changes to California workers’ compensation law and mandated significant changes to the audit program beginning in 2003. Therefore audit workload data from years prior to 2003 cannot be directly compared with data from 2003 and after.

Source: DWC Audit and Enforcement Unit

**Unpaid Compensation Due To Claimants**

Audits identify claim files in which injured workers were owed unpaid compensation. The administrator is required to pay these employees within 15 days after receipt of a notice advising the administrator of the amount due, unless a written request for a conference is filed within 7 days of receipt of the audit report. When employees due unpaid compensation cannot be located, the unpaid compensation is payable by the administrator to WCARF. In these instances, application by an employee can be made to DWC for payment of monies deposited by administrators into this fund.

The following chart depicts the average number of claims per audit where unpaid compensation was found and the average dollar amount of compensation due per claim.
The following chart shows unpaid compensation each year, broken down by percentage of the specific type of compensation that was unpaid.

**Unpaid Compensation in Audited Files**

**Type by Percentage of Total**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest and penalty and/or unreimbursed medical expenses</td>
<td>3.5%</td>
<td>2.5%</td>
<td>1.6%</td>
<td>0.8%</td>
<td>0.2%</td>
<td>0.8%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Self-imposed increases for late indemnity payments</td>
<td>16.5%</td>
<td>13.9%</td>
<td>10.7%</td>
<td>17.6%</td>
<td>16.0%</td>
<td>11.6%</td>
<td>14.2%</td>
<td>13.7%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Voc. Rehab Maintenance Allowance</td>
<td>5.9%</td>
<td>3.7%</td>
<td>5.2%</td>
<td>6.0%</td>
<td>3.8%</td>
<td>12.1%</td>
<td>5.9%</td>
<td>0.1%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Permanent Disability</td>
<td>44.5%</td>
<td>42.9%</td>
<td>36.6%</td>
<td>38.4%</td>
<td>50.0%</td>
<td>40.9%</td>
<td>40.3%</td>
<td>38.8%</td>
<td>45.4%</td>
</tr>
<tr>
<td>Death Benefits</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>TD &amp; salary continuation in lieu of TD</td>
<td>29.7%</td>
<td>36.9%</td>
<td>45.6%</td>
<td>37.1%</td>
<td>30.0%</td>
<td>34.5%</td>
<td>39.3%</td>
<td>46.7%</td>
<td>37.3%</td>
</tr>
</tbody>
</table>

Data Source: DWC Audit and Enforcement Unit

For further information …

DWC Annual Audit Reports may be accessed at [http://www.dir.ca.gov/dwc/audit.html](http://www.dir.ca.gov/dwc/audit.html)


**DISABILITY EVALUATION UNIT**

The DWC Disability Evaluation Unit (DEU) determines permanent disability (PD) ratings by assessing physical and mental impairments in accordance with the Permanent Disability Rating Schedule (PDRS). The ratings are used by workers' compensation judges, injured workers, and insurance claims administrators to determine PD benefits.

DEU prepares three types of ratings: formal, done at the request of a workers' compensation judge; consultative, done at the request of an attorney or DWC Information & Assistance (I&A) Officer; and summary, done at the request of a claims administrator or injured worker. Summary ratings are done only on non-litigated cases, and formal consultative ratings are done only on litigated cases.

The rating is a percentage that estimates how much a job injury permanently limits the kinds of work the injured employee can do. It is based on the employee’s medical condition, date of injury, age when injured, occupation when injured, how much of the disability is caused by the employee’s job, and his or her diminished future earning capacity. It determines the number of weeks that the injured employee is entitled to PD benefits.

The following charts depict DEU’s workload during 2003 and 2008. The first chart shows the written ratings produced each year by type. The second chart illustrates the total number of written and oral ratings each year.
**WORKERS' COMPENSATION SYSTEM PERFORMANCE**

**DEU Written Ratings 2003-2008**

![Graph showing DEU Written Ratings 2003-2008](image)

**DEU Oral and Written Ratings by Type 2003-2008**

![Graph showing DEU Oral and Written Ratings by Type 2003-2008](image)

**Summary**

- **Formal Ratings**
  - 2003: 2,386
  - 2004: 1,995
  - 2005: 2,299
  - 2006: 2,874
  - 2007: 2,786
  - 2008: 1,584

- **Summary - Treating Doctor**
  - 2003: 29,198
  - 2004: 25,385
  - 2005: 15,922
  - 2006: 13,422
  - 2007: 12,361
  - 2008: 8,440

- **Summary - Panel QME**
  - 2003: 14,753
  - 2004: 14,147
  - 2005: 18,001
  - 2006: 22,139
  - 2007: 23,142
  - 2008: 16,027

- **Consultative - Walk-In**
  - 2003: 34,369
  - 2004: 36,563
  - 2005: 30,553
  - 2006: 31,181
  - 2007: 24,528
  - 2008: 16,383

- **Consultative - Other**
  - 2003: 57,367
  - 2004: 51,442
  - 2005: 50,275
  - 2006: 46,210
  - 2007: 46,530
  - 2008: 34,607

- **Total Written Ratings**
  - 2003: 138,073
  - 2004: 129,532
  - 2005: 117,050
  - 2006: 115,826
  - 2007: 109,347
  - 2008: 79,041

**Source:** DWC Disability Evaluation Unit

*From 2008, statistics on Oral Ratings are not maintained.*

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WORKERS’ COMPENSATION SYSTEM PERFORMANCE

QUALIFIED MEDICAL EVALUATOR PANELS

DWC assigns panels composed of three QMEs from which an injured worker without an attorney selects the evaluator for a medical dispute. Beginning in 2005, a similar process became effective for cases where the worker has an attorney. This resulted in an increased number of QME panels. The changes contributed to a larger percentage of problems with the panel assignments.

The chart below indicates the number of Qualified Medical Evaluator (QME) Panel Lists issued each year.

![Number of Qualified Medical Evaluator (QME) Panel Lists](chart1)

Data Source: DWC

The following chart indicates the number of problems with the original QME panel issued necessitating a replacement list. Some of the problems with panel assignment include parties not submitting documentation or submitting inadequate documentation, parties not being eligible for a QME panel, or DWC needing additional information in order to make a determination for panel eligibility.

![Number of Qualified Medical Evaluator (QME) Panel Problems](chart2)

Data Source: DWC
MEDICAL PROVIDER NETWORKS AND HEALTH CARE ORGANIZATIONS

Medical Provider Networks

Background

In recent years, the California workers' compensation system has seen significant increases in medical costs. Between 1997 and 2003, workers' compensation medical treatment expenses in California increased by an estimated 138 percent,²¹ outpacing the costs for equivalent medical treatment provided in non-industrial settings. To abate this rise in costs, major reforms were made in 2003 and 2004. One such effort was the signing into law of SB 899 in April of 2004. One major component of SB 899 was the option for self-insured employers or insurers to establish a medical provider network (MPN), as promulgated in Labor Code Section 4616 et. seq. MPNs were implemented beginning January 1, 2005.

An MPN is a network of providers established by an insurer, self-insured employer, Joint Powers Authority (JPA), the State, a group of self-insured employers, a self-insurer security fund, or California Insurance Guarantee Association (CIGA) to treat work-related injuries.

The establishment of an MPN gives significant medical control to employers. With the exception of employees who have a pre-designated physician, according to California Labor Code Section 4600, employers that have established an MPN control the medical treatment of employees injured at work for the life of the claim as opposed to 30 days of medical control that employers had prior to SB 899. Having an MPN means the employer has more control with regard to who is in the network and who the injured worker sees for care for the life of the claim. The employer gets to choose who the injured worker goes to on the first visit: after the first visit, the injured worker can go to a doctor of his/her choosing in the MPN.

Before the implementation of an MPN, insurers and employers are required to file an MPN application with DWC for review and approval, pursuant to Title 8 CCR § 9767.1 et. seq.

Application Review Process

California Labor Code Section 4616(b) mandates that DWC review and approve MPN plans submitted by employers or insurers within 60 days of plan submission. If DWC does not act on the plan within 60 days, the plan is deemed approved by default.

Upon receipt of an MPN application, DWC does an initial cursory review of all applications received. The result of the review is communicated to each applicant in a “complete” or “incomplete” letter, as applicable. Applicants with sections missing in their application will be asked to complete the missing part(s). Applicants with a complete application will receive a “complete” letter indicating the target date of when the full review of their application will be completed. The clock for the 60-day time frame within which DWC should act starts from the day a complete application is received at DWC.

The full review of an application involves a thorough scrutiny, using a standard checklist, to see if the application followed the statutory and regulatory requirements set forth in California Labor Code Section 4616 et. seq. and the California Code of Regulations sections 9767.1 et. seq. The full review culminates with an approval letter if no deficiency is discovered in the submitted application. Applicants with deficient applications are sent a disapproval letter listing deficiencies that need to be corrected.

Material modification filings go through a similar review process as an initial application. Except in cases where an applicant was approved under the emergency regulations and is now updating the application

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²⁰ The information in this section was provided by the DWC Medical Unit, with minor edits by CHSWC staff.
²¹ Based on WCIRB annual report California Workers’ Compensation Losses and Expenses prepared pursuant to § 11759.1 of the California Insurance Code.
to the permanent regulations, reviews of material modifications are done only for those sections of the applications affected by the material change.

Applications Received and Approved

The Table below provides a summary of MPN program activities from the inception of the MPN program in November 1, 2004, to August 04, 2009. During this time frame, the MPN program received 1,557 MPN applications. Of these, 19 were ineligible as they were erroneously submitted by insured employers who under the MPN regulations are not eligible to set up an MPN. As of August 4, 2009, 1,416 applications were approved. Of these, 987 were approved under the emergency regulations and the remaining 429 under the permanent regulations. Seventeen (17) approved applications were revoked by DWC. The reason for revocation was the applicants’ erroneous reporting of their status as self-insured when in fact they were insured entities. One hundred and five (105) were withdrawn after approval and forty-three (43) were withdrawn before approval. The reasons for the withdrawals were either that the applicant decided not to pursue an MPN or there was a duplicate submission of the same application.

Table: MPN Program Activities from November 1, 2004, to August 4, 2009

<table>
<thead>
<tr>
<th>MPN Applications</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received</td>
<td>1,557</td>
</tr>
<tr>
<td>Approved</td>
<td>1,416</td>
</tr>
<tr>
<td>Material Modifiers</td>
<td>1,571</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>148</td>
</tr>
<tr>
<td>Revoked</td>
<td>17</td>
</tr>
<tr>
<td>Ineligible</td>
<td>19</td>
</tr>
</tbody>
</table>

The chart below shows the time of receipt of MPN applications by month and year. The bulk of applications, 48.2 percent (752), were received in 2005. About 8.4 percent (131) were received in 2006, 4.9 percent (76) were received in 2007, and 9.6 percent (149) were received in 2008.

Number of MPN Applications Received by Month and Year of Receipt (Total = 1,559)

<table>
<thead>
<tr>
<th>Data Source: DWC</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>JANUARY</td>
<td>175</td>
<td>28</td>
<td>3</td>
<td>15</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>FEBRUARY</td>
<td>168</td>
<td>14</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>MARCH</td>
<td>74</td>
<td>12</td>
<td>8</td>
<td>10</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>APRIL</td>
<td>95</td>
<td>9</td>
<td>5</td>
<td>10</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>MAY</td>
<td>64</td>
<td>18</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>JUNE</td>
<td>71</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>JULY</td>
<td>35</td>
<td>4</td>
<td>14</td>
<td>15</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>AUGUST</td>
<td>12</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEPTEMBER</td>
<td>20</td>
<td>18</td>
<td>3</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCTOBER</td>
<td>13</td>
<td>5</td>
<td>7</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOVEMBER</td>
<td>125</td>
<td>13</td>
<td>10</td>
<td>4</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>DECEMBER</td>
<td>260</td>
<td>12</td>
<td>1</td>
<td>12</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>385</td>
<td>752</td>
<td>131</td>
<td>76</td>
<td>149</td>
<td>66</td>
</tr>
</tbody>
</table>

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The chart below shows that 70.2 percent (994) of MPN applications were approved in 2005, while only 9.7 percent (137) were approved in 2006, 5.3 percent (75) were approved in 2007, and 7.5 percent (106) were approved in 2008.

### Number of MPN Applications Approved by Month and Year (Total = 1,416)

<table>
<thead>
<tr>
<th>Month</th>
<th>2004 (Dec)</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009 (Jan-Jul)</th>
</tr>
</thead>
<tbody>
<tr>
<td>JANUARY</td>
<td>0</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>FEBRUARY</td>
<td>138</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>MARCH</td>
<td>288</td>
<td>18</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>APRIL</td>
<td>121</td>
<td>20</td>
<td>4</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>MAY</td>
<td>129</td>
<td>27</td>
<td>5</td>
<td>8</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>JUNE</td>
<td>71</td>
<td>10</td>
<td>6</td>
<td>17</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>JULY</td>
<td>89</td>
<td>9</td>
<td>7</td>
<td>9</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>AUGUST</td>
<td>76</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEPTEMBER</td>
<td>36</td>
<td>14</td>
<td>6</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCTOBER</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOVEMBER</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DECEMBER</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>3</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>10</td>
<td>994</td>
<td>137</td>
<td>75</td>
<td>106</td>
<td>94</td>
</tr>
</tbody>
</table>

DataSource: DWC

### Material Modifications

MPN applicants are required by Title 8 CCR §9767.8 to provide notice to DWC for any material change to their approved MPN application. In addition, MPN applicants approved under the emergency regulations must update their application to conform to the permanent MPN regulations when providing notice of material change to their approved application.

As of August 4, 2009, 1,571 applicants had filed a material modification with DWC. Some applicants have more than one material modification. Two hundred and ninety-three (293) applicants had two material modification filings and 72 had three filings, while 1 had 27 filings.

The following chart shows how many material modification filings were received at DWC; 78 material modifications were filed in 2005, 231 in 2006, 510 in 2007, 382 in 2008, and 370 from January to August 2009.
WORKERS' COMPENSATION SYSTEM PERFORMANCE

Number of MPN Material Modifications Received by Month and Year (Total = 1,571)

MPN Applicants

The table below shows the numbers of MPN applicants by type of applicant. The majority, 61.4 percent, of MPN applications were filed by insurers, followed by self-insured employers (33.5 percent).

Table: Distribution of Approved MPN Applications by Type of Applicant (Total for all years = 1,416)
The chart below shows the distribution of MPN applicants by type.

**Distribution of All Approved MPN Applications by Type of Applicant from 2004 to 2009 (Total = 1,416)**

<table>
<thead>
<tr>
<th>Type of Applicant</th>
<th>Number</th>
<th>% Applications Received</th>
<th>% Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurer</td>
<td>870</td>
<td>61%</td>
<td>61%</td>
</tr>
<tr>
<td>Self ‐ Insured</td>
<td>475</td>
<td>34%</td>
<td>34%</td>
</tr>
<tr>
<td>Joint Powers Authority</td>
<td>46</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Group of Self ‐ Insured Employers</td>
<td>23</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>State</td>
<td>2</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Data Source: DWC

**HCO Networks**

HCO networks are used by 668 (47.2 percent) of the approved MPNs. The distribution of MPNs by HCO is shown in the Table below. First Health HCO has 31.5 percent of the MPN market share followed by Corvel HCO, which has 8.7 percent, and Prudent Buyer HCO, which has 4.5 percent. There seems to be a decrease in the use of HCO networks for MPNs.

MPN applicants are allowed to have more than one MPN. As a result, 62.4 percent of applicants have more than one MPN, including 19.7 percent with 21 to 40 MPNs. (See Table, Distribution of Approved Applicants by Number of MPNs per Applicant, above). The names of MPN applicants with 10 or more approved MPNs are shown in the Table on the next page (Names of MPN Applicants with 10 or More Approved MPNs). ACE American Insurance Company leads with 40 MPNs followed by Zurich American Insurance Company with 36 MPNs, and American Home Assurance Company with 33 MPNs.

**Table: Number of MPN Applicants Using HCO Networks**

<table>
<thead>
<tr>
<th>Name of HCO</th>
<th>Number</th>
<th>% Applications Received</th>
<th>% Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>CompAmerica (First Health)</td>
<td>446</td>
<td>66.8%</td>
<td>31.5%</td>
</tr>
<tr>
<td>Corvel</td>
<td>114</td>
<td>17.1%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Prudent Buyer (Blue Cross)</td>
<td>64</td>
<td>9.6%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Medex</td>
<td>35</td>
<td>5.2%</td>
<td>2.4%</td>
</tr>
<tr>
<td>CompPartners</td>
<td>5</td>
<td>0.7%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Net-Work</td>
<td>3</td>
<td>0.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Intracorp</td>
<td>1</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total Using HCO</strong></td>
<td><strong>668</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>47.2%</strong></td>
</tr>
</tbody>
</table>
WORKERS’ COMPENSATION SYSTEM PERFORMANCE

Distribution of Approved MPNs by Number of MPNs per Applicant, 2009

- 1 MPN per applicant: 532, 38%
- 2-9 MPNs per applicant: 450, 32%
- 10-20 MPNs per applicant: 155, 11%
- 21-35 MPNs per applicant: 203, 14%
- 36-40 MPNs per applicant: 76, 5%

Data Source: DWC

Table: Names of MPN Applicants with 10 or More Approved MPNs

<table>
<thead>
<tr>
<th>Name of Applicant</th>
<th>Number of MPNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE American Insurance Company</td>
<td>40</td>
</tr>
<tr>
<td>Zurich American Insurance Company</td>
<td>36</td>
</tr>
<tr>
<td>American Home Assurance Company</td>
<td>33</td>
</tr>
<tr>
<td>The Insurance Company of the State of Pennsylvania</td>
<td>28</td>
</tr>
<tr>
<td>Fidelity and Guaranty Insurance Company</td>
<td>27</td>
</tr>
<tr>
<td>National Union Fire Insurance Company of Pittsburgh, PA</td>
<td>25</td>
</tr>
<tr>
<td>United States Fidelity and Guaranty Company</td>
<td>23</td>
</tr>
<tr>
<td>Discover Property and Casualty Insurance Company</td>
<td>23</td>
</tr>
<tr>
<td>Fidelity &amp; Guaranty Insurance Underwriters, Inc</td>
<td>22</td>
</tr>
<tr>
<td>Old Republic Insurance Company</td>
<td>22</td>
</tr>
<tr>
<td>New Hampshire Insurance Company, Ltd.</td>
<td>17</td>
</tr>
<tr>
<td>American Zurich Insurance Company</td>
<td>16</td>
</tr>
<tr>
<td>Commerce and Industry Insurance Company</td>
<td>16</td>
</tr>
<tr>
<td>ARCH Insurance Company</td>
<td>15</td>
</tr>
<tr>
<td>AIG Casualty Company</td>
<td>13</td>
</tr>
<tr>
<td>Granite State Insurance Company</td>
<td>13</td>
</tr>
<tr>
<td>XL Specialty Insurance Company</td>
<td>12</td>
</tr>
<tr>
<td>Safety National Casualty Corporation (SNCC)</td>
<td>12</td>
</tr>
<tr>
<td>American Guarantee &amp; Liability Insurance Company</td>
<td>11</td>
</tr>
<tr>
<td>Continental Casualty Company (CNA)</td>
<td>10</td>
</tr>
<tr>
<td>Landmark Insurance Company</td>
<td>10</td>
</tr>
<tr>
<td>Hartford Insurance Company of the Midwest</td>
<td>10</td>
</tr>
</tbody>
</table>
Covered employees

The number of MPN applicants reporting employees under their MPN has increased since the last report, as more and more MPN applicants are reporting the number of employees covered under the MPN, at the time of filing their material modification to update their MPN application to conform to the MPN permanent regulations. Currently, we have information on 73.8 percent (1038) of approved MPN applicants. The total estimated number of covered employees, as reported by these MPN applicants, is 27,752,709. DWC recommends that this number be used with caution, as it believes this number to possibly be inflated due to insurers’ multiple counting of covered employees in their multiple MPN applications.

Employers/Insurers with MPN

Neither the number nor the name of insured employers using MPNs can be obtained from MPN applications. Insurers are not required to report who among their insured employers are using their MPN. The list of self-insured employers with a self-reported number of covered employees greater than five thousand is shown below. This list includes some large self-insured companies such as Albertsons, AT&T, FedEx, Safeway, Home Depot, Target Corporation, Raley’s, and Federated Department Store.

MPN Complaints

The MPN program has set up a complaint logging and resolution system. Complaints are received by phone, fax, email and mail. Since January 2006, DWC has received 194 complaints. DWC has contacted the liaison of the MPNs and resolved and closed 194 of the complaints.

Status of the MPN Program

The MPN program is a new program that is growing and as such, the intake, application tracking and review process are works in progress. The program has improved over time but there is still room for improvement. Professional as well as clerical staff could benefit from more training on programs such as Excel and Access which could facilitate the intake logging process. In addition, scanning of copies of application documents could reduce the space that is currently being used by MPN applications. Currently, two hard copies of each application are kept by DWC.

During the past year, the main focus of the program has been to review and approve MPN material modifications and to process the change of MPN notice. However, more research on the MPN provider networks and the functioning of MPNs needs to be undertaken on the following: what percentage of the different networks overlap, i.e., which networks have the same doctors? what are the economic profiling policies of the different networks? which areas of the State are covered by MPNs and which areas lack providers? and which provider specialties are lacking?

DWC does not have any mechanism to monitor if approved MPNs are indeed functioning according to their approved application. However, a complaint-tracking system has been put in place, and so far, DWC has received 172 complaints. Most of the complaints were regarding insufficient provider listings given to the injured worker.
## List of Self-Insured MPN Applicants with Covered Employees of 5,000 or More, August 2009

<table>
<thead>
<tr>
<th>Name of Applicant</th>
<th>Name of MPN</th>
<th>Number of Covered employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regents of The University of California</td>
<td>Regents of The University of California MPN</td>
<td>189,925</td>
</tr>
<tr>
<td>Los Angeles Unified School District</td>
<td>Sedgwick CMS Extended Medical Provider Network</td>
<td>138,000</td>
</tr>
<tr>
<td>County of Los Angeles</td>
<td>CorVel HCO</td>
<td>94,000</td>
</tr>
<tr>
<td>Target Corporation</td>
<td>Target Medical Provider Network</td>
<td>75,300</td>
</tr>
<tr>
<td>Safeway, Inc.</td>
<td>Safeway Select MPN</td>
<td>60,000</td>
</tr>
<tr>
<td>Kelly Services, Inc</td>
<td>Kelly Services Medical Provider Network</td>
<td>58,500</td>
</tr>
<tr>
<td>The Home Depot</td>
<td>The Home Depot Medical Provider Network</td>
<td>58,048</td>
</tr>
<tr>
<td>Target Corporation</td>
<td>Sedgwick CMS/Harbor Net-Target</td>
<td>50,000</td>
</tr>
<tr>
<td>K-Mart Corporation</td>
<td>Sedgwick CMS / Harbor Net - SHG</td>
<td>40,000</td>
</tr>
<tr>
<td>Macy's Inc.</td>
<td>Macy's Inc. Medical Provider Network</td>
<td>32,575</td>
</tr>
<tr>
<td>Pacific Bell Telephone Company</td>
<td>Sedgwick CMS Extended Medical Provider Network</td>
<td>31,500</td>
</tr>
<tr>
<td>Costco Wholesale</td>
<td>Costco MPN</td>
<td>31,000</td>
</tr>
<tr>
<td>Kaiser Foundation Hospitals, a California Corporation</td>
<td>Kaiser Permanente MPN</td>
<td>29,880</td>
</tr>
<tr>
<td>New Albertsons, Inc.(A SuperValu Company)</td>
<td>New Albertson's Inc. CA MPN</td>
<td>27,000</td>
</tr>
<tr>
<td>Southern California Permanente Medical Group</td>
<td>Kaiser Permanente MPN</td>
<td>26,353</td>
</tr>
<tr>
<td>Kimco Staffing Services, Inc.</td>
<td>First Health CompAmerica Primary Network</td>
<td>26,000</td>
</tr>
<tr>
<td>Mainstay Business Solutions</td>
<td>WellComp Medical Provider Network</td>
<td>22,500</td>
</tr>
<tr>
<td>County of Orange</td>
<td>WellComp Medical Provider Network</td>
<td>22,000</td>
</tr>
<tr>
<td>San Diego Unified School District</td>
<td>State Fund Medical Provider Network</td>
<td>22,000</td>
</tr>
<tr>
<td>County of Orange</td>
<td>Cambridge Orange County MPN</td>
<td>21,500</td>
</tr>
<tr>
<td>County of Orange</td>
<td>Intracorp</td>
<td>21,400</td>
</tr>
<tr>
<td>Pacific Gas and Electric Company</td>
<td>PG&amp;E /Blue Cross Medical Provider Network</td>
<td>21,000</td>
</tr>
<tr>
<td>San Diego Unified School District</td>
<td>wellComp Medical Provider Network</td>
<td>20,762</td>
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<tr>
<td>Marriott International, Inc.</td>
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<td>Manpower Inc.</td>
<td>Concentra MPN</td>
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<tr>
<td>The County of Riverside</td>
<td>First Health Comp America Select</td>
<td>20,173</td>
</tr>
<tr>
<td>City and County of San Francisco</td>
<td>City and County of San Francisco Medical Provider Network</td>
<td>20,000</td>
</tr>
<tr>
<td>Name of Applicant</td>
<td>Name of MPN</td>
<td>Number of Covered employees</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>San Diego Unified School District</td>
<td>TRISTAR - CompAmerica Primary HCO</td>
<td>20,000</td>
</tr>
<tr>
<td>Sun Microsystems, Inc. (Sun)</td>
<td>First Health Network</td>
<td>20,000</td>
</tr>
<tr>
<td>Walt Disney World Co (The Disneyland Resort Division)</td>
<td>Disneyland Resort Medical Provider Network</td>
<td>20,000</td>
</tr>
<tr>
<td>Ventura County Schools Self-Funding Authority</td>
<td>WellComp Medical Provider Network</td>
<td>19,566</td>
</tr>
<tr>
<td>County of Riverside</td>
<td>CorVel MPN/County of Riverside</td>
<td>19,000</td>
</tr>
<tr>
<td>Manpower, Inc.</td>
<td>Sedgwick CMS MPN</td>
<td>19,000</td>
</tr>
<tr>
<td>Viacom International Services, Inc.</td>
<td>First Health Comp America HCO Select Network</td>
<td>18,913</td>
</tr>
<tr>
<td>Countrywide Financial Corporation</td>
<td>Countrywide Network</td>
<td>18,000</td>
</tr>
<tr>
<td>Nordstrom Inc.</td>
<td>Nordstrom Medical Provider Network</td>
<td>17,000</td>
</tr>
<tr>
<td>Securitas Security Services USA, Inc.</td>
<td>Securitas Broadspire SNP</td>
<td>16,890</td>
</tr>
<tr>
<td>Hewlett Packard Company</td>
<td>Sedgwick CMS Extended Medical Provider Network</td>
<td>16,500</td>
</tr>
<tr>
<td>COP/CPB of the Church of Jesus Christ of the Latter-day Saints</td>
<td>Deseret MPN</td>
<td>16,000</td>
</tr>
<tr>
<td>American Building Maintenance (ABM)</td>
<td>ABM Network</td>
<td>15,800</td>
</tr>
<tr>
<td>Southern California Edison</td>
<td>SCE Select</td>
<td>15,514</td>
</tr>
<tr>
<td>Federal Express Corporation</td>
<td>Intracorp</td>
<td>14,878</td>
</tr>
<tr>
<td>County of San Bernardino</td>
<td>CorVel MPN</td>
<td>14,000</td>
</tr>
<tr>
<td>The Walt Disney Company</td>
<td>The Liberty Mutual Group MPN</td>
<td>13,924</td>
</tr>
<tr>
<td>Alliance of Schools for Cooperative Insurance Programs</td>
<td>WellComp Medical Provider Network</td>
<td>13,764</td>
</tr>
<tr>
<td>Raley's</td>
<td>Raley's Quality Medical Provider Network</td>
<td>13,500</td>
</tr>
<tr>
<td>Lockheed Martin Corporation</td>
<td>INTRACORP/Lockheed Martin MPN</td>
<td>13,400</td>
</tr>
<tr>
<td>Intel Corporation</td>
<td>Broadspire MPN</td>
<td>13,223</td>
</tr>
<tr>
<td>Barrett Business Services, Inc.</td>
<td>BBSI/CorVel MPN</td>
<td>12,000</td>
</tr>
<tr>
<td>AT&amp;T</td>
<td>Sedgwick CMS Extended Medical Provider Network</td>
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</tr>
<tr>
<td>Lowe's HIW, Inc.</td>
<td>Lowe's CA MPN</td>
<td>11,500</td>
</tr>
<tr>
<td>Santa Barbara County Schools - SIPE</td>
<td>PacMed, Inc. HCO</td>
<td>11,000</td>
</tr>
<tr>
<td>Dole Food Company, Inc.</td>
<td>First Health CompAmerica Select HCO Network (or &quot;First Health Select&quot;)</td>
<td>10,980</td>
</tr>
<tr>
<td>Memorial Health Services</td>
<td>TRISTAR CompAmerica Primary HCO</td>
<td>10,827</td>
</tr>
<tr>
<td>Name of Applicant</td>
<td>Name of MPN</td>
<td>Number of Covered employees</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>County of Kern</td>
<td>County of Kern Medical Provider Network</td>
<td>10,800</td>
</tr>
<tr>
<td>Saugus Union School District</td>
<td>Prime Advantage Medical Network</td>
<td>10,707</td>
</tr>
<tr>
<td>Tenet Healthcare Corporation</td>
<td>First Health CompAmerica Primary HCO Network (or &quot;First Health Primary&quot;)</td>
<td>10,642</td>
</tr>
<tr>
<td>Foster Farms</td>
<td>CorVel Custom MPN</td>
<td>10,000</td>
</tr>
<tr>
<td>LFP, Inc. and Affiliates</td>
<td>CorVel MPN</td>
<td>10,000</td>
</tr>
<tr>
<td>99¢ Only Stores</td>
<td>WellComp Medical Provider Network</td>
<td>9,976</td>
</tr>
<tr>
<td>Circuit City Stores, Inc.</td>
<td>Sedgwick CMS Extended Medical Provider</td>
<td>9,775</td>
</tr>
<tr>
<td>San Francisco Unified School District</td>
<td>First Health CompAmerica Primary HCO</td>
<td>9,500</td>
</tr>
<tr>
<td>United Airlines</td>
<td>CorVel/UAL/Kaiser MPN</td>
<td>9,500</td>
</tr>
<tr>
<td>Foster Poultry Farms</td>
<td>Foster Farms Custom CorVel MPN</td>
<td>9,200</td>
</tr>
<tr>
<td>Smart &amp; Final, Inc.</td>
<td>Sedgwick CMS Extended Medical Provider</td>
<td>9,000</td>
</tr>
<tr>
<td>BCI Coca-Cola Bottling Company of Los Angeles (Coca-Cola Enterprises, Inc.)</td>
<td>Sedgwick CMS Medical Provider Network</td>
<td>8,500</td>
</tr>
<tr>
<td>Alameda County</td>
<td>First Health CompAmerica Primary Network</td>
<td>8,494</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan, Inc. A California Corporation</td>
<td>Kaiser Permanente MPN</td>
<td>8,448</td>
</tr>
<tr>
<td>Save Mart Supermarkets, Inc.</td>
<td>The Status MPN-Save Mart</td>
<td>8,000</td>
</tr>
<tr>
<td>The County of Fresno</td>
<td>The County of Fresno MPN</td>
<td>7,500</td>
</tr>
<tr>
<td>BLP Schools' Self-Insurance Authority</td>
<td>WellComp Medical Provider Network</td>
<td>7,132</td>
</tr>
<tr>
<td>Whittier Area Schools Insurance Authority</td>
<td>WellComp Medical Provider Network</td>
<td>6,850</td>
</tr>
<tr>
<td>MERGE Risk Management JPA</td>
<td>WellComp Medical Provider Network</td>
<td>6,778</td>
</tr>
<tr>
<td>Santa Ana Unified School District</td>
<td>WellComp Medical Provider Network</td>
<td>6,677</td>
</tr>
<tr>
<td>City of Long Beach</td>
<td>TRISTAR CompAmerica Primary HCO</td>
<td>6,674</td>
</tr>
<tr>
<td>Providence Health System</td>
<td>Intracorp/Providence Medical Provider Network</td>
<td>6,500</td>
</tr>
<tr>
<td>Raley's</td>
<td>CorVel HCO/CorVel HCO Select</td>
<td>6,000</td>
</tr>
<tr>
<td>Los Angeles County Office of Education</td>
<td>Los Angeles County Office of Education - Comp Care MPN</td>
<td>5,857</td>
</tr>
<tr>
<td>City of Glendale</td>
<td>City of Glendale/Concentra</td>
<td>5,641</td>
</tr>
<tr>
<td>New United Motor Manufacturers, Inc.</td>
<td>NUMMI MPN</td>
<td>5,536</td>
</tr>
</tbody>
</table>
WORKERS’ COMPENSATION SYSTEM PERFORMANCE

<table>
<thead>
<tr>
<th>Name of Applicant</th>
<th>Name of MPN</th>
<th>Number of Covered employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orange Unified School District</td>
<td>WellComp Medical Provider Network</td>
<td>5,449</td>
</tr>
<tr>
<td>The Salvation Army</td>
<td>Red Shield</td>
<td>5,440</td>
</tr>
<tr>
<td>Circuit City Stores, Inc.</td>
<td>SRS First Health CompAmerica Primary</td>
<td>5,336</td>
</tr>
<tr>
<td>Oakland Unified School District</td>
<td>Oakland Unified School District MPN</td>
<td>5,217</td>
</tr>
<tr>
<td>San Mateo County</td>
<td>San Mateo County MPN</td>
<td>5,200</td>
</tr>
<tr>
<td>San Jose Unified School District</td>
<td>First Health CompAmerica Primary HCO</td>
<td>5,141</td>
</tr>
<tr>
<td>County of Monterey</td>
<td>Liberty Mutual Group MPN</td>
<td>5,046</td>
</tr>
<tr>
<td>International Paper Company</td>
<td>Sedgwick CMS Medical Provider Network</td>
<td>5,000</td>
</tr>
<tr>
<td>Yellow Transportation, Inc.</td>
<td>CorVel MPN</td>
<td>5,000</td>
</tr>
</tbody>
</table>

**Health Care Organization Program**

Health Care Organizations (HCOs) were created by the 1993 workers’ compensation reforms. The statutes for HCOs are given in California Labor Code Sections 4600.3 through 4600.7 and Title 8 California Code of Regulations (CCR) sections 9770 through 9779.3.

HCOs are managed care organizations established to provide health care to employees injured at work. A health care service plan (HMO), disability insurer, workers’ compensation insurer, or a workers’ compensation third-party administrator can be certified as an HCO.

Employers who contract with an HCO can direct treatment of injured workers from 90 to 180 days depending on the contribution of the employer to the employees’ non-occupational health care coverage.

An HCO must file an application and be certified according to Labor Code Section 4600.3 et seq. and Title 8 CCR sections 9770 et. seq. HCOs pay a fee of $20,000 at the time of initial certification and a fee of $10,000 at the time of each three-year certification. In addition, annually, HCOs are required to pay $1.00 per enrollee based on their enrollment figure as of December 31 of each year. The HCO loan from the General Fund has been paid off in full. Therefore, the $0.50 per enrollee surcharge has been eliminated as of July 2007.

DWC has revised regulations to reduce the certification application fee and recertification fee and to remove redundant data collection requirements of HCOs. A public hearing was held on Title 8 CCR Sections 9771, 9778, 9779, 9779.5, and 9779.9 in July 2009. The revised regulations are effective January 1, 2010.
Currently, the HCO program has 9 certified HCOs. The list of certified HCOs and their most recent date of certification/recertification are given in the table below. Even though there are 9 certified HCOs, only 6 have enrollees. The rest are keeping their certification and use their provider network as a deemed entity for MPNs.

Table 1: List of Currently Certified HCOs by Date of Certification/Recertification

<table>
<thead>
<tr>
<th>Name of HCO</th>
<th>Date of Certification/Recertification</th>
</tr>
</thead>
<tbody>
<tr>
<td>CompPartners</td>
<td>07/24/2008</td>
</tr>
<tr>
<td>Corvel Corporation</td>
<td>12/30/2008</td>
</tr>
<tr>
<td>First Health/ CompAmerica Primary</td>
<td>10/05/2007</td>
</tr>
<tr>
<td>First Health/ CompAmerica Select</td>
<td>10/05/2007</td>
</tr>
<tr>
<td>Kaiser On The Job HCO</td>
<td>12/03/2006</td>
</tr>
<tr>
<td>MedEx Health Care</td>
<td>03/16/2007</td>
</tr>
<tr>
<td>MedEx 2 Health Care</td>
<td>10/10/2006</td>
</tr>
<tr>
<td>Network HCO</td>
<td>04/16/2007</td>
</tr>
<tr>
<td>Promesa Inc. HCO</td>
<td>04/12/2007</td>
</tr>
</tbody>
</table>

**HCO Enrollment**

At its maximum, mid-2004, the HCO enrollment had reached about half a million enrollees. However, with the enactment of the MPN laws, the enrollment for the large HCOs such as First Health and Corvel declined considerably. Compared to the 2004 enrollment, First Health lost 100 percent of its enrollees while CorVel's declined by 96.6 percent to 3,384. As of June 2009, the total enrollment figure had fallen by 69.6 percent from the 2004 number of 481,337 to 146,056. Table 2 shows the number of enrollees as of December 31 of each year 2004 through 2008 and as of June 30, 2009.

Table 2: List of HCOs by Number of Enrollees for 2004 Through June 2009

<table>
<thead>
<tr>
<th>Name of HCO</th>
<th>Dec-04</th>
<th>Dec-05</th>
<th>Dec-06</th>
<th>Dec-07</th>
<th>Dec-08</th>
<th>Jun-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>CompPartners</td>
<td>60,935</td>
<td>61,403</td>
<td>53,279</td>
<td>13,210</td>
<td>1,765</td>
<td>0</td>
</tr>
<tr>
<td>CorVel/ Corvel Select</td>
<td>100,080</td>
<td>20,403</td>
<td>3,719</td>
<td>3,050</td>
<td>3,384</td>
<td>0</td>
</tr>
<tr>
<td>CompAmerica Primary/ Select (First Health)</td>
<td>218,919</td>
<td>2,403</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intracorp</td>
<td>6,329</td>
<td>3,186</td>
<td>2,976</td>
<td>2,870</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kaiser</td>
<td>30,086</td>
<td>67,147</td>
<td>66,138</td>
<td>69,602</td>
<td>77,567</td>
<td>73,074</td>
</tr>
<tr>
<td>Medex/ Medex 2</td>
<td>62,154</td>
<td>66,304</td>
<td>46,085</td>
<td>69,410</td>
<td>69,783</td>
<td>54,800</td>
</tr>
<tr>
<td>Net Work HCO</td>
<td>1,204</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Promesa</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>21,197</td>
<td>18,182</td>
</tr>
<tr>
<td>Prudent Buyer (Blue Cross)</td>
<td>1,390</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sierra</td>
<td>240</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>481,337</strong></td>
<td><strong>220,846</strong></td>
<td><strong>172,197</strong></td>
<td><strong>158,142</strong></td>
<td><strong>173,696</strong></td>
<td><strong>146,056</strong></td>
</tr>
</tbody>
</table>
Health Care Organization Program Status

Even though HCO enrollment has decreased significantly, because HCOs use their network as deemed entities for MPNs, DWC still has the mandate to ensure that all HCO documentation is up to date and all fees are collected. In 2008, the HCO staff workload included a review of two recertification filings, CompPartners and Corvel Corporation.

Proposed Regulatory Changes

HCOs are required to file a data report annually according to Labor Code Section 4600.5(d)(3) and Title 8 CCR section 9778. However, since Workers' Compensation Information System (WCIS) now requires reporting of medical services provided on or after 9/22/2006, as mandated by Title 8 CCR section 9700 et seq., the HCO data collection on the same subject is redundant. DWC revised its regulations to eliminate duplicative HCO reporting requirements. Effective January 1, 2010, information collected by WCIS will not be required to be resubmitted to DWC by HCOs.

Pre-designation laws for HCOs in Labor Code Section 4600.3 should be in accord with the pre-designation for MPNs as stated in Labor Code Section 4600.

Pre-Designation Under Health Care Organization versus Medical Provider Networks

An employee’s right of pre-designation under an HCO has become different from the right under an MPN. The general right of pre-designation under Labor Code Section 4600 as it existed in 1993 was mirrored in Section 4600.3 for HCOs. Eligibility to pre-designate was subsequently restricted by the 2004 amendments of Section 4600. The provisions of the HCO statutes were not amended to conform, so employees who would not otherwise be eligible to pre-designate a personal physician may become eligible if their employers adopt an HCO. An HCO may lose medical control more frequently than an MPN due to this lack of conformity in the statute. Unless there is a change in the legislation, Labor Code Section 4600(d), the right to predesignate, will sunset on December 31, 2009.

For further information …

www.dir.ca.gov/dwc and http://www.dir.ca.gov/dwc/MPN/DWC_MPN_Main.html

DIVISION OF WORKERS’ COMPENSATION MEDICAL ACCESS STUDY

Medical Access Study – Released February 2007

Labor Code Section 5307.2 of SB 228 mandates that the AD of the DWC contract with an independent research firm to perform an annual study of access to medical treatment for injured workers. There are two major goals to the study: the first is to analyze whether there is adequate access to quality health care and health care products for injured workers; and the second is to make recommendations to ensure continued access. The Labor Code has one mechanism for the AD to respond to a finding of insufficient access, should one exist, by making appropriate adjustments to the Fee Schedules; in addition, if substantial access problems exist, the AD may adopt fees in excess of 120 percent of Medicare fees.

Data for two of the surveys, the Injured Worker Survey and the Provider Survey, were collected by the San Francisco State University (SFSU) Public Research Institute. A third survey was administered to claims administrators, including insurers, third-party administrators, self-insured and self-administered employers.

Results of the injured worker study included that:

- 83 percent of those surveyed felt they were able to get access to quality medical care for their injury.
• 78 percent of those surveyed were satisfied with the overall care they received for their injury. This figure compares with 77 percent who were satisfied with their overall care in a 1998 DWC Study and with 83 percent in a 2004 Pennsylvania study.

• Comparing responses in both the injured worker survey and the provider survey to questions about occupational medicine behaviors indicated that:
  - 83 percent of injured workers and 84 percent of providers responded that they felt that the physician understood the worker’s job demands.
  - 87 percent of workers and 92 percent of providers responded that the physician discussed work restrictions.
    - 81 percent of injured workers responded that their physician discussed ways to avoid re-injury.

The survey looked at return to work (RTW). Findings included that:

• 2.4 percent of injured workers reported that they did not get specialty care.
• 5.5 percent reported that they got specialty care but had difficulties obtaining it.
• 2.3 percent reported that they did not get any of the recommended occupational therapy or physical therapy treatment.
• 6.3 percent reported that they got specialty care but had difficulties obtaining it.

Findings of the survey about RTW included that:

• 78 percent were currently working at the time of the interview.
• 11 percent were not working for reasons unrelated to their injury.
• 10 percent reported that they were not working as a result of their injury.
• 55 percent reported that they had not fully recovered more than one year after injury, although these workers may be back at work even though they are not fully recovered.
• 45 percent reported that they were fully recovered, and 10 percent reported that there was no improvement. These figures for RTW are somewhat comparable to previous studies: 70 percent of workers had not fully recovered in the 1998 DWC study; and 72 percent in the 2000 Washington State study had not fully recovered. These studies, however, had shorter time frames.

Results of the provider survey, which assesses the physicians’ perception of access to care and therefore is not a qualitative measure, included that:

• 65 percent of physicians felt that access to care has declined since 2004.
• 27 percent reported that access to care stayed the same.
• 7 percent reported that access to care improved.
Findings

Findings of the study included that:

- Most injured workers have access to quality care.
- Most injured workers are satisfied with their care, and levels of satisfaction appear unchanged since 1998.
- The percentage of injured workers experiencing problems accessing care is low; however, the number of individuals potentially affected is large, given the large number of workplace illnesses and injuries reported each year in California.
- Providers’ perceptions of access and quality differ substantially from injured workers’ perception.
- Providers’ negative ratings of access and quality are concentrated among certain provider types and specialties.

DWC has contracted with the University of Washington to conduct a new medical access study. The study is currently being finalized.

INFORMATION AND ASSISTANCE UNIT

The DWC Information and Assistance (I&A) Unit provides information and assistance to employees, employers, labor unions, insurance carriers, physicians, attorneys and other interested parties concerning rights, benefits and obligations under California's workers' compensation laws. The I&A Unit, often the first DWC contact for injured workers, plays a major role in reducing litigation before WCAB.

In calendar year 2006, the DWC I&A Unit:
- Handled 408,529 calls from the public.
- Reviewed 15,883 settlements.
- Conducted 23,377 face-to-face meetings with injured workers at the counter.
- Made 163 public presentations.

In calendar year 2007, the DWC I&A Unit:
- Handled 404,501 incoming calls.
- Reviewed 16,853 settlements.
- Had 22,858 face-to-face meetings with injured workers at the counter.
- Held 183 workshops for injured workers and 6 workshops for employers.

In calendar year 2008, the DWC I&A Unit:
- Handled 323,520 calls from the public.
- Reviewed 16,320 settlements.
- Conducted 22,818 face-to-face informal meetings with members of the public seeking advice on workers' compensation matters.
- Made 199 public presentations, in addition to regular monthly workshops for injured workers at eight district offices.

After the enactment of SB 899 in April 2004, DWC held a special three-day statewide training seminar for all I&A officers, as well as other DWC staff, to provide early guidance on implementing the new reform
law. Later in the year, efforts commenced to revitalize the monthly workshops in all 24 district offices and to update all I&A guides and fact sheets.

UNINSURED EMPLOYERS BENEFITS TRUST FUND

Claims are paid from the Uninsured Employers Benefit Trust Fund (UEBTF) when illegally uninsured employers fail to pay workers’ compensation benefits awarded to their injured employees by Workers’ Compensation Appeals Board (WCAB). The number of new UEBTF cases and dollar amounts associated with new opened claims for the past seven fiscal years are shown below.

![UEBTF Total Benefits Paid and Total Revenue Recovered*](image)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>New Cases Opened</th>
<th>Total Benefits Paid</th>
<th>Total Revenue Recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2001/02</td>
<td>1,001</td>
<td>$22.40</td>
<td>$36.36</td>
</tr>
<tr>
<td>FY 2002/03</td>
<td>1,083</td>
<td>$18.90</td>
<td>$33.36</td>
</tr>
<tr>
<td>FY 2003/04</td>
<td>1,251</td>
<td>$22.01</td>
<td>$28.26</td>
</tr>
<tr>
<td>FY 2004/05</td>
<td>1,451</td>
<td>$26.36</td>
<td>$26.36</td>
</tr>
<tr>
<td>FY 2005/06</td>
<td>1,794</td>
<td>$28.26</td>
<td>$36.36</td>
</tr>
<tr>
<td>FY 2006/07</td>
<td>1,267</td>
<td>$20.00</td>
<td>$33.36</td>
</tr>
<tr>
<td>FY 2007/08</td>
<td>1,121</td>
<td>$25.00</td>
<td>$33.36</td>
</tr>
</tbody>
</table>

* Includes collections, DLSE penalties, and inmates without dependents

Data Source: DWC

ADJUDICATION SIMPLIFICATION EFFORTS

Division of Workers’ Compensation Information System

The Workers’ Compensation Information System (WCIS) is intended to be an information source to help the AD of the DWC and other State policymakers carry out their decision-making responsibilities and to provide accurate and reliable statistical data and analyses to other stakeholders in the industry. The specific legislative mandate for WCIS states that it should provide information in a cost-effective manner for:

- Managing the workers’ compensation system.
- Evaluating the benefit-delivery system.
- Assessing the adequacy of indemnity payments.
- Providing data for research.

WCIS has been collecting information about workers’ compensation injuries via electronic (computer-to-computer) data interchange since March 2000. As of January 2009, the system had collected more
than 7 million employers’ first report of injury (FROI), subsequent reports of injury (SROI) pertaining to over 3.4 million claims, and detailed medical billing data pertaining to over 1.6 million claims. Hundreds of claims administrators provide data to WCIS, representing all segments of industry in California.

WCIS medical billing data are currently being used in a CHSWC medical study by RAND to analyze a series of legislative changes affecting medical care provided to California’s injured workers. In addition to developing measures that could be used in an ongoing system of monitoring the cost and quality of care provided to injured workers, the CHSWC/RAND study will assess the representativeness and reliability of the medical data reported in WCIS and compare the data to external sources of information, including the Workers’ Compensation Insurance Rating Bureau (WCIRB) and the California Department of Statewide Health Planning and Development (OSHPD).

One important recent use of the WCIS database is for estimating the impact of the 2005 PDRS. Data from WCIS are being used in conjunction with data from DWC’s Disability Evaluation Unit (DEU) and from the Employment Development Department (EDD) to assess the existence and magnitude of post-injury wage loss experienced by permanently disabled workers. This analysis will help the AD to determine whether and how to adjust the 2005 PDRS to mitigate the impact on injured workers of diminished future earnings.

Other uses of WCIS have included the creation of tables and reports providing statistical descriptive information about industry-wide characteristics of injured workers and injuries, such as age, gender, part of body, cause of injury, etc. Data for selected injuries are provided regularly to state agencies such as the Department of Public Health (DPH) and DIR’s Division of Occupational Safety and Health (DOSH). WCIS has been used to create special analyses for the Division of Labor Standards and Enforcement (DLSE), CHSWC, the Bureau of State Audits, and EDD. WCIS data have been used for analyzing claim denial for the WCIRB and for law enforcement related to fraud. For example, CHSWC and researchers under contract with CHSWC were provided with data to conduct a study to determine the extent of workers’ compensation medical overpayments and underpayments. This study will help the California Department of Insurance (CDI) to allocate an appropriate level of resources to detect and evaluate suspected medical provider fraud in California.

Outside researchers at the University of California San Francisco and Boston University have been provided with data extracts from WCIS, and DWC is preparing quarterly timeliness of (claims) payments reports by claim administrators at the request of a state legislator. WCIS was used as the source for the physician and injured worker samples for the Year 2 Medical Access Study, which is being conducted pursuant to Labor Code section 5307.2. It has also been used to produce statistics used to estimate the economic and fiscal impact of updating the Medical Treatment Utilization Schedule (MTUS) and as one of the data sources to test the representativeness of data used by the Lewin Group in their current study on adopting a workers’ compensation physician fee schedule based on the Resource-Based Relative Value Scale (RBRVS).

**Electronic Adjudication Management System**

The Electronic Adjudication Management System (EAMS) is a computer-based system that is designed to simplify and improve the DWC case management process to more efficiently resolve claims, improve the ability to schedule and manage court calendars, allow files to be shared between multiple users, and transform paper files into secure electronic files, reducing the need for physical storage space at local DWC offices and the State Records Center.

The goals of EAMS are to better serve injured workers and employers by eliminating redundancy, creating efficiency in the system and making the system more accessible to users while preserving confidentiality. EAMS will reduce environmental and physical stress, along with injuries to DWC employees, and help guide policy decisions to better distribute resources.

EAMS went live internally at the State’s 24 district offices on August 25, 2008. Regulations now require external parties to file documents via paper Optical Character Recognition (OCR) forms or e-forms, with
increased access being a key goal for the near future. DWC has formed a working group to create an electronic filing method for bulk filing, which will expand access to EAMS while meeting state requirements for technology projects. The EAMS Access Project includes extensive input from external parties.

**Carve-outs: Alternative Workers’ Compensation Systems**

A provision of the workers’ compensation reform legislation in 1993, implemented through Labor Code Section 3201.5, allowed construction contractors and unions, via the collective bargaining process, to establish alternative workers’ compensation programs, also known as carve-outs.

CHSWC is monitoring the carve-out program, which is administered by DWC.

**CHSWC Study of Carve-Outs**

CHSWC engaged in a study to identify the various methods of alternative dispute resolution (ADR) that are being employed in California carve-outs and to begin the process of assessing their efficiency, effectiveness and compliance with legal requirements.

Since carve-out programs have operated only since the mid-1990s, the data collected are preliminary. The study team found indications that: the most optimistic predictions about the effects of carve-outs on increased safety, lower dispute rates, far lower dispute costs, and significantly more rapid RTW have not occurred; and that the most pessimistic predictions about the effect of carve-outs on reduced benefits and access to representation have not occurred.

For further information …


**Impact of Senate Bill 228**

Senate Bill (SB) 228 adds Labor Code Section 3201.7, establishing the creation of a new carve-out program for any unionized industry that meets the requirements. This is in addition to the existing carve-out in the construction industry (already covered in current law by Labor Code Section 3201.5).

Only the union may initiate the carve-out process by petitioning the Administrative Director (AD). The AD will review the petition according to the statutory requirements and issue a letter allowing each employer and labor representative a one-year window for negotiations. The parties may jointly request a one-year extension to negotiate the labor-management agreement.

In order to be considered, the carve-out must meet several requirements including:

- The union has petitioned the AD as the first step in the process.
- A labor-management agreement has been negotiated separate and apart from any collective bargaining agreement covering affected employees.
- The labor-management agreement has been negotiated in accordance with the authorization of the AD between an employer or groups of employers and a union that is recognized or certified as the exclusive bargaining representative that establishes any of the following:
  - An ADR system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the Appeals Board in the same manner as provided for reconsideration of a final order, decision, or award made and filed by a workers' compensation administrative law judge.
  - The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.
WORKERS’ COMPENSATION SYSTEM PERFORMANCE

- The use of an agreed, limited list of qualified medical evaluators (QMEs) and agreed medical evaluators (AMEs) that may be the exclusive source of QMEs and AMEs under this division.
- A joint labor-management safety committee.
- A light-duty, modified job or return-to-work program.
- A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.

- The minimum annual employer premium for the carve-out program for employers with 50 employees or more is $50,000, and the minimum group premium is $500,000.
- Any agreement must include right of counsel throughout the ADR process.

Impact of Senate Bill 899

Construction industry carve-outs were amended per Labor Code Section 3201.5 and carve-outs in other industries were amended per Labor Code Section 3201.7 to permit the parties to negotiate any aspect of the delivery of medical benefits and the delivery of disability compensation to employees of the employer or group of employers who are eligible for group health benefits and non-occupational disability benefits through their employer.

Recognizing that many cities and counties, as well as private industries, are interested in knowing more about carve-outs and about health and safety training and education within a carve-out, CHSWC hosted a conference devoted to carve-outs/alternative dispute resolution on August 2, 2007, in Emeryville, California. The conference was for all stakeholders in the workers’ compensation system including: those in existing carve-outs; those considering establishing a carve-out; unions and employers; risk managers; government agencies; third-party administrators; insurers; policymakers; attorneys; and health care providers.

The conference provided an opportunity for the health and safety and workers’ compensation communities and the public to share ideas for establishing carve-outs which have the potential to: improve safety programs and reduce injury and illness claims; achieve cost savings for employers; provide effective medical delivery and improved quality of medical care; improve collaboration between unions and employers; and increase the satisfaction of all parties.

Carve-Out Participation

As shown in the following table, participation in the carve-out program has grown, with significant increases in the number of employees, work hours, and amount of payroll.

Table: Participation in Carve-Out Program

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employers</td>
<td>242</td>
<td>277</td>
<td>550</td>
<td>683</td>
<td>442</td>
<td>260</td>
<td>143</td>
<td>512</td>
<td>316</td>
<td>462</td>
<td>739</td>
<td>981</td>
<td>1,087</td>
<td>1,274</td>
</tr>
<tr>
<td>Work Hours (in millions)</td>
<td>6.9</td>
<td>11.6</td>
<td>10.4</td>
<td>18.5</td>
<td>24.8</td>
<td>16.9</td>
<td>7.9</td>
<td>29.4</td>
<td>22.9</td>
<td>25.4</td>
<td>49.4</td>
<td>56.1</td>
<td>76.5</td>
<td></td>
</tr>
<tr>
<td>Employees (full-time equivalent)</td>
<td>3,450</td>
<td>5,822</td>
<td>5,186</td>
<td>9,250</td>
<td>12,395</td>
<td>8,448</td>
<td>3,949</td>
<td>14,691</td>
<td>11,449</td>
<td>12,700</td>
<td>12,254</td>
<td>24,680</td>
<td>28,028</td>
<td>38,269</td>
</tr>
<tr>
<td>Payroll (in million $)</td>
<td>158</td>
<td>272</td>
<td>243</td>
<td>415</td>
<td>585</td>
<td>443</td>
<td>202</td>
<td>634</td>
<td>624</td>
<td>1,200</td>
<td>966</td>
<td>1,348</td>
<td>1,777</td>
<td>2,300</td>
</tr>
</tbody>
</table>

* Please note that data are incomplete

Source: DWC
Aggregate Data Analysis of Carve-out Programs

Due to a lack of available historical data and a discrepancy between the reporting requirements of Labor Code Section 3201.9 and the data collection requirements of CCR section 10203, the earliest data presented here are from 2004 forward.

Person hours and payroll covered by agreements filed

Carve-out programs reported that for the 2007 calendar year, they covered 56.1 million work hours and $1.8 billion in payroll.

For the 2008 calendar year, carve-out programs reported that they covered 76.5 million work hours and $2.3 billion in payroll.

Number of claims filed

During 2008, there were a total of 4,855 claims filed, of which 2,425 (49.9 percent) claims were medical-only claims, and 2,430 (50.1 percent) were indemnity claims.

Paid, incurred and average cost per claim

The chart below shows projected total paid and incurred costs for all claims combined. The paid costs for claims filed in 2008 increased 71.7 percent compared to 2007, while the total incurred costs increased 35 percent from 2007.

Total Paid and Incurred Costs, 2004-2008
(Million $)

Data Source: DWC, WCIRB
According to the chart above, the actual costs for claims filed in 2008 totaled $35,063,167, while the incurred costs totaled $79,639,281. The largest share of costs is attributable to payment of medical and temporary disability benefits. These benefits accounted for 44.5 percent and 47.6 percent of total actual costs, and 60.4 percent and 27.3 percent of total incurred costs, respectively.

### Table: Total Actual and Incurred Costs, Overall and by Cost Component in 2008

<table>
<thead>
<tr>
<th>Cost Component</th>
<th>Total Actual Cost</th>
<th>Total Incurred Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Claim Components</td>
<td>$35,063,167</td>
<td>$79,639,281</td>
</tr>
<tr>
<td>Medical</td>
<td>$15,619,355</td>
<td>$48,137,679</td>
</tr>
<tr>
<td>Temporary Disability</td>
<td>$16,676,018</td>
<td>$21,778,468</td>
</tr>
<tr>
<td>Permanent Disability</td>
<td>$2,053,041</td>
<td>$5,086,155</td>
</tr>
<tr>
<td>Death Benefit</td>
<td>$279,913</td>
<td>$2,824,359</td>
</tr>
<tr>
<td>Life Pension</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Vocational Rehabilitation</td>
<td>$39,573</td>
<td>$752,312</td>
</tr>
<tr>
<td>Medical-legal</td>
<td>$395,268</td>
<td>$1,060,309</td>
</tr>
</tbody>
</table>

**Data Source:** DWC

The following two charts show the average paid and incurred costs per claim by cost components across all claims from 2004 to 2008.

### Average Paid Cost per Claim by Cost Components, 2004 - 2008

```
 2004  2005  2006  2007  2008
Life Pension  $500  $45  $0  $41  $0
Death Benefit  $0  $146  $44  $46  $24
Permanent Disability  $3,067  $592  $609  $640  $430
Vocational Rehabilitation  $97  $13  $18  $25  $5
Temporary Disability  $4,738  $3,983  $3,223  $2,810  $3,486
Medical-legal  $197  $61  $201  $84  $108
Medical  $6,934  $5,304  $5,109  $5,201  $4,273
All Claim Components  $16,321  $10,519  $9,204  $8,968  $8,284
```

**Data Source:** DWC, WCIRB

---

22 The calculation of total actual cost for all claim components excludes temporary disability data from one carve-out that failed to provide accurate information on actual temporary disability costs. However, the remainder of the individual cost components for this carve-out is included in the calculation of the total actual costs of all claim components.

23 The calculation of average actual temporary disability cost per claim excludes data from one carve-out that failed to provide accurate information on actual temporary disability costs.
In contrast, the following chart shows the cost by the type of claims filed in 2006 and 2007 (latest available data.)

### Average Incurred Cost per Claim by Cost Components, 2004 - 2008

<table>
<thead>
<tr>
<th>Component</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Pension</td>
<td>$361</td>
<td>$45</td>
<td>$0</td>
<td>$144</td>
<td>$0</td>
</tr>
<tr>
<td>Death Benefit</td>
<td>$0</td>
<td>$229</td>
<td>$201</td>
<td>$187</td>
<td>$258</td>
</tr>
<tr>
<td>Permanent Disability</td>
<td>$4,349</td>
<td>$1,975</td>
<td>$1,375</td>
<td>$1,739</td>
<td>$1,528</td>
</tr>
<tr>
<td>Vocational Rehabilitation</td>
<td>$256</td>
<td>$166</td>
<td>$153</td>
<td>$166</td>
<td>$157</td>
</tr>
<tr>
<td>Temporary Disability</td>
<td>$5,989</td>
<td>$4,660</td>
<td>$4,020</td>
<td>$3,920</td>
<td>$5,922</td>
</tr>
<tr>
<td>Medical-legal</td>
<td>$308</td>
<td>$143</td>
<td>$280</td>
<td>$121</td>
<td>$512</td>
</tr>
<tr>
<td>Medical</td>
<td>$10,995</td>
<td>$12,084</td>
<td>$10,269</td>
<td>$12,695</td>
<td>$11,177</td>
</tr>
<tr>
<td>All Claim Components *</td>
<td>$24,398</td>
<td>$19,058</td>
<td>$15,925</td>
<td>$19,664</td>
<td>$19,552</td>
</tr>
</tbody>
</table>

* With regard to average incurred costs for all claim components, only carve-outs reporting data on every cost component are included in computing the average. Data Source: DWC, WCIRB

### Average Paid and Incurred Cost by Claim Type, 2006 and 2007

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>2006 Paid</th>
<th>2006 Incurred</th>
<th>2007 Paid</th>
<th>2007 Incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medical-Only Claims</td>
<td>$433</td>
<td>$481</td>
<td>$400</td>
<td>$490</td>
</tr>
<tr>
<td>Total Claims with Indemnity</td>
<td>$11,970</td>
<td>$22,116</td>
<td>$13,000</td>
<td>$22,000</td>
</tr>
</tbody>
</table>

Data Source: DWC, WCIRB
Number of disputed claims

The tables below show the numbers and distribution of claims resolved by stage of dispute resolution process in total claims in carve-outs for years 2004 through 2008. Among the subset of carve-outs with acceptable data reporting, the percentage of claims that were disputed varied from less than one percent in 2004 to 13.4 percent in 2006. Since 2004, these programs reported that 7 out of 67 (10.4 percent) disputed claims have been heard by the WCAB or the Court of Appeals.

Table: Total Disputed Carve-Out Claims in Programs Reporting

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Programs Reporting</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Total Number of Claims</td>
<td>150</td>
<td>77</td>
<td>97</td>
<td>603</td>
<td>1157</td>
</tr>
<tr>
<td>Total Number of Disputed Claims</td>
<td>1</td>
<td>2</td>
<td>13</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Percentage of Disputed Claims in Total</td>
<td>0.67%</td>
<td>2.60%</td>
<td>13.40%</td>
<td>1.20%</td>
<td>3.80%</td>
</tr>
</tbody>
</table>

Table Source: DWC

Table: Number of Disputed Claims by Type of Resolution

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Mediation</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>32</td>
</tr>
<tr>
<td>By Arbitration</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>By WCAB</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>By Court of Appeals</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Number Disputed</td>
<td>1</td>
<td>2</td>
<td>13</td>
<td>7</td>
<td>44</td>
</tr>
</tbody>
</table>

Table Source: DWC

Table: Distribution of Disputed Claims by Type of Resolution in Total Claims

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Mediation</td>
<td>0.0%</td>
<td>0.0%</td>
<td>6.19%</td>
<td>1.00%</td>
<td>2.77%</td>
</tr>
<tr>
<td>By Arbitration</td>
<td>0.0%</td>
<td>0.0%</td>
<td>4.12%</td>
<td>0.17%</td>
<td>0.95%</td>
</tr>
<tr>
<td>By WCAB</td>
<td>0.67%</td>
<td>0.0%</td>
<td>3.09%</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>By Court of Appeals</td>
<td>0.0%</td>
<td>2.60%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total for Disputed Claims</td>
<td>0.67%</td>
<td>2.60%</td>
<td>13.40%</td>
<td>1.20%</td>
<td>3.80%</td>
</tr>
</tbody>
</table>

Table Source: DWC

Number of contested claims resolved prior to arbitration

Among the subset of carve-outs with acceptable data reporting, no contested claims were reported resolved prior to arbitration in 2004 or 2005, while 6 and 32 claims were reported resolved prior to arbitration in 2007 and 2008 respectively.

---

24 “Resolved” means that ultimate liability has been determined, even though payments for the claim may be made beyond the reporting period.
WORKERS’ COMPENSATION SYSTEM PERFORMANCE

Table: Number of Contested Claims Resolved Prior to Arbitration

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Number of Contested Claims</strong>&lt;sup&gt;25&lt;/sup&gt;</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>32</td>
</tr>
<tr>
<td><strong>Number of Programs Reporting</strong></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td><strong>Average Per Program</strong></td>
<td>0</td>
<td>0</td>
<td>1.5</td>
<td>1.2</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Data Source: DWC

Safety history

The number of injuries reported on OSHA Form 300<sup>26</sup> is significantly lower than the number of claims filed. In 2007, 99 incidents were filed with the U.S. Department of Labor using OSHA Form Number 300. OSHA requires employers to file an injury and/or illness with Form Number 300 if a work-related injury results in death, loss of consciousness, days away from work, restricted work activity, and/or medical care beyond first aid. In 2007, this reporting was 20.8 percent less per program than 2006. There was a significant increase in number of injuries reported on OSHA Form Number 300 in 2008.

Table: Number of Injuries Filed Using OSHA Form 300

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of injuries filed on OSHA Form 300</strong></td>
<td>0</td>
<td>3</td>
<td>125</td>
<td>99</td>
<td>2,059</td>
</tr>
<tr>
<td><strong>Number of Programs Reporting</strong></td>
<td>10</td>
<td>14</td>
<td>16</td>
<td>18</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Average per Program</strong></td>
<td>0.0</td>
<td>0.2</td>
<td>7.8</td>
<td>5.5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Data Source: DWC

The number of workers participating in vocational rehabilitation programs

The ADR/carve-out system for 2008 reported 11 workers participating in a vocational rehabilitation program. From 2004 to 2007, the number of employees taking part in a vocational rehabilitation program was never more than 7.

Table: Number of Workers in a Vocational Rehabilitation Program

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Programs Reporting</strong>&lt;sup&gt;27&lt;/sup&gt;</td>
<td>7</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td><strong>Number of Workers</strong></td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td><strong>Average per Program</strong></td>
<td>0.7</td>
<td>0.5</td>
<td>0.4</td>
<td>0.3</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Data Source: DWC

The number of workers participating in light-duty programs

From 2004 to 2008, the number of workers participating in a light-duty program has grown 14,400 percent, from 2 to 290 participants. The average number of participants per program has grown from 0.2 to 12.6 over the same time period.

---

<sup>25</sup>The total number of contested claims resolved prior to arbitration was calculated by aggregating each program’s answer to the GV-1 Form question on the number of claims that were resolved at or after mediation.

<sup>26</sup>OSHA requires employers to file an injury and/or illness Form 300 if work-related injuries result in death, a loss of consciousness, days away from work, restricted work activity, and/or medical care beyond first aid.

<sup>27</sup>Excludes programs reporting vocational rehabilitation costs but not vocational rehabilitation program participants.
Table: Number of Workers Participating in Light-Duty Programs

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Programs Reporting</td>
<td>12</td>
<td>16</td>
<td>19</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>Number of workers</td>
<td>2</td>
<td>61</td>
<td>101</td>
<td>108</td>
<td>290</td>
</tr>
<tr>
<td>Average per Program</td>
<td>0.2</td>
<td>3.8</td>
<td>5.3</td>
<td>5.1</td>
<td>12.6</td>
</tr>
</tbody>
</table>

Data Source: DWC

Worker satisfaction

Labor Code Section 3201.7 also requires non-construction ADR/carve-out programs to include information on worker satisfaction. However in 2007, due to the confidentiality concerns raised by having only one active non-construction program, the worker satisfaction component of Labor Code Section 3201.9 was not conducted for this report.

In 2008, two Section 3201.7 programs did not report the results of a worker satisfaction survey for 2008. One Section 3201.7 program reported that 78.3 percent of injured workers surveyed were satisfied with how their workers’ compensation claim was handled by their ADR/Carve-out program.

A listing of employers and unions in carve-out agreements follows.
### Status of Carve-out Agreements

The following charts show the current status of carve-out agreements pursuant to Labor Code Sections 3201.5 and 3201.7, as reported by DWC.

#### Construction Industry Carve-out Participants as of November 30, 2009

**Labor Code Section 3201.5**

*Key: (1) = one employer, one union; (2) = one union, multi employer; (3) = project labor agreement*

<table>
<thead>
<tr>
<th>No.</th>
<th>Union</th>
<th>Company</th>
<th>Exp. Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>(3) CA Building &amp; Construction Trades Council</td>
<td>Metropolitan Water District So. CA - Diamond Valley Lake</td>
<td>11/7/06</td>
</tr>
<tr>
<td>2.</td>
<td>(2) International Brotherhood of Electrical Workers (IBEW)</td>
<td>National Electrical Contractors Association (NECA)</td>
<td>8/14/10</td>
</tr>
<tr>
<td>3.</td>
<td>(2) So. CA District of Carpenters &amp; 19 local unions</td>
<td>6 multi-employer groups - 1000 contractors</td>
<td>8/14/10</td>
</tr>
<tr>
<td>4.</td>
<td>(2) So. CA Pipe Trades Council 16</td>
<td>Multi employer - Plumbing &amp; Piping Industry Council</td>
<td>8/24/10</td>
</tr>
<tr>
<td>5.</td>
<td>(1) Steamfitters Local 250</td>
<td>Cherne - two projects completed in 1996</td>
<td>Complete</td>
</tr>
<tr>
<td>6.</td>
<td>(1) International Union of Petroleum &amp; Industrial Workers</td>
<td>TIMEC Co., Inc./TIMEC So. CA., Inc.</td>
<td>7/31/10</td>
</tr>
<tr>
<td>7.</td>
<td>(3) Contra Costa Building &amp; Construction Trades Council</td>
<td>Contra Costa Water District - Los Vaqueros</td>
<td>Complete</td>
</tr>
<tr>
<td>8.</td>
<td>(2) So. CA District Council of Laborers</td>
<td>Association General Contractors of CA, Building Industry Association; So. CA, So. CA Contractors’ Association; Engineering Contractors’ Association.</td>
<td>7/31/11</td>
</tr>
<tr>
<td>9.</td>
<td>(3) CA Building &amp; Construction Trades Council</td>
<td>Metropolitan Water District So. CA Inland Feeder Parsons</td>
<td>Ended 12/31/02</td>
</tr>
<tr>
<td>11.</td>
<td>(2) District Council of Painters</td>
<td>LA Painting &amp; Decorating Contractors’ Association</td>
<td>10/28/12</td>
</tr>
<tr>
<td>12.</td>
<td>(1) Plumbing &amp; Pipefitting Local 342</td>
<td>Cherne Contracting - Chevron Base Oil 2000 project</td>
<td>Complete</td>
</tr>
<tr>
<td>13.</td>
<td>(3) LA Building &amp; Construction Trades Council AFL-CIO</td>
<td>Cherne Contracting - ARCO</td>
<td>Complete</td>
</tr>
<tr>
<td>14.</td>
<td>(2) Operating Engineers Local 12</td>
<td>So. CA Contractors’ Association</td>
<td>4/1/11</td>
</tr>
<tr>
<td>15.</td>
<td>(2) Sheet Metal International Union</td>
<td>Sheet Metal-A/V/C Contractors National Association</td>
<td>4/1/11</td>
</tr>
<tr>
<td>16.</td>
<td>(3) Building &amp; Construction Trades Council San Diego</td>
<td>San Diego County Water Authority Emergency Storage Project</td>
<td>2/20/12</td>
</tr>
<tr>
<td>17.</td>
<td>(3) LA County Building &amp; Construction Trades Council</td>
<td>Cherne Contracting – Equilon Refinery – Wilmington</td>
<td>3/1/07</td>
</tr>
<tr>
<td>18.</td>
<td>(3) Plumbers &amp; Steamfitters</td>
<td>Cherne Contracting – Chevron Refinery – Richmond</td>
<td>7/1/05</td>
</tr>
<tr>
<td>19.</td>
<td>(3) Plumbers &amp; Steamfitters</td>
<td>Cherne Contracting – Tesoro Refinery – Martinez</td>
<td>7/1/05</td>
</tr>
<tr>
<td>20.</td>
<td>(3) LA/Orange Counties Building &amp; Construction Trade Council</td>
<td>Cherne Contracting – Chevron Refinery – El Segundo</td>
<td>7/26/05</td>
</tr>
<tr>
<td>No.</td>
<td>Union</td>
<td>Company</td>
<td>Exp. Date</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>21.</td>
<td>(2) District Council of Iron Workers- State CA &amp; Vicinity</td>
<td>California Ironworker Employers Council</td>
<td>2/25/12</td>
</tr>
<tr>
<td>22.</td>
<td>(2) Sheet Metal Workers International Association #105</td>
<td>Sheet Metal &amp; A/C Labor Management Safety Oversight Committee (LMSOC)</td>
<td>4/17/12</td>
</tr>
<tr>
<td>23.</td>
<td>(2) United Union of Roofers, Waterproofers &amp; Allied workers, Local 36 and 220</td>
<td>Union Roofing Contractors Association</td>
<td>7/31/11</td>
</tr>
<tr>
<td>24.</td>
<td>(2) United Union of Roofers, Waterproofers &amp; Allied Workers, Locals 27, 40, 81 &amp; 95</td>
<td>Associated Roofing Contractors of the Bay Area Counties</td>
<td>7/31/10</td>
</tr>
<tr>
<td>25.</td>
<td>(2) United Association -Journeyman &amp; Apprentices - Plumbers &amp; Pipefitters, Local #447</td>
<td>No.CA Mechanical Contractors Association &amp; Association Plumbing &amp; Mechanical Contractors of Sacramento, Inc.</td>
<td>11/7/12</td>
</tr>
<tr>
<td>26.</td>
<td>(2) Operatives Plasterers &amp; Cement Masons International Association, Local 500 &amp; 600</td>
<td>So. CA Contractors Association, Inc.</td>
<td>4/1/11</td>
</tr>
<tr>
<td>27.</td>
<td>(1) International Unions Public &amp; Industrial Workers</td>
<td>Inwin Industries, Inc.</td>
<td>3/23/10</td>
</tr>
<tr>
<td>28.</td>
<td>(2) PIPE Trades District Council.# 36</td>
<td>Mechanical Contractors Council of Central CA</td>
<td>4/14/10</td>
</tr>
<tr>
<td>29.</td>
<td>(2) No. CA Carpenters Regional Council</td>
<td>Basic Crafts Workers’ Compensation Benefits Trust</td>
<td>8/30/10</td>
</tr>
<tr>
<td>30.</td>
<td>(2) No. CA District Council of Laborers</td>
<td>Basic Crafts Workers’ Compensation Benefits Trust</td>
<td>8/30/10</td>
</tr>
<tr>
<td>31.</td>
<td>(2) Operating Engineers Local 3</td>
<td>Basic Crafts Workers’ Compensation Benefits Trust</td>
<td>8/30/10</td>
</tr>
<tr>
<td>32.</td>
<td>(1) Industrial, Professional &amp; Technical Workers</td>
<td>Irish Construction</td>
<td>12/20/10</td>
</tr>
<tr>
<td>33.</td>
<td>(3) Building Trades Council of Los Angeles Orange County</td>
<td>Los Angeles Community College District Prop A &amp; AA Facilities Project</td>
<td>5/6/11</td>
</tr>
</tbody>
</table>

Data Source: DWC

Key: (1) = one employer, one union; (2) = one union, multi employer; (3) = project labor agreement
## WORKERS' COMPENSATION SYSTEM PERFORMANCE

### Non-Construction Industry Carve-Out Participants as of August 31, 2009
*(Labor Code Section 3201.7)*

<table>
<thead>
<tr>
<th>No.</th>
<th>Union</th>
<th>Company</th>
<th>Permission to Negotiate Date/Expires</th>
<th>Application for Recognition of Agreement</th>
<th>Agreement Recognition Letter Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>United Food &amp; Commercial Workers Union Local 324</td>
<td>Super A Foods-2 locations 76 employees</td>
<td>09/01/04-09/01/05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>United Food &amp; Commercial Workers Union Local 1167</td>
<td>Super A Foods – Meat Department 8 employees</td>
<td>09/01/04-09/01/05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Teamsters Cal. State Council-Cannery &amp; Food Processing Unions, IBT, AFL-CIO</td>
<td>Cal. Processors, Inc. Multi-Employer Bargaining Representative</td>
<td>07/06/04-07/05/05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>United Food &amp; Commercial Workers Union Local 770</td>
<td>Super A Foods – 10 locations - ~ 283 members</td>
<td>09/01/04-09/01/05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>United Food &amp; Commercial Workers Union Local 1036</td>
<td>Super A Foods - All employees, except those engaged in janitorial work or covered under a CBA w/Culinary Workers and demonstrators</td>
<td>09/01/04-09/01/05</td>
<td></td>
<td>Withdrawn 7/28/09</td>
</tr>
<tr>
<td>6.</td>
<td>Operating Engineers-Local 3 Non-Construction</td>
<td>Basic Crafts Workers' Compensation Benefits Trust Fund</td>
<td>12/09/04-12/09/05</td>
<td>02/15/05</td>
<td>02/28/05</td>
</tr>
<tr>
<td>7.</td>
<td>Laborers - Non-Construction</td>
<td>Basic Crafts Workers' Compensation Benefits Trust Fund</td>
<td>12/09/04-12/09/05</td>
<td>02/15/05</td>
<td>02/28/05</td>
</tr>
<tr>
<td>8.</td>
<td>Carpenters-Non-Construction</td>
<td>Basic Crafts Workers' Compensation Benefits Trust Fund</td>
<td>12/09/04-12/09/05</td>
<td>02/15/05</td>
<td>02/28/05</td>
</tr>
<tr>
<td>9.</td>
<td>United Food &amp; Commercial Workers Union Local 588</td>
<td>Mainstay Business Solutions</td>
<td>8/11/05-8/11/06</td>
<td>09/02/05</td>
<td>09/12/05</td>
</tr>
<tr>
<td>10.</td>
<td>Teamsters Local 952</td>
<td>Orange County Transportation Authority Coach Operators</td>
<td>04/17/06-04/17/07</td>
<td></td>
<td>Withdrawn 7/28/09</td>
</tr>
<tr>
<td>No.</td>
<td>Union</td>
<td>Company</td>
<td>Permission to Negotiate Date/Expires</td>
<td>Application for Recognition of Agreement</td>
<td>Agreement Recognition Letter Date</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>--------------------------------------</td>
<td>------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>11</td>
<td>Teamsters Local 630</td>
<td>SYSCO Food Services</td>
<td>06/22/07-06/22/08</td>
<td>Withdrawn</td>
<td>7/30/09</td>
</tr>
<tr>
<td>12</td>
<td>Teamsters Local 848</td>
<td>SYSCO Food Services</td>
<td>06/22/07-06/22/08</td>
<td>Withdrawn</td>
<td>7/30/09</td>
</tr>
<tr>
<td>13</td>
<td>Teamsters Local 952</td>
<td>Orange County Transportation Authority</td>
<td>07/31/06-07/31/07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Long Beach Peace Officers’ Assoc. &amp; Long Beach Firefighters Assoc. Local 372</td>
<td>City of Long Beach</td>
<td>12/11/06-12/11/07</td>
<td>11/2/07</td>
<td>11/13/07</td>
</tr>
<tr>
<td>15</td>
<td>SEIU Local 1877</td>
<td>Various Maintenance Companies</td>
<td>04/13/07-04/13/08</td>
<td>2/12/08</td>
<td>2/28/08</td>
</tr>
<tr>
<td>16</td>
<td>SEIU Local 721</td>
<td>City of LA</td>
<td>06/18/07-06/18/08</td>
<td>4/15/08</td>
<td>5/8/08</td>
</tr>
<tr>
<td>17</td>
<td>United Food &amp; Commercial Workers Union (UFCW) Local 5</td>
<td>Berkeley Bowl</td>
<td>07/07/08-07/07/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>UFCW Local 5</td>
<td>Smoked Prime Meats, Inc.</td>
<td>07/07/08-07/07/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>UFCW Local 5</td>
<td>Milan Salami</td>
<td>07/07/08-07/07/09</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Source: DWC

For further information …

The latest information on carve-outs may be obtained at: [http://www.dir.ca.gov/dwc/carveout.html](http://www.dir.ca.gov/dwc/carveout.html)


ANTI-FRAUD ACTIVITIES

Background

During the past decade, there has been a dedicated and rapidly growing campaign in California against workers' compensation fraud. This report on the nature and results of that campaign is based primarily on information obtained from the CDI Fraud Division, as well as applicable Insurance Code and Labor Code sections and data published in periodic Bulletin[s] of the California Workers’ Compensation Institute (CWCI).

Suspected Fraudulent Claims

Suspected Fraudulent Claims (SFCs) are reports of suspected fraudulent activities received by CDI from various sources, including insurance carriers, informants, witnesses, law enforcement agencies, fraud investigators, and the public. The number of SFCs represents only a small portion that has been reported by the insurers and does not necessarily reflect the whole picture of fraud since many fraudulent activities have not been identified or investigated.

According to CDI Fraud Division, the number of suspected fraudulent claims increased near the end of fiscal year 2003-2004. Several reasons for this increase include:

- The extensive efforts to provide training to the insurance claim adjusters and Special Investigation Unit (SIU) personnel by the Fraud Division and District Attorneys.
- Changing submission of SFCs by filling out the FD-1 Form electronically through the Internet.
- The Department promulgated new regulations to help insurance carriers step up their anti-fraud efforts and become more effective in identifying, investigating, and reporting workers' compensation fraud. A work plan to increase the number of audits performed by the Fraud Division SIU Compliance Unit has been established and continues with an aggressive outreach plan to educate the public on anti-fraud efforts and how to identify and report fraud. This has ensured a more consistent approach to the oversight and monitoring of the SIU functions with the primary insurers as well as the subsidiary companies.
- Finally, CDI is strengthening its working relationship with the Workers' Compensation Insurance Rating Bureau (WCIRB) to support the Department's anti-fraud efforts.

For fiscal year 2007-08, the total number of SFCs reported is 4,973.

Workers’ Compensation Fraud Suspect Arrests

After a fraud referral, an investigation must take place before any warrants are issued or arrests are made. The time for investigation ranges from a few months to a few years depending on the complexity of the caseload. For this reason, the number of arrests does not necessarily correspond to the number of referrals in a particular year. (See the following chart.)
Workers’ Compensation Fraud Suspect Convictions

Based on information from the Fraud Division and CWCI Bulletin[s], the number of workers’ compensation fraud suspects convicted annually while many cases are still pending in court is reported in the chart below.
Workers’ Compensation System Performance

Workers’ Compensation Fraud Investigations

Types of Workers’ Compensation Fraud Investigations

The charts “Caseload by Type of Fraud Investigations” and “Type of Fraud Investigations by Percentage of Total” on the next page indicate the number and types of investigations opened and carried from fiscal years 2001-02 to 2007-08 reported by district attorneys. Applicant fraud appears to be the area generating the most cases followed by premium fraud and medical provider fraud.

Some of the categories for fraud-related investigations were changed in the fiscal years 2005-2006, 2006-2007, and 2007-2008 as reflected in the following charts. In 2008, two new categories Legal and Pharmacy were introduced as separate categories.

Trends in Workers’ Compensation Fraud Investigations

The chart below shows that there was a 69 percent increase in workers’ compensation fraud investigations from FY 2001-02 to FY 2005-06 followed by 52 percent decrease from FY 2005-06 to FY 2007-08.

<table>
<thead>
<tr>
<th>Year</th>
<th>Legal</th>
<th>Pharmacy</th>
<th>Applicant</th>
<th>Deriving Employee</th>
<th>Uninsured Employer</th>
<th>Premium*</th>
<th>Medical Provider**</th>
<th>Insider</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2001-02</td>
<td>N/A</td>
<td>N/A</td>
<td>1293</td>
<td>0.0%</td>
<td>159</td>
<td>105</td>
<td>8</td>
<td>64</td>
<td>1,629</td>
<td>2,604</td>
</tr>
<tr>
<td>FY 2002-03</td>
<td>N/A</td>
<td>N/A</td>
<td>1,293</td>
<td>1263</td>
<td>1,263</td>
<td>207</td>
<td>61</td>
<td>93</td>
<td>2,734</td>
<td>4,389</td>
</tr>
<tr>
<td>FY 2003-04</td>
<td>N/A</td>
<td>N/A</td>
<td>1,957</td>
<td>1,177</td>
<td>1,177</td>
<td>327</td>
<td>141</td>
<td>56</td>
<td>3,993</td>
<td>6,988</td>
</tr>
<tr>
<td>FY 2004-05</td>
<td>N/A</td>
<td>N/A</td>
<td>2,136</td>
<td>1,478</td>
<td>1,478</td>
<td>325</td>
<td>112</td>
<td>43</td>
<td>4,275</td>
<td>7,453</td>
</tr>
<tr>
<td>FY 2005-06</td>
<td>N/A</td>
<td>N/A</td>
<td>2,757</td>
<td>1,573</td>
<td>1,573</td>
<td>580</td>
<td>193</td>
<td>25</td>
<td>4,330</td>
<td>7,967</td>
</tr>
<tr>
<td>FY 2006-07</td>
<td>N/A</td>
<td>N/A</td>
<td>1,439</td>
<td>778</td>
<td>778</td>
<td>312</td>
<td>69</td>
<td>12</td>
<td>1,411</td>
<td>2,820</td>
</tr>
<tr>
<td>FY 2007-08</td>
<td>N/A</td>
<td>N/A</td>
<td>1,319</td>
<td>714</td>
<td>714</td>
<td>265</td>
<td>50</td>
<td>12</td>
<td>1,286</td>
<td>2,566</td>
</tr>
</tbody>
</table>

** From FY 2005-06, includes Capping and Fraud Rings that had been separate categories before, and for 2006-07, includes Legal Provider and Treatment frauds

Data Source: California Department of Insurance, Fraud Division
As seen in the chart below, the focus of the investigations has been changing. Applicant fraud investigations have dropped from nearly 80 percent of the total in 2001-02 to about 54 percent of the total number of investigations in FY 2007-08. At the same time, there has been an increase in the percentage of investigations of uninsured employers and premium fraud. The percentage of investigations of medical provider fraud decreased from 7 percent to 3.8 percent between 2005-06 and 2007-08.

In addition, the 2008 Annual Report of the Insurance Commissioner notes that the great majority of suspected fraudulent claims in calendar year 2008 came from Los Angeles County (1,777 or 35 percent of total cases) followed by Orange County (527 or 10 percent), and then San Diego County (383 or 7.5 percent).

**Underground Economy**

While most California businesses comply with health, safety and workers’ compensation regulations, there are businesses that do not. Those businesses are operating in the “underground economy.” Such businesses may not have all their employees on the official company payroll or may not report wages paid to employees that reflect their real job duties. Businesses in the underground economy are therefore competing unfairly with those that comply with the laws. According to EDD, the California underground economy is estimated at $60 billion to $140 billion.28

**Potential Areas for Improvement in Workers’ Compensation Anti-Fraud Efforts**

CHSWC has engaged in many studies that focus on improving workers’ compensation anti-fraud efforts. For further information on these studies please see the “Special Report: Fraud Studies” and the “Projects and Studies” sections of this report.

28 [http://www.edd.ca.gov/taxrep/txueoind.htm#What_Does_It_Cost_You](http://www.edd.ca.gov/taxrep/txueoind.htm#What_Does_It_Cost_You)
WORKPLACE HEALTH AND SAFETY PERFORMANCE MEASURES

Occupational Injury and Illness Prevention Efforts

Workplace health and safety is of primary importance and the shared goal of all Californians. Ongoing cooperative efforts among workers, employers, employer and labor organizations, government agencies, health and safety professionals, independent researchers, and the public have resulted in significant reductions in workplace injuries, illnesses and deaths.

This section will discuss the numbers and incidence rates of occupational injuries and illnesses, injuries and illnesses by occupation and other factors, and the efforts to prevent occupational injuries and illnesses. Also included is an overview of the requirements and methods to record and report occupational injuries and illnesses in the United States (U.S.) and California.

Where data are available, comparisons among private industry, state government and local government are also included.

Occupational Injuries, Illnesses and Fatalities

The numbers of occupational injuries, illnesses and fatalities in the private sector (private industry) and the public sector (state and local government) for the past several years are displayed and discussed in this subsection. Fatality data for 2008 are preliminary as of December 2009.

Please note that “lost-work-time” occupational injury and illness cases involve days away from work, job transfer, or days of restricted work activity, and that days-away-from-work cases involve days away from work, whether or not there is also job transfer or restricted work activity.

The National Academy of Social Insurance (NASI) estimated that there were 131.7 million workers covered by workers’ compensation in the U.S. in 2007, including 15.4 million in California.

Public and Private Sectors Compared

Non-Fatal Occupational Injuries and Illnesses

The following chart shows occupational injuries and illnesses in California’s private industry, state government and local government. Occupational injuries and illnesses in California have decreased noticeably in the past nine years. As shown in the following chart, the number of recordable occupational injury and illness cases, number of lost-work-time cases, and number of days-away-from-work cases have all declined from 2000 to 2008.
California Non-Fatal Occupational Injuries and Illnesses
Private Industry, State and Local Governments - Thousands of Cases

Fatal Occupational Injuries and Illnesses

Fatal occupational injuries and illnesses in California have also decreased significantly as depicted in the chart below. Fatal occupational injuries and illnesses in California declined by 27.4 percent from 1997 to 2003 and increased by 15.7 percent from 2003 to 2006. Between 2006 and 2007, fatal injuries decreased by 23.8 percent, the largest decrease within the past ten years, and stayed at that level in 2008.

California Fatal Occupational Injuries and Illnesses
Private Industry, State and Local Governments*

Data Source: DIR - DLSR and BLS
WORKPLACE HEALTH AND SAFETY PERFORMANCE MEASURES

Private Sector

Non-Fatal Occupational Injuries and Illnesses

Occupational injuries and illnesses in California’s private industry have also decreased noticeably in the past nine years. The total number of recordable injury and illness cases dropped by 36 percent, the number of lost-work-time cases declined by 30 percent, and the number of days-away-from-work cases decreased by 41 percent, all from 2000 to 2008.

California Non-Fatal Occupational Injuries and Illnesses
Private Industry - Thousands of Cases

<table>
<thead>
<tr>
<th>Year</th>
<th>All Recordable Cases</th>
<th>Lost-Worktime Cases</th>
<th>Days-Away-from-Work Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>670.5</td>
<td>350.3</td>
<td>205.5</td>
</tr>
<tr>
<td>1998</td>
<td>644.0</td>
<td>330.4</td>
<td>195.3</td>
</tr>
<tr>
<td>1999</td>
<td>624.9</td>
<td>313.2</td>
<td>185.0</td>
</tr>
<tr>
<td>2000</td>
<td>640.9</td>
<td>337.2</td>
<td>201.3</td>
</tr>
<tr>
<td>2001</td>
<td>586.9</td>
<td>330.3</td>
<td>195.5</td>
</tr>
<tr>
<td>2002</td>
<td>556.7</td>
<td>331.8</td>
<td>181.4</td>
</tr>
<tr>
<td>2003</td>
<td>540.8</td>
<td>316.7</td>
<td>171.7</td>
</tr>
<tr>
<td>2004</td>
<td>496.1</td>
<td>291.3</td>
<td>148.8</td>
</tr>
<tr>
<td>2005</td>
<td>503.7</td>
<td>289.0</td>
<td>141.3</td>
</tr>
<tr>
<td>2006</td>
<td>473.7</td>
<td>278.4</td>
<td>131.7</td>
</tr>
<tr>
<td>2007</td>
<td>477.0</td>
<td>270.9</td>
<td>131.6</td>
</tr>
<tr>
<td>2008</td>
<td>411.7</td>
<td>236.2</td>
<td>118.8</td>
</tr>
</tbody>
</table>

Source: DIR Division of Labor Statistics and Research

Fatal Occupational Injuries and Illnesses

From 1997 to 2003, fatal injuries in private industry decreased by 23.8 percent and increased by 15.2 percent from 2003 to 2006. The number of fatal injuries decreased by 25.7 percent in private industry from 2006 to 2008.

California Fatal Occupational Injuries and Illnesses
Private Industry

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>537</td>
</tr>
<tr>
<td>1998</td>
<td>538</td>
</tr>
<tr>
<td>1999</td>
<td>523</td>
</tr>
<tr>
<td>2000</td>
<td>500</td>
</tr>
<tr>
<td>2001</td>
<td>459</td>
</tr>
<tr>
<td>2002</td>
<td>415</td>
</tr>
<tr>
<td>2003</td>
<td>409</td>
</tr>
<tr>
<td>2004</td>
<td>411</td>
</tr>
<tr>
<td>2005</td>
<td>421</td>
</tr>
<tr>
<td>2006</td>
<td>471</td>
</tr>
<tr>
<td>2007</td>
<td>354</td>
</tr>
<tr>
<td>2008*</td>
<td>350</td>
</tr>
</tbody>
</table>

* Preliminary data

Source: DIR - DLSR and BLS
Public Sector – State Government

Non-Fatal Occupational Injuries and Illnesses

In contrast to private industry, the numbers of non-fatal occupational injuries and illnesses in state government have changed less appreciably in the past nine years, as shown on the following chart. It should be noted that many state and local government occupations are high-risk, such as law enforcement, fire fighting, rescue, and other public safety operations. Although the total number of cases declined by about 34.7 percent between 2003 and 2007, there was a 5 percent increase in the total number of cases from 2007 to 2008.

Fatal Occupational Injuries and Illnesses

Fatal occupational injuries and illnesses in California state government have decreased since the mid-1990s. The number of annual fatalities decreased from 15 in 1997 to 6 in 2000; then, the average number of fatalities of 6.5 from 2000 to 2005 increased to an average of 10 from 2005 to 2007, as shown on the following chart. There was a decrease in fatal occupational injuries and illnesses from 12 to 5 from 2006 to 2008.
Public Sector - Local Government

Non-Fatal Occupational Injuries and Illnesses

The total number of non-fatal occupational injuries and illnesses in local government fluctuated over the past several years. The number of injuries and illnesses in this sector decreased from 2004 to 2005 by 16 percent, increased by 4.6 percent from 2005 to 2006, decreased by 8 percent from 2006 to 2007, and again increased by 12 percent from 2007 to 2008.

California Non-Fatal Occupational Injuries and Illnesses
Local Government - Thousands of Cases

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Recordable Cases</th>
<th>Lost-Worktime Cases</th>
<th>Cases with Days away from Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>111.5</td>
<td>47.0</td>
<td>37.5</td>
</tr>
<tr>
<td>1998</td>
<td>106.5</td>
<td>45.6</td>
<td>36.7</td>
</tr>
<tr>
<td>1999</td>
<td>107.0</td>
<td>45.6</td>
<td>37.3</td>
</tr>
<tr>
<td>2000</td>
<td>118.5</td>
<td>46.7</td>
<td>35.4</td>
</tr>
<tr>
<td>2001</td>
<td>129.2</td>
<td>67.2</td>
<td>52.6</td>
</tr>
<tr>
<td>2002</td>
<td>111.4</td>
<td>59.0</td>
<td>41.4</td>
</tr>
<tr>
<td>2003</td>
<td>112.7</td>
<td>54.6</td>
<td>40.7</td>
</tr>
<tr>
<td>2004</td>
<td>120.5</td>
<td>60.8</td>
<td>41.7</td>
</tr>
<tr>
<td>2005</td>
<td>100.7</td>
<td>42.0</td>
<td>29.0</td>
</tr>
<tr>
<td>2006</td>
<td>105.3</td>
<td>50.2</td>
<td>31.5</td>
</tr>
<tr>
<td>2007</td>
<td>96.9</td>
<td>47.5</td>
<td>30.3</td>
</tr>
<tr>
<td>2008</td>
<td>108.5</td>
<td>50.5</td>
<td>32.8</td>
</tr>
</tbody>
</table>

Source: DIR Division of Labor Statistics and Research

Fatal Occupational Injuries and Illnesses

After increasing from 22 to 33 from 1997 to 1998, the number of fatal occupational injuries and illnesses in California’s local governments averaged 32 in 1998 and 1999, while from 2000 to 2007, the annual average was 24.25. There was a 43.5 percent increase in number of fatal occupational injuries and illnesses from 2007 to 2008.

California Fatal Occupational Injuries and Illnesses
Local Government

<table>
<thead>
<tr>
<th>Year</th>
<th>Fatal Occupational Injuries and Illnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>22</td>
</tr>
<tr>
<td>1998</td>
<td>33</td>
</tr>
<tr>
<td>1999</td>
<td>31</td>
</tr>
<tr>
<td>2000</td>
<td>25</td>
</tr>
<tr>
<td>2001</td>
<td>27</td>
</tr>
<tr>
<td>2002</td>
<td>23</td>
</tr>
<tr>
<td>2003</td>
<td>25</td>
</tr>
<tr>
<td>2004</td>
<td>25</td>
</tr>
<tr>
<td>2005</td>
<td>23</td>
</tr>
<tr>
<td>2006</td>
<td>23</td>
</tr>
<tr>
<td>2007</td>
<td>23</td>
</tr>
<tr>
<td>2008*</td>
<td>33</td>
</tr>
</tbody>
</table>

* Preliminary data

Source: DIR - DSLR and BLS
Occupational Injury and Illness Incidence Rates

Public and Private Sectors Compared

From 1997 to 2008, incidence rates for all cases and lost-work-time cases in California declined. Between 1999 and 2002, the incidence rates for days-away-from-work cases remained relatively the same but have declined since 2002.

Private Sector

From 1997 to 2008, the occupational injury and illness incidence rate for all cases in California’s private industry declined from 7.1 to 3.9, a decrease of 45 percent, while the incidence rate for lost-time cases dropped from 3.5 to 2.2, a decrease of 37 percent.

Data Source: DIR - Department of Labor Statistics and Research
Public Sector - State Government

California state government occupational injury and illness incidence rates increased by 2 percent from 1997 to 1998, declined by 41 percent between 1998 and 2007, and increased by 6 percent from 2007 to 2008.

![California Occupational Injury and Illness Incidence Rates (State Government)](image)

Public Sector – Local Government

Local government occupational injury and illness incidence rates decreased from 1996 to 1999, increased through 2001, decreased through 2003, and then increased again in 2004. From 2004 to 2005, injury and illness rates decreased by 17 percent, then remained fairly stable between 2005 and 2007, and from 2007 to 2008, increased again by 16 percent from 7.3 to 8.5 per 100 full-time employees.

![California Occupational Injury and Illness Incidence Rates (Local Government)](image)
California Fatality Incidence Rates

Fatality per employment rates may be used to compare the risk of incurring injury among worker groups with varying employment levels. From 1999 to 2004, there was a decrease of 33.3 percent in fatality rates in California. From 2004 to 2006, the fatality rate increased by 29 percent and then decreased again to the 2004 level from 2006 to 2007.

The chart below shows the fatality incidence rates by major industries in 2003, 2004 and 2005.

Data Source: U.S. Department of Labor, BLS, in cooperation with State and Federal agencies, Census of Fatal Occupational Injuries

*From 2003, classified by NAICS. Because of substantial differences between NAICS and SIC used for prior years, comparisons between prior years and 2003 and on should not be made.
United States and California Incidence Rates: A Comparison

Both the U.S. and California have experienced a decrease in occupational injury and illness incidence rates from 1997 through 2008. During that time, the U.S. incidence rate dropped by 45 percent, while the California rate declined by 42 percent. Since 2002, the incidence rate in California has been mostly above the national average.

<table>
<thead>
<tr>
<th>Year</th>
<th>USA</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>7.1</td>
<td>6.7</td>
</tr>
<tr>
<td>1998</td>
<td>6.7</td>
<td>6.3</td>
</tr>
<tr>
<td>1999</td>
<td>6.1</td>
<td>5.9</td>
</tr>
<tr>
<td>2000</td>
<td>5.7</td>
<td>6.1</td>
</tr>
<tr>
<td>2001</td>
<td>5.3</td>
<td>5.4</td>
</tr>
<tr>
<td>2002</td>
<td>5.0</td>
<td>5.6</td>
</tr>
<tr>
<td>2003</td>
<td>4.8</td>
<td>4.4</td>
</tr>
<tr>
<td>2004</td>
<td>4.6</td>
<td>4.7</td>
</tr>
<tr>
<td>2005</td>
<td>4.4</td>
<td>4.3</td>
</tr>
<tr>
<td>2006</td>
<td>4.2</td>
<td>4.4</td>
</tr>
<tr>
<td>2007</td>
<td>3.9</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Source: US Department of Labor, Bureau of Labor Statistics

The incidence rate of occupational injury and illness days-away-from-work cases has also declined in the U.S. and California from 1997 through 2008. During that period of time, the rate for both U.S. and California decreased by 47 percent.

<table>
<thead>
<tr>
<th>Year</th>
<th>USA</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>1998</td>
<td>2.0</td>
<td>1.9</td>
</tr>
<tr>
<td>1999</td>
<td>1.9</td>
<td>1.8</td>
</tr>
<tr>
<td>2000</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>2001</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>2002</td>
<td>1.6</td>
<td>1.7</td>
</tr>
<tr>
<td>2003</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>2004</td>
<td>1.4</td>
<td>1.3</td>
</tr>
<tr>
<td>2005</td>
<td>1.3</td>
<td>1.2</td>
</tr>
<tr>
<td>2006</td>
<td>1.2</td>
<td>1.1</td>
</tr>
<tr>
<td>2007</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>2008</td>
<td>1.1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Source: US Department of Labor, Bureau of Labor Statistics
Characteristics of California Occupational Injuries and Illnesses

This section compares incidence rates by industry in 1999 with those in 2008. Not only have the overall California occupational injury and illness incidence rates declined, but the incidence rates in major industries have also declined. The following chart compares incidence rates for total recordable cases in 1999 and 2008 by type of major industry including state and local government.

<table>
<thead>
<tr>
<th>Industry</th>
<th>2008</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>4.4</td>
<td>6.3</td>
</tr>
<tr>
<td>Private Industry</td>
<td>3.9</td>
<td>5.9</td>
</tr>
<tr>
<td>State and Local Government</td>
<td>7.9</td>
<td>8.7</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>4.6</td>
<td>6.5</td>
</tr>
<tr>
<td>Construction</td>
<td>4.8</td>
<td>8.9</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>3.4</td>
<td>5.1</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>3.8</td>
<td>6.6</td>
</tr>
<tr>
<td>Agriculture, Forestry, Fishing and Hunting</td>
<td>4.5</td>
<td>6.6</td>
</tr>
</tbody>
</table>

Source: Division of Labor Statistics and Research

The smallest decline during this period in incidence rates was in the wholesale trade industry, and the largest decrease was in construction.
Characteristics of California Non-Fatal Occupational Injuries and Illnesses

The following charts illustrate various demographic characteristics of non-fatal occupational injuries and illnesses in California’s private industry.

**Number of Non-Fatal Occupational Injuries and Illnesses in California by Gender (Private Industry), 2006-2008**

**California Occupational Injury and Illness Incidence Rates* by Gender**
(Cases per 10,000 full-time employees)
Private Industry, 2006 - 2008

*With days away from work with or without job transfer or restriction.

Data Source: BLS, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses in cooperation with participating State agencies.
Number of Non-Fatal Occupational Injuries and Illnesses in California by Age (Private Industry) - 2008

Data Source: DLSR

California Occupational Injury and Illness Incidence Rates by Age (Cases per 10,000 full-time workers) Private Industry - 2008

Data Source: BLS, Department of Labor, Survey of Occupational Injuries and Illnesses in cooperation with participating State Agencies
WORKPLACE HEALTH AND SAFETY PERFORMANCE MEASURES

California Non-Fatal Occupational Injuries and Illnesses by Race or Ethnic Origin (Private) - 2008
Total=118,690

Data Source: DLSR

California Non-Fatal Occupational Injuries and Illnesses by Event and Exposure (Private) - 2008

Data Source: DLSR
The following chart shows that the trunk and upper extremities were the major body parts with the greatest incidence rates in 2006, 2007 and 2008.

**Incidence Rates for Non-Fatal Occupational Injuries and Illnesses by Major Body Parts**

(Per 10,000 full-time workers) Private Industry, 2006 - 2008

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trunk</td>
<td>38.0</td>
<td>27.9</td>
<td>36.5</td>
</tr>
<tr>
<td>Upper Extremities</td>
<td>36.5</td>
<td>29.5</td>
<td>37.4</td>
</tr>
<tr>
<td>Lower Extremities</td>
<td>36.5</td>
<td>29.5</td>
<td>36.5</td>
</tr>
<tr>
<td>All Other Body Parts</td>
<td>25.8</td>
<td>22.5</td>
<td>24.8</td>
</tr>
<tr>
<td>Head</td>
<td>11.2</td>
<td>9.2</td>
<td>11.2</td>
</tr>
<tr>
<td>Multiple Parts</td>
<td>14.2</td>
<td>12.5</td>
<td>12.5</td>
</tr>
<tr>
<td>Neck</td>
<td>1.2</td>
<td>1.8</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Data Source: BLS, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses (SOII) in cooperation with participating State agencies.

The following chart shows that the back was the body part with the highest incidence rate in 2006, 2007 and 2008.

**Incidence Rates for Non-Fatal Occupational Injuries and Illnesses by Body Part Units**

(Per 10,000 full-time workers) Private Industry, 2006 - 2008

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Back</td>
<td>23.2</td>
<td>25.1</td>
<td>25.8</td>
</tr>
<tr>
<td>Shoulder</td>
<td>5.9</td>
<td>5.9</td>
<td>5.4</td>
</tr>
<tr>
<td>Knee</td>
<td>8.1</td>
<td>7.6</td>
<td>8.4</td>
</tr>
<tr>
<td>Foot, Toe</td>
<td>5.0</td>
<td>5.9</td>
<td>5.8</td>
</tr>
<tr>
<td>Finger</td>
<td>5.2</td>
<td>5.8</td>
<td>10.1</td>
</tr>
<tr>
<td>Hand, except fingers</td>
<td>4.4</td>
<td>4.4</td>
<td>5.2</td>
</tr>
<tr>
<td>Wrist</td>
<td>4.9</td>
<td>7.6</td>
<td>11.2</td>
</tr>
<tr>
<td>Eyes</td>
<td>2.6</td>
<td>3.6</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Data Source: BLS, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses (SOII) in cooperation with participating State agencies.

The following three charts compare the median days away from work for private industry occupations, state government occupations, and local government occupations. Arts, design, entertainment, sports,
and media occupations have the greatest median days away from work in private industry, followed by installation, maintenance, and repair occupations in the state government.²⁹

²⁹ Recent data on median days away from work were available only for 2008.
The following two charts compare the injury and illness incidence rates, including back injury, for various occupations. The transportation and material moving occupations had the highest incidence rate in 2008, followed by the building and grounds cleaning and maintenance occupations.
The following chart compares the number of fatalities for various occupations. The transportation and material moving occupation had the greatest number of fatalities in 2008, followed by the construction and extraction occupation.
Characteristics of California Fatal Occupational Injuries and Illnesses

The following charts illustrate various characteristics of fatal occupational injuries and illnesses in California’s private industry and federal, state and local governments.

California Fatal Occupational Injuries and Illnesses by Gender - 2008

Data Source: BLS

California Fatal Occupational Injuries and Illnesses by Age of Worker - 2008

Source: BLS
California Fatal Occupational Injuries and Illnesses by Race and Ethnic Origin - 2008

Data Source: BLS

California Fatal Occupational Injuries and Illnesses by Event and Exposure - 2008

Data Source: BLS
Profile of Occupational Injury and Illness Statistics: California and the Nation

Data for the following analyses, except where noted, were derived from the Department of Industrial Relations (DIR) Division of Labor Statistics and Research (DLSR), from the U.S. Department of Labor (DOL) Bureau of Labor Statistics (BLS), and from the California Workers’ Compensation Institute (CWCI).  

Incidence Rates

- California’s most recent work injury and illness statistics for 2008 indicate a non-fatal injury and illness rate of 3.9 cases per 100 full-time employees in the private sector in 2008. This is a 58.5 percent decline from the 1990 peak level of 9.4 and an estimated 11 percent decrease from the previous year’s figures.

- The trend in California mirrors a national trend. DOL figures for private employers show that from 1990 to 2008, the work injury and illness rate across the U.S. fell from 8.8 to 3.9 cases per 100 employees in the private sector. The reduction in the number of incidences of job injuries is likely due to various factors including a greater emphasis on job safety, the improving economy since the early 1990s, and the shift from manufacturing toward service jobs.

- Although the national fatality rate decreased by 5 percent between 2006 and 2007, California’s fatality rate decreased by 16 percent during the same period, decreasing from 3.1 to 2.6 cases per 100,000 employed.

- From the Western region states, Alaska, Arizona, California, Hawaii, Nevada, Oregon and Washington, Arizona’s and California’s 2008 private industry rates of 3.7 and 3.9 respectively for non-fatal occupational injuries and illnesses were the lowest. The state that had the third-lowest incidence rate was Hawaii (4.3).

Duration

- Days-away-from-work cases, including those that result in days away from work with or without a job transfer or restriction, dropped from 1.8 to 1.1 cases per 100 full-time employees from 1999 to 2008 in the private sector. This also mirrors the national trend with the number of days-away-from-work cases falling from 1.9 to 1.1 cases in the national private sector during the same period.

Industry Data

- In 2008, injury and illness incidence rates varied greatly between private industries ranging from 1.9 injuries/illnesses per 100 full-time workers in the finance and insurance industry to 6.1 in transportation and warehousing. California’s private industry rates for total cases were higher than the national rates in every major industry division, except for manufacturing (5.0 and 3.8), agriculture, forestry, fishing and hunting (5.3 and 4.5), wholesale trade (3.7 and 3.4), and accommodation and food services (4.1 and 3.8).

- The private industry total case rate for non-fat al injuries decreased between 2007 and 2008 from 4.4 to 3.9, while the rate for the public sector (state and local government) increased by 14.5 percent from 6.9 in 2007 to 7.9 in 2008.

- According to DLSR, the largest decrease in injury and illness by major industry category was in wholesale trade, from 5.1 to 3.4 per 100 full-time worker injuries in 2007 and 2008 respectively, followed by mining and professional, scientific, and technical services, where both industries experienced a decrease from 2.3 to 1.7 per 100 full-time worker injuries in 2007 and 2008, and by accommodation and food services, from 4.9 to 3.8 per 100 full-time worker injuries in 2007 and 2008.  

30 Please note that specific case and demographic data for non-fatal occupational injuries and illnesses were only available for 2008.

31 The comparisons of industry rates have not been adjusted for industry mix within each state.

32 DLSR, Table 1: Incidence rates of non-fatal occupational injuries and illnesses by selected industries and case types, 2006, 2007.
• According to DLSR, the largest increase in injury and illness by industry sectors was in real estate and rental and leasing, from 2.4 to 3.0 per 100 full-time worker injuries in 2007 and 2008 respectively, followed by utilities with an increase from 4.1 to 5.0 per 100 full-time worker injuries in 2007 and 2008, and arts, entertainment and recreation, from 4.5 to 5.3 in 2007 and 2008.33

• Over the past decade (1998-2008), the number of fatal injuries declined by 33.3 percent, from 582 to 388.34 From 2007 to 2008, the number of fatal injuries had not changed. The highest number of fatal injuries was in trade, transportation and utilities (93), followed by natural resources and mining (70) and construction (63).

• In private industry, the top ten occupations with the most non-fatal injuries and illnesses in 2008 are: laborers and freight, stock, and material movers, hand; truck drivers, light or delivery services; truck drivers, heavy and tractor-trailer; janitors and cleaners, except maids and housekeeping cleaners; farm workers and laborers, crop, nursery, and greenhouse; construction laborers; retail sales persons; customer service representatives; registered nurses; nursing aides, orderlies, and attendants.

• In California state government, the top ten occupations with the most non-fatal injuries and illnesses in 2008 are: psychiatric technicians; correctional officers and jailers; police and sheriff's patrol officers; janitors and cleaners, except maids and housekeeping cleaners; registered nurses; cooks, institution and cafeteria; licensed practical and licensed vocational nurses; forest and conservation workers; nursing aides, orderlies, and attendants; office clerks, general.

• In local government, the top ten occupations with the most non-fatal injuries and illnesses in 2008 are: police and sheriff's patrol officers; janitors and cleaners, except maids and house-keeping cleaners; elementary school teachers, except special education; fire fighters; teacher assistants; correctional officers and jailers; landscaping and grounds keeping workers; bus drivers, school; nursing aides, orderlies, and attendants; first-line supervisors/managers of fire fighting and prevention workers.

• Transportation and material-moving occupations (91) and construction and extraction (60) accounted for 39 percent of the fatal injuries in 2008. Protective services (42), farming, fishing, and forestry (34), management (30), installation, maintenance, and repair (27), building and grounds cleaning and maintenance (27), sales and related (22) were the other occupations with the most number of fatal injuries in 2008. Transportation and material-moving incidents were the number one cause of fatal injuries accounting for about 23 percent of fatal injuries in 2008.

• Transportation incidents accounted for about 37.9 percent of fatal injuries in 2008 and are a major cause of fatalities among: transportation and material moving occupations (62); protective-service occupations (20); and farming, fishing, and forestry occupations (18).

**Establishment Size and Type**

• The lowest rate for the total recordable non-fatal cases in 2008 was experienced by the smallest employers. Employers with 1 to 10 employees and 11 to 49 employees had incidence rates of 2.0 and 3.3 cases, respectively, per 100 full-time employees. There was a 25 percent increase in incidence rates for employers with 1 to 10 employees from 2007 to 2008. Employers with 11 to 49 employees experienced a 15 percent decrease in incidence rates compared to 2007.

• Establishments with 250 to 999 and 1,000 and more employees reported the highest rates of 5.5 and 5.4 cases per 100 full-time employees, respectively, in 2008. Establishments with 50 to 249 employees experienced a 12 percent decrease from 5.8 to 5.1 cases per 100 full-time employees from 2007 to 2008.

33 Ibid.
34 The number of fatalities excludes the number of fatalities for the Federal government.
Types of Injuries

- Most types of work injuries have declined since 1998 in the private sector. The number of sprains and strains continued to decline from 1998; however, these injuries remain by far the most common type of work injury accounting for 34 percent of days-away-from-work cases in the private sector. Cuts, lacerations, bruises, contusions, heat burns, carpal tunnel syndrome, tendonitis, amputations, and multiple injuries have decreased from 1998 to 2008, with the biggest decreases, 71 and 63 percent, seen in carpal tunnel syndrome and tendonitis respectively. From 1998 to 2008, the only injury category that experienced about 38 percent increase was chemical burns.

- In the private sector, contact with objects and equipment was the leading cause of days-away-from-work injuries, cited in about 26.6 percent of days-away-from-work cases. Overexertion was the second common cause of injury, accounting for about 18.2 percent of injuries.

- In California state government, the two main causes of injury were assaults and violent acts and contact with object, equipment accounting for about 21.4 and 15.8 percent of days-away-from-work cases, respectively, in 2008.

- In local government, the main causes of injury were contact with object, equipment and falls on the same level, accounting for 20.9 and 16.2 percent of days-away-from-work cases, respectively, in 2008.

- The most frequently injured body part is the back, accounting for about 14.5 percent of the cases in state government and about 16.5 percent cases in local government. In the private sector, back injuries account for 22.5 percent of non-fatal cases.

Demographics

- Over the period from 1998 to 2008 in the California private sector, the number of days-away-from-work cases for women decreased by about 28.6 percent. Days-away-from-work cases for men decreased by 44.2 percent.

- Between 1998 and 2008, in private industry, the age groups 16 to 19, 20 to 24, 25 to 34, 35 to 44, and 45 to 54, experienced a decline. The biggest decline (53.5 percent) occurred among 35 to 44 year-old workers. The age group 25 to 34 experienced a 49 percent decline, and the age group of 16 to 19 experienced a 38.9 percent decrease in the numbers of days away from work. During the same period, the age groups 55 to 64 and 65 and over experienced an increase of 1.7 percent and 22.3 percent respectively.

- In 2008, out of 404 fatalities, approximately 93 percent were male and 7 percent were female. The age group categories 35 to 44 years, 55 to 64 years, and 65 and over experienced a decrease in fatal injuries between 2007 and 2008, and age group categories 18 to 19, 20 to 24, 25 to 34, and 45 to 54 years experienced an increase in fatal injuries. The biggest decrease in the number of fatalities (21 percent) was seen in the 65 and over age group from 34 to 27 cases, followed by an 8 percent decrease in the age group 35 to 44 (from 102 to 94 cases) in the period of time from 2007 to 2008.

The highest number of fatalities in 2008 by race or ethnic origin categories was experienced by “White, non-Hispanic” group closely followed by “Hispanic or Latino” group, accounting for 43 percent and 41 percent of the fatalities, respectively. From 2007 to 2008, there was some decrease (7 percent) for fatal injuries in the “Black or African American” group and “White, non-Hispanic” group (2.3 percent). There was a 3 percent increase in fatal injuries in the “Asian” group (from 32 to 33) and about 1 percent increase in “Hispanic or Latino” group (from 162 to 163) for the same period of time.
**Occupational Injury and Illness Reporting**

Occupational injury and illness information is the responsibility of BLS within the U.S. and DOL and DLSR within the California DIR. Occupational injuries and illnesses are recorded and reported by California employers through several national surveys administered by DOL with the assistance of DIR.

**OSHA Reporting and Recording Requirements**

The U.S. Occupational Safety and Health Act (OSH Act) of 1970 requires covered employers to prepare and maintain records of occupational injuries and illnesses. It provides specific recording and reporting requirements that comprise the framework for the nationwide occupational safety and health recording system. The Occupational Safety and Health Administration (OSHA) in DOL administers the OSH Act recordkeeping system.

Although there are exemptions for some employers from keeping Cal/OSHA injury and illness records, all California employers must report injuries to DLSR. Every employer must also report any serious occupational injuries, illnesses or deaths to California OSHA within DIR.

The data assist employers, employees and compliance officers in analyzing the safety and health environment at the employer's establishment and are the source of information for the BLS Annual Survey of Occupational Injuries and Illnesses and the OSHA Occupational Injury and Illness Survey.

**BLS Annual Survey of Occupational Injuries and Illnesses**

To estimate the number of occupational injuries and illnesses in the U.S., BLS established a nationwide annual survey of employers' occupational injuries and illnesses. The state-level statistics on non-fatal and fatal occupational injuries and illnesses are derived from this survey.

**Non-Fatal Injuries and Illnesses**

The BLS Annual Survey develops frequency counts and incidence rates by industry and also profiles worker and case characteristics of non-fatal workplace injuries and illnesses that result in lost work time. Each year, BLS collects employer reports from about 173,800 randomly selected private industry establishments.

**Fatal Injuries and Illnesses**

The estimates of fatal injuries are compiled through the Census of Fatal Occupational Injuries (CFOI), which is part of the BLS occupational safety and health statistics program. CFOI uses diverse state and federal data sources to identify, verify and profile fatal work injuries.

**OSHA Occupational Injury and Illness Survey**

Federal OSHA administers the annual Occupational Injury and Illness Survey. OSHA utilizes this collection of employer-specific injury and illness data to improve its ability to identify and target agency interventions to those employers who have serious workplace problems. For this survey, OSHA collects data from 80,000 non-construction establishments and from up to 15,000 construction establishments.

**Occupational Injury and Illness Prevention Efforts**

Efforts to prevent occupational injury and illness in California take many forms, but all are derived from cooperative efforts between the public and private sectors. This section describes consultation and compliance programs, health and safety standards, and education and outreach designed to prevent injuries and illnesses to improve worker health and safety.
Cal/OSHA Program

The Cal/OSHA Program is responsible for enforcing California laws and regulations pertaining to workplace health and safety and for providing assistance to employers and workers about workplace safety and health issues.

The Cal/OSHA Enforcement Unit conducts inspections of California workplaces based on worker complaints, accident reports and high hazard industries. There are 22 Cal/OSHA Enforcement Unit district offices located throughout the State of California. Specialized enforcement units, such as the Mining and Tunneling Unit and the High Hazard Enforcement Unit, augment the efforts of district offices in protecting California workers from workplace hazards in high hazard industries.

Other specialized units, such as the Crane Certifier Accreditation Unit, the Asbestos Contractors' Registration Unit, the Asbestos Consultant and Site Surveillance Technician Unit and the Asbestos Trainers Approval Unit, are responsible for enforcing regulations pertaining to crane safety and prevention of asbestos exposure.

The Cal/OSHA Consultation Service provides assistance to employers and workers about workplace safety and health issues through on-site assistance, high hazard consultation, and other special emphasis programs. The Consultation Service also develops educational materials on workplace safety and health topics.
Profile of Division of Occupational Safety and Health (DOSH) On-Site Inspections and Violations Cited

The trends in types of inspections have varied in the past few years, with Accidents and Complaints being consistently predominant. However, starting in fiscal year (FY) 2006, Programmed Inspections started to reach higher levels compared to Accidents and Complaints.

The following chart shows the total numbers of investigations and on-site inspections for the period from calendar year (CY) 1993 through 2008. From CY 1993 to 1995, the total number of investigations averaged 13,278 per year with an average of 10,714 on-site inspections. During the next seven years, from 1996 to 2002, the average number of investigations decreased to 12,830, and the average number of on-site inspections decreased to 9,268. During the next two years (2003 and 2004), there was further decrease in both the average number of investigations (to 11,157) and average number of on-site inspections (to 8,028). From 2004 to 2008, there was a 29.6 percent increase in investigations and 33 percent increase in the number of on-site inspections.

DOSH Total Investigations and On-Site Inspections

![Graph showing total investigations and on-site inspections from 1993 to 2008.](image)

Data Source: DOSH

---

35 The numbers of investigations, on-site inspections and violations for calendar years could differ from the fiscal year numbers provided later in this section.
The chart below shows that the total inspections have been increasing in the past four years from 7,536 in FY 2004-05 to 9,170 in FY 2007-08.

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident (unprogrammed)</td>
<td>2,539</td>
<td>2,424</td>
<td>2,536</td>
<td>2,537</td>
<td>2,463</td>
</tr>
<tr>
<td>Complaint (unprogrammed)</td>
<td>2,829</td>
<td>2,448</td>
<td>2,386</td>
<td>2,382</td>
<td>2,393</td>
</tr>
<tr>
<td>Referral (unprogrammed)</td>
<td>110</td>
<td>85</td>
<td>92</td>
<td>75</td>
<td>83</td>
</tr>
<tr>
<td>Follow-up (unprogrammed)</td>
<td>113</td>
<td>61</td>
<td>105</td>
<td>121</td>
<td>233</td>
</tr>
<tr>
<td>Unprogrammed Related (different employer, same worksite)</td>
<td>936</td>
<td>795</td>
<td>831</td>
<td>789</td>
<td>673</td>
</tr>
<tr>
<td>Programmed</td>
<td>1,441</td>
<td>1,723</td>
<td>2,392</td>
<td>3,135</td>
<td>3,325</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,968</strong></td>
<td><strong>7,536</strong></td>
<td><strong>8,342</strong></td>
<td><strong>9,039</strong></td>
<td><strong>9,170</strong></td>
</tr>
</tbody>
</table>

Source: DIR Division of Occupational Safety and Health

The number of violations is greater than inspections due to the fact that most inspections where violations occur yield more than one violation. Violations are further broken down into serious and other-than-serious. In FY 2007-08, 63 percent of inspections resulted in violations cited. The breakdown by type is shown in the chart below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspect-s without violations cited</td>
<td>3,333</td>
<td>3,236</td>
<td>3,162</td>
<td>3,502</td>
<td>3,393</td>
</tr>
<tr>
<td>Inspections with violations</td>
<td>4,635</td>
<td>4,300</td>
<td>5,180</td>
<td>5,537</td>
<td>5,776</td>
</tr>
<tr>
<td><strong>Total Inspections</strong></td>
<td><strong>7,968</strong></td>
<td><strong>7,536</strong></td>
<td><strong>8,342</strong></td>
<td><strong>9,039</strong></td>
<td><strong>9,170</strong></td>
</tr>
<tr>
<td>Serious Violations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other than Serious Violations</td>
<td>12,911</td>
<td>11,742</td>
<td>13,997</td>
<td>15,585</td>
<td>15,312</td>
</tr>
<tr>
<td><strong>Total Violations</strong></td>
<td><strong>17,536</strong></td>
<td><strong>15,918</strong></td>
<td><strong>18,400</strong></td>
<td><strong>20,334</strong></td>
<td><strong>18,825</strong></td>
</tr>
</tbody>
</table>

Data Source: DIR - Division of Occupational Safety and Health
The following chart shows the total numbers of violations, including the number of serious DOSH violations from CY 1993 to CY 2008. The total number of violations increased by 24 percent from 1993 to 1995. After decreasing by 13.5 percent from 1995 to 1996, the total number of DOSH violations averaged 21,350 per year from 1996 to 2001. From 2001 to 2005, there was a 24 percent decrease in the total number of DOSH violations, and from 2005 to 2008, the total number of violations increased again by 28.5 percent.

As the chart above shows, the number of serious violations increased by 43.7 percent from 1993 to 1995. From 1995 to 2000, the number of serious violations decreased by 37.4 percent, increased by 17 percent from 2000 to 2002, and then again decreased by 21.6 percent from 2002 to 2005. After increasing by 18 percent from 2005 to 2006, the number of serious DOSH violations decreased by 6.2 percent from 2006 to 2008.
The chart below shows the trend in the share of serious DOSH violations in the total number of all violations from 1993 to 2008. The share of serious DOSH violations increased from 24 percent in 1993 to its peak of 28 percent of total violations in 1995, and decreased to 21 percent in 2000. From 2000 to 2004, the share of serious violations increased to 27 percent of total DOSH violations and then decreased to 21 percent from 2004 to 2008.

Percent of Serious Violations in Total DOSH Violations
1993 - 2008

The average number of DOSH violations per inspection averaged 1.91 in 1993 and 1994. The increase of 31.6 percent in average number of violations per inspection from 1994 to 1995 followed with a 14 percent decrease from 1995 to 1999. During the next six years, from 1999 to 2004, the average number of violations per inspection averaged 2.2 and then decreased by 8.6 percent from 2004 to 2005. After an increase of 15 percent from 2005 to 2006, the average number of violations per inspection decreased again by about 8.5 percent from 2006 to 2008.

Average Number of DOSH Violations per Inspection
1993 - 2008
### Twenty-Five Most Frequently Cited Title 8 California Code of Regulations (CCR) Standards in 2008

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Total Violations</th>
<th>Serious Violations</th>
<th>Percent of Serious Violations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3203</td>
<td>Injury and Illness Prevention Program</td>
<td>2049</td>
<td>84</td>
<td>4.1</td>
</tr>
<tr>
<td>3395</td>
<td>Heat Illness Prevention</td>
<td>1138</td>
<td>198</td>
<td>17.4</td>
</tr>
<tr>
<td>1509</td>
<td>Construction Injury Prevention Program</td>
<td>980</td>
<td>14</td>
<td>1.4</td>
</tr>
<tr>
<td>5194</td>
<td>Hazard Communication</td>
<td>757</td>
<td>13</td>
<td>1.7</td>
</tr>
<tr>
<td>3314</td>
<td>Clean, Repair, Service and Adjust Prime Movers, Machinery and Equipment</td>
<td>674</td>
<td>222</td>
<td>32.9</td>
</tr>
<tr>
<td>6151</td>
<td>Portable Fire Extinguishers</td>
<td>618</td>
<td>2</td>
<td>0.3</td>
</tr>
<tr>
<td>342</td>
<td>Reporting Work Fatality of Serious Injury</td>
<td>526</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>461</td>
<td>Permits to Operate Air Tanks</td>
<td>441</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>5144</td>
<td>Respiratory Protection Equipment</td>
<td>417</td>
<td>7</td>
<td>1.7</td>
</tr>
<tr>
<td>2340.16</td>
<td>Work Space About Electrical Equipment</td>
<td>406</td>
<td>6</td>
<td>1.5</td>
</tr>
<tr>
<td>2340.23</td>
<td>Guarding Openings in Electrical Boxes</td>
<td>324</td>
<td>69</td>
<td>21.3</td>
</tr>
<tr>
<td>3457</td>
<td>Field Sanitation</td>
<td>320</td>
<td>4</td>
<td>1.2</td>
</tr>
<tr>
<td>3668</td>
<td>Powered Industrial Truck Operator Training</td>
<td>263</td>
<td>13</td>
<td>4.9</td>
</tr>
<tr>
<td>4650</td>
<td>Compressed Gas and Air Cylinders</td>
<td>242</td>
<td>38</td>
<td>15.7</td>
</tr>
<tr>
<td>2500.08</td>
<td>Flexible Electrical Cords and Cables: Uses Not Permitted</td>
<td>242</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>5162</td>
<td>Emergency Eyewash</td>
<td>226</td>
<td>69</td>
<td>30.5</td>
</tr>
<tr>
<td>5189</td>
<td>Process Safety Management of Acutely Hazardous Substance</td>
<td>220</td>
<td>78</td>
<td>35.4</td>
</tr>
<tr>
<td>2340.22</td>
<td>Equipment Identification in Electrical Installations</td>
<td>213</td>
<td>35</td>
<td>16.4</td>
</tr>
<tr>
<td>3328</td>
<td>Safe Practices, Personal Protection: Machinery and Equipment</td>
<td>200</td>
<td>58</td>
<td>29</td>
</tr>
<tr>
<td>4070</td>
<td>Belt and Pulley Drive, Guarding</td>
<td>191</td>
<td>150</td>
<td>78.5</td>
</tr>
<tr>
<td>1512</td>
<td>Construction : Emergency Medical Services</td>
<td>177</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1644</td>
<td>Metal Scaffold</td>
<td>175</td>
<td>99</td>
<td>56.6</td>
</tr>
<tr>
<td>3650</td>
<td>Industrial Trucks: General Requirements</td>
<td>175</td>
<td>40</td>
<td>22.8</td>
</tr>
<tr>
<td>1529</td>
<td>Asbestos</td>
<td>162</td>
<td>41</td>
<td>25.3</td>
</tr>
<tr>
<td>3577</td>
<td>Use, Care, and Protection of Abrasive Wheels: Protection Devices</td>
<td>157</td>
<td>59</td>
<td>37.6</td>
</tr>
</tbody>
</table>

Data Source: DIR-DOSH
The chart below demonstrates the trends in penalties and collections. Total Penalties Assessed were $34.8 million in 2008. Many employers appeal those “recommended” penalties at the Cal/OSHA Appeals Board, and they may be ordered to pay in full, pay a reduced amount, or have the penalties eliminated due to procedural issues. Because of the appeals process, Penalties Collected will almost always be less than the initial recommended Penalties Assessed. Total Collections were $5.8 million in FY 2008.

Although the chart below demonstrates the trends in penalties and collections, it cannot be viewed entirely as an indicator of progress in health and safety at places of employment, due to related impacts on the data from DOSH staffing changes and resource changes from year to year, as well as activities at the Appeals Board. Nevertheless, the data do give a sense of the general magnitude and accounting of penalties and collections, as well as provide a starting point for further analysis.

<table>
<thead>
<tr>
<th>Year</th>
<th>Assessments (Million $)</th>
<th>Total Collectible (after appeals) (Million $)</th>
<th>Collections (Million $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>$33.7</td>
<td>$16.8</td>
<td>$13.6</td>
</tr>
<tr>
<td>2004</td>
<td>$32.5</td>
<td>$14.8</td>
<td>$12.3</td>
</tr>
<tr>
<td>2005</td>
<td>$32.4</td>
<td>$13.5</td>
<td>$11.1</td>
</tr>
<tr>
<td>2006</td>
<td>$35.6</td>
<td>$13.5</td>
<td>$10.9</td>
</tr>
<tr>
<td>2007</td>
<td>$31.9</td>
<td>$9.9</td>
<td>$6.6</td>
</tr>
<tr>
<td>2008</td>
<td>$34.8</td>
<td>$8.5</td>
<td>$5.8</td>
</tr>
</tbody>
</table>

* In 2008, Total Collectible Penalties (after appeals) and Penalties Collected are shown as of January 30, 2009

Data Source: DOSH
The chart below illustrates the proportion of inspections and violations in major industrial groups. Of the 9,169 workplace health and safety inspections conducted in FY 2007-08, 2,960 (32 percent) were in construction and 6,209 (68 percent) were in non-construction.

Despite the fact that the greatest percentage of inspections were in construction, the greatest percentage (31 percent) of violations were found to be in manufacturing, as shown in the chart below.
Economic and Employment Enforcement Coalition\(^{36}\)

According to the DIR website, “For decades California has had some of the strongest labor and workforce safety laws in the country.” To help enforce these labor laws and regulations, the “Triple E.C.” Coalition, the Economic and Employment Enforcement Coalition (EEEC), was created in 2005 as a multi-agency enforcement program consisting of investigators from the Division of Labor Standards Enforcement (DLSE), DOSH, Employment Development Department (EDD), Contractors State License Board, and U.S. DOL. The primary emphasis of EEEC is to combine enforcement efforts. EEEC is a partnership of state and federal agencies, each expert in their own field, collaborating to:

- Educate business owners and employees on federal and state labor, employment and licensing laws.
- Conduct vigorous and targeted enforcement against labor law violators.
- Help level the playing field and restore the competitive advantage to law-abiding businesses and their employees.”\(^{37}\)

Given the newness of EEEC, there are only four full years of data. Total EEEC inspections rose from FY 2005-06 to FY 2008-09, from 1,018 to 1,169, respectively, and violations increased from 3,398 to 3,534 from FY 2005-06 to FY 2008-09. The penalties given were $1.6 million in FY 2005-06 and $2.0 million in FY 2008-09; however, only $0.8 million (50 percent) were collected in FY 2005-06 and $0.4 million (20 percent) in FY 2008-09. The following two charts illustrate the comparisons.\(^{38}\)

![Total Number of EEEC Inspections and Violations (FY 2005/06 - FY 2008/09)](chart.png)

Data Source: DOSH

\(^{36}\) For further information about the EEEC, visit any of these agency links: [http://www.dir.ca.gov/EEEC/EEEC.html](http://www.dir.ca.gov/EEEC/EEEC.html), or [http://www.edd.ca.gov/eddeeec.htm](http://www.edd.ca.gov/eddeeec.htm), or [http://www.labor.ca.gov/eeec.htm](http://www.labor.ca.gov/eeec.htm)

\(^{37}\) [http://www.dir.ca.gov/EEEC/EEEC.html](http://www.dir.ca.gov/EEEC/EEEC.html)

\(^{38}\) Data provided by DOSH. These totals reflect only DOSH citations and penalties; other types of Labor Code citations and penalties resulting from the enforcement action are independently accounted for by the respected agency or unit.
The four charts below describe EEEC inspections and violations by industry, along with the penalties assessed and collected. Construction and agriculture have led in the number of inspections in all four fiscal years, except for FY 2007-08, when inspections in the garment industry reached 234. The auto body, construction, restaurant and garment industries had the greatest number of violations in FY 2008-09. However, garment and construction industries’ violations decreased by 55 percent and 25 percent respectively from FY 2007-08 to FY 2008-09, while the auto body and restaurant industries’ violations increased by 156 percent and 22.4 percent respectively during the same period. Agriculture and auto body industries are leading in penalties assessed for the FY 2008–09.

**EEEC Report: Inspections FY 2005/06 - FY 2008/09**

<table>
<thead>
<tr>
<th>Industry</th>
<th>FY 2005-06</th>
<th>FY 2006-07</th>
<th>FY 2007-08</th>
<th>FY 2008-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto Body</td>
<td>N/A</td>
<td>N/A</td>
<td>89</td>
<td>179</td>
</tr>
<tr>
<td>Pallet</td>
<td>N/A</td>
<td>N/A</td>
<td>29</td>
<td>68</td>
</tr>
<tr>
<td>Race Track</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Janitorial</td>
<td>15</td>
<td>16</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Car Wash</td>
<td>41</td>
<td>116</td>
<td>96</td>
<td>86</td>
</tr>
<tr>
<td>Garment</td>
<td>194</td>
<td>184</td>
<td>234</td>
<td>128</td>
</tr>
<tr>
<td>Restaurant</td>
<td>203</td>
<td>160</td>
<td>141</td>
<td>169</td>
</tr>
<tr>
<td>Agriculture</td>
<td>264</td>
<td>252</td>
<td>136</td>
<td>253</td>
</tr>
<tr>
<td>Construction</td>
<td>298</td>
<td>445</td>
<td>246</td>
<td>286</td>
</tr>
</tbody>
</table>

**Data Source:** DIR - DOSH
### EEEC Report: Violations FY 2005/06 - FY 2008/09

<table>
<thead>
<tr>
<th></th>
<th>FY 2005-06</th>
<th>FY 2006-07</th>
<th>FY 2007-08</th>
<th>FY 2008-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto Body</td>
<td>0.0</td>
<td>0.0</td>
<td>152</td>
<td>465</td>
</tr>
<tr>
<td>Pallet</td>
<td>0.0</td>
<td>0.0</td>
<td>189</td>
<td>129</td>
</tr>
<tr>
<td>Race Track</td>
<td>3</td>
<td>0.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Janitorial</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0.0</td>
</tr>
<tr>
<td>Agriculture</td>
<td>213</td>
<td>179</td>
<td>112</td>
<td>124</td>
</tr>
<tr>
<td>Car Wash</td>
<td>107</td>
<td>183</td>
<td>178</td>
<td>133</td>
</tr>
<tr>
<td>Restaurant</td>
<td>441</td>
<td>421</td>
<td>516</td>
<td>382</td>
</tr>
<tr>
<td>Garment</td>
<td>360</td>
<td>388</td>
<td>285</td>
<td>525</td>
</tr>
<tr>
<td>Construction</td>
<td>453</td>
<td>669</td>
<td>387</td>
<td>330</td>
</tr>
</tbody>
</table>

Data Source: DIR - DOSH

### EEEC Report: Penalties Assessed FY 2005/06 - FY 2008/09

(Thousand $)

<table>
<thead>
<tr>
<th></th>
<th>FY 2005-06</th>
<th>FY 2006-07</th>
<th>FY 2007-08</th>
<th>FY 2008-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto Body</td>
<td>0.0</td>
<td>0.0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Pallet</td>
<td>0.0</td>
<td>0.0</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Race Track</td>
<td>3</td>
<td>0.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Janitorial</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>0.0</td>
</tr>
<tr>
<td>Agriculture</td>
<td>213</td>
<td>179</td>
<td>112</td>
<td>124</td>
</tr>
<tr>
<td>Car Wash</td>
<td>107</td>
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<td>178</td>
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<td>Restaurant</td>
<td>441</td>
<td>421</td>
<td>516</td>
<td>382</td>
</tr>
<tr>
<td>Garment</td>
<td>360</td>
<td>388</td>
<td>285</td>
<td>525</td>
</tr>
<tr>
<td>Construction</td>
<td>453</td>
<td>669</td>
<td>387</td>
<td>330</td>
</tr>
</tbody>
</table>

Data Source: DIR - DOSH
High Hazard Identification, Consultation and Compliance Programs

The 1993 reforms of the California workers’ compensation system required Cal/OSHA to focus its consultative and compliance resources on “employers in high hazardous industries with the highest incidence of preventable occupational injuries and illnesses and workers’ compensation losses.”

High Hazard Employer Program

The High Hazard Employer Program (HHEP) is designed to:

- Identify employers in hazardous industries with the highest incidence of preventable occupational injuries and illnesses and workers’ compensation losses.
- Offer and provide consultative assistance to those employers to eliminate preventable injuries and illnesses and workers’ compensation losses.
- Inspect those employers on a random basis to verify that they have made appropriate changes in their health and safety programs.
- Develop appropriate educational materials and model programs to aid employers in maintaining a safe and healthful workplace.

In 1999, the passage of Assembly Bill (AB) 1655 gave DIR the statutory authority to levy and collect assessments from employers to support the targeted inspection and consultation programs on an ongoing annual basis.
High Hazard Consultation Program

DOSH reports that in 2008, it provided on-site high hazard consultative assistance to 1,231 employers, as compared to 942 employers in 2007. During consultation with these employers, 7,190 Title 8 violations were observed and corrected as a result of the provision of consultative assistance.

Since 1994, 12,939 employers have been provided direct on-site consultative assistance, and 72,701 Title 8 violations have been observed and corrected. Of these violations, 37.2 percent or 27,045 were classified as "serious."

The following chart indicates the yearly number of consultations and violations observed and corrected during the years 1994-2008. It should be noted that for years 2002 and 2003, all Consultative Safety and Health Inspection Projects (SHIPs) were included in the High Hazard Consultation Program figures. Effective 2004, only SHIPs with experience modification (Ex-mod) rates of 125 percent and above are included in the High Hazard Consultation Program figures.

The efficacy of High Hazard Consultation is measured by comparisons of employer lost-and-restricted-workday data. Beginning in 2001, Log 200 was replaced with Log 300 as the source for lost-and-restricted-workday data. The use of the Lost Work Day Case Incidence (LWDI) rate was transitioned and replaced with the Days Away, Restricted, or Transferred (DART) rate. Additionally, High Hazard Consultation uses Ex-mod rates to measure efficacy.

High Hazard Enforcement Program

DOSH reports that in 2008, 427 employers underwent a targeted high hazard enforcement inspection, down from 477 employers in 2007. During these inspections in 2008, 2,328 violations were observed and cited, whereas in 2007, 2,405 violations were observed and cited.

In addition, in 2008, 845 employers underwent an inspection as part of the Agricultural Safety and Health Inspection Project (ASHIP). Of these, 31 inspections were also targeted. During these inspections, 1,335 violations were observed and cited.
In addition, in 2008, 2,942 employers underwent an inspection as part of the Construction Safety and Health Inspection Project (CSHIP). Of these, 21 inspections were also targeted. During these inspections, 4,108 violations were observed and cited.

Since 1994, 31,874 employers have undergone a high hazard enforcement inspection, and 71,861 Title 8 violations have been observed and cited. Of these violations, 33.9 percent were classified as "serious."

The chart below indicates the yearly number of targeted inspections and violations observed and cited during the years 1994-2008. It should be noted that effective 2002, the Safety and Health Inspection Projects (SHIPs) are included in the High Hazard Enforcement Program figures.

The same lost-and-restricted-workday methodology is used for both the High Hazard Consultation and Enforcement programs. Efficacy is measured by comparisons of employer lost-and-restricted-workday data.

Beginning in 2001, Log 200 was replaced with Log 300 as the source for lost-and-restricted-workday data. The use of the LWDI rate was transitioned and replaced with the DART rate.
Safety Inspections

DOSH has two major units devoted to conducting inspections to protect the public from safety hazards:

- The Elevator, Ride and Tramway Unit conducts public safety inspections of elevators, amusement rides, both portable and permanent, and aerial passenger tramways or ski lifts.
- The Pressure Vessel Unit conducts public safety inspections of boilers (pressure vessels used to generate steam pressure by the application of heat, air and liquid storage tanks), and other types of pressure vessels.

Health and Safety Standards

The Occupational Safety and Health Standards Board (OSHSB), a seven-member body appointed by the Governor, is the standards-setting agency within the Cal/OSHA program. The mission of OSHSB is to promote, adopt and maintain reasonable and enforceable standards that will ensure a safe and healthy workplace for California workers.

To meet the DIR Goal 1 on ensuring that California workplaces are lawful and safe, the Board shall pursue the following goals:

- Adopt and maintain effective occupational safety and health standards.
- Evaluate petitions to determine the need for new or revised occupational safety and health standards.
- Evaluate permanent variance applications from occupational safety and health standards to determine if equivalent safety will be provided.

OSHSB also has the responsibility to grant or deny applications for variances from adopted standards and respond to petitions for new or revised standards. The OSHSB safety and health standards provide the basis for Cal/OSHA enforcement.

For further information …

www.dir.ca.gov/OSHSB/oshsb.html
Ergonomics Standards

Efforts to adopt an ergonomics standard in California and the U.S. are outlined in the following state and federal histories.

Ergonomics Standard in California: A Brief History

July 16, 1993
Governor Pete Wilson signs a package of bills that enacts major reform of California's workers' compensation system. A provision in AB 110 (Peace) added Section 6357 to the Labor Code requiring the Occupational Safety and Health Standards Board (OSHSB) to adopt workplace ergonomics standards by January 1, 1995, in order to minimize repetitive motion injuries.

January 18 and 23, 1996
OSHSB holds public hearings on the proposed ergonomics standard and receives over 900 comments from 203 commentators. The proposed standards are revised.

July 15, 1996
OSHSB provides a 15-day public comment period on revisions to proposed standards.

September 19, 1996
OSHSB discusses the proposal at its business meeting and makes further revisions.

October 2, 1996
OSHSB provides a 15-day public comment period on the further revisions.

November 14, 1996
OSHSB adopts the proposal at its business meeting and submits it to the state Office of Administrative Law (OAL) for review and approval.

January 2, 1997
OAL disapproves the proposed regulations based on clarity issues.

February 25, 1997
OSHSB provides a 15-day public comment period on new revisions addressing OAL concerns.

April 17, 1997
OSHSB adopts the new revisions and resubmits the proposal to OAL.

June 3, 1997
Proposed ergonomics standard is approved by OAL and becomes Title 8, California Code Regulations (8 CCR), Section (§) 5110, Repetitive Motion Injuries.

July 3, 1997
The ergonomics standard – 8 CCR §5110 - becomes effective.

September 5, 1997
Sacramento Superior Court holds a hearing to resolve the legal disputes filed by labor and business industries.

October 15, 1997
Judge James T. Ford of the Sacramento Superior Court issued a Peremptory Writ of Mandate, Judgment, and Minute Order relative to challenges brought before the Court. The Order invalidated the four parts of the standard.

December 12, 1997
OSHSB appealed Judge Ford's Order with its legal position that the Judge’s Order would be stayed pending a decision by the Court of Appeal.

(Continued on following page)  Source: OSHSB
**Federal Ergonomics Standard: A Brief History**

**1990**
Former United States Secretary of Labor Elizabeth Dole pledges to “take the most effective steps necessary to address the problem of ergonomic hazards on an industry-wide basis.”

**July 1991**

**April 1992**
Secretary of Labor denies petition for Emergency Temporary Standard.

**August 1992**
OSHA publishes an Advance Notice of Proposed Rulemaking on ergonomics.

**1993**
OSHA conducts survey to obtain information on the extent of ergonomics programs.

**March 1995**
OSHA begins meeting with stakeholders to discuss approaches to drafting an ergonomics standard.

**January 1997**
OSHA/NIOSH conference on successful ergonomics programs.

**February 1998**
OSHA begins meetings with national stakeholders about the draft ergonomics standard under development.

**February 1999**
OSHA begins small business review (SBREFA) of its draft and makes draft regulatory text available to the public.

**April 1999**
OSHA receives SBREFA report on draft and begins to address the concerns raised in the report.

**November 23, 1999**
OSHA publishes proposed ergonomics program standard by filing in the Federal Register (64 FR 65768). OSHA asks for written comments from the public, including materials such as studies and journal articles and notices of intention to appear at informal public hearings.

**March-May 2000**
Informal public hearings held in Washington D.C. (March 13 - April 7, May 8-12), Chicago (April 11-21) and Portland (April 24 - May 5).

**May 24, 2000**
The House Appropriations Committee votes to amend $342 billion spending bill by barring the Occupational Safety and Health Administration from using their budget to promulgate, issue, implement, administer or enforce any ergonomics standard. President Clinton responds by threatening to veto the bill.

Source: OSHSB

(Continued on following page)
Federal Ergonomics Standard: A Brief History (continued)

November 14, 2000
OSHA issues Ergonomics Program Standard.

January 16, 2001
Final Ergonomics Program Standard - 29 CFR 1910.900 - becomes effective. The standard was challenged in court with over 30 lawsuits.

March 20, 2001
President George W. Bush signs into law S.J. Res. 6, a measure that repeals the ergonomic regulation. This is the first time the Congressional Review Act has been put to use. The Congressional Review Act allows Congress to review every new federal regulation issued by the government agencies and, by passage of a joint resolution, overrule a regulation.

April 23, 2001
Federal OSHA publishes a notice in the Federal Register stating that the former 29 CFR 1910.900 was repealed as of that date.

April 26, 2001
Secretary of Labor Elaine L. Chao testifies before the Subcommittee on Labor, Health and Human Services, and Education of the Senate Appropriations Committee, about reducing musculoskeletal disorders in the workplace.

April 5, 2002
The Occupational Safety and Health Administration unveils a comprehensive plan designed to reduce ergonomic injuries through “a combination of industry-targeted guidelines, tough enforcement measures, workplace outreach, advanced research, and dedicated efforts to protect Hispanic and other immigrant workers.”

Source: OSHSB
The Occupational Safety and Health Appeals Board (OSHAB) consists of three members appointed by the governor for four-year terms. By statute, the members are selected each from the field of management, labor and the general public. The chairman is selected by the governor.

The mission of OSHAB is to fairly, timely and efficiently resolve appeals and to provide clear, consistent guidance to the public, thereby promoting workplace health and safety. OSHAB handles appeals from private and public sector employers regarding citations issued by DOSH for alleged violation of workplace health and safety laws and regulations.

The chart below shows the OSHAB workload: appeals filed, resolved, and unresolved. From 1989, when Cal/OSHA Program was reintroduced, the numbers of appeals filed with OSHAB yearly have been growing steadily until 1995, reaching 4,741 cases in 1995. From 1995 to 2008, the number of appeals filed yearly stabilized at average number of 4,720 cases, with a maximum 5,367 appeals filed in 2002.

From 1989 to 1996, an average of 82 percent of filed appeals was resolved each year. From 1997 to 2000, the OSHAB processed appeals in a shorter time frame (10 months) than the Fed/OSHA standard, averaging 123 percent of yearly filed cases; therefore, the number of unresolved appeals reached its minimum in 1999. From 2000 to 2006, the processed appeals had slowed down again because an average of 83 percent of filed appeals was resolved each year, increasing the number of unresolved cases to its maximum of 8,000 cases in 2005. From 2005 to 2008, the numbers of unresolved cases decreased by 43 percent because an average of 131 percent of yearly filed cases were resolved in 2007 and 2008.

The trend and level of backlogged appeals reflect changes in unresolved cases as they accumulate from previous years. As the chart below shows, the pattern of backlog repeats the pattern of unresolved cases described in the above paragraph.

* 1989 was the year when the Cal/OSHA Program was re-engaged

Data Source: OSHAB
The chart below shows the total number of appeals docketed and disposed from 2004 to 2008.

* Data was available for 11 months.

Data Source: OSHAB
Educational and Outreach Programs

In conjunction and cooperation with the entire health and safety and workers’ compensation community, DIR administers and participates in several major efforts to improve occupational health and safety through education and outreach programs.

Worker Occupational Safety and Health Training and Education Program

The Commission on Health and Safety and Workers’ Compensation (CHSWC) is mandated by Labor Code Section 6354.7 to maintain the Worker Occupational Safety and Health Training and Education Program (WOSHTEP). The purpose of WOSHTEP is to promote injury and illness prevention programs. For further information about WOSHTEP and its activities, see the “Projects and Studies” section of this report.

The California Partnership for Young Worker Health and Safety

CHSWC has convened the California Partnership for Young Worker Health and Safety. The Partnership is a statewide task force that brings together government agencies and statewide organizations representing educators, employers, parents, job trainers and others. The Partnership develops and promotes strategies to protect youth at work and provides training, educational materials, technical assistance, and information and referrals to help educate young workers. See the “Projects and Studies” section of this report for further information about the Partnership.

Cal/OSHA Consultation

Consultative assistance is provided to employers through on-site visits, telephone support, publications and educational outreach. All services provided by Cal/OSHA Consultation are provided free of charge to California employers.

Partnership Programs

California has developed several programs that rely on industry, labor, and government to work as partners in encouraging and recognizing workplace health and safety programs that effectively prevent and control injuries and illnesses to workers. These partnership programs include the Voluntary Protection Program (VPP), Golden State, SHARP, Golden Gate, and special alliances formed between industry, labor and OSHA.
Background

In California, approximately two-thirds of the total payroll in the State is covered for workers’ compensation through insurance policies, while the remainder is through self-insurance. There are more than 100 private for-profit insurers and one public nonprofit insurer, the State Compensation Insurance Fund (State Fund).

The California Department of Insurance (CDI) oversees these insurers. To accomplish its principal objective of protecting insurance policyholders in the State, CDI examines insurance companies to ensure that operations are consistent with the requirements of the Insurance Code.

Minimum Rate Law and Open Rating

In 1993, workers’ compensation reform legislation repealed California’s 80-year-old minimum rate law and replaced it beginning in 1995 with an open-competition system of rate regulation in which insurers set their own rates based on “pure premium advisory rates” developed by the Workers’ Compensation Insurance Rating Bureau (WCIRB). These rates, approved by the Insurance Commissioner (IC) and subject to annual adjustment, are based on historical loss data for more than 500 job categories.

Under this “open rating” system, these recommended, non-mandatory pure premium rates are intended to cover the average costs of benefits and loss-adjustment expenses for all employers in an occupational class and thus provide insurers with benchmarks for pricing their policies. Insurers typically file rates that are intended to cover other costs and expenses, including unallocated loss-adjustment expenses.

Insurance Market After Elimination of Minimum Rate Law

Subsequent to the repeal of the minimum rate law effective January 1995, changes were noted in the actions of insurers and employers.

Price Competition

Open rating apparently spurred competition among insurers seeking to retain or add to their market share. Some insurers attempted to increase their market share by writing coverage at low prices that eventually proved to be below loss costs. This deregulated market kept premium rates near their historic lows throughout the latter half of the 1990s, even though losses were no longer declining.

As the link between the price of insurance and loss costs became more and more tenuous, some insurers left the State, others ceased writing workers’ compensation or were merged or acquired by other carriers, and still others, including several of the largest insurers in the State, became insolvent and had to be taken over or supervised by the State. As a result, the workers’ compensation market became much more concentrated than in the past. Aside from State Fund, there were only a few large national carriers that accounted for the largest portion of the statewide premium.
**Insurers Liquidated Since 2000**

**2000**
- California Compensation Insurance Company
- Combined Benefits Insurance Company
- Commercial Compensation Casualty Insurance Company
- Credit General Indemnity Company
- LMI Insurance Company
- Superior National Insurance Company
- Superior Pacific Insurance Company

**2001**
- Credit General Insurance Company
- Great States Insurance Company
- HIH America Compensation & Liability Insurance Company
- Amwest Surety Insurance Company
- Sable Insurance Company
- Reliance Insurance Company
- Far West Insurance Company
- Frontier Pacific Insurance Company

**2002**
- PHICO
- National Auto Casualty Insurance Company
- Paula Insurance Company
- Alistar Insurance Company

**2003**
- Western Growers Insurance Company
- Legion Insurance Company
- Villanova Insurance Company
- Home Insurance Company
- Fremont Indemnity Corporation
- Wasatch Crest Insurance Co. (No WC policies)
- Pacific National Insurance Company

**2004**
- Protective National Insurance Company
- Holland-America Insurance Company
- Casualty Reciprocal Exchange

**2005**
- Cascade National Insurance Company/Washington
- South Carolina Insurance Company/South Carolina
- Consolidated American Insurance Company/South Carolina

**2006**
- Vesta Fire Insurance Company
- Hawaiian Insurance & Guaranty Company
- Municipal Mutual Insurance Company

**Insurance Market Changes**

Since 2000, a significant number of workers’ compensation insurance companies have experienced problems with payment of workers’ compensation claims. Thirty-five (35) insurance companies have gone under liquidation, and 18 companies have withdrawn from offering workers’ compensation insurance during that time. However, since 2004, 27 insurance/reinsurance companies have entered the California workers’ compensation market, while only 12 companies withdrew from the market.39

**Changing Insurers**

WCIRB estimated that before open rating, about 25 percent of California employers with experience modifications (Ex-mods) changed insurance carriers each year. After open rating, about 35 percent of the employers did so. However, in many post-open rating situations, employers had no choice but to change insurers, as the market had deteriorated to the point that many carriers, including several of the largest workers’ compensation insurers in the State, ceased to exist or stopped writing workers’ compensation in California.

**Reinsurance**

After open rating, many carriers shifted the risk of their workers’ compensation claims to other insurance companies, some of which were inexperienced with the California workers’ compensation insurance market. It was reported that many carriers used reinsurance aggressively in order to mitigate the risk of having to make large future payoffs. Some primary workers’ compensation carriers offered extremely low rates that proved to be inadequate in the face of soaring losses. Some reinsurance companies also sold off their risk to other reinsurers in a process called “retrocession.” During 1999, several major reinsurance pools experienced financial difficulty and ceased operations.

**Impact of Recent Workers’ Compensation Reforms on Insurance Companies**

Workers’ compensation reform legislation, Senate Bill (SB) 228, Assembly Bill (AB) 227 and SB 899, were enacted with the intent of controlling costs and improving the benefit-delivery process in the workers’ compensation system.

In 2007, SB 316 eliminated a duplicative reserve requirement that was inadvertently not removed when risk-based capital requirements went into effect for workers’ compensation insurers in 2002. That same bill also mandated a study by the Commission on Health and Safety and Workers’ Compensation (CHSWC) of the causes of many of the insolvencies in this decade. The study is under contract with RAND and is currently underway. It is expected that recommendations from the study will also address prevention of future insolvencies.

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39 The information on the companies that have withdrawn and entered the market since 2004 is through 07/15/2009.
Workers’ Compensation Advisory Premium Rates

As a result of recent legislative reforms, WCIRB recommended changes and the IC approved either decreases or no changes in the pure premium advisory rates between January 2002 and January 2010. On August 18, 2009, WCIRB recommended a 22.8 percent increase in advisory pure premium rates effective January 1, 2010, due to the increasing medical costs and two recent Workers’ Compensation Appeals Board (WCAB) en banc decisions (Almaraz/Guzman and Ogilvie). On November 9, 2009, the IC issued a decision approving no change to the pure premium rates for January 1, 2010. (A history of pure premium rates since 1993 appears later in this section.)

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

<table>
<thead>
<tr>
<th>Jan 1</th>
<th>July 1</th>
<th>Jan 1</th>
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<th>Jan 1</th>
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<th>Jan 1</th>
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<th>Jan 1</th>
<th>July 1</th>
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</thead>
<tbody>
<tr>
<td>WCIRB Recommendation</td>
<td>10.2%</td>
<td>10.1%</td>
<td>13.4%</td>
<td>10.8%</td>
<td>-5.3%</td>
<td>-2.3%</td>
<td>5.5%</td>
<td>-10.4%</td>
<td>-15.9%</td>
<td>-16.4%</td>
<td>-6.3%</td>
<td>-11.3%</td>
<td>5.2%</td>
<td>16%</td>
<td>23.7%</td>
<td>22.8%</td>
<td></td>
</tr>
<tr>
<td>Insurance Commissioner Approved</td>
<td>10.2%</td>
<td>10.1%</td>
<td>10.5%</td>
<td>7.2%</td>
<td>-14.3%</td>
<td>-7.8%</td>
<td>-2.2%</td>
<td>-18.0%</td>
<td>-15.3%</td>
<td>-16.4%</td>
<td>-9.5%</td>
<td>-14.2%</td>
<td>0%</td>
<td>5.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

* WCIRB did not issue any recommendations for changes to pure premium rates effective July 1, 2008, and the IC did not issue the interim advisory rate for this period.

Data Source: WCIRB

California Workers’ Compensation Filed Rate Changes

As a result of recent workers’ compensation legislative reforms and the subsequent decisions by the IC on advisory premium rates, workers’ compensation insurers have reduced their average filed rates as indicated in the chart below.

Average Workers’ Compensation Rate Reductions Filed by Insurers

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>-3.6%</td>
<td>-7.3%</td>
<td>-3.8%</td>
<td>-14.6%</td>
<td>-14.7%</td>
<td>-10.7%</td>
<td>-7.0%</td>
<td>-11.0%</td>
<td>-0.5%</td>
<td>-2.6%</td>
<td>5.8%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Data Source: California Department of Insurance (CDI)
California Workers’ Compensation Rate Changes

As a result of recent workers’ compensation legislative reforms and the subsequent decisions by the IC on advisory claims cost benchmarks and pure premium rates, the top ten California workers’ compensation insurers have reduced their filed rates as indicated in the chart below.

As of July 1, 2009, the cumulative premium weighted average rate reduction filed by insurers with CDI since the reforms is 51.0 percent for all writers including State Compensation Insurance Fund (State Fund). There have been eight advisory pure premium rate reductions since the passage of AB 227 and SB 228, and individually stated, filed insurer rates were reduced 3.6 percent on January 1, 2004, 7.3 percent on July 1, 2004, 3.8 percent on January 1, 2005, 14.6 percent on July 1, 2005, 14.7 percent on January 1, 2006, 10.7 percent on July 1, 2006, 7.0 percent on January 1, 2007, and 11.0 percent on July 1, 2007. Insurer rates were further reduced by 0.5 percent on January 1, 2008, and 2.6 percent on July 1, 2008, at times when the advisory rates remained unchanged. For the first time since the reforms, the advisory pure premium rates were increased effective January 1, 2009, and filed insurer rates increased 5.8 percent. Filed insurer rates were further increased 8.5 percent on July 1, 2009, also at a time when the advisory rates remained unchanged.40

WCIRB reports that actual rates charged in the market place as of December 31, 2008, had fallen by 65 percent since the enactment of AB 227, SB 228, and SB 899. The average rate per $100 of payroll fell from $6.45 in 2003 to $2.33 in 2008.41

### California Workers’ Compensation Top 10 Insurers Rate Filing Changes

<table>
<thead>
<tr>
<th>COMPANY NAME</th>
<th>GROUP NAME</th>
<th>Market Share 2008</th>
<th>Cumulative Rate Change 1-04 to 7-09</th>
<th>7-1-2009 % Filed Rate Change</th>
<th>1-1-2009 % Filed Rate Change</th>
<th>7-1-2008 % Filed Rate Change</th>
<th>1-1-2008 % Filed Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATE COMPENSATION INSURANCE FUND</td>
<td>Zenith National Insurance Gp</td>
<td>22.56%</td>
<td>-45.41%</td>
<td>15.00%</td>
<td>8.90%</td>
<td>-3.50%</td>
<td>0.00%</td>
</tr>
<tr>
<td>ZENITH INSURANCE COMPANY</td>
<td>Zenith National Insurance Gp</td>
<td>3.23%</td>
<td>-33.41%</td>
<td>4.00%</td>
<td>4.00%</td>
<td>n/a</td>
<td>0.00%</td>
</tr>
<tr>
<td>ENDURANCE REINS CORP OF AMERICA</td>
<td>Endurance Group</td>
<td>3.04%</td>
<td>-40.36%</td>
<td>n/a</td>
<td>5.00%</td>
<td>n/a</td>
<td>0.00%</td>
</tr>
<tr>
<td>EMPLOYERS COMPENSATION INSURANCE COMPANY</td>
<td>Employers Group</td>
<td>2.91%</td>
<td>-38.43%</td>
<td>n/a</td>
<td>0.00%</td>
<td>n/a</td>
<td>-4.40%</td>
</tr>
<tr>
<td>NATIONAL UNION FIRE INS COMPANY OF PITTS</td>
<td>AIG</td>
<td>2.86%</td>
<td>-52.63%</td>
<td>7.00%</td>
<td>10.00%</td>
<td>-15.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>ZURICH AMERICAN INSURANCE COMPANY</td>
<td>Zurich Ins Gp</td>
<td>2.53%</td>
<td>-57.71%</td>
<td>10.00%</td>
<td>5.80%</td>
<td>n/a</td>
<td>-0.20%</td>
</tr>
<tr>
<td>TRAVLERS INDEMNITY COMPANY OF CT</td>
<td>Travelers Group</td>
<td>2.29%</td>
<td>-53.09%</td>
<td>13.00%</td>
<td>9.50%</td>
<td>n/a</td>
<td>0.30%</td>
</tr>
<tr>
<td>REDWOOD FIRE AND CASUALTY INS COMPANY</td>
<td>Berkshire Hathaway Gp</td>
<td>1.85%</td>
<td>-65.27%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>5.20%</td>
</tr>
<tr>
<td>WAUSAU UNDERWRITERS INSURANCE COMPANY</td>
<td>Liberty Mutual Group</td>
<td>1.79%</td>
<td>-64.56%</td>
<td>23.20%</td>
<td>8.80%</td>
<td>n/a</td>
<td>-3.30%</td>
</tr>
<tr>
<td>LIBERTY MUTUAL FIRE INSURANCE COMPANY</td>
<td>Liberty Mutual Group</td>
<td>1.67%</td>
<td>-54.64%</td>
<td>n/a</td>
<td>6.80%</td>
<td>n/a</td>
<td>0.10%</td>
</tr>
</tbody>
</table>

40 Source: California Department of Insurance, RFLA3 Rate Filing Bureau.
Since the first reform package was chaptered, 35 new insurers have entered the market and existing private insurers have increased their writings. The significant rate reductions totaling 51.0 percent since the first reforms were enacted, coupled with the reduced market share of State Fund (53.0 percent at its peak in 2003, declining to 22.6 percent in 2008) and an estimated 2008 accident year combined loss and expense ratio of 108 percent, all point to the dramatic success of the cost containment reforms and a stabilizing market with increased capacity and greater rate competition.

**Workers' Compensation Premium**

After elimination of the minimum rate law, the total written premium declined from a high of $8.9 billion in 1993 to a low of $5.7 billion ($5.1 billion net of deductible) in 1995. The written premium grew slightly from 1996 to 1999 due to growth of insured payroll, an increase in economic growth, movement from self-insurance to insurance, and other factors, rather than due to increased rates. However, even with well over a million new workers covered by the system, the total premium paid by employers remained below the level seen at the beginning of the decade.

At the end of 1999, the IC approved an 18.4 percent pure premium rate increase for 2000, and the market began to harden after five years of open rating, though rates remained less than two-thirds of the 1993 level. Since then, the market has continued to firm, with the IC approving a 10.1 percent increase in the advisory rates for 2001 and a 10.2 percent increase for 2002. The total written premium has increased by 37.8 percent to $21.5 billion from 2002 to 2003 and increased by 9.3 percent to a peak of $23.5 billion from 2003 to 2004. The written premium declined by 54.5 percent from $23.5 billion to $10.7 billion between 2004 and 2008 due to rate decreases.

The chart below shows the California workers’ compensation written premium before and after the application of deductible credits. Note that these amounts are exclusive of dividends.

![Chart: Workers' Compensation Written Premium as of September 30, 2009](chart)

Data Source: WCIRB

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Combined Loss and Expense Ratio

The accident year combined loss and expense ratio, which measures workers’ compensation claims payments and administrative expenses against earned premium, increased during the late 1990s, declined from 1999 through 2005, and doubled from 2005 to 2008.

In accident year 2008, insurers’ claim costs and expenses amounted to $1.11 for every dollar of premium collected.

California Workers’ Compensation Combined Loss and Expense Ratios
After Reflecting the Estimated Impact of the Ogilvie and Almaraz/Guzman Decisions (as of September 30, 2009)

WCIRB estimates that the total cost of benefits for injuries occurring prior to January 1, 2009, is $5.3 billion less than insurer-reported loss amounts.

Policy Holder Dividends

Dividends paid to policyholders dropped from 1996 to 1997, were less than 3 percent from 1997 to 2002, were not paid at all in 2003 and 2004, and then were reinstated from 2005 through 2008 at a very low rate.
Average Claim Costs

At the same time that premiums and claim frequency were declining, the total amount insurers paid on indemnity claims jumped sharply during the late 1990s.

The total average cost of indemnity claims decreased by 22 percent from 2001 to 2005, reflecting the impact of AB 227, SB 228 and SB 899. However, the total indemnity and medical average costs per claim increased by almost 47 percent between 2005 and 2008. Please note that WCIRB’s estimates of average indemnity claim costs have not been indexed to take into account wage increase and medical inflation.

Estimated Ultimate Total Loss* per Indemnity Claim
After Reflecting the Estimated Impact of the Ogilvie and Almaraz/Guzman Decisions
as of September 30, 2009

Source: WCIRB

* Excludes medical-only

** Loss severities prior to adjustment for the impact of the Ogilvie and Almaraz/Guzman decisions for accident years 2004 to 2008 are: $39,538, $38,295, $44,410, $49,697, and $55,292, respectively.

Source: WCIRB
Insurer Profit/Loss

Workers' compensation insurers experienced large fluctuations in profits and losses during the past decade, as measured by actual dollars and percentage of earned premium. Since the reforms of 2004, insurer underwriting profits have been uncharacteristically high. Investment income typically was the main source of insurer profits, but underwriting profits from policies have been a recent development. In 2008, workers' compensation insurers experienced losses for the first time since 2004.

Insurer Pre-Tax Underwriting Profit/Loss as a Percentage of Earned Premium

![Bar chart showing the percentage of earned premium for insurer pre-tax underwriting profit/loss from 1996 to 2008.]

Data Source: WCIRB

Insurer Pre-Tax Underwriting Profit/Loss in Million$

![Bar chart showing the million dollar figures for insurer pre-tax underwriting profit/loss from 1996 to 2008.]

Data Source: WCIRB
Current State of the Insurance Industry

Market Share

A number of California insurers left the market or reduced their writings as a result of the decrease in profitability, contributing to a major redistribution of market share among insurers since 1993, as shown in the following chart.

According to WCIRB, from 2002 through 2004, State Fund attained about 35 percent of the California workers’ compensation insurance market, double the market share it had in the 1990s. However, between 2004 and 2008, State Fund’s market share decreased to 16 percent. On the other hand, the market share of California companies, excluding State Fund, between 2004 and 2008 increased from 5 percent to 13 percent.

Workers’ Compensation Insurance Market Share in California by Type of Insurer

Based on Written Premium Prior to Deductible Credits

Source: WCIRB

*Please note that totals may not equal 100% due to rounding.

"California Insurers" are defined as private insurers who write at least 80% of their workers' compensation business in California

September 11, 2001 Impact on Insurance Industry

The problems in the reinsurance market caused by the events of September 11, 2001, have significantly affected the cost and availability of catastrophe reinsurance and, correspondingly, have a significant effect on the cost of workers’ compensation insurance. This effect extends to more than acts of terrorism and is a critical component of any evaluation of the California workers’ compensation insurance marketplace. The insurance industry has remained concerned about the renewal of the Terrorism Risk Insurance Act, often known as TRIA, which was reauthorized in 2007 to extend to December, 2014.
Advisory Workers’ Compensation Pure Premium Rates
A History Since the 1993 Reform Legislation

1993

Insurance Commissioner approval:
Pure premium rate reduction of 7 percent effective July 16, 1993, due to a statutory mandate.

1994

WCIRB recommendation:
No change in pure premium rates.

Insurance Commissioner approval:
Two pure premium rate decreases: a decrease of 12.7 percent effective January 1, 1994; and a second decrease of 16 percent effective October 1, 1994.

1995

WCIRB recommendation:
A 7.4 percent decrease from the pure premium rates that were in effect on January 1, 1994.

Insurance Commissioner approval:
A total of 18 percent decrease to the premium rates in effect on January 1, 1994, approved effective January 1, 1995 (including the already approved 16 percent decrease effective October 1, 1994).

1996

WCIRB recommendation:
An 18.7 percent increase in pure premium rates.

Insurance Commissioner approval:
An 11.3 percent increase effective January 1, 1996.

1997

WCIRB recommendation:
A 2.6 percent decrease in pure premium rates.

Insurance Commissioner approval:
A 6.2 percent decrease effective January 1, 1997.

1998

WCIRB recommendation:
The initial recommendation for a 1.4 percent decrease was later amended to a 0.5 percent increase.

Insurance Commissioner approval:
A 2.5 percent decrease effective January 1, 1998.

1999

WCIRB recommendation:
The WCIRB initial recommendation of a 3.6 percent pure premium rate increase for 1999 was later amended to a recommendation for a 5.8 percent increase.

Insurance Commissioner approval:
No change in pure premium rates in 1999.
2000

**WCIRB recommendation:**
An 18.4 percent increase in the pure premium rate for 2000.

**Insurance Commissioner approval:**
An 18.4 percent increase effective January 1, 2000.

2001

**WCIRB recommendations:**
The WCIRB initial recommendation of a 5.5 percent increase in the pure premium rate was later amended to a recommendation for a 10.1 percent increase.

**Insurance Commissioner approval:**
A 10.1 percent increase effective January 1, 2001.

January 1, 2002

**WCIRB recommendations:**
The WCIRB initial recommendation of a 9 percent increase in the pure premium rate was later amended to a recommendation for a 10.2 percent increase effective January 1, 2002.

**Insurance Commissioner approval:**
The Insurance Commissioner approved a 10.2 percent increase effective January 1, 2002.

April 1, 2002

**WCIRB recommendations:**

**Insurance Commissioner approval:**
The Insurance Commissioner approved the WCIRB’s requests effective April 1, 2002.

July 1, 2002

**WCIRB recommendation:**
The WCIRB filed a mid-term recommendation that pure premium rates be increased by 10.1 percent effective July 1, 2002, for new and renewal policies with anniversary rating dates on or after July 1, 2002.

**Insurance Commissioner approval:**
On May 20, 2002, the Insurance Commissioner approved a mid-term increase of 10.1 percent effective July 1, 2002.

January 1, 2003

**WCIRB recommendations:**
On July 31, 2002, the WCIRB proposed an average increase in pure premium rates of 11.9 percent for 2003. On September 16, 2002, the WCIRB amended the proposed 2003 pure premium rates submitted to the California Department of Insurance (CDI). Based on updated loss experience valued as of June 30, 2002, the WCIRB proposed an average increase of 13.4 percent in pure premium rates to be effective on January 1, 2003, and later policies.
Advisory Workers’ Compensation Pure Premium Rates
A History since the 1993 Reform Legislation

Page 3 of 6

January 1, 2003

Insurance Commissioner approval:
On October 18, 2002, the Insurance Commissioner approved a 10.5 percent increase in pure premium rates applicable to policies with anniversary rating dates in 2003. This increase takes into account the increases in workers' compensation benefits enacted by AB 749 for 2003.

July 1, 2003

WCIRB recommendation:
The WCIRB filed a mid-term recommendation on April 2, 2003, that pure premium rates be increased by 10.6 percent effective July 1, 2003, for policies with anniversary dates on or after July 1, 2003.

Insurance Commissioner approval:
The Insurance Commissioner approved a 7.2 percent increase in pure premium rates applicable to new and renewal policies with anniversary rating dates on or after July 1, 2003.

January 1, 2004

WCIRB recommendations:
On July 30, 2003, the WCIRB proposed an average increase in advisory pure premium rates of 12.0 percent to be effective on January 1, 2004, for new and renewal policies with anniversary rating dates on or after January 1, 2004.

The original WCIRB filing of an average increase of 12 percent on July 30, 2003, was later amended on September 29, 2003, to an average decrease of 2.9 percent to reflect the WCIRB's initial evaluation of AB 227 and SB 228.

In an amended filing made on November 3, 2003, the WCIRB recommended that pure premium rates be reduced, on average, from 2.9 percent to 5.3 percent.

Insurance Commissioner approval:
On November 7, 2003, the Insurance Commissioner approved a 14.9 percent decrease in pure premium rates applicable to new and renewal policies with anniversary rating dates on or after January 1, 2004.

July 1, 2004

WCIRB recommendation:
On May 13, 2004, the WCIRB proposed advisory pure premium rates that are a 2.9 percent decrease from the January 1, 2004, approved pure premium rates. These rates reflect the WCIRB’s analysis of the impact of provisions of SB 899 on advisory pure premium rates.

Insurance Commissioner approval:
In a decision issued May 28, 2004, the Insurance Commissioner approved a 7.0 percent decrease in pure premium rates, effective July 1, 2004, with respect to new and renewal policies, as compared to the approved January 1, 2004, pure premium rates.

January 1, 2005

WCIRB recommendation:
On July 28, 2004, the WCIRB proposed advisory premium rates applicable to new and renewal policies with anniversary rating dates on or after January 1, 2005, that are, on average, 3.5 percent greater than the July 1, 2004, advisory pure premium rates approved by the Insurance Commissioner.

Insurance Commissioner approval:
In a decision issued November 17, 2004, the Insurance Commissioner approved a total 2.2 percent decrease in advisory pure premium rates applicable to new and renewal policies with anniversary rating dates on or after January 1, 2005.
July 1, 2005

**WCIRB recommendations:**

On March 25, 2005, the WCIRB submitted a filing to the California Insurance Commissioner recommending a 10.4 percent decrease in advisory pure premium rates effective July 1, 2005, on new and renewal policies.

On May 19, 2005, in recognition of the cost impact of the new Permanent Disability Rating Schedule adopted pursuant to SB 899, the WCIRB amended its recommendation. In lieu of the 10.4 percent reduction originally proposed in March, the WCIRB recommended a 13.8 percent reduction in pure premium rates effective July 1, 2005. In addition, the WCIRB recommended a 3.8 percent reduction in the pure premium rates effective July 1, 2005, with respect to the outstanding portion of policies incepting January 1, 2005, through June 30, 2005.

**Insurance Commissioner approval:**

On May 31, 2005, the Insurance Commissioner approved an 18 percent decrease in advisory pure premium rates effective July 1, 2005, applicable to new and renewal policies with anniversary rating dates on or after July 1, 2005. As a result of the change in pure premium rates, the experience rating eligibility threshold was reduced to $23,288. The Insurance Commissioner also approved a 7.9 percent decrease in pure premium rates, effective July 1, 2005, applicable to policies that are outstanding as of July 1, 2005. The reduction in pure premium rates applicable to these policies reflects the estimated impact on the cost of benefits of the new Permanent Disability Rating Schedule.

January 1, 2006

**WCIRB recommendations:**

On July 28, 2005, the WCIRB submitted to the California Insurance Commissioner a proposed 5.2 percent average decrease in advisory pure premium rates as well as changes to the California Workers' Compensation Uniform Statistical Reporting Plan -1995 and the California Workers' Compensation Experience Rating Plan -1995.

On September 15, 2005, the WCIRB amended its filing to propose an average 15.9 percent decrease in pure premium rates based on insurer loss experience valued as of June 30, 2005, and a re-evaluation of the cost impact of the January 1, 2005 Permanent Disability Rating Schedule.

**Insurance Commissioner approval:**

On November 10, 2005, the Insurance Commissioner approved an average 15.3 percent decrease in advisory pure premium rates effective January 1, 2006, applicable to new and renewal policies with anniversary rating dates on or after January 1, 2006. As a result of the change in pure premium rates, the experience rating eligibility threshold was reduced to $20,300.

July 1, 2006

**WCIRB recommendations:**

On March 24, 2006, the WCIRB submitted a rate filing to the California Department of Insurance recommending a 16.4 percent decrease in advisory pure premium rates to be effective on policies incepting on or after July 1, 2006. The recommended decrease in pure premium rates is based on an analysis of loss experience valued as of December 31, 2005. The WCIRB filing also includes an amendment to the California Workers' Compensation Experience Rating Plan-1995, effective July 1, 2006, to adjust the experience rating eligibility threshold to reflect the proposed change in pure premium rates. A public hearing on the matters contained in the WCIRB's filing was held April 27, 2006.

**Insurance Commissioner approval:**

On May 31, 2006, the Insurance Commissioner approved a 16.4 percent decrease in advisory pure premium rates effective July 1, 2006, applicable to new and renewal policies as of the first anniversary rating date of a risk on or after July 1, 2006. In addition, the experience rating eligibility threshold was reduced to $16,971 to reflect the decrease in pure premium rates.
Advisory Workers’ Compensation Pure Premium Rates
A History since the 1993 Reform Legislation

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January 1, 2007

WCIRB recommendation:
On October 10, 2006, the WCIRB recommended a 6.3 percent decrease in advisory pure premium rates decrease for California policies incepting January 1, 2007.

Insurance Commissioner approval:
On November 2, 2006, the Insurance Commissioner approved an average 9.5 percent decrease in advisory pure premium rates effective January 1, 2007, applicable to new and renewal policies with anniversary rating dates on or after January 1, 2007. As a result of the change in pure premium rates, the experience rating eligibility threshold was reduced to $16,000.

July 1, 2007

WCIRB recommendation:
On March 30, 2007, the WCIRB recommended an 11.3 percent decrease in advisory pure premium rates for California to be effective on policies incepting on or after July 1, 2007.

Insurance Commissioner approval:
On May 29, 2007, the Insurance Commissioner approved an average 14.2 percent decrease in advisory pure premium rates effective July 1, 2007, applicable to new and renewal policies with anniversary rating dates on or after July 1, 2007. As a result of the change in pure premium rates, the experience rating eligibility threshold was reduced to $13,728.

January 1, 2008

WCIRB recommendations:
On September 23, 2007, the WCIRB recommended 4.2 percent increase in advisory pure premium rates for California to be effective on policies incepting on or after January 1, 2008.

On October 13, 2007, the Governor signed Assembly Bill (AB) 338 which extends the time period for which temporary disability payments may be taken. On October 19, 2007, the WCIRB amended its January 1, 2008 pure premium rate filing to propose an overall 5.2 percent increase in pure premium rates in lieu of 4.2 percent to incorporate the impact of AB 338.

Insurance Commissioner approval:
On November 28, 2007, the Insurance Commissioner approved no overall change to the advisory pure premium rates effective January 1, 2008.

July 1, 2008

WCIRB recommendation:
On March 26, 2008, accepting a recommendation made by the WCIRB Actuarial Committee, the WCIRB Governing Committee decided that the WCIRB would propose 0 percent change in advisory pure premium rates for California to be effective on policies incepting on or after January 1, 2008.
January 1, 2009

**WCIRB recommendations:**

On August 13, 2008, the WCIRB recommended a 16 percent increase in advisory pure premium rates for California to be effective on policies incepting on or after January 1, 2009. See the WCIRB website below for further details and updates to this information.

At its September 10, 2008 meeting, the Governing Committee agreed that the WCIRB's January 1, 2009 pure premium rate filing should be amended to reflect the most recent accident year experience valued as of June 30, 2008, as well as a revised loss development methodology. The original filing should be supplemented to include a recommendation that the proposed January 1, 2009 pure premium rates be adjusted to reflect (a) the impact of the Division of Workers' Compensation proposed changes to the Permanent Disability Rating Schedule (+3.7%) if adopted as proposed and (b) the impact of SB 1717 (+9.3%) if signed into law by the Governor.

**Insurance Commissioner approval:**

On October 24, 2008, the Insurance Commissioner approved a 5 percent increase in pure premium rates effective January 1, 2009, applicable to new and renewal policies with anniversary rating dates on or after January 1, 2009.

July 1, 2009

**WCIRB recommendations:**

On March 27, 2009, WCIRB recommended a 24.4 percent increase in advisory pure premium rates for California to be effective on policies incepting on or after July 1, 2009.

WCIRB amended its filing on April 23, 2009, to reflect the revised aggregate financial data calls recently submitted by an insurer to WCIRB. These revisions reduced the indicated July 1, 2009, increase in the claims cost benchmark from 24.4 percent to 23.7 percent.

**Insurance Commissioner approval:**

On July 8, 2009, the Insurance Commissioner approved no change to the pure premium rates effective July 1, 2009, applicable to new and renewal policies with anniversary rating dates on or after July 1, 2009.

January 1, 2010

**WCIRB recommendation:**

On August 18, 2009, the WCIRB submitted a pure premium rate filing to the California Insurance Commissioner recommending a 22.8 percent increase in advisory pure premium rates with respect to new and renewal policies as of the first anniversary rating date of a risk on or after January 1, 2010.

**Insurance Commissioner approval:**

On November 9, 2009, the Insurance Commissioner approved no change to the pure premium rates effective January 1, 2010, applicable to new and renewal policies as of the first anniversary rating date of a risk on or after January 1, 2010.

[https://wcirbonline.org/resources/rate_filings/current_rate_filings.html](https://wcirbonline.org/resources/rate_filings/current_rate_filings.html)
SPECIAL REPORT: PERMANENT DISABILITY RATING COMPENSATION

Introduction

This report will review the recent history of changes to permanent disability (PD) compensation, the impacts of the changes, and empirical evidence that may inform future policymaking deliberations.

Compensation for permanent partial disability remains one of the more disputed areas of workers’ compensation at the policymaking level and at the individual case level. Other disability insurance systems, such as social security or long-term disability insurance policies, cover only total disabilities. Among social insurance systems, workers’ compensation is unusual in its attempt to comprehensively address permanent partial disabilities.

Of all indemnity and medical benefits paid by California insurers in 2006, 1 percent went to permanent total disability while 22 percent went to permanent partial disability. By 2008, those proportions were 1 percent for permanent total disability and 18 percent for permanent partial disability. Discussions of PD usually are focused on the evaluation and compensation of permanent partial disability, and unless otherwise indicated, all references to PD in this report are to permanent partial disability.

The PD compensation system has evolved in the absence of a general agreement on the appropriate level of compensation for PD. For temporary disability, the benchmark is replacement of two-thirds of wage loss. Such a simple target has not been found for PD. Instead, the PD compensation system has evolved in an environment dominated by the tension between demands for adequate compensation and the demands for affordable costs. Additional influences have included concerns for appropriate distribution of the available funds, appropriate incentives for all parties, and political feasibility.

The amount of PD compensation for an injured worker in California is the product of the injured workers’ permanent partial disability rating, the number of weeks of benefits allowed for that rating, and the weekly amount of the PD payment. The administrative method of rating disabilities evolved gradually for decades. Until 2004, the contest between adequacy and cost was generally played out in sporadic legislative increases in the number of weeks or the weekly amounts. Dramatic changes occurred by legislation in 2004 and by the adoption of a new PD rating schedule (PDRS) effective in 2005.

The Reforms

When employers’ costs for workers’ compensation coverage became clearly excessive in 2003, cost savings were sought throughout the workers’ compensation system. The 2003 legislation attacked excessive medical costs and abolished the vocational rehabilitation program. Before the impacts of these changes could be determined, these were followed by the 2004 legislation requiring certain PD benefit reductions and setting the stage for further reductions. As illustrated later in this report, the statutory changes directly reduced total PD costs by about a third, and the 2005 PDRS reduced benefits by about a third, so that only about one-third of the PD dollars are payable for post-2004 injuries compared to what they would have been without the 2004 legislation.

California employers have enjoyed dramatic reductions in workers’ compensation costs since 2003, largely due to reforms targeted at medical costs. At the same time, injured workers have experienced the first substantial decline in PD compensation in decades, possibly in the history of California worker’s compensation.

43 WCIRB, 2008 California Workers’ Compensation Losses and Expenses, Released June 25, 2009. The proportions of benefits paid are assumed to be similar for self insured employers as for insurers. For these purposes, permanent partial disability includes life pensions. Numbers are rounded to nearest whole percent.
Evaluation of 2004 – 2005 Changes to Permanent Disability

The 2004 legislation and the 2005 revision of the PDRS have eliminated about two-thirds of the benefits payable for permanent partial disabilities. PD cost savings were clearly intended to result from a reduction in the number of weeks of benefits payable for most ratings, from changes to the law of apportionment, from the adoption of return-to-work (RTW) incentives, and from the elimination of subjective ratings through the adoption of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, 5th edition. The reduction in weeks of benefits was obviously intended to save costs, and the other changes had clear public policy purposes in addition to cost reductions. Administrative implementation was required for the switch to the AMA Guides, however, and the legislation provided neither cost/benefit goals nor unambiguous policy goals for the revision of the schedule.

The Administrative Director (AD) of the Division of Workers’ Compensation (DWC) adopted a revised PDRS that used multipliers to adjust the AMA Guides impairment ratings in consideration of diminished future earning capacity. These multipliers, often called FEC factors or DFEC factors, serve two purposes. A noncontroversial purpose is to correct for discrepancies where impairment ratings under the AMA Guides for injuries to different parts of the body do not have a consistent relationship to the severity of the disability as observed in average earnings losses. A more controversial purpose is to increase the scale of the AMA impairment ratings to something closer to the scale of the PD ratings that prevailed for decades under the previous rating system. To the extent that average ratings under the new PDRS are still substantially lower than average ratings under the former PDRS, the revised PDRS itself has contributed to the dramatic reduction in PD compensation.

<table>
<thead>
<tr>
<th>Statutory Change</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Disability evaluation shall be based on the AMA Guides, 5th edition.</td>
<td>Undetermined. Early evidence suggested 10 percent to 30 percent of cases would be zero-rated and will drop out. Recent observations support the higher range.</td>
</tr>
<tr>
<td>The number of weeks of benefits is reduced for all but the most severe ratings.</td>
<td>16 percent reduction in overall PD cost, according to Workers’ Compensation Insurance Rating Bureau (WCIRB) estimate.</td>
</tr>
<tr>
<td>Where a disability has multiple causes, apportionment is based on causation.</td>
<td>6 percent reduction in awards, based on study of thousands of ratings.</td>
</tr>
<tr>
<td>PD payments may be increased or decreased by 15 percent depending on whether</td>
<td>No cost savings demonstrated. Predicted 3 percent savings assumed that statutory criteria would fit real-world situations, which has not occurred.</td>
</tr>
<tr>
<td>the employer offers RTW.</td>
<td></td>
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</tbody>
</table>

<table>
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<tr>
<th>2005 PD Rating Schedule</th>
<th>Impact</th>
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</thead>
<tbody>
<tr>
<td>The schedule uses multipliers to scale up AMA impairment ratings, but the final</td>
<td>Taken alone, 52 percent reduction in dollar value of ratings. In context with other changes, approximately 30-35 percent reduction in overall PD costs.</td>
</tr>
<tr>
<td>ratings remain consistently lower than the old schedule.</td>
<td></td>
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</tbody>
</table>

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The incurred cost for PD benefits has been reduced by statutory provisions that had clear cost-cutting goals or public policy goals. The cost has been further reduced by administrative interpretation with less clear guidance from the Legislature. Altogether, the aggregate dollar amount of PD benefits was reduced to about one-third of what it would have been without the 2004 and 2005 changes.

Permanent Disability Changes per SB 899 and 2005 PDRS

Because of the interaction of the statutes and regulations, efforts to address benefit adequacy may not be as simple as revising the schedule. This will be discussed in more detail later in this special report on the PDRS.

At the individual level, case outcomes remain unpredictable. Initially, there were many disputes over the application of the "new" (2005) rating schedule versus the "old" (1997) rating schedule. Because of a difference in appellate court interpretations over how apportionment should be applied in calculating the dollar awards, apportionment awards at the Workers' Compensation Appeals Board (WCAB) came to a standstill until the Supreme Court resolved the dispute in the Brodie and Welcher cases in 2007. As those issues recede into the background, the focus of attention has shifted to the question of how the PDRS can be rebutted and, once it is rebutted, how a rating can be computed. WCAB decisions on these issues in the cases known as Almaraz/Guzman and Ogilvie have been vigorously debated and remain subject to possible appellate court review. Throughout the time these issues are a key focus, there are continuing questions of whether physicians are accurately evaluating workers' impairments as prescribed by the AMA Guides, as well as the question, which became prominent with the Almaraz/Guzman decisions, of how much latitude physicians may take in the application of the Guides. While all these issues remain in flux, employers and employees face unpredictable outcomes. Unpredictability promotes litigation and inefficiency and dissatisfaction with the system. The reduction in PD awards, which are the traditional source of attorney fees, has constricted the availability of legal representation for injured workers. Whether the remaining benefits are appropriately targeted to the workers who need them
remains to be seen. Other social insurance programs or individuals may be bearing the burden if compensation has been cut too much, while employers may still be paying for excessive benefits in some cases.

**DWC Research in 2007**

Moving beyond comparisons to the former system, DWC has produced three studies.

*DWC Return-to-Work Study*

In the first study, DWC looked at Employment Development Department (EDD) earnings records of workers who had received PD ratings within 18 months of their dates of injury. A worker would be counted as having returned to work in some fashion if the worker showed any earnings in the EDD quarterly record four quarters after the date of injury. This approximation of the 12-month RTW rate is believed to be a strong predictor of the long-term economic outcome of an injury. The findings indicate that RTW rates improved to 70 percent for injuries occurring in 2005, after holding steady at 64.8 percent for 2003-2004 and 64 percent for 2000-2002.

The significance of these findings is difficult to establish. The apparent improvement in the RTW rate could be an artifact of the study methodology, but it could be a real improvement attributable to medical treatment guidelines, statutory incentives for RTW, and a cultural shift in expectations involving injuries and compensation.

The DWC study incidentally revealed a fact that warrants further investigation. The number of PD ratings meeting the criteria for inclusion in the study fell by more than 75 percent, from over 15,000 cases a year in 2003-2004 to only 3,323 cases in 2005. One implication is that a difference in the sample characteristics may undermine any conclusions drawn from the sample. The more interesting question is, where did all those cases go? This observation tends to support the higher estimates of the “zeros” mentioned previously.

*For further information …*

“Return to Work Rates for Injured Workers with Permanent Disability” (January, 2007)  
http://www.dir.ca.gov/dwc/ReturnToWorkRates/ReturnToWorkRates.htm

*DWC Wage Loss Study*

In the second study, DWC examined proportional wage losses and PD ratings for 28,593 workers with dates of injury from October 2000 through June 2003. The DWC study, like the RAND study before it, provides an important picture of the differences in average severity of economic impacts across different types of injuries. One function of the rating schedule is to achieve equity across types of injuries, so that the average compensation is proportional to the average loss of earning capacity regardless of type of injury.

DWC methodology was not identical to the methodology employed in the RAND study of 108,373 workers with dates of injury from 1991 to 1996, so the results are not entirely comparable. The results of the two studies, however, are generally consistent, and small differences may not be significant.

The DWC wage loss study provides an important baseline for future research. The Commission on Health and Safety and Workers’ Compensation (CHSWC) recommends that the wage loss study be repeated using the same methodology for comparison purposes.
SPECIAL REPORT: PERMANENT DISABILITY RATING COMPENSATION

For further information …

“Wage Loss for Injured Workers with Permanent Disabilities” (March, 2007)
http://www.dir.ca.gov/dwc/WageLossForInjuredWorkerswithTD/WageLossForInjuredWorkerswithTD.htm

DWC Uncompensated Wage-Loss Study

The third report adds two more steps. It calculates the uncompensated wage losses under the 1997 rating schedule, and it compares average final ratings under the 2005 rating schedule to average final ratings under the 1997 schedule. This DWC report shows that large decreases in the average ratings for most types of injury are only partially offset by increases in temporary disability compensation since 2002.

For further information …

“Uncompensated Wage Loss for Injured Workers with Permanent Disabilities” (May, 2007)
http://www.dir.ca.gov/dwc/UncompensatedWageLossforInjuredWorkerswithPD/UncompensatedWageLossforInjuredWorkerswithPD.html

RAND Research Post-Reforms

New RAND research under contract with CHSWC is expected to be released in 2010. Preliminary results indicate that RTW trends have been generally improving since 2002, but with no particular bump for 2005 injuries as suggested by the DWC RTW study. The RAND method compares injured workers to their uninjured peers two years after the injury to determine the relative employment rate. The final report is expected to provide additional information on relative earnings losses.

Foundations for Future Changes

Further changes in the PD compensation system appear to be inevitable as employers and labor express dissatisfaction with the existing state of affairs. Public policy decisions will continue to be shaped by the tension between adequate benefits and affordable costs. At the same time, the existing body of research provides a foundational understanding of disabilities may inform future decisions about appropriate distribution of benefits and appropriate incentives.

The Relevance of Pre-2005 Information

A wealth of information is provided by the RAND 2005 report prepared for CHSWC. Although the scale for rating PD has changed, the fundamental characteristics of disability are unlikely to be significantly different, and the lessons learned from this research can be applied to the current compensation system.

Two of the desired characteristics of a PD compensation system are that it should achieve horizontal equity, meaning that workers with equal earnings losses should receive equal benefits, and vertical equity, meaning that workers with different losses of income should receive benefits proportional to their losses, or at least that there be a positive correlation between losses and benefits.

The rating schedule plays a crucial role in achieving equity. Figure 5.3 of the RAND 2005 report which follows shows that the old PDRS was generally successful at achieving vertical equity both in standard ratings and in final adjusted ratings.

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Figure 5.8 of the RAND 2005 report below illustrates that the old PDRS was not so successful at horizontal equity across types of injury.
Earnings losses for workers with permanent disabilities are the result of both reduced labor force participation and reduced earnings while working. Figure B.1 below from the RAND 2005 report shows how labor force participation declines with increasing ratings. Figure B.2 below from the RAND 2005 report shows that reduced earnings for workers who are employed account for nearly all the losses for very low-rated disabilities, but as the ratings increase, larger portions of the losses are due to reduced employment.
SPECIAL REPORT: PERMANENT DISABILITY RATING COMPENSATION

Other work by RAND has shown that the reduced participation is substantially attributed to movement in and out of the work force; the partially disabled workers who are not working at 48 months post-injury are not necessarily the same ones who were not working at 24 months post-injury. These irregular losses continue long past the usual three-year study period. Three-year studies are adequate for large numbers of workers because they average out the variations. A snapshot of an individual worker’s earnings over such a short period is an unreliable indicator of that particular worker’s earnings over the remainder of his or her working life.

Distribution of Compensation Across Range of Severity

As noted previously, the amount of PD compensation for an injured worker in California is the product of the injured workers’ permanent partial disability rating, the number of weeks of benefits allowed for that rating, and the weekly amount of the PD payment. Equity, as previously defined, depends not only on the way PD ratings are determined, but also on the weeks and dollars assigned for those ratings.

Existing law produces an almost geometric relationship between ratings and compensation. This relationship is the result of a statutory formula that awards 3 weeks of compensation for each percent of disability below 10 percent, 4 weeks for each percent from 10 to 14.75 percent, 5 weeks for each percent in the ratings from 15 to 24.75 percent, and so forth up to 16 weeks for each percent in the range of 70 to 99.75 percent. Additionally, the maximum weekly rate is $230 for awards under 70 percent but $270 per week for awards of 70 percent or greater disability. Furthermore, life pensions are added to awards of 70 percent or greater disability. If the value of life pensions were included, the chart would rise even more steeply for ratings above 70 percent.
In contrast to that geometric relationship between compensation and ratings, diminished earning capacity bears a more linear relationship to ratings. Figure 5.3 below from the RAND 2005 report contrasts the progressive relationship between compensation and ratings with the more linear relationship between earnings losses and ratings.

Three-Year Cumulative Proportional Earnings Losses by Disability Rating Group

Comparison of the previous two charts, one showing sharply rising PD values with increasing ratings, and one showing more gradually rising earnings losses with increasing ratings, illustrates the disproportion of compensation to losses across the range of severity.

Another way to view proportionality is to look at the replacement rates. A measure of equity across the range of severity would be to evaluate whether the replacement rates are consistent across the range. In previous work, RAND found that the replacement rate for the lowest-rated one-fifth of workers was the lowest, at just 13.8 percent of ten-year after-tax wage losses being replaced, while 54.3 percent of the ten-year after-tax wage loss was replaced by indemnity benefits for the highest-rated one-fifth of workers.\(^45\) It is likely that this disparity was worsened by the 2004 amendments that raised the number of weeks for each percent above 70 percent PD from 9 weeks to 16 weeks.

Distribution of Compensation in Proportion to Losses

As stated earlier, vertical equity means that, on average, workers with different losses of income should receive benefits proportional to their losses. Vertical equity can be evaluated not only in terms of disability ratings, but also in terms of dollars of compensation. With most workers' benefits being capped at $230 per week, the amount of compensation is the same for workers with the same ratings but with different pre-injury earnings and, therefore, different average losses.

The replacement rate, i.e., the percent of earnings loss which is replaced by indemnity benefits, is lower for workers with higher pre-injury earnings. The RAND 2001 report found this clearly among employees of insured firms and less clearly but still suggested among employees of self-insured firms. In insured firms, only 14.7 percent of ten-year after-tax losses were replaced for workers who were in the top quartile of pre-injury earnings and the lower half of ratings; 49.6 percent of such losses were replaced for workers in the bottom quartile of pre-injury earnings and the lower half of ratings. For workers in the upper half of ratings, the replacement rates were higher (see discussion of distribution across range of severity, above), but it held true that the higher the pre-injury wages, the lower the replacement rate.

The particular rates have undoubtedly changed because of intervening changes in weekly indemnity rates, changes in the number of weeks, and other factors. None of these changes are likely to alter the underlying relationship. As long as the maximum weekly temporary disability rate is so low that over 90 percent of injured workers receive the same weekly PD benefit amount, regardless of pre-injury earnings, workers with different losses will not receive benefits proportional to their losses.

Anticipated Changes, Interactions of Statutes and Regulations

In 2008, the AD proposed a revised rating schedule. As described above, the PDRS uses multipliers to convert AMA Guides impairment ratings into permanent partial disability ratings, with different multipliers assigned for different parts of the body. The proposed revision of the PDRS would re-rank the several types of injury so that the types with greater wage losses in relation to their AMA impairment ratings would be assigned to higher multipliers, while the types with smaller wage losses in relation to their AMA impairment ratings would be assigned to lower multipliers. The proposed schedule would also increase average ratings by increasing those multipliers from the existing range of 1.1 to 1.4 to a new range of 1.2 to 1.5. In addition, the proposed schedule would change the age adjustments to better reflect how age affects earnings losses as shown by empirical research. The overall cost impact of the proposed schedule would be an increase of about 16 percent over the average value of PD ratings under the existing schedule. The amendment was not adopted within the one-year period permitted for completion of the rulemaking process.

Debate over the proposed PDRS has often focused on whether the multipliers are high enough to produce adequate awards of compensation. This Special Report shows that there are issues of the appropriate distribution of benefits which cannot be solved merely by changing the multipliers in the PDRS. Another way to reach an acceptable level of overall compensation would be to change the statutory method of converting a PD rating to a dollar value of compensation. Changes in any one component – impairment ratings, PDRS calculations, weeks per point, or dollars per week – will interact with the other components. The complex interactions require sophisticated modeling to forecast the impacts of changes to any one component. By addressing all of these components simultaneously, it will be possible to improve the distribution of benefits as well as adjust the overall level of PD compensation.
SPECIAL REPORT: RETURN-TO-WORK REIMBURSEMENT PROGRAM

Introduction

In November 2008, at the request of the Acting Administrative Director (AD) of the Division of Workers’ Compensation (DWC), the Commission on Health and Safety and Workers’ Compensation (CHSWC) voted to conduct a study of the Return-to-Work Program established in former Labor Code Section 139.48. The report, “Recommendations for the Return-to-Work Program Established in Labor Code Section 139.48,” describes the operation of the program in the period August 18, 2006, to December 15, 2008. It discusses rates of participation by employers, awareness of the program among small employers, and possible future funding.

Background and Legislative History

Section 139.48 of the Labor Code, as amended by Senate Bill (SB) 899 (Poochigian, 2004), requires the AD to establish a Return-to-Work Program to promote the early and sustained return to work of injured employees. The program reimburses employers for expenses to modify the workplace to accommodate injured employees. It is available to private employers with 50 or fewer full-time employees that seek reimbursement of expenses to accommodate an employee with a work-related injury or illness occurring on or after July 1, 2004. As originally enacted, the program was to sunset on January 1, 2009. Pursuant to a 2008 budget trailer bill, Assembly Bill (AB) 1389, the sunset has been extended to January 1, 2010.

Upon submission by an eligible employer of adequate documentation, Labor Code Section 139.48 provides the following:

- The maximum reimbursement to an eligible employer for expenses to accommodate each temporarily disabled injured worker is one thousand two hundred fifty dollars ($1,250).

- The maximum reimbursement to an eligible employer for expenses to accommodate each permanently disabled worker who is a qualified injured worker is two thousand five hundred dollars ($2,500). If the employer received reimbursement under paragraph (1), the amount of reimbursement under paragraph (1) and this paragraph shall not exceed two thousand five hundred dollars ($2,500).

- The modification expenses shall be incurred in order to allow a temporarily disabled worker to perform modified or alternative work within physician-imposed temporary work restrictions, or to allow a permanently disabled worker who is an injured worker to return to sustained modified or alternative employment with the employer within physician-imposed permanent work restrictions.

- Allowable expenses may include physical modifications to the worksite, equipment, devices, furniture, tools, or other necessary costs for accommodation of the employee’s restrictions.

Reimbursement is paid from the Workers’ Compensation Return-to-Work Fund, which is funded by penalties collected pursuant to Labor Code Section 5814.6 (administrative penalties for unreasonable delay) and by transfers into the Fund from the Workers’ Compensation Administration Revolving Fund (WCARF) established pursuant to Labor Code Section 62.5 (user funding).

The original legislation requiring creation of the Return-to-Work Program (AB 749, Calderon, 2002) allowed all private employers to obtain reimbursement. It also allowed reimbursement of lost wages for the injured employee and reimbursement of workers’ compensation insurance premiums attributable to the sustained employment of the employee. It relied on funding of the Workers’ Compensation Return-to-Work Fund only from the State Treasury. That funding was never appropriated, and the program was not implemented. SB 899 limited the program to private employers with 50 or fewer full-time employees,
eliminated reimbursement of lost wages, eliminated reimbursement of insurance premiums, and provided for funding for the Return-to-Work/Workplace Expense Modification Program from penalty collections under Labor Code Section 5814.6 and by transfers from WCARF.

The regulations to implement the program were filed in July 2006 and became operative in August 2006. They are set forth in the California Code of Regulations, title 8, sections 10004 and 10005.

Section 139.49 of the Labor Code required that a study be conducted and a report issued on the Return-to-Work Program. This section was not amended after its enactment in 2002, and it was repealed by its own provisions effective January 1, 2009. The section directed the study to examine at least two years’ operation of the program and to address the following areas:

- The effectiveness of the wage reimbursement, workplace modification expense reimbursement, and premium reimbursement components of the program.
- The rate of participation by insured and self-insured employers, including information on the size and industry of employers.
- Comparison of rates of utilization of modified and alternative work before and after establishment of the program and evaluation of whether there is an increase in sustained return to work.
- The impact of the program on injured employees.
- The cost-effectiveness of the program.
- Identification of potential future funding mechanisms for the program.

Note: Because SB 899 eliminated reimbursement of lost wages, reimbursement of insurance premiums, and participation by self-insured (i.e., large) employers, those elements are not described in this report.

Operation, Participation and Utilization of the Program

The CHSWC report summarizes information provided by the DWC Retraining and Return to Work (RRTW) Unit describing employers' applications for workplace modification expense reimbursement and approvals and denials of those applications. It also discusses rates of participation by eligible employers and potential future funding mechanisms.

Applications, Approvals and Expenditures

After regulations to implement the program were adopted in Summer 2006, employers began applying for reimbursement in 2007. The RRTW Unit received 36 applications in the two-year period January 2, 2007, to December 15, 2008. Of these, less than one-third (11) were approved and more than two-thirds (25) were denied.

The 11 approved applications were for the following workplace modifications and amounts:

- Keyboard tray, $443.02
- Microscope tube, $1,064.00
- Custom knee pads, $232.00
- Ergonomic chair and mouse, $727.52
- Support camera equipment, $2,500.00
- Headset, chair, and keyboard shelf, $325.78
- Ergonomic workstation, $1,250.00
- [Description missing from summary] $1,012.47


SPECIAL REPORT: RETURN-TO-WORK REIMBURSEMENT PROGRAM

- Mouse, keyboard and brace, $472.55
- Chair and keyboard, $490.17
- Keyboard, document holder, mouse, etc., $226.93

The total amount reimbursed was $8,744.44, and the average amount reimbursed was $794.95. In contrast, $500,000.00 was available in the Workers’ Compensation Return-to-Work Fund in this period.

Reasons for Denial

The RRTW Unit denied 25 applications for the following reasons:

- No industrial injury – 1 employer
- Payee Data Record form STD 204 not submitted (required when receiving payment from the State of California) – 2 employers
- Requested reimbursement of salary instead of workplace modification expenses – 2 employers
- Employed more than 50 employees – 10 employers
- Incomplete Request for Reimbursement of Accommodation Expenses form 10005, or supporting documentation not included – 5 employers
- Notice of Offer of Modified or Alternative Work form not submitted – 5 employers

Rates of Participation in the Program

In 2007, more than one million (1,000,000) businesses in California employed 50 or fewer full-time employees; those businesses employed more than six million (6,000,000) employees. Of those employees, roughly one to four percent (i.e., tens or hundreds of thousands of workers) had a work-related illness or injury in 2007. In the two-year period January 2, 2007, to December 15, 2008, only 36 employers applied for reimbursement and only 11 eventually received funds. These figures are very small compared to the number of businesses that were eligible to apply for reimbursement and the number of employees who were eligible to receive job accommodations through this program.

Industries of the Participating Employers

Based on a Web search, the industries of the 11 participating employers were as follows:

1. Technology consultation for small businesses
2. Chemical and biological testing and research
3. Tile installation
4. Nonprofit lobbying
5. Television and video production services
6. Real estate management
7. Medical practice
8. Banking
9. Electrical contracting (construction)
10. Supplier of gases to technical and research firms
11. Software development

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46 In 2007, there were 1,247,919 businesses in California employing 50 or fewer full-time employees. These businesses employed a total of 6,225,883 employees. “Number of Businesses, Number of Employees, and Third Quarter Payroll by Size of Business, Third Quarter, 2007” [table], Employment Development Department, Labor Market Information Division.

47 In 2007, among establishments in California employing 1-10 and 11-49 employees, for the equivalent of every 100 full-time employees, there were 1.8 and 3.9 injuries and illnesses, respectively. “Incidence rates of nonfatal occupational injuries and illnesses by industry sector and employment size, 2007” [table], Division of Labor Statistics and Research, citing Bureau of Labor Statistics, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses, in cooperation with participating state agencies.
Awareness of the Program Among Small Employers

The RRTW Unit promoted the program with claims adjusters and administrators. This was done primarily through the annual DWC Educational Conference and in public presentations statewide. Information was included in a DWC Newsline (emailed to interested persons and organizations) and posted at the DWC website.

CHSWC staff prepared a brief questionnaire asking small employers whether they were aware of the Return-to-Work Program, how they learned about it, and whether they would use it in the future. Small Business California, a nonprofit advocacy organization, sent the questionnaire to its members in December 2008. Although this group is not necessarily representative of the entire population of eligible employers, the questionnaire results give some indication of the extent that small employers are aware of the program and possible reasons why the program has not been fully utilized.

Fifty (50) employers responded to the questionnaire. Of the 50 persons who responded, only one in 10 (i.e., 5) had heard of the program. In contrast, two-thirds (34) said they would consider applying for reimbursement from the program in the future, and one-fifth (11) said they would not. Of those who said they would not consider applying, two (2) felt it would involve too much time and trouble to apply compared to the potential benefit. Most respondents recommended that small employers be informed about the program through communications from employer organizations, state agencies, city business licensing offices, workers’ compensation insurers and brokers, and news media.

Based on responses to the questionnaire, more employers would probably participate if insurers, brokers, and city licensing offices notify employers about the program and information is posted and publicized through the additional channels identified by the respondents (as summarized above and in the attached table).

It is possible that the efforts undertaken by the RRTW Unit to publicize the program did not reach the intended audience. Small employers may be difficult to reach through educational conferences. The RRTW Unit plans to conduct informational workshops about the program around the State in 2009. Careful design and planning of future outreach may need to consider how, where, and when small employers usually receive information relevant to their businesses. Examples of effective channels were identified by the respondents described above and summarized in the attached table.

Cost-Effectiveness of the Program

The cost to operate the Return-to-Work Program is $324,553.48

Possible Future Funding

The Return-to-Work Program paid out reimbursements totaling $8,744.44 in the two-year period covered by this report out of a total of $500,000.00 that was available in the Workers’ Compensation Return-to-Work Fund. If it is determined that the program should be continued, the current funding level is adequate given the extent that the program was utilized. There is no need for additional funding at this time.

Other States’ Programs

CHSWC conducted a survey of selected states. Oregon, Washington and Texas have worksite modification reimbursement programs. In all three of the programs, the worksite modification reimbursement either is not the key incentive for employers to rehire injured workers or is seldom used.

Oregon provides worksite modification reimbursements as part of its extensive return-to-work programs. Oregon’s Employer-at-Injury Program reimburses employers up to $2,500 per claim to modify the

48 Figures provided by the Division of Workers’ Compensation, July 2009.
worksite to enable an injured worker to return to light-duty, transitional work while recovering. Oregon’s Preferred Worker Program reimburses workers and employers up to an aggregate of $25,000 per claim to modify the worksite for workers with a permanent disability. In addition to worksite modification reimbursements, Oregon’s programs contain other provisions to motivate employers to retain or hire injured workers, such as premium exemptions and wage subsidies.

Washington’s Early Intervention Program, which is part of its vocational rehabilitation program, provides up to $5,000 for worksite modifications. However, Washington reported that the worksite modification benefit is not commonly used. Instead, most employers make other kinds of changes such as reducing work schedules.

Texas has a pilot worksite modification reimbursement program which grants up to $2,500 to employers with fewer than 50 employees. It is modeled on California’s program. Since implementation of the program in February 2006, Texas received only five applications and awarded only two grants. This was despite extensive outreach to the employer community.

Findings

Findings of the study and report include:

- The California workplace modification program has been underutilized, probably because most small employers who qualify for the program were unaware of it. In a two-year period from January 2007 to December 2008, 11 applications were approved.  
- More than two-thirds of the employers that applied were denied.
- The average amount received per employer was less than $800.00.
- To date, the program has not been cost-effective. The costs to process applications and administer the program far exceeded the amounts paid out.

Recommendations

California could increase utilization and cost-effectiveness of the Return-to-Work Program by conducting extensive outreach to inform small employers about the program and by streamlining the process to apply for reimbursement. Alternatively, California may wish to consider eliminating the program and replacing it with another program that more directly assists injured workers who are unable to return to their previous jobs.

Increasing Utilization and Cost-Effectiveness

The program has been underutilized, probably because most small employers who qualify for the program were unaware of it. Most of the fifty (50) respondents to the questionnaire distributed by Small Business California made recommendations on how small employers could be made aware of the program. Sources of information they identified included employer organizations, trade groups, workers’ compensation insurers and brokers, state agencies, city business licensing offices, and news media. Methods of communication included email messages with links to further information online, bulletins, newsletters, written notices, regular mail, meetings, seminars, and training classes. Their recommendations were as follows:

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Sources of Information | Methods of Communication
---|---
Employer organizations (e.g., Small Business California, California Small Business Association, California Chamber of Commerce) and trade groups | Email messages with links to more information online, bulletins, newsletters, seminars, training classes
Workers’ compensation insurers and brokers | Written information with insurance policy quotes, with premium invoices, and whenever there is a new claim
Division of Workers’ Compensation | Official mail, information with audits, references to more information online
Employment Development Department | With instructions for quarterly wage reports, email messages, meetings
City business licensing agencies | With business license applications
Business and financial newspapers and magazines

Based on these recommendations, the RRTW Unit could prepare articles and notices about the program and coordinate with the sources of information listed above to disseminate the information widely among small employers. The RRTW Unit could also offer to prepare additional materials as needed and make presentations in employer and trade-affiliated seminars and training classes that small employers will attend.

In addition, California could standardize the information provided to small employers about this program by requiring workers’ compensation insurers to notify their employers about the program when sending premium invoices and whenever there is a new claim.

Utilization may also increase if the application process is streamlined. More than two-thirds (25) of the employers that applied for reimbursement from the RRTW Unit were denied for a variety of reasons, most due to incomplete understanding about the application process or about the program itself, and several because of an unnecessary criterion that was used to deny applications.

The form to request reimbursement (found in the California Code of Regulations, title 8, section 10005) could be improved through rewriting, formatting and design, and clear instructions could be added. It could explain that employers may request reimbursement for workplace modifications only (not for other types of accommodation), that the injury must be work-related, and that the employer must employ no more than 50 full-time employees. In addition, the form could state more clearly that supporting medical reports and receipts for payment of the modifications must be attached.

The RRTW Unit reported that five (5) employers were denied reimbursement because the employer did not submit a copy of a Notice of Offer of Modified or Alternative Work given to the employee. However, this form is not required as a condition of receiving reimbursement. This criterion should therefore be eliminated in considering applications from employers.

**Eliminating the Program**

Alternatively, the Return-to-Work Program could be eliminated due to high administrative costs relative to the amounts reimbursable to employers. User funding could then be reduced by the amounts that fund
the Workers’ Compensation Return-to-Work Fund. Those reductions could pay for increased benefits for workers who are unable to return to their previous jobs.

Under Labor Code Section 4658, for workers whose employer has 50 or more full-time employees, permanent disability payments are increased or decreased by 15 percent depending on whether the employer makes an appropriate offer of regular, modified, or alternative work. To directly assist all workers with permanent disability who are unable to return to their previous jobs, the percentage could be increased, and Labor Code Section 4658 could be made applicable to all employers regardless of size.

For further Information …


SPECIAL REPORT: SUMMARY OF DECEMBER 9, 2008 RETURN-TO-WORK/FEHA/ADA ADVISORY GROUP MEETING AND HANDBOOK

Introduction

Return to work after an injury or illness is important for employers and workers and their families in the State of California. Efforts need to be made to reduce litigation, reduce friction, and provide information to employers, particularly small employers who have the most difficult time complying with requirements regarding return to work. Improved information for all system participants about the requirements of the Fair Employment and Housing Act (FEHA) and the Americans with Disabilities Act (ADA) will be critical to efforts to improve return to work in California.

Return to work is a key issue for 2009 for the Division of Workers’ Compensation (DWC) and for employers and the public sector. For employers, return to work is a complicated area for human resource and workers’ compensation professionals. It is challenging to identify how benefits are delivered and coordinated in cases involving job accommodations, as well as how these issues relate to conditions in the economy.

This project emerged as a result of discussions about introducing legislation to develop guidebooks; for small businesses, it was determined that authority already exists within the Department of Industrial Relations (DIR). Several stakeholders have requested information to help workers and employers meet their responsibilities under FEHA and ADA. At the request of the DIR Director, the Commission on Health and Safety and Workers’ Compensation (CHSWC) worked with the Department of Fair Employment and Housing (DFEH) and partnered with DWC on a new handbook on return to work, FEHA and ADA. The Commission voted at its November 6, 2008 meeting to proceed with this project. This is a multi-agency effort to improve return to work and improve information for workers and employers in order to reduce confusion and litigation.

Summary of Briefing from the Department of Fair Employment and Housing

Role of DFEH and the FEHA Complaint Process

The Department of Fair Employment and Housing (DFEH) is a state agency that enforces the State’s civil rights laws including discrimination in employment, housing, public accommodations, and hate crimes. Its investigations are neutral, not adversarial. When a complaint is filed, DFEH works with employers to request information. Some believe that DFEH pursues every complaint from an employee; this is not the case. The first point of contact is the 800 phone number for the DFEH Communications Center. Approximately half the calls do not result in an appointment with agency staff because it is clear that they are not an issue under FEHA. When an appointment is scheduled, a consultant conducts an interview at a District Office or on the phone to determine whether there is sufficient information to investigate a possible violation of law. About half of the appointments do not result in investigations. If DFEH declines to investigate, it issues a right-to-sue letter if the employee so requests. There are people who hire attorneys and go directly to court. There is also a right-to-sue process online, primarily for attorneys who choose to pursue claims without going through DFEH.

Most employers comply voluntarily with requests for information. If a request is burdensome, DFEH will work with the employer to get the information as easily as possible. If an employer ignores a DFEH request or resists complying with the request, DFEH will resort to subpoenas. It tries to resolve complaints and work with employers to make discovery requests reasonable. When it receives a response from an employer, it is reviewed with the complainant and a resolution to a “no fault” settlement is attempted. Complainants often think DFEH is siding with the employer, especially if the employer makes negative statements about the complainant. If at some point DFEH thinks that illegal discrimination has occurred, it will work with the employer to try to resolve the issue. First, an investigator talks to the employer. If the problem cannot be resolved, there is a conciliation conference where the
investigator explains to the employer the findings of the investigation and why it is believed there is a violation. The complainant is present to receive any offers of settlement. If the complaint is not resolved in the conciliation conference and there is still reason to believe that discrimination has occurred, it is then referred to the Legal Department for a review for possible legal action. From the conciliation conference forward, DFEH is no longer neutral but an advocate for the law. The injured party is entitled to remedies under the law. Complainants are entitled to make-whole damages, including back pay, job opportunities and emotional damages. The State has enforcement remedies, such as requiring the employer to adopt policies, requiring implementation of training, and collecting administrative fines that go to the State’s General Fund.

The administrative law judge (ALJ) is an employee of the DFEH Commission. The ALJ hears cases. The employer can ask that a case be removed to Superior Court if the employee is seeking emotional distress damages. DFEH will continue to be present and represent the interests of the State, which are also the interests of the complainant. Few cases get to this point as there are many opportunities to resolve the case before this.

DFEH offers assistance to employers. If an employer has a policy and wants to know if it is consistent with the law, DFEH can consult with the employer about this. At the 800 phone number, there is a consultant and a district administrator who can answer technical questions. There are also employer roundtables; there is one active in southern California and one active in Central California; in addition, one is being revitalized in Northern California. The roundtables have breakfast meetings and annual conferences with panelists with discussion topics of benefit to employers.

From the time a complaint is filed, DFEH has one year in which to bring an accusation. DFEH sends to employers by certified mail a letter with a copy of the complaint signed by the employee and other pieces of information. At any point when DFEH closes a case that it has investigated without settlement or adjudication, DFEH issues a right-to-sue letter. If the case goes to the administrative adjudication process and no discrimination is found, there is no right to sue; the employee has had due process and does not proceed further.

Dual Claims with the U.S. Equal Employment Opportunity Commission

DFEH has a work-sharing agreement with the Equal Employment Opportunity Commission (EEOC); the case is dual-filed, but the EEOC defers the process to DFEH, and EEOC generally accepts the DFEH determination. Conversely, if an employee in California goes first to EEOC, DFEH accepts the EEOC determination. If someone gets a right-to-sue letter from EEOC, they have shorter time than the one year that they have to file suit after getting a DFEH right-to-sue letter.

The Interactive Process Under FEHA

The interactive process requires engagement of both employers and employees to determine whether or not that employee can continue to work for that employer. The discussion may not exhaust every possibility, but there has to be meaningful dialogue. The process can end when the requested accommodation is far too expensive for the employer, when it imposes undue hardship on either party, or when the employee cannot perform the job even with accommodation. The process is specific to each employer. For example, large employers may have a slow process for approving accommodations; small employers may have a faster process but costs of accommodations may be prohibitive. Employers get in trouble when communication breaks down.

Good faith is required of the employee as well, including disclosing medical information and accepting less costly accommodations that would allow the employee to continue working. Employers generally get in trouble when they do not engage in any interactive process; it is not usually a question of the degree of interactive process. For example, first-line supervisors often think the employee is just trying to get special treatment without need. The interactive process is not right from the beginning if it starts with the attitude of “What is going on with you now” or “I will do what I have to do, but I do not believe you,” or “We let your job go; give me a call when you have a chance.” If the first step is dismissive, the process will
usually lead to a violation. Instead, the process should begin with asking what is needed for accommodation. If the employer cannot accommodate the employee in his/her job, the discussion should be about what other work the employer has that the employee can do. It would be helpful to provide training for supervisors on how to take the first steps in the interactive process in a positive way and how to identify when requests for accommodations need to be discussed with senior management and/or the Human Resources Department.

**Key Issues from Advisory Group Participants**

*Employer and Employee Responsibilities in the Interactive Process*

Often, a large employer with a Human Resources Department does work with front-line supervisors to look for options for accommodation. Still, clearly defined standards are needed to educate employers about reasonable accommodations and how much an employer needs to try to engage the employee when the employee has not responded (sometimes this occurs in cases where a workers’ compensation attorney has advised the employee not to talk to the employer). The employee has to provide the necessary contact information, especially if this information has changed. Employers should document attempts they have made to engage in the interactive process even if the attempts have not been successful. If they provide documentation of efforts to engage the employee and there has been no response, the employer will not be held accountable for the failure of the interactive process.

Large employers would like to know that there will be communication about some protection for employers if they do engage in the interactive process and have made attempts to engage the employee in the process, for example, by encouraging communication about accommodation and asking for medical information about why the requested accommodation is needed. DFEH has found that when employers make good faith efforts, it is rare in case law to find liability for discrimination because they failed to take one extra step. Most cases involve employees providing all the necessary information and employers failing to take the claim seriously even after they have been put on notice.

Employers need to know that there is an automatic violation of FEHA if there is no attempt to communicate with the employee in the interactive process. Manager/supervisor training should identify clues that constitute a trigger to contact the manager or Human Resources Department and say that there is a problem. There are many compliance training vendors available to provide these types of training resources.

*Role of Workers’ Compensation Insurance Carriers and Applicants’ Attorneys*

Insured employers used to rely on the insurance carrier to walk them through many of the steps. Now, insurers are prohibited from advising about compliance with other laws, and they cannot require an employer to bring an employee back to work. The scope of FEHA was expanded in 2001, and vocational rehabilitation has been eliminated since then. Before the expansion of FEHA and the elimination of vocational rehabilitation, timelines provided for an earlier intervention than the current return-to-work incentives. There was also an ending point to the process which was the commencement of a vocational rehabilitation plan. The elimination of vocational rehabilitation has led to applicants’ attorneys becoming more involved in FEHA cases, including disability discrimination cases.

*Workers’ Compensation Claims and the Interaction of Different Systems*

Where conduct is covered by both FEHA and ADA, pursuant to a work-sharing agreement, an adjudication by DFEH also binds EEOC. The only appeal is if DFEH declines to take it to a hearing; then the employee may request a substantial merit review by EEOC. A pending workers’ compensation claim does not affect a DFEH investigation. Sometimes a worker comes to an agreement on both the DFEH and workers’ compensation claims, and sometimes employers want workers’ compensation language in the DFEH settlement agreement. DFEH will not enter into an agreement that releases claims other than those under FEHA, but there can be a separate release with the employer addressing workers’ compensation.
In 2006-07 (after vocational rehabilitation was eliminated for new injuries), there was an increase in disability discrimination suits, but it would not necessarily be known if there was a workers’ compensation case behind the claim. DFEH has had a slight increase in the past year in disability claims, but there was a brief drop the year prior to that. There were 65 disability discrimination cases that went before the Fair Employment and Housing Commission (FEHC) for hearing, constituting the majority of cases that go before the Commission.

Preserving Rights to Employment Practices Insurance Benefits

Businesses that have employment practices insurance need to know that a claim needs to be reported to the insurer when the complaint is filed. The right to insurance benefits could be lost if a claim is not reported in a timely manner after an employer learns of a complaint. DFEH does not advise employers about potential insurance issues.

Suggested Reform to the DFEH Process

DFEH files about 19,000 cases a year. Therefore, almost everybody gets a right-to-sue letter, either when the case is closed after an investigation or upon request. The only time there is no right-to-sue letter is when there is a settlement or an adjudication by FEHC.

There is concern that employees get right-to-sue letters and demand settlements and employers are unaware that a right-to-sue letter does not necessarily mean there is a valid claim. The employer should understand that there might be a right-to-sue letter simply because a complaint was filed. One possible reform to the process would be to remove the right-to-sue letter at the end of a DFEH investigation that finds that the employer did everything right.

Advisory Group Recommendations and Next Steps

Advisory Group meeting participants suggested the following recommendations for a new Return-to-Work/FEHA/ADA handbook and next steps:

- Provide an informational piece that: explains to employers, employees, clinicians and other interested parties how various benefits interact with one another; presents best practices for bringing an injured employee back to work; and explains FEHA and workers' compensation, as well as workers’ compensation and human resources, and how to make them compatible with the required interactive process.

- Emphasize the economic necessity of keeping Californians working safely and productively; emphasize the importance of being proactive, not waiting until there is an investigation in process, and the importance of having a timely, cordial, well-documented engagement with the employee.

- Clarify roles and responsibilities: employers have the privilege and duty to define the essential functions for all jobs; employers have the right to ask for medical information; employees have the duty to bring relevant information to the table to protect their own health and productivity; and clinicians have the responsibility to comment on capacity, what the patient can safely do between now and the next visit, and they should not define accommodations but should have information about work requirements.

- Provide a tool kit including:
  - Common timeframes, common vocabulary, and common requirements for the different processes.
  - A model interactive process; sample dialogues that reflect civility, concern and timeliness and that begin a verbal and documented exploration of the desired outcome; sample job
descriptions that focus on essential duties; guidelines for accommodations and examples of modified or alternate work under workers’ compensation law.

- Sample notifications: notifying the insurance carrier; notifying the DFEH, if appropriate; and notifying first-line supervisors about what events or discussions to watch for that trigger the need to contact a manager or the Human Resources Department.

- Available resources, including Department of Public Health (DPH) information for employers on wellness programs.

- Develop strategies for dissemination, particularly co-branding with other organizations serving small businesses such as: Small Business California; Chambers of Commerce; local and state agencies; joint powers authorities (JPAs); and others. These organizations would promote the handbook and facilitate translation into multiple languages.

The Advisory Group emphasized that there is a need for a new and better approach to return to work, especially with an aging workforce and the economy shedding jobs. Public policy is emphasizing that employers bring people back to work. The system in place now has to be reformed to be an affirmative approach with FEHA as the umbrella, rather than the defensive posture created by the workers’ compensation system.

**Handbook on Return to Work**

*Helping Injured Employees Return to Work: Practical Guidance Under Workers’ Compensation and Disability Rights Laws in California*

As a result of the request by the Director of the Department of Industrial Relations (DIR) that the Commission on Health and Safety and Workers’ Compensation (CHSWC) work with the Department of Fair Employment and Housing (DFEH) and partner with the Division of Workers’ Compensation (DWC) on a new handbook on return to work, FEHA and ADA, *Helping Injured Employees Return to Work: Practical Guidance Under Workers’ Compensation and Disability Rights Laws in California*, has been prepared by CHSWC and UC Berkeley, in collaboration with DFEH and DWC.

The handbook is especially geared for small employers and their employees. It briefly describes workers’ compensation anti-discrimination and disability rights laws in California, including: how workers compensation law protects injured employees from discrimination; and what employers’ obligations are under the FEHA. It also describes six basic steps that constitute best practices to help injured employees return to safe and appropriate work in a timely fashion, including: how employers can comply with the requirements of the interactive process under FEHA; what the time frames are for engaging in the interactive process and offering work; and examples of return to work in construction and agriculture. In addition, it discusses: how to establish an effective program to carry out the best practices; how to ensure that everyone assumes their roles and responsibilities; and why employers should evaluate existing jobs and working conditions.

Additional resources are included in Appendix sections for physicians and insurers and about job accommodations, workers’ compensation benefits rights and procedures, and disability rights and procedures under FEHA. Appendix A lists additional resources to help employers and employees design, implement, and participate in an effective return-to-work program. It also lists resources of the state agencies that administer workers’ compensation and disability rights laws. Appendix B and Appendix C explain how to access the laws and regulations discussed in this handbook.
For further Information …

SPECIAL REPORT: WORKERS’ COMPENSATION MEDICAL STUDY OF THE IMPACT OF RECENT REFORMS

Introduction

Senate Bills (SB) 228 and SB 899 made a number of changes that affect how medical-necessity determinations are made for medical care furnished to injured worker in California. These changes included the following: linking the Official Medical Fee Schedule (OMFS) to Medicare or (Medi-Cal fee schedule in case of pharmaceuticals); providing medical care through Medical Provider Networks (MPNs); repealing the treating physician presumption; extending the presumption to the utilization schedule issued by the Administrative Director (AD) of the Division of Workers’ Compensation (DWC) (i.e., the ACOEM Guidelines); placing limits on the number of chiropractic, physical therapy and occupational therapy visits per occupational injury; establishing new utilization review (UR) requirements; and creating a new appeals process.

Despite declines in medical costs in 2004 and 2005, after the reforms, medical costs are reportedly increasing again. In particular, the Workers’ Compensation Insurance Rating Bureau (WCIRB) recommended an 15 percent increase to its pure premium rates due to medical inflation in its January 2010 rate filing.50

The Commission on Health and Safety and Workers’ Compensation (CHSWC) contracted with RAND to evaluate the impact of SB 228 and SB 899 and how they affected medical treatments to workers who have sustained industrial injuries and illnesses in California. The CHSWC study by RAND “Workers’ Compensation Medical Study of the Impact of Recent Reforms” focuses its analysis on the following:

- Changes to the Official Medical Fee Schedule (OMFS) and the impact of these changes on access and costs including an analysis of issues related to refinement and expansion of Medicare-based fee schedules.
- Processes used to form medical provider networks (MPNs), including the considerations affecting the employer decision to establish an MPN, the strategies used to form the network (pre-existing or new, narrow or broad), quality assurance and enrollment processes, profiling, and fee discounting, etc.
- Generation of aggregate payment information by type of service for MPN and non-MPN care.
- Development of measures that could be used in an ongoing system of monitoring of the cost and quality of care provided to injured workers.
- Evaluation of potential legislative and administrative refinements to the current system.
- Assessment of the ways payment incentives might be used to improve the safety and quality of care in the California workers’ compensation medical care delivery system.

As part of the Medical Treatment study, CHSWC/RAND issued the following working papers: “Inpatient Hospital Services”; “Facility Services for Ambulatory Surgery”; “Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California’s Workers’ Compensation Program”; “Hospital Emergency Department Services Furnished Under California’s Workers’ Compensation Program”; “Pay-For-Performance in California’s Worker’s Compensation Medical Treatment System”; and “Repackaging Pharmacy Drugs”.

50 Based on WCIRB Regulatory Report WCIRB January 1, 2010 Pure Premium Filing Part A. Correspondence from David Belluscì, WCIRB, stated: “Approximately 15 percent of the 22.8 percent is attributable to medical inflation.”
Inpatient Hospital Services

Background

The AD of the DWC maintains an Official Medical Fee Schedule (OMFS) that establishes the maximum allowable fees for most medical services. The OMFS amounts apply unless the payor and provider have contracted a different price. On January 1, 2004, the OMFS was revised to provide for annual updates for acute care inpatient stays based on the Medicare payment system with an additional pass-through for the cost of devices and instrumentation used during complex spinal surgery. The OMFS for inpatient hospital care is adapted from the Medicare payment system for these services. In the aggregate, OMFS allowances are limited to 120 percent of Medicare payments for comparable services; OMFS determined that the medical treatment guidelines are presumptively correct and injured workers of employers of medical provider networks have to use these guidelines for the course of their treatment. To determine the effect of the changes in the California Labor Code and their effect on injured workers, CHSWC commissioned the “Inpatient Hospital Services” study by RAND. The analysis reported in this paper uses transaction-level data on workers’ compensation hospital discharges during 2003-2007 available from the California Office of Statewide Health Planning and Development (OSHPD).

Description

The CHSWC study by RAND examined the number and types of discharges and maximum allowable fees under the California workers’ compensation OMFS for inpatient hospital services from 2003-2007. The study focused on analyzing the following questions:

- What changes occurred in the volume and distribution of inpatient stays for workers’ compensation patients between 2003 and 2007?
- What is the impact of a duplicate payment generally called a “pass-through”?
- What changes occurred in the allowances for acute inpatient hospital services?
- What has been the effect of the OMFS changes on allowances for inpatient hospital services?
- How do the estimated OMFS allowances compare to the estimated costs for inpatient stays?
- What are the volumes and types of care provided by both freestanding hospitals that are currently exempt from the OMFS and what are the payment implications of continued exemption for these hospitals?

Findings

The findings of the study over the 2003-2007 period include:

- There was a 17 percent decrease in the number of workers’ compensation hospital stays, which is not unexpected given the reduction in the number of workers’ compensation claims. While the number of stays decreased, the mix of inpatient stays remained relatively stable.

- The pass-through for costs of hardware used during complex spinal surgery is problematic and should be re-considered. Passing through workers’ compensation device costs on top of 120 percent of Medicare payment results in paying for spinal hardware twice, creates incentives for unnecessary device usage, and imposes unnecessary administrative burdens. Based on the average device costs for Medicare patients, the hardware pass-through involves at least $60 million in additional allowances.
The overall estimated allowance-to-cost ratio for acute care inpatient stays was 1.17 in 2007 and is likely to increase with implementation of severity-adjusted diagnosis-related groups (DRGs).

The estimated payment per discharge increased 20.7 percent. Although the 2004 OMFS revisions increased the allowances for acute care inpatient hospital stays, these higher allowances were more than offset by the elimination of the OMFS exemptions for certain types of stays in acute care hospitals and updating of the composite rates and cost-to-charge ratios. Since 2004, the increases are attributable to the annual updates for inflation and other refinements in the payment rates.

The combination of the decrease in discharges and increase in average payment resulted in initial reductions in aggregate payments that were gradually diminished by inflation, so that total estimated payments in 2007 were at 2003 levels. This finding assumes payment levels consistent with the OMFS for acute care hospital stays and at 90 percent of charges for OMFS-exempt stays.

The OMFS has not been expanded to include specialty hospitals. In 2007, charges for workers’ compensation stays in these hospitals totaled $77 million. Stays in rehabilitation hospitals accounted for nearly $52 million of this amount.

While some Medicare Severity (MS)-DRGs should improve payment accuracy, they may also lead to unwarranted payment increases caused by coding improvement rather than real change in patient mix. The Medicare program will adjust for coding improvement through the update factor. The Labor Code precludes incorporating this adjustment in the update factor but does give the AD the authority to adopt a multiplier that is less than 1.20 times the Medicare rate.

**Recommendations**

CHSWC recommendations include:

- Continue to use of the OMFS for inpatient hospital services.

- The AD should review the pass-through for the following options: eliminate the pass-through; reduce the pass-through to the estimated cost in excess of the allowance included in the OMFS rate; and reduce the OMFS multiplier to exclude the amounts implicit for hardware in Medicare’s payments rates in continuing to allow a pass-through or a fixed allowance for spinal hardware.

- The AD should consider adopting a Medicare-based fee schedule for specialty hospitals; however, modifications of the Medicare methodologies for the workers’ compensation patient populations may be needed, particularly with respect to workers’ compensation stays in rehabilitation and long-term care facilities.

**Status**

CHSWC approved this study.

For further information …


http://www.dir.ca.gov/chswc/Reports/CHSWC_InpatientHospitalServices.pdf
CHSWC Study on Facility Services for Ambulatory Surgery

Background

Ambulatory surgery can be performed in either a hospital or a freestanding ambulatory surgery center (ASC). As amended, Section 5307.1 of the California Labor Code requires that the Official Medicare Fee Schedule (OMFS) for ambulatory surgery be based on the fee-related structure and rules of the Medicare program. The Labor Code caps the aggregate allowance for ambulatory surgery at 120 percent of the fee paid by Medicare for the same services performed in a hospital; therefore, the Labor Code requires that the same rates apply to hospital ambulatory surgery and procedures performed in freestanding ASCs.

Description

The paper examined the types of procedures performed on workers’ compensation patients in California in ambulatory surgery facilities, whether they vary by setting and how they compare to ambulatory surgical procedures for non-workers’ compensation patients. The study used data obtained from Office of Statewide and Health Planning and Development (OSHPD) for 2005-2007 ambulatory surgery encounters and focused on analyzing the following questions:

- What volume and mix of procedures were performed on workers’ compensation patients? What were the maximum allowable fees?
- How do the volume and mix of surgical services provided to hospital outpatients compare to ASCs?
- Using the discharge deposition on the records, are there differences in post-surgery hospital admission rates by the setting in which the surgery was performed?
- Are surgical services that are commonly provided in physician offices being provided in hospital outpatient departments or ASCs? These are services that Medicare rules reimburse based on the physician fee schedule when performed in an ASC. A concern is that the OMFS allowance for ASC services could encourage a shift from physician offices to the more costly ASC setting.
- What facility services are being provided in conjunction with ambulatory surgery that are payable under OMFS for physician and other practitioners? The Medicare-based fee schedule applies only to ambulatory surgery and emergency services. DWC is considering whether to adopt Medicare-based fee schedules for physician services.
- What percentage of ASC patient encounters are for workers’ compensation patients? Is there a relationship between a facility’s reliance on workers’ compensation patients and profitability? The answer to this question could be informative in gauging the adequacy of OMFS payments.

Findings

- Over the two-year period from 2005-2007, total maximum allowable facility fees for ambulatory surgery increased 16 percent despite an 8 percent decline in the number of encounters.
- There were no major changes in the types and distribution of ambulatory surgical procedures. In 2007, nerve injections accounted for 30 percent of the procedures and 10 percent of the allowable fees. Arthroscopy procedures accounted for 29 percent of the procedures and 46 percent of the allowable fees.
- There was a slight increase in the proportion of surgical procedures performed in ASCs. In 2007, about 69 percent of ambulatory surgical procedures for workers’ compensation patients were performed in ASCs (compared to 66 percent in 2005), and 31 percent were performed in hospitals. In contrast, 59 percent of the surgical procedures performed on the non-workers’ compensation comparison group were done in hospitals.
ASCs are more reliant on workers’ compensation patients than hospitals for ambulatory surgery, but there is no linear relationship between workers’ compensation reliance and profitability. Overall, ASCs have lower costs than hospitals.

With the exception of nerve procedures, relatively few “office-based” procedures are performed on workers’ compensation patients in the ambulatory surgery facilities. Further, few “inpatient only” procedures are performed in ambulatory surgery facilities.

Under the revised Medicare payment system, most ASC services are paid under a system that parallels the payment system for hospital outpatient services but at a lower rate. For procedures that are commonly performed in a physician’s office, the ASC payment rate is capped at the non-facility practice expense payment amount in the physician fee schedule. The OMFS allows reimbursements based on the Medicare hospital rate even for ASCs and for certain physician office settings that do not meet Medicare ASC standards.

**Recommendations**

The AD of the DWC has broad authority to establish different multipliers or conversion factors within the 120 percent aggregate cap. Consideration should be given to adopting a new Medicare-based fee schedule for ASC services because ASC services are paid under a system that parallels the payment system for hospital outpatient services but at a lower rate (about 67 percent of the hospital rate).

CHSWC recommends that the AD should consider the adoption of a lower conversion factor for ASC services, which would reduce OMFS allowances by approximately $70 million in 2010.

CHSWC recommends that the AD should consider defining ASCs eligible for payment of facility fees in a way that is more similar to the requirements of Medicare or other payors.

**Status**

CHSWC has approved the study.

For further information …

“Ambulatory Surgery Facility Services Provided to California’s Injured Workers,” RAND (March 2009).

**Physician and Other Practitioner Services**

**Background**

The current Official Medical Fee Schedule (OMFS) ties inpatient hospital and ambulatory surgery fees to 120 percent of Medicare payments. However, physician services still remain under the former fee schedule until a new fee schedule is implemented; these fees were reduced by 5 percent (with Medicare as a floor) effective in 2004.

**Description**

The Administrative Director (AD) of the Division of Workers’ Compensation (DWC) is developing a new OMFS for physician services. The current fee schedule is based on historical charge-based relative values that undervalue primary care services relative to other services and do not explicitly pay for many work-related services that medical providers offer to injured workers such as care coordination. A resource-based fee schedule has the potential to improve payment equity under the OMFS particularly if
a single conversion factor is adopted that would increase payments for primary care relative to other services. The new fee schedule will be based on the Medicare fee schedule for physician services, which sets rates based on relative resources (physician time and effort, practice expenses, and malpractice insurance costs) required to provide services.

Findings

The findings of the study include the following:

- A resource-based fee schedule has the potential to improve payment equity under the OMFS, particularly if a single conversion factor is adopted that would increase payments for primary care relative to other services.

- Labor Code Section 4603.4 requires the AD to adopt rules to establish standardized medical treatment billing forms and adopt standard protocols for electronic billing of medical treatment. Employers are required to accept electronic billing after the regulations are adopted. Submission of electronic bills is optional on the part of the provider. Standardized billing forms and electronic billing have the potential to reduce the paperwork burden for payors and providers, reduce claims processing costs and timeframes, and make medical cost containment activities more efficient.

Recommendations

CHSWC recommendations include the following:

- Since the AD has already established the Medicare rate as a floor on evaluation and management visits, further rate increases are appropriate for these services under a resource-based relative value fee schedule but they should be accompanied by the adoption of Medicare’s documentation requirement for evaluation and management (E/M) visits.

- The OMFS could be modified to include explicit fees for activities that are unique to work-related injuries.

- The AD could adopt a resource-based fee schedule for physician services, which would include a single conversion factor that would increase payments for primary care relative to other services.

- In addition to issuing the final rules on electronic billing, the AD could create incentives for physicians to bill electronically by explicitly providing for a higher allowance for services billed electronically compared to those submitted on paper bills.

Status

CHSWC approved posting of this study on its website for public comments.

For further information …

“Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California’s Workers’ Compensation Program,” RAND (July 2009).
http://www.dir.ca.gov/chswc/Reports/
Hospital Emergency Department Services Furnished under California’s Workers’ Compensation Program

Background

Emergency Department (ED) Services include not only care for injuries and other emergent conditions that require immediate treatment in EDs, but also urgent care that could have been provided in a physician’s office and non-emergent care that does not require immediate attention. Until recently, no comprehensive data have been available on Emergency Department services furnished to workers’ compensation patients. The CHSWC study by RAND, “Hospital Emergency Department Services Furnished Under California’s Workers’ Compensation Program” examines hospital emergency room services received by injured workers covered by the California workers’ compensation system. The study used emergency department data for 2005-2007 from the California Office of Statewide Health Planning and Development (OSHPD) to explore where there might be payment or quality-of-care issues for workers’ compensation patients that warrant further examination. A survey, noted in this working paper, conducted by the California HealthCare Foundation found that 21 percent of ED encounters by insured Californians could be considered “avoidable.” The survey results suggest that a finding of excessive use of ED services for non-emergent workers’ compensation care would be an indicator of potential access problems and poor communications between patients and primary care physicians.

Description

The study tries to understand the ED services that are being provided to workers’ compensation patients and whether there are any indications of potential access or quality-of-care problems. The paper examines the following questions:

- What were the most common conditions treated in EDs?
- To what extent were ED encounters related? What is the likelihood that other visits were avoidable ED services? Does the pattern vary across countries?
- What percentage of ED encounters resulted in a hospital admission? Does the pattern vary across counties?
- What are the high-volume services provided to workers’ compensation patients in EDs?
- What were the maximum allowable fees for ED services? To what extent were services subject to the OMFS for outpatient services versus the OMFS for physician services and laboratory services?

Findings

Key findings from the analysis of ED encounters for workers’ compensation patients from 2005-2007 include:

- Most ED encounters for workers’ compensation patients are for treatment of injuries. The proportion of ED encounters reported as initial treatment of injuries increased from 62 percent to 68 percent of total ED encounters during the study period.
- The volume of encounters that were for other-than-initial treatment of injuries declined 27.2 percent compared to a 5.9 percent reduction in encounters for initial treatment of injuries.

SPECIAL REPORT: WORKERS’ COMPENSATION MEDICAL STUDY
OF THE IMPACT OF RECENT REFORMS

- Statewide, about 20 percent of total workers’ compensation encounters were classified as either non-emergent or emergent conditions that could have been treated in an office-based setting.

- The trend in the Workers’ Compensation Research Institute (WCRI) price index documents the impact of the implementation of the OMFS for outpatient facility fees. These represent the majority of the payments provided in conjunction with ED services, but the technical components of diagnostic tests and drug administration also account for a significant portion of allowances.

- The underlying question for this study was whether there is evidence of excessive use of ED services that might be indicative of potential access or quality-of-care issues following implementation of the reforms affecting workers’ compensation medical care. The study did not find any indications that the recent reforms may contribute to excessive use of ED services. The findings from the analyses in this study of the 2005-2007 OSHPD data as well as WCRI trend data show a reduction in ED services. Further, the disproportionately higher reduction in non-injury encounters is a potential sign of improvement in access to an office-based setting.

For further information …

“Hospital Emergency Department Services Furnished under California’s Workers’ Compensation Program,” RAND (April 2009)
http://www.dir.ca.gov/chswc/Reports/

Pay-For-Performance In California’s Workers’ Compensation Medical Treatment System

Background

The Commission on Health and Safety and Workers’ Compensation (CHSWC) asked RAND to examine the major considerations that would be involved in developing a pay-for-performance program. This study drew on the literature and interviews from an earlier RAND study, a roundtable discussion among workers’ compensation stakeholders, and interviews with stakeholders.

The key mechanism of a pay-for-performance system is to reward health care providers on a set of specified measures related to quality, efficiency, compliance with administrative processes, adoption of information technology, and patient satisfaction. Generally, a program’s goals and objectives will determine what is measured and what the reward structure looks like. However, other constraints, such as data availability and sound evidence-based measures, will also affect program design.

Findings

Findings include:

- The current payment system does not reward quality or efficiency, and the Official Medical Fee Schedule (OMFS) does not reward disability management, prevention activities, or care coordination. Currently, payment levels are based on outdated fee schedules rather than the actual cost of providing the services, which creates perverse incentives.

- Significant effort is needed to implement a pay-for-performance system. In California, potential roadblocks include: the complexity of the current system due to implementation of recent legislative provisions; the level of distrust among parties in the system; the lack of consistent, ongoing monitoring and evaluation; and the multiple payors in the system.
Decisions need to be made whether a pay-for-performance program should be mandatory or voluntary. Financing a mandatory program may require changes in the OMFS. A voluntary program would not require changes in the OMFS.

The potential measures for a pay-for-performance program include: clinical process and outcome measures, such as the number of surgeries or repeat surgeries; efficiency measures on the total cost of the claim; patient experience, both patient satisfaction measures and time between referral and an appointment; administrative measures, such as timely filing of reports and compliance with medical treatment guidelines; work-related outcomes of care; and structural measures.

In addition, several decisions need to be made about a reward structure, including: the form of financial reward, whether a modified fee schedule payment, which is the easiest form, or a bonus payment at the end of the year; the criteria for receiving a reward, whether a fee-for-service basis, an absolute threshold, or a relative threshold; and the financing mechanism, whether insurance premiums, a bonus pool created through withholds, or a shared cost-savings formula. A shared savings formula would be difficult to generate in the workers’ compensation system as cases extend over time.

Two main data systems could be used to support the infrastructure for a pay-for-performance program in workers’ compensation. One data system is the database maintained by the California Worker’ Compensation Institute (CWCI). The second system would build on the Workers’ Compensation Information System (WCIS) which is maintained by the Division of Workers’ Compensation (DWC).

From the interviews conducted, the key elements that might lead to a “win-win” pay-for-performance program include: (1) establish safeguards and processes that build trust among stakeholders; (2) choose performance measures that will generate overall savings through improved quality and better work-related outcomes; (3) use a pilot test to determine realistic goals, measures, and reporting burden; (4) create financial incentives that provide bonuses for good performers without reducing payments below current levels for poor performers; and (5) build on existing data infrastructure and reporting systems.

Progress is being made in the areas which would support improving value-based medical care including that: WCIS is being established and could eventually lead to an ongoing monitoring system; RAND is doing more work on developing quality indicators for carpal tunnel syndrome; the National Committee for Quality Assurance (NCQA) has established quality indicators for low-back pain; DWC recently released additional medical treatment guidelines for chronic pain; and DWC has started work on a new OMFS.

Recommended Next Steps

Several recommended next steps include:

- Convene a work group with representatives of stakeholder groups to gauge the level of interest in pay-for-performance, to flesh out “straw man” models for further discussion and to identify “idea champions” to promote the concept.

- Assure that WCIS is structured to support ongoing monitoring and performance measurement at the physician level.

- Consider how pay-for-performance incentives might be incorporated into the new physician fee schedule.
SPECIAL REPORT: FIRST AID CASES

Introduction

At its November 6, 2008 meeting, the Commission on Health and Safety and Workers’ Compensation (CHSWC) voted to prepare an issue paper on problems with how first aid cases are handled and recommendations to ensure consistent reporting and fair allocation of costs among all employers, while at the same time preserve injured workers’ access to the workers’ compensation system. The Commission also advised that an Advisory Group be convened to discuss issues and potential solutions to problems with reporting first aid cases in order to find ways to assure appropriate medical care, reduce administrative costs, discourage fraud by defining the process more clearly, and even the playing field for employers.

Background

Both employers and workers have raised problems involved with reporting first aid cases. For some employers, first aid cases are included in their reporting and therefore increase their experience modification (Ex-mod) rating and their insurance premiums; other employers do not report first aid cases, so their Ex-mods are not increased. For workers, either some first aid cases are fully taken care of under workers’ compensation, which is required by law, or workers are not getting any care because they do not know that they have workers’ compensation as a right, or there is care for the first aid case but it is not tied into the workers’ compensation system. In addition, if there is permanent disability at a later stage, it may not be handled and compensated appropriately.

Some employers arrange for medical providers to withhold the Doctor's First Report (DFR) from their insurers in order to control their premiums. This constitutes fraud, which in turn raises premiums for employers that do allow the DFR to be sent to their insurers. It can also lead to fraudulent denial of workers’ compensation benefits to injured workers because of lack of notice to the insurer.

It appears that this type of fraud occurs most frequently with injuries that do not require treatment beyond first aid or time off beyond the employee's work shift at the time of injury (first aid cases). Differences in reporting requirements for first aid cases may cause well-meaning employers to be confused about their obligations and may enable unscrupulous enterprises to exploit the confusion. Employers that correctly process first aid cases with their insurers believe that they are paying disproportionate costs due to increased premiums resulting from the fraud committed by other employers, as well as high costs of administration and overhead with workers’ compensation cases generally.

First Aid Cases

Requirements

There are several requirements contained in the Labor Code that relate to first aid treatment. These include the following:

- First aid treatment is included as medical care that all employers must provide for their injured employees (Labor Code Section 4600).
- Physicians who treat injured employees must file a DFR with the claims administrator, even if the case involves only first aid with no lost time from work beyond the date of injury or illness or beyond the employee's work shift at the time of injury [Labor Code Section 6409(a)].
- Employers are not required to file an Employer's Report of Occupational Injury or Illness (Form 5020) with the insurer if the injury or illness requires only first aid with no lost time from work beyond the date of injury or illness [Labor Code Section 6409.1(a)].
Employers are not required to provide a Workers’ Compensation Claim Form (DWC 1) to an injured employee if the injury or illness requires only first aid with no lost time from work beyond the employee's work shift at the time of injury [Labor Code Section 5401(a)].

Problems

The California Department of Insurance (CDI) and the Department of Industrial Relations (DIR) believe that there are improper arrangements in place between some medical providers and employers that allow the employer to dictate how injuries are to be classified by the physicians. In some cases, and at the request of the employers, the physicians send the DFR only to the employers and not to the insurance carriers. This arrangement occurs even though the injuries clearly require more treatment than just first aid. This agreement is often marketed to employers as a way to keep premiums from rising or to lower them. Such marketing practices are improper and may contribute to possible criminal violations related to premium fraud and the fraudulent denial of workers' compensation benefits to injured workers. [Posted at the Division of Workers’ Compensation (DWC) website.]

Insurers count first aid cases the same as other medical-only cases in determining an employer's Ex-mod. Therefore, employers that withhold first aid cases from insurers appear to have lower accident frequency and obtain lower Ex-mods than employers that allow reporting of all cases as they should. Because the net effect of Ex-mods is intended to be cost-neutral (i.e., for every premium dollar an employer saves due to a low Ex-mod, another employer in the same industry will pay a dollar more), lower Ex-mods and lower premiums for the employers who cheat mean higher Ex-mods and higher premiums for employers who follow the rules.

Key Issues from Advisory Group Meeting Participants

Issues raised and goals suggested by individual Advisory Group participants included the following:

- Advisory Group objective:
  - Define the main client(s) to benefit from changes: e.g., DWC, DIR, Workers’ Compensation Insurance Rating Bureau (WCIRB), employer, worker, and physician.
  - Intent is to have an overall consistent reporting system.

- Reporting requirements:
  - Whether first aid cases have to be reported on the Cal/OSHA Log.
  - Small businesses need to know what the “rules” are so they are not liable for non-compliance.
  - Every claim has to be reported; there should be no threshold.
  - Physicians would prefer to report all claims.

- Jurisdictional issues:
  - Should first aid be an Ex-mod claim?
  - Claim cost information is sent to WCIRB; the claim is not coded to be defined as to whether it is a first aid claim.

- Costs to administer a claim:
  - There is a processing cost for opening and closing a claim. The cost to process a small medical-only claim can be much greater than the value of the claim.
• The definition of first aid:
  o There is confusion between the Cal/OSHA definition and the workers' compensation
    definition of first aid, with the Cal/OSHA definition being more detailed than the workers'
    compensation definition.
  o The confusion leads to unintentional as well as intentional underreporting.
  o There should be a definition of “provider” as medical provider (physician) or a Physician’s
    Assistant (PA).
  o The words “follow-up visit” need to be defined more specifically. This is currently being
    interpreted as either one visit or more than one visit.
  o There are situations when an injured worker would go to a physician that are not defined
    by the Cal/OSHA definition.
  o The federal OSHA definition is largely the same.
  o Physicians and employers generally use the Cal/OSHA definition.
  o Employers who are not knowledgeable about the definitions generally follow the
    physicians’ lead; small employers rely on the broker.
  o Small businesses most often do not know that there are two definitions.
  o Many employers would like to have one definition.
  o Whether there would be any negative impacts from using the Cal/OSHA definition and
    whether modifying the Cal/OSHA definition would require also modifying the federal
    OSHA definition.
  o If there is a change to a single definition or a unified definition, there should be significant
    education efforts.
  o Whether WCIRB could work with the Cal/OSHA definition.

• Whether the DWC-1 Form is necessary.

• Public access to insurance coverage information:
  o There should be a system for public access to insurance coverage information; this could
    enforce employer coverage and facilitate physician reporting. Thirty-three (33) other
    states have such a system.
  o Some physicians state that the employer will not tell the physician who the insurer is, so
    they have to send the report to the employer.
  o Physicians have a financial incentive to have the employer pay directly, so that the bills
    are not run through the fee schedules and physicians can charge whatever they choose.
  o Brokers sometimes instruct the employer community to use the OSHA definition instead
    of the workers’ compensation definition and to submit only certain claims in order to
    reduce insurance claims.
  o Some employers pay directly to the medical providers to circumvent the insurers,
    believing that this will control their workers’ compensation costs. This is not necessarily
    true.
  o Having one party (physician) report and the other party (employer) not report creates
    inconsistencies.
  o Need to ensure that the employee gets the best possible medical care:
    ▪ There should no penalty if an employer, out of an abundance of caution, wants
      the injured worker to see a physician; there should be a mechanism for that to
      happen.
  o Businesses (for example, Mobile Medical Assistance) have been set up to appeal to
    employers not to send the injured worker to a physician and offer to come to the
    company and care for the employee without medical care by a physician.

• Thresholds:
  o The Experience Rating Taskforce examined the issue of thresholds:
    ▪ Many medical-only claims valued at $2,000 or less are reported to WCIRB on a
      grouped basis and therefore cannot be individually identified from WCIRB
      records. WCIRB sees tens of thousands of small claims under $500 but there
may be even more. Experience rating is an actuarial prediction. An employer that has more claims is more likely to have greater losses in the future.

- Eliminating claims with cost less than $2,000 was tested by the Commissioner’s Experience Rating Task Force but ultimately rejected as it reduced the Plan’s predictive values and negatively impacted employers who were loss-free.
- Going to an even lower threshold, such as the first $50, $100 or $500, was not tested, but that might not have as much impact as eliminating the first $2,000.
- There is little market for a small deductible policy even though WCIRB has an Advisory Plan for this. The large deductible is the most common.
- It may be valuable to have a threshold; then there may be fewer small deductibles going on underground.

- Self-insureds:
  - There is constant confusion between the two definitions of first aid.
  - The self-insured employer pays for all medical care, so there may not be accurate distinction between occupational and non-occupational cases.

- Physicians:
  - Want everything recordable for liability issues. Reportability is a different issue. Need to have “follow-up” defined more specifically.

- What gets reported:
  - Insurance carriers may not want to take on the responsibility for reimbursing employers for first aid claims.
  - Administering the cost of the claim may be more than the value of the claim itself.
  - Reporting on the Log 300 generates statistical data for loss information for the Bureau of Labor Statistics (BLS) on injury and illness in the workplace:
    - Insurers can request more information from employers on cases listed on the Log 300:
      - Small employers do not have to do a Log 300.
    - There is a difference between the statistical needs for BLS and WCIRB.
    - A consistent definition of the injuries and accidents would help make compliance with the OSHA Log 300 reporting easier.
    - There are other required pieces of information on the OSHA Log 300, such as modified duty.

- Process to change the definition:
  - The workers’ compensation definition of first aid is embedded in statute and the statute would have to be changed.
  - The Administrative Director (AD) of the DWC could be allowed to define the definition (and examples) of first aid through regulations with the OSHA regulation as a guide, and this would allow for more flexibility, rather than just defining it in the Labor Code.

- Fraud issues:
  - Employer fraud:
    - Employer does not report.
    - Very small employers do not have an experience rating:
      - This applies to employers with approximately 4-5 full-time employees or less.
      - About 80 percent of insurance policies are not experience-rated; they do not generate a lot of premium (20 percent).
      - Over 90 percent of sole proprietors in California have less than $250,000 gross receipts.
    - Broker fraud: telling the employer not to report.
Health and safety prevention:
  - Reporting all injuries could lead to identifying trends in safety issues and could assist employers in improving their injury and illness prevention program:
    - Often, the employer relies on the insurance company’s compilation of accident information, so complete reporting of all injuries, including first aid cases, provides valuable information.

Advisory Group Recommendations and Next Steps

The Advisory Group suggested the following possibilities:

- Develop a single definition of first aid that reflects Cal/OSHA’s definition, but retain the last sentence of the current definition of first aid addressing toxic chemical exposures:
  - Consider including language about the AD having discretion to make adjustments to the definition.

- Do not make any changes to existing thresholds.

- Develop an educational factsheet.

- Ensure that there are resources available to make any changes part of public information:
  - Have a consistent message.
  - Include information in the poster for the workplace.
  - Include information in Employment Development Department (EDD) newsletter (sent out in hard copy). This goes to every physician, claims adjuster, and employer.
  - Include information in the DIR’s annual fraud warning notice to employers.

- Conduct further discussions about equity issues that arise when employers double pay (i.e., pay for first aid directly and pay through increased insurance premiums).

- Investigate and review the State of Oregon’s handling of first aid cases.

Booklet on Reporting Occupational Injuries and Illnesses: Workers’ Compensation and Cal/OSHA Requirements

This booklet was prepared for CHSWC in 2008 and is included in the “Summary of January 9, 2009 First Aid Cases Advisory Group Meeting.” It was adapted from informational materials prepared for the Labor Occupational Health Program, University of California, Berkeley. It describes the requirements in California for physicians and employers (or their workers’ compensation insurers) to report occupational injuries and illnesses, provide medical care, and process forms and reports in a workers’ compensation case. Also described, for comparison purposes, are employers’ requirements to maintain and summarize records of occupational injuries and illnesses.

For further Information …

“Summary of January 9, 2009 First Aid Cases Advisory Group Meeting” (April 2009) which includes the booklet on Reporting Occupational Injuries and Illnesses: Workers’ Compensation and Cal/OSHA Requirements.

SPECIAL REPORT: INTERNATIONAL FORUM
ON DISABILITY MANAGEMENT 2010

Introduction

Disability management, including preventing needless work disability, is an issue of high priority across the globe, as it the most effective way of creating and maintaining jobs, reducing costs to employers, improving productivity, and ensuring improved outcomes for workers.

As part of its commitment to disability management, the Commission on Health and Safety and Workers’ Compensation (CHSWC) and the Department of Industrial Relations (DIR) are collaborating with the International Association of Industrial Accident Boards and Commissions (IAIABC) to host the International Forum on Disability Management (IFDM) 2010, an event devoted to multi-national dialogue on disability management. Held every two years since 2002, IFDM is the only global conference dedicated to in-depth discussion of problems, trends, and best practices in disability management.

IFMD 2010: Collaborating for Success, to be held September 20-22, 2010, in Los Angeles, California, is expected to bring together over 500 attendees, representing more than 25 countries, from the health, safety and workers' compensation communities. The diverse audience will include large, medium-size and small employers, workers, disability management practitioners, health care providers, advocates for full employment of workers with disabilities, risk managers, unions, jurisdictional and local government agencies, the insurance industry, policymakers, and the public to participate in presentations, discussion, and workshops. A major goal of IFDM is to bring key policymakers into the discussion and to be an agent of change.

Planning Advisory Committee

The IFDM 2010 Planning Advisory Committee meets monthly and is guiding the planning efforts for the forum. The Committee includes experts on disability management and other social services, researchers, and representatives of international government agencies including:

- Christine Baker, Chair IFDM 2010
  California Commission on Health and Safety and Workers' Compensation
- John C. Duncan
  California Department of Industrial Relations
- Gregory Krohm
  International Association of Industrial Accident Boards and Commissions
- Carrie Bibens
  Clinical, Vocational, Medical Quality Assurance, Unum
- Elyce Biddle
  National Institute for Occupational Safety and Health
- Susanne Bruyére
  Cornell University, Industrial Labor Relations School
- Nick Buys
  Learning and Teaching, Griffith University, Australia
- Marcia Carruthers
  Disability Management Employer Coalition
- Brenda Croucher
  Association of Workers' Compensation Boards of Canada
- Jim Curcio
  Council on Employee Health & Productivity, National Business Group on Health
Conference Goals

IFDM 2010 Conference Goals include:

- Highlight how disability management benefits workers, businesses and society.
- Offer convincing evidence that disability management processes are being widely adopted and are successfully helping disabled individuals find and maintain gainful employment.
- Identify the effects of periods of economic crisis on disability management on both industrialized and non-industrialized economies.
- Identify public policy and institutional changes that industrializing economies can feasibly use to manage disability in their workforce.
- Highlight success stories for large, medium-size and small employers in disability management, including prevention and stay-at-work and return-to-work programs.
- Acquaint participants with leading international experts on disability management through presentations and informal networking.
• Share best practices for gaining stakeholder cooperation and achieving measurable gains in disability management.

• Provide a forum for sharing different models of government safety net programs and incentives.

• Identify disability management performance metrics, data gathering, analysis, interpretation, reporting and dissemination that lead to better disability management among employers and regulatory agencies.

• Persuade government decision-makers that public policy initiatives with multi-stakeholder support have made significant and practically achievable gains in assisting disabled individuals to find and maintain gainful employment.

Key Topics

The conference will seek to identify successful disability management policies and practices that decrease occupational injuries and promote positive outcomes after occupational injuries or illness. Participants in IFDM 2010 will share information and achievements in disability management and advocate for public policy changes that provide better social protection and economic empowerment for everyone. Key topics for the conference include:

• A Global Perspective on Disability Management: successful partnerships in disability management; an overview of global trends in the workplace; the impact of the economic downturn.

• The New Paradigm: changing social attitudes toward disability management; the next steps in moving disability management forward.

• The Government’s Role in Disability Management: models from around the world; the state and disability management: lessons learned from government initiatives and reforms.

• Emerging Economies and Disability Management.

• The Legal Aspects of Disability Management.

• Using Research and Information to Guide Public Policy Decisions on Disability Management: measuring the value of disability management programs for employers and for insurers; measuring the success of disability management certification programs; identifying resources to assist in the development and promotion of disability management programs for employers; evaluating the impact of incentives on the development and implementation of workplace disability programs.

• Innovative Programs in Workplace Health & Safety: An Employer Perspective: integration of wellness, disability and absence management programs; opportunities and barriers to safe, early and sustainable return to work.

• Medical Issues in Disability Management: psychological well-being: addressing the mental barriers to return to work; advances in medical technology and the impact on disability management; disability management techniques to deal with specific medical conditions.

• Disability Management for Special Populations: special problems in workforces with large migratory and minority culture segments.

• Success Stories, Case Studies and Solutions for Stakeholders.
The Planning Advisory Committee issued a Call for Papers in August 2009. Accepted proposals will be announced by April 9, 2010, and final presentations will need to be submitted by July 12, 2010.

*For further Information …*

- IAIABC website, [www.iaiabc.org](http://www.iaiabc.org)
- CHSWC website, [www.dir.ca.gov/chswc](http://www.dir.ca.gov/chswc)
SPECIAL REPORT: QUALITY-OF-CARE INDICATORS

Introduction

Research shows that the medical care provided in the U.S. may not be of high quality. Only 55 percent of medical care provided is consistent with recommendations based on published literature and the opinions of experts. For the most common conditions in workers’ compensation, i.e., back, shoulder and knee problems, only 56 to 67 percent of the right care is provided. No one has looked systematically at the quality of care provided in workers’ compensation. The study by RAND for the Commission on Health and Safety and Workers’ Compensation (CHSWC) includes all settings, including workers’ compensation settings.

Background

Improving the quality of medical care in workers’ compensation settings would benefit both injured workers and employers. For injured workers, better care can improve recoveries and reduce temporary and permanent disability which would decrease economic losses. For employers, lack of recovery can create a need for medical care in the long run, and reducing temporary and permanent disability would decrease economic losses. One rigorous study, done in Spain and focusing on guidelines and appropriate activities for injured workers, indicates that better care: reduced time on temporary disability by 37 percent; reduced the number of temporarily disabled workers who became permanently disabled by 50 percent; and reduced medical and disability costs by 37 percent, a return of $11 on each one dollar invested.

To measure quality in workers’ compensation settings, specific quality-of-care measures are needed. Measurable standards permit objective evaluations of practice and indicate the extent to which current practice meets standards, as well as ensure that results can be compared fairly among organizations or providers. Attributes of quality measure standards for care include that they are: relevant, scientifically sound, and feasible for measurement; described in detail so they can be applied in an objective manner; and supported by information that explains qualifying terms, time frames and patient eligibility for the different measures.

Quality-of-care measures are related to but different from medical treatment guidelines. Quality-of-care measures are quantitative tools that: indicate performance related to a specific process or outcome and measure the quality of medical care; and have language that provides specific criteria for which practices are “right” and “wrong.” In terms of complexity, simplistic algorithms provide clear scoring instructions for a process that can be measured practically. Measures are used in accountability systems, as there are assigned penalties or rewards based on performance applied in an objective manner. In contrast, guidelines are sources of recommendation to be applied prudently based on clinical experience. They consolidate information to reduce gaps between scientific knowledge and clinical practice. They are flexible in that they acknowledge the “gray zone” of uncertain appropriateness. In addition, they acknowledge medical complexity and patient preferences.

Scope of the Study

The goal of the study was to demonstrate quality measurement in workers’ compensation. The objectives were to: develop quality-of-care measures for carpal tunnel syndrome (CTS); pilot test the measure in workers’ compensation provider and payor organizations; place measures and supporting tools in the public domain; and use the measures to assess quality of care for a larger population of patients.

Public-private partnerships made the study possible. Funding support was provided by the Commission and Zenith Insurance. The Commission also provided essential assistance in developing the project. Partners-in-kind included Kaiser Permanente Northern California Regional Occupational Health and the California State Compensation Insurance Fund (State Fund), which have been involved in pilot testing.
The research approach of the project was to develop quality measures for CTS and included the following steps: Step 1 -- a multidisciplinary research team developed draft measures from guidelines and literature; Step 2 -- a multidisciplinary panel of 11 national experts in CTS rated the measures for validity and feasibility; Step 3 -- the RAND/UCLA team created a tool that explains how the measures should be used; and Step 4 -- Kaiser Permanent Northern California Regional Occupational Health and California State Fund pilot tested the measures.

Seventy-seven (77) measures were developed: 31 measures address diagnosis and non-operative management of CTS including history and physical examination, medications, splints, activity modification and return-to-work planning; 6 measures address the use of electrodiagnostic tests; 18 measures are for indications for carpal tunnel surgery including when surgery is necessary and when it is inappropriate; and 22 measures address care before, during and after surgery.

In a Washington state study of CTS claims, half of the claims were initially filed for other conditions. In 20 percent of the claims, CTS was not diagnosed until more than three months after initiation of the workers’ compensation. The longer the delay until the CTS diagnosis, the longer the disability tended to be. One measure therefore specifically addresses delays in recognizing CTS symptoms. New symptoms characteristic of CTS should lead to suspicion: if a patient complains of any of the following symptoms highly characteristic of CTS – paresthesias, numbness, or tingling on the first to third fingers or palm -- then a suspicion of CTS should be documented in the medical record at the initial evaluation of those systems, because early diagnosis of CTS can lead to earlier intervention.

Many clinicians use the wrong examination techniques to check for CTS. Phalen's and Tinel's maneuvers, taught in medical residencies, are the wrong techniques. If the progress notes document that CTS is suspected, then the right technique should involve at least one of the following physical examination maneuvers that should be documented at the initial evaluation: testing for sensory abnormalities in median nerve distribution; testing for thenar muscle weakness; and examination for thenar muscle atrophy. In addition, splints are often positioned poorly, which actually worsens symptoms. The wrong technique is defined as use of splints that come out of the box in a position of 20-30 degrees of wrist extension; use of this type a wrist splint in extension worsens CTS. The right technique is for splints to be placed in a neutral position; if a patient with CTS is prescribed a splint, then the chart should document that the splint was positioned so that the wrist is neutral (neither extension >10 degrees or flexed).

Several measures address work-relatedness, activity and return-to-work planning. Measure titles include: new CTS diagnosis requires detailed occupational history; new CTS diagnosis requires assessment of occupational factors; new CTS diagnosis requires assessment of non-occupational factors; exacerbating activities should be identified when CTS limits functioning; rationale for work-association should be documented; patients diagnosed with CTS should be educated about the condition; exposures to vibration, force and repetition should be minimized; work-associated CTS symptoms require prompt follow-up; work status should be monitored when CTS appears work-associated; return to work after CTS-related disability requires follow-up assessment; and prolonged CTS-related disability should trigger evaluation.

In the study, the measures for electrodiagnostic tests, which are nerve conduction studies that measure conduction across the carpal tunnel nerve, appear to be the first in that field. One measure indicates that people should be tested when anyone who has work-associated CTS may be a candidate to undergo surgery. There are essential examination components to test for CTS, including measuring and correcting skin temperature. Interpreting findings should be based on criteria for calling a result consistent with CTS. Although electrodiagnostic test results are one important consideration in determining when surgery is appropriate, the severity and pattern of symptoms, as well physical examination findings, are more important. The decision to operate should not just be based on electrodiagnostic test results. Electrodiagnostic tests are helpful but not the main reason to operate, as there can be false positives, although the test can be helpful in confirming the impression of CTS.
Indications for surgery have two uses. First, there are quality measures to examine prior care. For example, if a patient has mild CTS present for up to 12 months and all of the following criteria are met – conservative therapy has not been attempted or has adequately resolved the patient’s symptoms and the presentation is less than “high probability” and an electrodiagnostic test is positive for CTS – then the patient should not undergo carpal tunnel surgery. The study also created an algorithm to determine appropriateness of future surgery which considers symptoms, examination findings, conservative therapy and electrodiagnostic tests. The algorithm could supplement the current American College of Occupational and Environmental Medicine (ACOEM) Guidelines in utilization review and help determine whether and when there should be surgery. A part of the algorithm looks at whether there are ongoing symptoms. The algorithm determines whether the surgery is inappropriate, optional or necessary. Prior studies that have developed similar algorithms have shown improved quality of life among people for whom surgery was consistent with recommendations.

**Manuscripts Based on the Study**

Four manuscripts based on the study have been submitted to medical journals: *Journal of Occupational and Environmental Medicine; Muscle and Nerve;* and *Plastic and Reconstructive Surgery*. A tool, the RAND/UCLA Quality-of-Care Measures for Carpal Tunnel Syndrome: Data Collection Tools, which will include the algorithm, will be posted online.

**Conclusions**

Observations from developing the tool and pilot testing the measures regarding requirements for use include the following. A complete record for prior care is important, so usually, medical records are needed. First, users must accurately identify patients with CTS; administrative (i.e., claims) databases are usually used, but they generally do not indicate the medical examination. Current Procedural Terminology (CPT) and International Classification of Diseases, 9th Revision (ICD-9) codes should be used when possible. Second, assessing adherence to the measures requires a complete record of the care provided for CTS: the claims databases do not provide the necessary information; DFS and PR-2s may suffice if they are easily obtained and contain all information that is in the medical record, but usually, medical records are required. Third, staff with appropriate skill levels is needed; most measures can be rated by nurses and other providers particularly if they have a claims review background, but some measures addressing electrodiagnostic tests and how surgery is performed require physicians in those fields.

Providers could use these measures in their practices. The measures provide advantages for many workers’ compensation payors that are interested in selecting high-quality providers for their medical networks. They are rigorously developed by physicians, based on the latest guidelines, and developed by national experts in the care of CTS. They are also adaptable, as providers can select the measures they consider important and choose how to apply them. In addition, they are easy to use on a trial basis, as no special technology or expertise is needed for most of the measures. Finally, they are inexpensive, as measures are free and start-up costs include training staff. These measures will become more useful if widely adopted, and ultimately, report cards could compare provider organizations. It would be feasible in the workers’ compensation setting to reduce the burden on the utilization review process.

The results of the study lay the groundwork for a comprehensive study of quality for CTS. The U.S. Agency for Healthcare Research & Quality has awarded a grant to develop projects and expertise addressing the relationship between quality and costs. The work on this project was instrumental in securing this grant. In addition, RAND and Kaiser Permanente Northern California Regional Occupational Health are partnering to do a study examining the quality of care among workers’ compensation patients with CTS, as well as the relationship of quality care to workers’ clinical outcomes and the costs to major stakeholders. A grant will be submitted to the U.S. Agency for Healthcare Research & Quality. At the same time, Kaiser Permanente will use the measures to develop an internal quality assurance program.
Conclusions based on the study include that quality of care is important in workers’ compensation settings and quality measures are needed. Low-quality care impedes recovery and increases cost to everybody. CTS is a good place to start. Also, provider organizations can use the CTS measures and tools developed by the study to monitor quality of care; for payors, it may be more feasible to encourage providers to monitor quality than to assess quality directly. In addition, payors could assess the appropriateness of future surgeries for CTS using the algorithm developed in the study.
SPECIAL REPORT: FRAUD STUDIES

Recent and ongoing fraud studies are described in the “Project and Studies” section on fraud. The major findings of the fraud studies that have been completed are summarized here.

Introduction

The California Bureau of State Audits (BSA) evaluated the “effectiveness of the Fraud Assessment Commission (FAC), the Department of Insurance (CDI) Fraud Division, the Department of Industrial Relations (DIR) and local law enforcement agencies in identifying, investigating, and prosecuting workers’ compensation fraud and employers’ willful failure to provide workers’ compensation benefits for their employees.”

The audit report “Workers’ Compensation Fraud: Detection and Prevention Efforts Are Poorly Planned and Lack Accountability,” 2002-18, April 2004, included the following recommendations on measuring fraud:

“To better determine the assessment to levy against employers each year for use in reducing fraud in the workers’ compensation system, the fraud commission and the insurance commissioner should direct the fraud division to measure the nature and extent of fraud in the workers’ compensation system.

To establish benchmarks to gauge the effectiveness of future anti-fraud activities, these measures should include analyses of available data from insurers and state departments engaged in employment-related activities, such as Industrial Relations and the Employment Development Department.

In addition, the insurance commissioner should consider reactivating an advisory committee comprising stakeholders focused on reducing fraud in the workers’ compensation system to contribute to the data analyses, provide input about the effects of fraud, and suggest priorities for reducing it. This advisory committee should meet regularly and in an open forum to increase public awareness and the accountability of the process.”

The FAC and the Commission on Health and Safety and Workers’ Compensation (CHSWC) have continued their ongoing collaboration against fraud and have engaged in several studies and activities to carry out these recommendations.

These studies establish some baselines for additional studies in the future and serve as the starting point for implementing anti-fraud program improvements and monitoring their effectiveness and success.

This report summarizes key findings and recommendations from these studies. Two were in collaboration with CDI and the others were conducted by CHSWC staff and contractors. Some of these studies were completed in 2006 and 2007; however, they are still relevant in the discussion of fraud and proposed policy improvements. Links to the study reports are provided in the “Further Information” section at the end of this discussion. Other studies not yet completed are discussed in the “Projects and Studies” section of this Annual Report.

Insurance Commissioner’s Advisory Task Force on Insurance Fraud

Background

The Insurance Commissioner’s Advisory Task Force on Insurance Fraud was convened on May 31, 2007, at the invitation of Insurance Commissioner Steve Poizner. The Task Force was to work for one year and
deliver recommendations to Insurance Commissioner Poizner on ways to reduce or eliminate insurance fraud. The Executive Officer of CHSWC chaired the Workers’ Compensation Expert Working Group of the Task Force. The goals of the Task Force were to:

- Review the efficiency of the CDI Fraud Division.
- Review anti-fraud programs and efforts by the insurance industry and provide recommendations for improvement.
- Review statutes and regulations and make recommendations for improvement.
- Review and identify emerging technology for CDI which can be used to reduce the incidence of insurance fraud and can be used in the investigatory process.
- Review outreach efforts by CDI and make recommendations for improvement.

The Task Force report “Reducing Insurance Fraud in California” was issued in May 2008.

For further Information …

“Reducing Insurance Fraud in California” (May 2008).
http://www.insurance.ca.gov/0300-fraud/upload/FraudTaskReport05-08.pdf

Workers’ Compensation Medical Payment Accuracy Study

Background

CDI contracted with Navigant Consulting for the “Workers’ Compensation Medical Payment Accuracy Study.” CHSWC staff provided administrative and technical assistance to this study. A draft report was produced in May 2008.

The purpose of the “Workers’ Compensation Medical Payment Accuracy Study” was to:

- Determine the extent of workers’ compensation medical overpayments and underpayments to justify and provide information on appropriate allocation of resources to detect and evaluate suspected medical provider fraud in California.
- Provide recommendations for ongoing detection and monitoring of suspected abuse and fraud in the workers’ compensation system.
- Identify potential vulnerabilities and suspected perpetrators of fraud.

The researchers conducted the following three reviews of injured workers’ medical bills in the sample:

- Examination of medical documentation to test whether it supported the services and amounts billed by the provider and paid by the insurer.
- Survey of injured workers to give them the opportunity to verify or deny that they received the medical services billed by the provider.
- Examination of the processing of the bill to test whether the bill submitted by the provider was paid correctly and according to policy.
Findings

- 21.9 percent of the sample dollars were paid in error (combined three reviews analysis).
- 27.4 percent of the sample dollars were paid in error (medical review only analysis).
- 4.5 percent of the sample dollars were paid in error (electronic processing only analysis).

Based on these sample error rate results, it is estimated that:

- Total potential payment errors in the entire California workers’ compensation system range from $494 million to $1,372 million (combined three reviews analysis).
- Total potential payment errors in the entire California workers’ compensation system range from $822 million to $1,513 million (medical review only analysis).
- Total potential payment errors in the entire California workers’ compensation system range from $122 million to $261 million (electronic processing analysis only).

Recommendations

The selected recommendations below include ways to address a variety of causes of payment errors identified in this study as well as ways to more directly identify potential fraud:

- Increase education efforts for providers and insurers about appropriate courses of care per American College of Environmental Medicine (ACOEM) Guidelines for the highest-volume types of injuries.
- Data mine the new medical bill database in the Workers’ Compensation Information System (WCIS) using a range of relevant analytic and pattern-recognition techniques, including advanced techniques such as artificial intelligence, to identify aberrant patterns and trends in workers’ compensation medical billing fraud on a systemwide basis, and focus investigative efforts.
- Consider expanding statutory authority for access by CDI to WCIS.
- Develop a medical benefits administration “best practices” checklist for employers to use in evaluating efforts by their workers’ compensation insurers or third-party administrators in ensuring medical payment accuracy and preventing and detecting fraud.

Recommendations for Next Steps

To build upon this study and evaluate the feasibility of implementing the above recommendations, the following next steps are recommended:

- Begin analyzing the medical bill data in WCIS.
- Conduct a follow-up payment accuracy study in 2010 using the WCIS medical bill database to determine if implementation of any of the recommendations above or others have had an effect on payment accuracy levels.
Study of Fraud in Workers' Compensation Payroll Reporting

Background

The workers' compensation premium paid by employers is based on employers' payroll. By misreporting payroll costs, employers avoid the higher premiums they would incur with full reporting of payroll. Employers can also misreport total payroll or workers in high-risk, high-premium classes as earning wages in lower-risk, lower-premium occupations.

It has long been suspected that a fraction of employers fraudulently under-report and misreport payroll for calculation of workers' compensation premium or illegally forego purchasing workers' compensation insurance altogether. In 1998, CHSWC contracted with the University of California (UC), Berkeley to develop a pilot project and analyze the degree to which employers fail to secure coverage.

The present study extends that prior study to include the impact of fraudulent under-reporting and misreporting of payroll by insurers to calculate premiums. During the period studied for this report, 1997-2002, premium rates for California were initially low and then increased rapidly. Subsequent to the study period, rates continued to increase through 2004 and then dropped to near earlier levels. This study examines the extent of fraudulent reporting and the impact of the rapid increase in premium rates on employer fraudulent behavior.

The report “Fraud in Workers' Compensation Payroll Reporting: How Much Employer Fraud Exists? What is the Impact on Honest Employers?” was published in August 2007, and researchers provided updated findings as data became available.

Findings

- The study found substantial misreporting of payroll in jobs where the employer pays high workers' compensation premium rates.

- The under-reporting becomes increasingly more severe as the cost of workers' compensation increases.

- During the initial study period of 1997 to 2002, the level of under-reporting increased from between 6-10 percent of private industry payroll when premium levels were low ($2.47/$100 payroll) to 19-23 percent when premium levels were high ($4.28/$100 payroll).

- This translates to a change from $19.5 to $31.3 billion in 1997 to as much as $100 billion in under-reported payroll in 2002.

- Under-reporting and misreporting increase dramatically as the premium rate for a class of workers increases. For very high-risk classes, as much as 65 percent to 75 percent of payroll is being under-reported or misreported.

Insurers are required to audit policyholders if the premium exceeds a threshold, which is currently $10,000. The Workers’ Compensation Insurance Rating Bureau (WCIRB) has a program of evaluating insurer audits, trying to ensure both employer and insurer compliance. The Test Audit Program involves re-auditing approximately 3,000 of the 600,000 policies issued by insurers in California each year. WCIRB results are compared to those reported by insurers, and discrepancies can result in fines, increased audits and other penalties.

Updated Findings

From 1997 to 2005 (the most recent data available at publication), there was a substantial under-reporting of premium by employers. Under-reporting ranges from a low of 4 percent in 1997, when rates were substantially lower, to an excess of 10 percent in 2004, when rates were several times higher.
higher than 1997. This amounts to about $15 billion of under-reported payroll in 1997 and to $60 billion in payroll in 2004.

Between $15 and $60 billion of payroll annually is under-reported over this period for employers that should be insured for workers’ compensation insurance. This includes the underground economy and under-reporting by employers that do have insurance. The result is that premium rates are likely to be unfairly high for honest employers who probably face rates three to ten times higher in the high-risk class codes than they would face under full reporting. Under-reporting also affects the competitiveness of honest employers. There are only limited incentives for insurers to accurately monitor under-reporting, and under-reporting is probably offset by the higher premium rates that are observed.

Possible Next Steps:

- **Consider ways to improve auditing incentives and behavior:**
  - Have "Test Audit" program conducted by an independent auditing entity.
  - Open audit results to public access at the insurer level.
  - WCIRB to report at least the direction of test audit errors.
  - Increase civil penalties for under-reporting and misreporting.

- **Consider ways to improve reporting incentives and behavior:**
  - Have "Test Audit" program conducted by an independent auditing entity.
  - Allow insurers access to employer reporting to the Employment Development Department (EDD) for tax and unemployment insurance (UI).
  - Have employers identify individual workers in high-risk classes.
  - Integrate occupational and non-occupational healthcare.

**Recommendations**

The report included the following recommendations:

- The Legislature, CDI, DIR/Division of Labor Standards and Enforcement (DLSE) could push for more aggressive enforcement against under-reporting and misreporting. This could include:
  - Focusing more FAC funding on premium fraud,
  - Raising the civil penalties for premium fraud, and/or
  - Raising the criminal penalties for premium fraud.

- The Test Audit Program that monitors insurer audits of policyholders is currently operated by WCIRB, an insurance industry association. CDI might consider having this process conducted by a separate, private contractor.

- Employers report payroll data to EDD for tax withholding and unemployment and disability insurance. These records could be matched to employers’ reporting to insurers for premium purposes. Currently, this avenue is limited by restrictions on insurer access to EDD data. Legislation could simplify this basic audit procedure.

- The Franchise Tax Board receives large amounts of information that could be used to identify fraudulent under-reporting. These data include income information from both employers and workers that could be used to identify fraudulent use of independent contractor status. Access to these data is heavily restricted, and legislation might be needed to facilitate access for investigators.
Professional Employer Organizations (PEOs) have been cited as a frequent avenue for employers to avoid the consequences of high experience modification rating (Ex-mod) or to disguise the risky nature of workers’ occupations. However, to date, there has been no systematic study of the size or scope of the PEO market or the claims experience of PEOs. The State could undertake a study to gauge the impact of PEOs in the workers’ compensation market.

Recently, at least one very large national insurer was fined for systematically under-reporting premium in several states (Bloomberg News, 5/26/07). It is unclear whether the under-reporting extended to payroll and occurred in California. If this under-reporting extended to California, then the estimates of under-reporting could include fraudulent behavior by at least one insurer, not just employers. This could be a topic for study by CHSWC and CDI.

If one or more insurers under-reported payroll and premium, there is a possibility that this action could have affected individual employers’ Ex-mods. In the aggregate, insurer under-reporting could also have altered pure premium rates set by WCIRB and CDI. This could be a topic for study by CHSWC and CDI.

Study of “Split” Class Codes in Fraudulent Payroll Reporting

Background

Within the construction industry, union employers typically paid substantially higher wages under collective bargaining agreements than were paid by non-union contractors. Hence, for the same number of hours worked, a union employer paid more in workers’ compensation premiums, even though the workers were not exposed to any greater period of occupational risk.

The construction industry and building trades unions requested that WCIRB use split class codes for the construction industry based on the hourly wage paid to the worker. Splitting class codes has resulted in substantially different premium rates for similar work but different underlying wage rates. The low-wage classes have higher premium rates, often more than double the rates for the high-wage classes. The difference in premium rates means that low-wage employers could misreport payroll by shifting it from low-wage classes to high-wage classes.

CHSWC contracted with UC Berkeley to study this issue, and the report “‘Split’ Class Codes: Evidence of Fraudulent Payroll Reporting” was issued in August 2007.

Findings

The study found evidence of abuse and presents evidence that payroll for low-wage workers is:

- Being systematically under-reported in the low-wage class codes.
- Some of that payroll may be misreported, that is, shifted from the low-wage classes to the high-wage classes to avoid the higher premium rates in the low-wage classes.

The study found that:

- 25 percent to 30 percent of low-wage payroll is being under-reported or misreported.
- Reported payroll is about 10 percent higher than actual payroll and 14 to 18 percent higher than expected reporting for premium purposes.
Study on Access to Workers’ Compensation Insurance Coverage Information

Background

In response to a request from the Legislature, CHSWC prepared an issue paper regarding public access to workers’ compensation insurance coverage information or proof of coverage (POC). The staff report “Workers’ Compensation Compliance and Proof of Coverage” was issued in 2006.

Findings

The following summarizes some of the advantages of improved public access:

- Employers are protected from broker fraud because they may verify that they are covered for workers’ compensation.

- The public is protected from engaging contractors or subcontractors, who may not be covered or who may have let coverage lapse, by allowing coverage verification by date, and employers can reduce their risk with immediate verification.

- Administrators save time and money spent collecting POC information. Two major workers’ compensation constituencies, medical providers and lawyers, can more efficiently serve injured workers with immediate verification of coverage.

- Parties to a claim before Division of Workers’ Compensation (DWC) can more easily save time and money preparing claims, as more POC data are available electronically.

- Workers are protected from lack of workers’ compensation coverage; employees and/or their representatives may verify that an employer is covered for workers’ compensation above and beyond the law.

- Insurers may ascertain if another insurance company could potentially share the liability in certain claims.

- Health and medical providers may determine the appropriate insurance carrier to bill.

- Insured employers are placed at a competitive disadvantage with respect to uninsured employers. This levels the economic playing field for insured employers by identifying illegally uninsured employers and bringing them into compliance.

- Insured employers are protected from being doubly disadvantaged when taxes or premiums are raised to cover costs shifted to other government or employer-supported services.

- Taxpayer money is saved by reducing the need for injured workers to use other social and benefit systems because the employer was illegally uninsured.

- The State of California and WCIRB (the rating bureau for California) would save time and money on resources spent handling inquiries and requests for data via forms, letters and phone calls. While the State does not directly provide such information, it would still save additional resources spent on handling misdirected inquiries and requests.

- The State could identify illegally uninsured employers more easily, which could reduce the Uninsured Employers Benefits Trust Fund (UEBTF) payout of over $20 million each year.

- A study by CHSWC in 1998 reported that recoveries and penalties from uninsured employers averaged only $2.3 million per year, while payment of claims on behalf of uninsured employers
resulted in a net loss to the State's General Fund of over $100 million during the five-year period. [As of 2004, losses previously incurred by the General Fund are now incurred by the Workers' Compensation Administrative Revolving Fund (WCARF) and are now funded by a surcharge on all insured employers, by penalties to non-compliant employers, and by recoveries from uninsured employers for actual worker injuries.] A $20 million gap per year appears to continue through 2005.

- Better access to POC should change the behavior of some employers who believe the risks of going without coverage are worth the savings until, or if, they are ever identified; POC would be an added deterrent.

- CHSWC conducted three pilot projects regarding illegally uninsured employers. The report entitled “CHSWC Recommendations to Identify Illegally Uninsured Employers and Bring Them into Compliance” describing these projects in detail is available at the CHSWC website: http://www.dir.ca.gov/CHSWC/uefcover.html. The rate of uninsured employers in California was found to be approximately 9 percent in 1998. A program to identify uninsured employers more consistently would create significant savings.

- The number of new cases received by UEBTF increased by 45 percent between fiscal year (FY) 01/02 and FY 04/05. Between those years, the number of cases increased 25 percent between FY 01/02 with 1,001 cases and FY 03/04 with 1,251 cases.

- Most recent data show a 16 percent increase from 1,251 cases in FY 03/04 to 1,451 cases in FY 04/05. These increases suggest that without better use of coverage data for compliance purposes, demands on the fund may increase.

**Recommendations**

**Recommendations for Enforcement**

- WCIRB to adopt what many other states are doing by providing daily POC database downloads so that the State may carry out its mandate to enforce employer compliance by conducting a program of matching EDD records with WCIRB records.

- EDD to provide monthly database downloads of employer-identification data, including federal employer identification numbers (FEINs) and names and addresses, so that the State may carry out its mandate to enforce employer compliance by conducting a program of matching EDD records with WCIRB records.

- DLSE to be funded to create and conduct an ongoing data-matching program to identify uninsured employers, contact uninsured employers, assess penalties, and bring the uninsured into compliance. Such a program may be funded by fines once started, with most of the penalties returned to the UEBTF fund. Such a program should create periodic reports on results, including fines levied, to CDI.52

**Recommendations for Public Access53**

- Determine the desirability and legality, in particular given the referenced case law with respect to the confidential and proprietary nature of policy effective dates, of making POC data available to the public in California, regardless of whether someone is a party to a claim.

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52 This recommendation became Senate Bill (SB) 869 (Ridley-Thomas) and was made law in 2007. It is statutorily in effect as of January 1, 2008, as part of Labor Code Section 90.3.

53 Since this report was written in 2006, Assembly Bill (AB) 483 was signed into law in 2009, providing for an Internet website maintained by WCIRB to display whether an employer is insured for workers’ compensation.
Determine whether WCIRB should be mandated to provide public access of POC information via the Internet, or whether WCIRB will deem the service valuable enough to WCIRB members and the related workers’ compensation community to host it on its own.\(^{54,55}\)

Determine how such public access will be funded. Given the planned WCIRB upgrades mentioned in this paper, the costs of hosting an online public access database may be recoverable, especially when manual paper requests currently require $8 administrative fees to cover overhead ($8 x 38,000 requests equals $304,000). Public access may reduce many of these paper requests and lower costs.\(^{56}\)

**Study of Workers’ Compensation Injury Reporting**

**Background**

Electronic reporting of injuries and illnesses to California’s WCIS became mandatory in 2000. Since then, claim administrators have been required to submit electronic data about all workers’ compensation claims, including information about the injured worker, the injury and benefit payments. In principle, WCIS should have information on every compensable injury occurring at a covered employer.

Still, eligible workplace injuries may go unreported. For example, WCIS may not receive injury reports because injured workers or their physicians have not reported injuries to their employers. Even if a report is made, the employer or insurer may not consider the injury to be compensable and reject the claim. Alternatively, a claim may be filed and paid, but the employer, insurer or third-party administrator may neglect to report the claim information to WCIS.

Barriers to reporting can occur for different reasons and are described in the report. A substantial disparity between the number of injuries that are reported and the actual number that occur has several implications. First, if policymakers think that the number of workplace injuries and illnesses is smaller than it actually is, they may devote fewer resources to prevention. Second, reporting may be particularly incomplete for specific conditions, groups of workers and employer types. As a consequence, we may pay less attention to safety for those conditions, workers and employers for which under-reporting is the greatest. In addition, when compensable work-related injuries and illnesses are not filed as workers' compensation cases, benefits go unpaid, and the costs of these injuries may be shifted to workers and their families, to private health insurance, and to government disability and health insurance programs.

This study addresses the reporting of lost-time injuries to WCIS for injuries occurring during two time periods: January 1, 2003 through December 31, 2003; and July 1, 2004, through June 30, 2005. These periods are just before and just after the 2004 workers’ compensation reform legislation. Researchers chose these time periods to see if they could find a substantial change in reporting that might have been influenced by the 2004 legislation. The study also compares reporting in the California workers’ compensation system with that in six other states: Minnesota, New Mexico, Oregon, Washington, Wisconsin and West Virginia.

CHSWC contracted with Boston University to conduct this injury-reporting study, using a large sample of WCIS data and Bureau of Labor Statistics (BLS) data and applying a capture-recapture analysis methodology. The report entitled “Reporting of Workers' Compensation Injuries in California: How Many are Missed?” was approved in 2008.

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\(^{54}\) Ibid.

\(^{55}\) As of 2008, 29 other state governments host a public Internet workers’ compensation coverage look-up website.

\(^{56}\) Ibid. AB 507, as all legislation, considered costs.
Findings

- The most conservative estimate of reporting of workplace injuries in California suggests that 21 percent to 25 percent of lost-time injuries go unreported to WCIS. A less conservative estimate of under-reporting implies that 40 percent of lost-time injuries went unreported.

- Reasonable alternate scenarios allow for the likelihood that reporting an injury to BLS increases the likelihood that it will be reported to WCIS. Under these circumstances, researchers estimate that only about two-thirds of injuries are reported to WCIS. This incomplete reporting places California in the middle of the seven states researchers studied.

- There appears to have been an increase in reporting from injuries occurring in 2003 to injuries between July 2004 and June 2005. This suggests that the 2004 reforms probably did not lead to a decline in the reporting of injuries to WCIS. Researchers do not know whether this increase is a random fluctuation or a stable change.

From a policy perspective, benefit payment is at least as important as injury reporting. Researchers do not know how many workers receive benefits for injuries that go unreported to WCIS. It seems likely that benefits have been paid but not reported in many cases, but evidence about this is inadequate to support an estimate.

- Unreported injuries may be eligible for workers' compensation benefits but receive none. In this case, the unpaid workers' compensation benefits pose a burden to the injured workers and their families, health insurance programs, and public and private disability programs.

Recommendations

- CHSWC, DWC, the California Department of Public Health (CDPH), DLSR, and Cal/OSHA should convene an interagency under-reporting task force to develop a plan for improving WCIS reporting. This would include identifying late reporting, but also identifying employers, insurers and third-party administrators that do not report compensated injuries. This task force could include not only knowledgeable people from these agencies, but also people involved in other relevant activities, like California's reporting to the BLS survey and planning for the California Trauma Registry.

Specific recommendations include:

- DWC could strengthen its efforts to identify problem areas in reporting of compensated injuries. This would include identifying late reporting, but also identifying employers, insurers and third-party administrators that do not report compensated injuries. In doing so, DWC may identify problems in the way reporting systems work, in addition to identifying noncompliance with reporting requirements.

- DWC and Cal/OSHA could consider collaborating to identify employers who under-report injuries. Employers who engage in substantial under-reporting to either system could be given substantial penalties, and the program and penalties could be publicized. DWC could also consider penalties for late reporting to WCIS. If current laws and regulations are inadequate to support such a program, this could be addressed.

- DWC could begin an inquiry into the 40-50 percent of reported claims that lack information about benefit payments. DWC could draw a random sample of such cases with dates of injury at least three years in the past from a subset of claims administrators for insurers, third-party administrators and self-insured employers. Initially the claims administrators might be chosen because they have a relatively high proportion of cases lacking benefit reports. DWC could submit the sample to the trading partners and request up-to-date information on benefit payments.
and claim status. From this information and discussions with trading partners, DWC may be able to diagnose systematic problems and fashion solutions.

- California collects data on hospital and emergency room discharges and from ambulatory surgery clinics through Medical Information Reporting for California (MIRCAL) system. DIR might explore whether these data could be used to look for unreported workplace injuries and illnesses. The data contain diagnosis and social security number of the patient and identify the expected source of payment. They do not identify the employer. If WCIS data included state EDD account numbers (EANs), cross-matching with EDD wage files to determine the employer would be easier and more accurate than otherwise. It is not known if there are any legal issues precluding this use of MIRCal data.

- CHSWC could explore linking other state occupational safety and health information systems with WCIS data to determine whether injuries and illnesses have been reported and compensated where appropriate.

- DIR could explore automating the doctor’s first report of occupational injury or illness and requiring all doctors’ first reports to be electronically transmitted. For example, reports could be filled out on the Internet and automatically transmitted to DIR. These reports could be compared with WCIS files to determine where under-reporting occurs.

- DWC may want to consider rejecting reports of injury with invalid or incorrect EINs. These numbers can be valuable for potential uses of WCIS, including but not limited to the under-reporting issue.

- DWC should consider adding the state EAN as a required field in the First Report of Injury. This would allow easier and more accurate linkage with EDD wage files and other state data collected from employers.

- California has recently added workers’ compensation questions to the states’ Behavioral Risk Factor Surveillance System (BRFSS) survey. This could be used as another way of getting a handle on the extent of workers’ compensation under-reporting. Over time, it could be used to determine whether reporting is improving.

For further Information …

All CHSWC reports concerning fraud may be viewed in their entirety at http://www.dir.ca.gov/chswc/FraudPage1.html

http://www.insurance.ca.gov/0300-fraud/upload/FraudTaskReport05-08.pdf

Information and descriptions of ongoing CHSWC anti-fraud activities are contained in CHSWC Annual Reports.
http://www.dir.ca.gov/chswc/AnnualReportpage1.html


“Reporting of Workers’ Compensation Injuries in California: How Many are Missed?” (August 2008).
SPECIAL REPORT: IMPROVEMENTS IN IDENTIFYING ILLEGALLY UNINSURED EMPLOYERS

Introduction

All employers in California except the State are required to provide workers’ compensation coverage for their employees through the purchase of workers’ compensation insurance or by being certified by the State as permissibly self-insured. However, not all employers comply with the law to obtain workers’ compensation coverage for their employees.

The Uninsured Employers Benefits Trust Fund (UEBTF) was established to provide for the payment of workers’ compensation benefits to injured employees of illegally uninsured employers. Labor Code Sections 3710 through 3732 describe the operation of the Fund, and Labor Code Section 62.5 describes the funding mechanism for UEBTF. All costs and expenses are paid by employers in the State of California.

The workers’ compensation community has expressed concern with several aspects of the program. In response, the Commission on Health and Safety and Workers’ Compensation (CHSWC) requested that Commission staff participate in addressing some of the emerging issues regarding uninsured employer program including:

- Access to benefits by injured workers of illegally uninsured employers.
- Instruction guides and information provided by Information & Assistance (I&A) Officers.
- Identification of uninsured employers.

Administration of the UEBTF Program

The UEBTF is administered by the director of the California Department of Industrial Relations (DIR). Claims are adjusted for the DIR director by the UEBTF Claims Unit in the Division of Workers’ Compensation (DWC). UEBTF pursues reimbursement of expenditures from the responsible employers through all available avenues, including filing liens against their property. Litigation for UEBTF is conducted in the name of the director of the DIR by the Office of the Director Legal Unit.

Cases involving the Fund may only be heard by the Workers’ Compensation Appeals Board (WCAB) of San Francisco, Los Angeles, Van Nuys, Anaheim, Sacramento, or San Diego in the absence of good cause and the with the consent of the director. UEBTF, moreover, cannot be joined in a proceeding unless the alleged uninsured employer has come under the jurisdiction of WCAB, either by making a general appearance or by being served with the application and a notice of lawsuit per Labor Code Section 3716.  

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UEBTF Payment Procedures

Several features of UEBTF make obtaining timely reimbursement or payment for medical treatment burdensome, and other features are beneficial only to those injured workers who are successful with their claim, including:

- A valid demand on UEBTF cannot be made unless the illegally uninsured employer either appeared or was served with the application and a notice of lawsuit before the regular hearing.
- UEBTF can make payments before the award issues if the injury, disability, and lack of insurance are not seriously in dispute.
- On receipt of the demand and a copy of the findings and award, UEBTF is mandated to begin payment of the award.
- If the uninsured employer has filed for bankruptcy, the injured worker must show that he or she filed a proof of claim in the bankruptcy proceeding and requested relief from the automatic stay of proceedings issued by the bankruptcy court. [Ortiz v. WCAB (1992) 4 CA4th 392, 57 CCC 172.]
- To facilitate prompt delivery of benefits, the DIR director has the discretion to pay compensation and provide medical treatment before WCAB makes an award.
- If an illegally uninsured employer does not pay an award against it within 10 days or post bond to secure the payment, the injured worker can make a written demand on UEBTF for payment of the award. Detailed instructions for injured workers were updated in May 2009 and are provided at http://www.dir.ca.gov/dwc/IWguides.html.

It is important that eligible injured workers obtain access to these benefits as their right, despite the legal complications and perceived delays.

Legal Difficulties in Accessing UEBTF Benefits and Related Costs

CHSWC has identified attorneys, injured workers and injured worker advocates who all have experienced difficulty with the process of obtaining jurisdiction and resulting joinder. People familiar with the process agree that there are barriers, and even DIR acknowledges the paradox of requiring refined legal expertise to obtain a benefit resulting from a workplace injury when the employer is suspected to be uninsured.

In particular, injured workers who do not have an experienced attorney are at a disadvantage when navigating the legal requirements for obtaining jurisdiction. Further, language barriers and lack of experience with a court system add another layer of complications to access justice and receive due process.

A related and larger challenge is to identify uninsured employers before a workplace injury occurs and before a workers’ compensation claim is made. If uninsured employers could be detected and brought into compliance, then the proper insurance of employer liabilities would not require such complicated steps as those of access to the UEBTF.
Past Recommendations to Address Difficulties in Accessing UEBTF Benefits and Related Costs

CHSWC reviewed the access difficulties and described findings including:

- Identifying and locating uninsured employers along with proper compliance enforcement would reduce the costs to all stakeholders of the workers’ compensation system.

- The surest way to reduce the long-term cost of UEBTF is to reduce the prevalence of illegally uninsured employers. In the CHSWC 1998 study on illegally uninsured employers, the rate of uninsured employers was found to be 9 percent of the system as a whole. For new employers and in the targeted industry of auto/truck repair, 15 percent and 20 percent, respectively, were uninsured.

- Labor Code Section 90.3 provided for a program to identify illegally uninsured employers through targeting and data matching. Due to lack of resources, this program was never implemented. In 2007, Senate Bill (SB) 869 was signed into law and set forth administrative funding as well as mandatory reporting on the program’s performance.

- There is a lack of knowledge of UEBTF and civil procedure in the workers’ compensation community.

- Unrepresented applicants lack easy access to UEBTF. Of some 1,800 claims filed during the 2007-2008 fiscal year, only four or five were filed by unrepresented applicants according to UEBTF. Injured workers will probably continue to require attorneys if they wish to pursue any of the additional remedies available against illegally uninsured employers.

- Applicants’ attorneys have consistently complained about the many technicalities and formalities with which they must comply to file a valid claim. The process cannot be greatly streamlined because it is necessary to build a case that can ultimately lead to a civil judgment against the illegally uninsured employer.

- Medical providers incur increased losses on liens while waiting to get paid:
  - UEBTF does not get involved early enough in the claims.
  - According to UEBTF, it learns of a claim on an average of 10 months after the injury.
  - Frequently, the claim is not promptly pursued by the injured worker because the employer pays bills directly for a while.
  - Other times, the injured worker goes without treatment until a critical situation arises or he or she initially receives treatment from Medi-Cal or another program.

Actions and Solutions for Improvement

- DWC initiated in late May 2009 a pilot enhanced customer service initiative in one I&A Office to assist unrepresented injured workers in properly identifying employers and serving papers. The pilot will formally review results after one year, but has already reported positive outcomes. If successful, the initiative may be replicated throughout the State, provided available resources.

- DWC released updated guides for filing UEBTF claims in May 2009, so as to clarify and streamline instructions.

- CHSWC has funded the development of a UEBTF booklet in simple language for use by uninsured workers. It will be available online and in I&A Offices and will be translated into Spanish.

Progress is being made in following the requirements of Labor Code Section 90.3, as evidenced by the Division of Labor Standards Enforcement (DLSE) release in June 2009 of the first report required by
Labor Code Section 90.3. The following is a more detailed background and description of these solutions.

**Pilot I&A Enhanced Customer Service Initiative**

As stated earlier, injured workers face unique barriers in pursuing claims when the employer is uninsured. Accessing UEBTF is procedurally complicated.

Before UEBTF can be joined in a case, the employer must be correctly identified using the legal name and then served notice of a claim in order to establish the court's jurisdiction. The process discourages attorneys and deters most injured workers without attorneys. The results are poor outcomes and cost shifting.

CHSWC participated with DWC and other stakeholders in the development of a plan to propose a "customer service initiative" in one I&A office in Salinas, in Northern California, to assist unrepresented (in pro per) injured workers in pursuing claims with uninsured employers and UEBTF.

**Background to the I&A Enhanced Customer Service Initiative**

The DWC I&A Unit provides information and assistance to employees, employers, labor unions, insurance carriers, physicians, attorneys, and other interested parties concerning rights, benefits and obligations under California's workers' compensation laws. The unit plays a major role in reducing litigation before the WCAB and is often the first DWC contact for injured workers.

The I&A Officer answers questions and assists injured workers, provides written materials and holds meetings to resolve problems with claims. Most of their services are designed to help injured workers who do not have an attorney. There are 24 I&A offices in the State.

DWC reports that 3,100 cases per year come through I&A offices, of which 1,700 become UEBTF claims. Virtually no UEBTF claims are prosecuted by unrepresented workers, implying that UEBTF procedures are a particular barrier to unrepresented injured workers. In the case of UEBTF claims, while DWC produces a Fact Sheet and Guides and I&A offices distribute and mail copies to injured workers who request them, the paperwork requirements can be complicated and confusing for injured workers who do not have an attorney. A customer service initiative was developed to test whether more assistance is needed or is productive in assisting injured workers.

CHSWC has published useful guides for injured workers, and it has reported on various barriers to the workers' compensation system for low-wage workers and other categories of workers with a view to improving access to the workers' compensation system for all injured workers. In particular, CHSWC has reported on UEBTF, including a review of the statutory provisions and DWC guidance materials that detail the required steps in filing a UEBTF claim. CHSWC has also been invited to and has participated in stakeholder meetings about the UEBTF claims process.

**The I&A Enhanced Customer Service Initiative**

In the pilot, the role of the I&A Officer is expanded to assisting injured workers by:

- Helping to name correctly the employer, possibly collecting several business names that the employer uses, and helping to verify insurance coverage information from the employer, using the correct legal name.

- If the employer is suspected to be uninsured, actions include: arranging for service of process to establish personal jurisdiction over the employer; assisting in joining the UEBTF and requesting benefits from the UEBTF; obtaining a WCAB hearing (filing Declaration of Readiness to Proceed, Application for Discretionary Payments); and reporting suspected fraud (suspected misdemeanor or felony crimes) to DLSE.

Once the unique demands of a UEBTF claim have been completed, the I&A process reverts to normal customer service in the provision of information and assistance.
The expectation is that rededicated efforts to provide customer service in UEBTF cases will demonstrate practices that are productive in strengthening the workers’ compensation system. Feedback from the I&A Officers themselves will be critical and will be documented for reporting purposes.

The additional assistance provided by I&A Officers requires additional training, including additional investigative expertise that is already available within the DIR.

Data Collection and Evaluation

In order to evaluate the pilot, data will be collected by the I&A Officer. A report will be prepared based on data collected and observed results. Recommendations for improvement will be included. The report will be prepared by CHSWC, with the assistance of I&A and DWC.

Duration of Initiative

This initiative began in the I&A Office in Salinas, California, on June 1, 2009.

DWC UEBTF Guides

DWC produces fact sheets and guides to explain the process and required forms in UEBTF claims, specifically, Fact Sheet F and I&A Guides 16, 16A, and 16B. The Guides include required forms or sample forms with additional instructions. The Guides were recently updated by DWC in April 2009 and May 2009, and the Fact Sheet was last updated in 2006. This information is available at: http://www.dir.ca.gov/dwc/iwguides.html

CHSWC UEBTF Booklet

Injured workers, legal services organizations, and agencies that investigate workers’ compensation fraud have expressed a need for these workers to receive help and support in following the UEBTF claims steps described above UEBTF Guides section, as well as the Pilot I&A Enhanced Customer Service Initiative section.

DWC produces basic materials on steps to take in a UEBTF case. Based on stakeholder input, further educational work is needed to clarify and fully explain the procedural steps set forth in the DWC materials with easy-to-understand terminology and examples.

Funding has been approved for University of California (UC), Berkeley staff to assist CHSWC in developing a fully designed educational booklet based on DWC materials and advisory input from members of the workers’ compensation community.

This project is being coordinated with the DWC’s project to streamline the UEBTF process and offer additional services to injured workers of uninsured employers and to pilot these services with the I&A office in Salinas. The booklet was drafted based on the design of the pilot.

The booklet will be available online and distributed at I&A Offices; a Spanish version will also be available.
Labor Code Section 90.3 Data Matching, Targeting and Reporting Program

Background

A series of pilot studies were conducted in 1998 to identify illegally uninsured employers and bring them into compliance. Each pilot project targeted a specific group of employers. (See http://www.dir.ca.gov/chswc/uefintro.html.) The results of these pilot projects provided impetus to create Labor Code Section 90.3.

In 2002, Labor Code Section 90.3 (AB 749) created a program “for targeting employers in industries with the highest incidence of unlawfully uninsured employers” and specified multi-agency/multi-organization data sources to be used. The law also required annual reporting to the Legislature on the effectiveness of the program.

Due to a lack of enabling funding authority, the program was never initiated, and the previously mentioned pilot projects served as the only quantitative evidence of the effectiveness of multi-agency/multi-source data matching methodologies to detect uninsured employers.

In 2007, Senate Bill (SB) 869 amended Labor Code Section 90.3 to further specify and require a program that “systematically identifies unlawfully uninsured employers” and allowed for targeting methods, along with other methods such as random sampling. Labor Code Section 90.3 provided the needed enabling funding language and refined the type of annual reporting to the Legislature (and to the public via the Internet) on the effectiveness of the program. The reporting requirements help guide the type of program that needs to be conducted. For example, the terms “matching records” and “matched to records” are used in order to require specific statistics, methodologies and measureable results; and, reported statistics should “permit analysis and estimation of the percentage of unlawfully uninsured employers that do not report to the Employment Development Department (EDD).”

The reporting requirements could be improved in order to guide implementation, but the report need “not be limited to” the specified results numbers listed in Labor Code Section 90.3(d)(1)-(8).

Recent DIR report

In June 2009, the first report required under the amended Labor Code 90.3 was released by DIR. The report is available at http://www.dir.ca.gov/dlse/UUEEP-2008.pdf.

The reported results of the program yielded 123 citations issued per Labor Code Section 3722(a) for not being insured and 33 citations issued per Labor Code Section 3722(b) for being found to not be insured in the past. Of the $484,489 in workers’ compensation penalties assessed, $151,783 in workers’ compensation penalties were collected, and $76,000 in citations were administratively dismissed. The report concludes that the efforts have yielded positive results in DLSE’s continued work in combating the underground economy and that DLSE will continue to refine the efficiency and effectiveness of this program for the benefit of both employees and employers.

Labor Code Section 90.3(d) June 2009 Report – Comments and Recommendations

The report’s “Program Results” section could be split into two sections. The first section would be a methodology section. It could go into greater detail on how the quarterly samples were drawn from EDD. It could also explain any targeting methodologies including methods that might be initiated in the future.

The next section could be the Results section and would clearly state the bottom line. The tables would be the supporting evidence in a discussion of the results and findings. One method of reporting required results could be the literal listing of required information by line item: Labor Code Section 90.3(d)(1), Labor Code Section 90.3(d)(2), and so on. As such, it is not easily evident whether the report is complying with all of the requirements.

The report is not in compliance with all of the requirements, specifically:

- The requirement in Labor Code Section 90.3(d)(5) to “permit analysis and estimation of the percentage of unlawfully uninsured employers that do not report wages to the EDD” is missing.
The Report does not provide results of the effort to obtain information or data going in the other direction, which would be verified uninsured data from records from UEBTF or DWC (or both) matched to EDD.

This element of the report might be conducted in the future.

Recommendations

Recommendation 1: Explain the data matching and contact process in a Methodology Section – is “contact” sending letters out? Is DLSE Form 601 sent out? How is “investigated” defined? Is it different from “inspected,” as written in Labor Code Section 90.3(d)(6)? Attach to the report any form letters or templates that are used in the program.

Recommendation 2: Report the results as a written Summary of Results by line item: Labor Code Section 90.3(d)(1), Labor Code Section 90.3(d)(2), and so on. Refer to the table only to support the written Summary of Results. Provide any calculations that are not obvious in footnotes; ideally, any results which require a calculation should be footnoted or otherwise explained, as a courtesy to the reader.

Recommendation 3: Consider re-writing the report for the DIR director with the assistance of CHSWC so that the findings and the data are more clearly stated; this would serve as a process and template for an improved report next year when it is due no later than March 1st of each year, per Labor Code Section 90.3(d).

Recommendation 4: Consider discussing in the report the problems with the process and areas in need of improvement, as suggested in Labor Code Section 90.3(d)(4).

Recommendation 5: Given that the matching process led to uncovering new information about employers with some unstated yet penalty-yielding percentage being found to be uninsured, consider expanding the program and the sampling number to more than 500 per quarter, to bring more employers into compliance, assuming 500 per quarter is already feasible. (Would an expanded program that increased the penalties also serve to more adequately fund the program?)

Recommendation 6: Consider explaining why the assessed penalty amount is different from the amount collected and consider tracking that difference over time in future reports if collections are expected to eventually increase.

Recommendation 7: Consider providing in the report the number of full-time employees (FTEs) expended in the program and indicate whether any Memoranda of Understanding (MOUs) established included transfer of funds.

Recommendation 8: Consider initiating any number of targeted programs as well, provided it is a program that “systematically identifies” potentially illegally uninsured employers. The 1998 Pilot Studies systematically targeted employers who: once had experience modification ratings (Ex-mods); employers in industries disproportionately represented in UEBTF claims; and random samples of new employers. All of these matching programs can be replicated by DIR, instead of by the designing contractor. They are described in the Appendix and in the report at: http://www.dir.ca.gov/chswc/uefinintro.html.

Recommendation 9: Consider establishing a schedule whereby WCIRB provides extracts from its database consisting of employers with expired policies, so that those uninsured employers may also be targeted for investigation for failure to maintain coverage. This might improve the accuracy and efficiency of the Labor Code Section 90.3 program in screening for unlawfully uninsured employers.

Recommendation 10: Mark or annotate any data in the table which are preliminary or based on “ongoing” investigation, or report only data which are considered final.
SPECIAL REPORT: OCCUPATIONAL AND NON-OCCUPATIONAL INTEGRATED CARE

Introduction

Group health costs have been rising much more quickly than inflation and wages. Costs have been rising even more quickly for treatment of occupational injuries in the California’s workers’ compensation system. This creates major financial challenges for employers, especially those in industries with already high workers’ compensation costs. Furthermore, group health care and workers’ compensation medical care are typically delivered through separate provider systems, resulting in unnecessary, duplicative and contraindicated treatment, and inefficient administration.

Integration of group health and workers’ compensation medical care is an alternative to two separate systems of medical care. The basic concept of occupational and non-occupational integrated care (ONIC) is having the same physician or medical group treat all conditions, both occupational and non-occupational, regardless of the cause of illness. Moving beyond this basic concept, the insurance products could also be integrated. An integrated system could offer savings on medical utilization, unit pricing and administrative expenses while potentially offering improvements in the quality of care. A secondary advantage of integration could be expanding access to affordable medical insurance.

Integrated Occupational and Non-Occupational Medical Care Pilot

Phase One: Partnerships

The initial phase of this project involved a partnership between the Commission on Health and Safety and Workers’ Compensation (CHSWC), the California HealthCare Foundation (CHCF), DMS Facility Services, and the Service Employees International Union (SEIU) Local 1877 in a pilot program of integrated occupational and non-occupational medical care.

SEIU Local 1877 requested assistance from CHSWC and the University of California (UC), Berkeley with negotiating a collective bargaining agreement that would integrate both occupational and non-occupational medical treatment under the union’s Taft-Hartley Health and Welfare Trust. A pilot program integrating occupational and non-occupational care began in February 2008 between DMS Facility Services, a unionized employer with employees throughout California, and SEIU 1877. The pilot is part of a carve-out agreement. The pilot uses Kaiser Permanente for delivery of both workers’ compensation medical care and group health benefits. The goal of the pilot is to identify areas of administrative savings and ways to reduce litigation. UC Berkeley is conducting data analysis for pricing issues and developing the evaluation strategy.

Savings are expected in medical utilization, indemnity costs, and administration. Medical services are expected to be delivered with fewer delays and disputes, enabling injured employees to recover more fully and return to work sooner.

Phase Two: Evaluating the Potential for Savings Under Integration

The current phase of the integration of care project involves a partnership between CHSWC, CHCF and UC Berkeley. Led by Frank Neuhauser at UC Berkeley, the project team has calculated the administrative and overhead cost of delivering occupational medical care under workers’ compensation insurance. The administrative costs are carefully segregated into loss adjustment expense, underwriting expenses and profit. Each of these cost categories from workers’ compensation is then compared to the counterpart in private health insurance.

This study confirms that workers’ compensation has administrative costs several times higher than private health insurance and that integration offers the opportunity for substantial savings as discussed below.
Administrative Cost of Insurance

- In California, based on review of all rate filings by insurers between 1999 and 2009, the administrative cost of delivering medical treatment for occupational injuries and illnesses through workers’ compensation insurance is between 52 percent and 57 percent of insurance premiums.

- A review of aggregate data on 37 other states finds similar, or possibly higher, administrative costs for workers’ compensation.

- The comparable cost for private health insurance, according to the Centers for Medicare and Medicaid Services, averaged 12.4 percent of premiums.

Savings Under 24-hour Care

- Integrating occupational and non-occupational medical treatment under the more efficient health insurance system would reduce administrative costs and produce large one-time savings from switching insurance models.

- Nationally, savings in the first ten years would be between $490 billion and $560 billion.

- In California, integration would produce savings in the first ten years of $100 billion to $120 billion.

Paying for Universal Coverage

- Using prior estimates of covering the uninsured, the study projects the ten-year cost of universal coverage to be between $715 billion and $1,870 billion nationally.

- Depending on the ultimate cost of universal coverage, the authors estimate the savings from 24-hour care could cover 26 percent to 78 percent of the cost of covering the uninsured.

The study cautions that 24-hour care is difficult to implement in the absence of near universal coverage for the working-age population. However, the savings from integration would cover a substantial fraction of extending coverage to the currently uninsured.

Next Steps

- The working paper is now available. CHSWC and CHCF will aid in the dissemination of draft materials for public comment.

- CHSWC will create an Advisory Group to discuss the findings of the study.

- The National Academy of Social Insurance (NASI) is interested in hosting a national conference on the issue of integration using the California example as a key focus. This conference is targeted for winter 2010.

For further information …

“Integrating Group Health and Workers’ Compensation Care Factsheet” (2008).
http://www.dir.ca.gov/chswc/Reports/CHSWC_IntegrationofCareFactsheet.pdf

Factsheet on Integrated Occupational-Non-Occupational Medical Care

The following factsheet provides an overview of the benefits of integration of occupational and non-occupational medical care. The factsheet describes how different levels of integration would provide different benefits.
Factsheet

Integrating Group Health and Workers’ Compensation Medical Care

What Is Integrated Health Care?
Traditionally, employers and their employees have been required to deal with two separate systems to obtain employee medical care. Non-occupational medical conditions have been treated through group health plans, while occupational injuries and illnesses have been treated through the workers’ compensation system.

With integrated health care, the same individual physician or medical group sees the employee for both occupational and non-occupational conditions. Starting with this simple concept, integration can be implemented in many ways, as described below.

Why Integrate Care?
Rising premiums for group health plans and the high costs of workers’ compensation continue to threaten employers’ profitability. The same factors can also limit employees’ access to group health coverage as the availability of affordable coverage declines.

Integrating care in the two systems can reduce costs by eliminating duplicative treatment and reducing the costly administration of workers’ compensation medical care. Integration can also improve quality of care through better coordination of care and broader access to treatment. The form and extent of integration determine the degree of improvement in quality of care and level of cost savings.

This factsheet describes findings from a pilot project conducted in 2006-08 to integrate medical care for unionized janitorial workers in California. The principal participants were the workers’ union, Service Employees International Union (SEIU) Local 1877, and a major janitorial employer, DMS Facility Services. Collaborating organizations included Kaiser Permanente, workers’ compensation insurers, and workers’ compensation brokers. The project was managed by the California Commission on Health and Safety and Workers’ Compensation and the University of California, Berkeley’s Survey Research Center and Institute for Research on Labor and Employment. Partial support was provided by a grant from the California HealthCare Foundation.

Achieving Integration
The important changes involved in integrating insurance as well as medical treatment will face resistance from entrenched interests. Our experience is that to be successful, implementing integration beyond simply using the same provider requires several conditions:

- Rising workers’ compensation premium rates to motivate employers.
- Commitment within an employer’s organization from both the group health and workers’ compensation administrators.

—continued—
Achieving Integration  —continued—

- A large enough pool of covered workers to motivate insurers to offer new, innovative products. This may involve a very large employer or an association of employers.
- A strong advocate at the highest level of the employer’s organization or employer association to drive the change despite the resistance of many established interests.

Group health and workers’ compensation are controlled by two different, complex, and often mismatched legal systems. Employers and employees can move integration forward despite these incompatibilities. However, legislative and regulatory changes would facilitate integration, reduce costs, and increase benefits. These changes could include:

- Aligning the definitions of necessary medical treatment in the two systems.
- Reducing and/or eliminating many reporting requirements that exist under workers’ compensation but are unnecessary under integration.
- Placing medical treatment dispute resolution under a single process for both occupational and non-occupational conditions.

Levels of Integration

The extent of integration is an important factor in cost and quality of care.

Basic Integration

At its most basic level, integrating care means that the same individual physician or medical group sees the employee for both occupational and non-occupational medical conditions.

What are the benefits of basic integration?

Basic integration can reduce costs by avoiding duplicative care. It can also improve the quality of care through better coordination of medical tests and treatment, as well as avoiding unnecessary or inconsistent care.

How can care be integrated at this level?

The employer and workers’ compensation claims administrator can integrate care at this level by selecting and offering to employees the same provider for both group health and workers’ compensation medical care, and by requiring the provider to fully coordinate all tests and treatment, including pharmaceuticals.

Cost of Delivering Treatment Through Group Health and Workers’ Compensation

In California from 1994-2006, the average total cost of delivering $1 of medical treatment through group health plans (A) was much lower than the cost of delivering it through workers’ compensation (B). The cost through workers’ compensation was even higher in 2004-06 (C) after changes were made in the system. (Data derived from Workers’ Compensation Insurance Rating Bureau publications, 2007, and Center for Policy and Research publications, 2005.)

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.25</td>
<td>$1.65</td>
<td>$3.25</td>
</tr>
<tr>
<td>$1.00</td>
<td>$1.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>Total = $1.25</td>
<td>$2.65</td>
<td>Total = $4.25</td>
</tr>
</tbody>
</table>

Significant potential savings in administrative costs from integrating medical care:

- Administrative Costs (claims handling, operating expenses, insurer profit, etc.)
- Medical Treatment Costs (payments to doctors, hospitals, pharmacies, etc.)
Greater Integration

Care can be further integrated under a single medical provider or medical group by combining the insurance premiums for both occupational and non-occupational medical treatment in a single insurance product.

*What are the benefits of this type of integration?*

In addition to the costs saved with basic integration, this type of integration offers the potential to save significant administrative costs. The main driver of workers' compensation medical care costs is the administrative expense to review and approve treatment recommendations and pay providers. This can be 8 to 15 times higher than in group health, and it consumes two-thirds or more of premium dollars related to medical benefits.

*How can care be integrated at this level?*

Combining insurance means paying a single premium to the group health insurer to cover occupational and non-occupational treatment. Usually this is a single premium per worker per month (the capitated rate commonly used by health insurers). This approach eliminates many of the administrative processes (e.g., utilization review, bill review, bill payment, etc.) that drive high administrative costs in workers' compensation.

Full Integration

Full integration means that the employee receives the same medical benefits regardless of whether his or her condition is work-related. No distinctions are needed regarding causation to determine whether the employee may receive care, whether the employee may see his or her regular physician, or whether deductibles or co-payments are required.

*What are the benefits of full integration?*

Full integration completely eliminates the expensive administration and overhead that characterize workers' compensation medical treatment. It eliminates disputes and delays in medical treatment related to identifying the source of payment, and eliminates the inefficient overlap between workers' compensation and group health.

*How can care be integrated at this level?*

Full integration requires health insurance coverage for the entire working-age population. It may require that workers share in some of the costs of care. If these structural changes can be made, workers will have greater access to care and total costs will be substantially reduced.

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**Benefits of Integrating Care**

This chart ranks the benefits of integrating care at different levels, with A+ indicating the best outcome and F indicating the worst.

<table>
<thead>
<tr>
<th></th>
<th>No Integration</th>
<th>Basic Integration</th>
<th>Greater Integration</th>
<th>Full Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>C</td>
<td>B</td>
<td>B+</td>
<td>A</td>
</tr>
<tr>
<td>Access and Timeliness of Care</td>
<td>D</td>
<td>C</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Disputes and Resolution</td>
<td>F</td>
<td>D</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>Administrative Streamlining</td>
<td>F</td>
<td>C-</td>
<td>B</td>
<td>A+</td>
</tr>
<tr>
<td>Cost Savings</td>
<td>F</td>
<td>C-</td>
<td>B+</td>
<td>A+</td>
</tr>
</tbody>
</table>
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SPECIAL REPORT: CLAIMS ADJUSTER AND BILL REVIEWER
TRAINING AND CERTIFICATION BY INSURERS

Introduction

At the November 6, 2008 meeting of the Commission on Health and Safety and Workers’ Compensation (CHSWC), the Commission instructed staff to review the regulation, compliance and enforcement of claims adjuster and bill reviewer training and certification.

At the December 12, 2008 CHSWC meeting, the draft report which reviewed regulation, compliance and enforcement of claims adjuster and bill reviewer training and certification was presented and approved for distribution for public comment and feedback. The Commission also requested that CHSWC staff hold an Advisory Group meeting to look further into the oversight process for claims adjuster and bill reviewer certification.

Background

The California Department of Insurance (CDI) is directed by statute to require insurers to assure that the individuals responsible for handling their claims will meet a minimum standard of training or experience. “Insurer” is defined for this purpose to mean a workers’ compensation insurance carrier, a self-insured employer, or a third-party administrator (TPA) for a self-insured employer. The regulations allow those insurers to manage the training and to designate as trained or experienced the individuals who have received the required training, including continuing education.

Three different levels of claims adjusting responsibility may be designated, each with its own required training and post-designation continuing education. The levels are Claims Adjuster, Medical-Only Claims Adjuster, and Medical Bill Reviewer. After an individual has been designated as “trained” at one of these levels, the regulations require periodic post-designation training. There is also a provision for designation of “experienced” claims handlers in each level. The “experienced” designation served to grandfather in many working claims handlers at the time the new program took effect, and it serves to qualify individuals to supervise trainees handling claims prior to completing training. As an alternative to the specified claims adjusting experience, an individual may be designated as an Experienced Claims Adjuster after passing the comprehensive examination issued by the Department of Industrial Relations (DIR) to qualify as a self-insurance administrator.

The designation of a trained or experienced adjuster or reviewer is issued by the insurer whether or not the insurer is the direct employer. Records of training or experience must be obtained and retained by the insurer. The designation is portable with the individual. The only filings required with CDI are the insurer’s certification of the total numbers of persons adjusting its claims and the numbers of those persons who are designated as trained or experienced, as well as the insurer’s certification that the training complies with the requirements.

Insurers (as defined to include self-insured employers and third-party adjusters) are the regulated entities under this program; this is not an adjuster-licensing program. No penalties are prescribed for insurers who do not comply. CDI does not have jurisdiction over self-insured employers or their third-party adjusting agents. Both CDI and the DIR are entitled to access to insurer (as defined) records of claims handlers’ training and experience, so verification of compliance is possible through one department if not the other.

Statute

California Insurance Code Section 11761 was enacted in 2003 to require the Insurance Commissioner to adopt “regulations setting forth the minimum standards of training, experience, and skill that workers' compensation claims adjusters must possess to perform their duties with regard to workers' compensation
claims.” The statute includes medical bill reviewers for workers’ compensation and requires that insurers certify that adjusters and bill reviewers meet the standards set by the Commissioner.

Subdivision (d) of the statute defines “insurer” to include workers’ compensation insurers, self-insured employers, and third-party administrators for self-insured employers. This language can give rise to some possibly unexpected results. For example, an insurer that uses third-party adjusting agents is required to make the certification rather than delegate the responsibility to its adjusting agents. This report uses the term “insurer” according to the statutory meaning.

**Regulations**

Regulations became effective on February 22, 2006, and are found in the California Code of Regulations, Title 10, Sections 2592 through 2592.14.

The regulations provide definitions, specify the qualifications an individual must meet to be designated by an insurer in any of six designations, prescribe the duty of insurers to file certifications with CDI, and prescribe the duty of insurers to maintain certain records and furnish them to regulators or to designated adjusters or reviewers.

**Training and Experience**

The six available designations are:

<table>
<thead>
<tr>
<th>Trained Claims Adjuster</th>
<th>Experienced Claims Adjuster</th>
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<tbody>
<tr>
<td>Trained Medical-Only Claims Adjuster</td>
<td>Experienced Medical-Only Claims Adjuster</td>
</tr>
<tr>
<td>Trained Medical Bill Reviewer</td>
<td>Experienced Medical Bill Reviewer</td>
</tr>
</tbody>
</table>

For each level of trained claims handler, regulations specify the number of hours of training, including classroom hours and the subjects to be taught. The regulations also specify continuing education, called post-designation training, which must be maintained. In addition, the regulations state the qualifications of instructors and that insurers must certify that the training meets the requirements. The curriculum content is not otherwise regulated or subject to CDI approval.

The regulations permit designation of an “experienced” adjuster or reviewer for two purposes. First, adjusters or reviewers who had already acquired the requisite years of experience were grandfathered in when the program began, without the necessity of the initial training to become designated. Second, adjusters or reviewers who are designated as “experienced” may supervise trainees who are handling claims while still in training. For each level of experienced claims handler, regulations specify the number of years of required experience. As an alternative, an individual may qualify for the designation of Experienced Claims Adjuster by passing the Self Insurance Administrator’s Examination given by the Department of Insurance, Office of Self Insurance Plans, pursuant to 8 Cal. Code of Regulations, Section 15452.

**Maintenance and Availability of Records**

All insurers must maintain a record of all courses given or taken by claims adjusters, medical-only claims adjusters, or medical bill reviewers to comply with the article.

Designations of trained or experienced adjusters or reviewers are issued by the insurers. Insurers must keep copies of designation forms and post-designation training forms, whether or not adjusters and medical bill reviewers were trained by the insurer, and maintain those copies for five years after separation. Copies of designation forms must be shared among insurers upon request for the purposes of maintaining records of adjusters.
All records maintained pursuant to this article must be made available to the Insurance Commissioner and to the Administrative Director (AD) of the Division of Workers’ Compensation (DWC). (Section 2592.06 (f))

Upon request of a policyholder or an injured worker whose claim is being adjusted, the insurer must provide a copy of the Designation Form, demonstrating the adjuster’s qualifications.

Each insurer must submit to CDI by July 1 annually a document certifying the number of persons adjusting and the number and percentage of those experienced or trained; likewise for medical-only adjusters and for bill reviewers. (An example of an Annual Certification form is in the Appendix.) CDI posts the results from insurer certification forms on its website at http://www.insurance.ca.gov/0200-industry/0100-education-provider/wc_training.cfm under the heading, Insurer and Third-Party Administrator (TPA) Certification Summaries. Note that because the certification combines the numbers of adjusters who are designated as “trained” or “experienced” (or both), CDI does not have separate figures for trained adjusters and experienced adjusters. Columns in the posted figures that are labeled “Experienced” actually refer to “Trained or Experienced.”

Compliance, Enforcement and Penalties

All “insurers,” including insurance carriers, self-insurers, and TPAs for self-insurers, are required to submit certification annually to the CDI Producer Licensing Bureau pursuant to regulations.

CDI and DIR each have potential jurisdiction to enforce training requirements and appropriate handling of claims and medical bills. CDI has the power over insurance companies admitted to transact business in this State. The CDI Statistical Analysis Division sends out a data call “workbook” to workers’ compensation insurance carriers and requests the specific information required by regulation and the certification form.

CDI has no jurisdiction over the other “insurers” as defined for this program to include self-insured employers and their TPAs. DIR has authority over self-insured employers and their TPAs. The legislation does not specify any enforcement power for either CDI or DIR, other than the fact that insurer’s certification is made under penalty of perjury. Regulations issued by CDI allow the AD of the DWC to have access to the records of training maintained by insurers as defined, although the jurisdiction over self-insured employers and their TPAs is with DIR.

Claims Adjuster and Bill Reviewer Training and Certification Advisory Group Meeting

At the request of the Commission at its December 12, 2008 meeting, CHSWC staff held an Advisory Group meeting on January 23, 2009, to look further into the oversight process for claims adjuster and bill reviewer certification.

The key question for the Advisory Group was whether there is sufficient oversight of the program and if not, what enforcement needs to be implemented. Also discussed was whether this is a training issue or an area that might be best left to the courts to enforce through adjudication of benefits or penalties, case-by-case.

Key Issues from Advisory Group Meeting Participants

Discussion about the differences between licensing requirements and certification requirements was held. Additional discussion included the following:
Program Accountability
- A question was raised about sufficient accountability of the certification process.
- Several stakeholders commented that it seems that only a small percentage of claims adjusters and medical bill reviewers perform poorly.
- Several stakeholders felt that accountability is triggered either through the audit process or when a complaint is filed; however, the audit process does not have authority over certification of training. Currently, the DWC Audit Unit does not have authority to review training certification.

Audit Process
- DWC has the authority to enforce claims handling.
- DWC audits have improved slightly. The sampling and selection of the audits are representative of the entire system.
- DWC audits look at whether the medical bill is paid in the correct amount and in a timely manner.
- The question was raised whether the authority to assess penalties for failure to train staff properly by not complying with certification requirements could be included in the audit authority.

Key Issues Regarding Training
- The training is new, so the question remains whether better outcomes, i.e., improvement of claims processing, have resulted from the training requirement:
  - The training program covers specific designated topics. Some stakeholders commented that the training focuses on the number of hours of training, and adjusters are often focused on counting hours. There should be more emphasis on outcomes.
- Several stakeholders commented that there is only a small percentage of poor performers or "bad actors."
- According to adult learning theory, providing training does not necessarily improve the level of performance.
- Incentives can change behavior. It was questioned whether incentives should be directed at individuals or at organizations and whether additional incentives are needed.
- It was suggested that creating increased bureaucracy and additional requirements when only a minority may be the problem would create issues for the community, as well as expense, which could increase the cost of the system.

Existing Gaps
- There needs to be a way to identify poor performers. Insurers are responsible for certifying that those who handle claims have the appropriate training. The adjuster training records go with the adjuster and they can be made available by the TPA to the insurers so they can implement the certification.
- Active TPAs and self-insurers are listed on the DIR Office of Self Insurance Plans (OSIP) website, and insurers (as defined to include self-insured self-administered employers, TPAs for self-insured employers, and insurance carriers) who report their claims adjusters’ certifications are listed on the CDI website:
OSIP does not post the numbers of claims adjusters and bill reviewers certified by self-insured employers and self-insured employers’ TPAs on the OSIP website. Data posted by CDI regarding TPAs seem to be incomplete, according to some stakeholders.

There seems to be less than full compliance with reporting by the self-insured employers’ TPAs on the CDI website.

Advisory Group Recommendations and Next Steps

Advisory Group meeting participants suggested the following:

- Claims adjuster and bill reviewer regulations are basically adequate. Accountability in relation to the regulations could be reviewed by DIR and CDI.
- Out-of-state claims adjuster training for California claims may not be nearly as good as training in California. Review of out-of-state insurers could be increased.
- There may be a gap in the reporting of training in terms of a match between those who report their training levels and those who should be reporting their training levels. Determine if there is such a cap.

Conclusion

The conclusion to the December 2008 report is that the program is relatively new and its strengths and weakness are not yet fully recognized. It is awkward for a single program to oversee the operations of both insurance carriers and self-insured employers because they are under the jurisdictions of different departments of state government. Mechanisms are available to encourage compliance.

CHSWC Staff Recommendation

The CHSWC staff recommendation based on discussion at the Advisory Group meeting was that any enforcement of claims adjuster and bill reviewer training should be the responsibility of the respective agencies currently responsible for self-insureds and their TPAs and for insurance companies. For self-insureds and their TPAs, enforcement should be done by OSIP and it should include confirming that the entities under its jurisdiction which are required to certify their claims adjuster and bill reviewer training have in fact submitted the required certifications to CDI. For insurance companies, CDI has advised that it is working to ensure complete compliance by the companies. The statute does not specifically provide enforcement powers, but the respective Departments may consider judicious use of general oversight authority. A Department can at least encourage compliance without need for statutory authority.

In addition, increased education and outreach should be implemented by DIR and CDI to improve compliance.

For further Information …

“Revised Claims Adjuster and Bill Reviewer Training and Certification by Insurers Report” (April 2009).

To test this proposal, CHSWC staff compared the first 13 pages of the 64-page list of private self-insured employers at http://www.dir.ca.gov/sip/PrivateRoster.pdf against the list of self-insurers reporting to CDI as shown at http://www.insurance.ca.gov/0200-industry/0100-education-provider/upload/WCSelfInsuredAdjRpt2008.pdf, with both sites accessed on February 10, 2009. Two private self-insured employers in this sample appear to warrant further inquiry. In the first 13 pages of the OSIP list, one employer characterized as “Self Administered and Administered” and one characterized as “Self Administered” do not appear on the CDI list. This review did not include the employers on the OSIP list that are characterized as “Administered,” because their TPAs would be the entities responsible for compliance. A more comprehensive effort would include data from additional lists maintained by OSIP and by CDI.
The Impact of Workers’ Compensation Experience Modification Rating (Ex-mod) and Firm Age on Safety Behavior and Risk

Introduction

At the request of the Commission on Health and Safety and Workers’ Compensation (CHSWC), Commission staff held a Health and Safety Research Advisory Committee meeting on November 19, 2007, in Oakland, to identify key health and safety areas where further research and study could help improve workplace health and safety in California. The Advisory Committee included stakeholders in the health, safety and workers’ compensation communities representing insured and self-insured employers, labor, health and safety researchers and state agencies.

One of the recommendations of the Health and Safety Research Advisory Committee was to rigorously identify the consequences of different:

- Safety policies and practices such as workers’ compensation experience modification (Ex-mod) rating.
- Workplace health and safety activities for different types of employers by size, age of firm, and industry.

In addition to the above recommendations, the Experience Rating Task Force, established in 2007 in response to concerns expressed by the California Insurance Commissioner, made recommendations regarding research on workers’ compensation Ex-mod. The Task Force report suggested that research opportunities to “evaluate the effectiveness of experience rating as a safety incentive” should be undertaken “to the extent such research is likely to produce meaningful results relevant to potential future Rating Plan changes.”

In response to the above research recommendations, CHSWC issued a Request for Proposal (RFP) and contracted with RAND for a study that is evaluating:

- The impact of workers’ compensation Ex-mod on the safety behavior of small employers and medium-size and large employers.
- The safety risk of new firms versus older firms.

Background

Safety Effect of Workers’ Compensation Experience Rating

Ex-mod factors are meant to adjust employer’s workers’ compensation premium rates to reflect their underlying safety. Ex-mods are calculated by the Workers’ Compensation Rating Bureau (WCIRB), and premium rates are set by insurers. Employers’ premiums are a product of the premium rate times the Ex-mod. Employers with poor safety records receive Ex-mods greater than 1, while employers with good past experience receive Ex-mods less than 1.

As noted above, an Experience Rating Task Force was established in 2007 to examine how well the current Ex-mod methods used by the California WCIRB promote safety. There are at least two key areas where the understanding of the incentive effects of Ex-mods could be substantially improved.

Small employers. There are a large number of smaller employers just above and below the threshold premium for experience rating. Because they have few employees and few claims, the predictive value
of Ex-mods for small employers is even lower than it is for larger employers. On the other hand, WCIRB has noted, as have others, that smaller employers are on average less safe. Consequently, this may be a group of employers for whom Ex-mod incentives could have a substantial impact on safety. However, there is no research to support whether Ex-mod affects small employer behavior, and, consequently, it is not known whether the threshold for Ex-mods should be lowered (subjecting more employers to rating but increasing the concerns about credibility) or raised (reducing the number of employers and concerns about credibility).

Medium-size and large employers. Substantial efforts are made to limit the impact of past experience when calculating Ex-mods. "Ballast" is added to the numerator and denominator, losses are capped, etc. These limitations reflect concerns about the predictive value at the individual employer level and employer concerns about year-to-year variability, but they ignore the possibility that greater variability may increase safety incentives. Again, almost nothing is known about how employers respond to the incentive effects of experience modifiers, and hence, appropriate judgments cannot be made about how incentive effects should be weighted in designing the Ex-mod calculation. In the absence of knowledge about incentive effects (if any), approaches to Ex-mod calculation will only consider insurer under-writing concerns and not other policy objectives.

Safety Risk at New Firms Versus Older Firms

The number of firms that are created and cease to exist each year in America is large. In 2005, with a stock of about 6.5 million firms, the nation witnessed the birth of 644,000 new firms and the exit of 566,000 existing ones. The new firms had 3.6 million employees by the end of the year, and the exiting firms had had 3.3 million at the end of the previous year. In that year, and in most years, over 12 percent of the national births occurred in California.

By themselves, the dynamics of firm creation and destruction have significant implications for occupational safety and health. For example, strategies that aim at changing organizational practices face limitations if organizations are constantly dying and being created. However, firm turnover is even more important if new firms present unusually high levels of injury and illness risk. This study will examine the trajectory of relative injury rates over several years for new firms in different industries. It is quite possible that any excess risk may persist over several years, which would magnify the importance of firm age as a risk factor.

There have not been studies that have looked specifically at firm age, but there are grounds for believing that new firms may be relatively unsafe. Their workers may be more likely to be inexperienced. Their managers may also be inexperienced and lack knowledge of the safety and health issues at their facilities. If these firms are relatively unsafe, then it may be especially worthwhile to consider interventions there that might be helpful.

Objective and Scope of the Study

The purpose of the study is to answer the following questions:

- Whether the application of and changes to workers’ compensation Ex-mod has an effect on the safety experience of small, medium-size, and large employers in addition to its original purpose of addressing insurer underwriting concerns.

- Whether the application of and changes to workers’ compensation Ex-mod to medium-size and large employers have an effect on their safety experience.

- If employers’ performance now affects their premiums but overall premiums are declining, would employers pay more or less attention to how to decrease their injury losses?

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59 [www.sba.gov/advo/research/dyn_b_d89-05.pdf](http://www.sba.gov/advo/research/dyn_b_d89-05.pdf)
• Policy recommendations on improving the current workers’ compensation Ex-mod methodology.

• Whether new firms have a greater safety risk than older firms. The analysis will look at firms by payroll, size, and rating class.

• Policy recommendations on safety interventions if new firms are determined to be more unsafe than older firms.

Data

The researchers will use data from WCIRB to conduct their analysis.

Evaluation of the Effectiveness of California’s Injury and Illness Prevention Program and Compliance Officers’ Inspections

Introduction

Little is currently known about the effectiveness of OSHA’s injury and illness prevention program (IIPP) standard and whether some compliance officers are especially good at reducing workplace injury and illness rates.

The purpose of the study is to conduct research that evaluates the effectiveness of the IIPP standard and compliance officers’ inspections at reducing injury and illness rates. The research can help to improve the ability of occupational health and safety agencies to prevent injuries, potentially preventing a significant number of injuries and illnesses.

Background

Compliance Officers’ Inspections

The Cal/OSHA Program is responsible for enforcing California laws and regulations pertaining to workplace health and safety and for providing assistance to employers and workers about workplace safety and health issues.

The Cal/OSHA Enforcement Unit conducts inspections of California workplaces based on worker complaints, accident reports and high hazard industries. There are 22 Cal/OSHA Enforcement Unit district offices located throughout California. Inspections are conducted by Cal/OSHA safety engineers and industrial hygienists from district offices throughout California. Complaint, referral and accident inspections, as well as scheduled (programmed) compliance inspections, are conducted by the district offices. In Fiscal Year 2006-07, 9,039 inspections were conducted.

There is no research currently on whether some compliance officers are more effective than others at reducing workplace injuries and illness rates. There is some information from earlier studies that suggests that there may be important variations in the effectiveness of inspections that depend on who conducts them or how they are conducted. Another study found that health inspections were more effective than safety inspections in preventing injuries. This unexpected finding may reflect that health inspections involve more time on-site than safety inspections do and thus give the compliance officer more time to observe the workplace, as well as that health inspections are conducted by industrial hygienists, who have more professional training. A study found that the number of violations cited was smaller for inexperienced compliance officers, although the effect was not statistically significant.

The most recent study of the impact of inspections on injury and illness rates, covering the years from 1999 through 2006 in Pennsylvania, estimated that the average effect in manufacturing was approximately a 20 percent reduction in the rate of lost-time injuries over the two years after the year of
the inspection. This reduction was seen, however, only when the inspection levied penalties, an outcome that generally accompanies citations for serious violations. A majority of inspections did levy penalties.

Evaluation of the Effectiveness of California’s Injury and Illness Prevention Program

As part of the inspection process, inspectors review employers’ compliance with required programs such as the IIPP. The requirement of the IIPP program is specified in Title 8 CCR Section 3203 of the General Industry Safety Orders which took effect in July 1991. The regulations required all employers in California to establish an IIPP. Having an IIPP is considered the first step towards creating a system for identifying, correcting, and preventing workplace safety and health hazards. Section 3203 has been the most frequently cited standard in general industry in California ever since it was promulgated.

Other Labor Code sections and regulations address specific industrial safety and health hazards and prevention requirements by type of workplace, type of equipment, environmental contexts and industry sectors. The Division of Occupational Safety and Health (DOSH) enforces the laws on IIPPs and safety standards through various means, including inspections and citations. Data on occupational injuries and illnesses can be used to measure or test the impact of safety and health standards, including enforcement efforts.

California is one of several states that has adopted a standard mandating that firms establish safety and health programs. These programs generally include measures to identify risks, investigate the causes of injuries that occur, provide appropriate training, and communicate with employees about the risks they face. In 1998, federal OSHA took initial steps to promulgate a federal standard. A recent review by RAND found an absence of good evidence about the effectiveness of these safety and health program mandates.

Objective and Scope of the Study

The purpose of this study is to identify:

- What the effect is of the adoption and enforcement of the IIPP regulations.
- Which of the elements of the IIPP standard may be most effective.
- Whether firms that comply with Section 3203 have lower injury and illness rates (and better Ex-mods) than similar firms which do not.
- Whether compliance with Section 3203 leads to a reduction in injury and illness rates?
- Which provisions, if any, of Section 3203 are most closely associated with reductions in injury rates. The rule includes seven substantive provisions, each of which can be cited separately.
- Whether there is any relation between the stringency of enforcement of Section 3203 and reductions in injury rates.
- When controlling for other factors that affect inspection outcomes, how the reductions in injury and illness rates vary depending on the particular compliance officer who carries out the inspection.
- What characteristics of the more successful compliance officers and their inspection activities distinguish them from other compliance officers.
- What the policy implications are for the selection, training, and incentives for compliance officers.
Data

The above research will most likely rely on the following sources of data: California Unemployment Insurance; California Workers’ Compensation Information System (WCIS); OSHA Integrated Management Information System; and WCIRB.

Occupational Safety and Health for Public Safety Employees: Assessing the Evidence and Implications for Public Policy

Background

The high rate of injury and disability sustained by vital public safety employees, particularly police and firefighters, is of great concern to the workers’ compensation community. In October 2004, Assembly Members Juan Vargas and Rick Keene requested that the Commission on Health and Safety and Workers’ Compensation (CHSWC) conduct a study of public sector injury prevention. In particular, they requested a comprehensive evaluation and recommendations on effective public safety employee injury and illness prevention measures.

In response to the above bi-partisan request, CHSWC contracted with RAND in September 2005 to conduct a study that will assist the legislature in its goals to minimize injuries incurred by public safety employees and provide adequate workers’ compensation and disability benefits to those who are injured.

Objectives of the Study

The objective of this study, which was funded by both CHSWC and the National Institute for Occupational Safety and Health (NIOSH), was to aid in the design of effective safety interventions by characterizing the important safety and health risks faced by public safety personnel and how those risks differ from those faced by non-safety personnel. To accomplish this, researchers pursued the following research goals:

- Summarize the existing literature on the injury and fatality risks to public safety employees.
- Characterize the perceived risks and the efforts currently used by public safety departments to reduce those risks.
- Describe the differences in the rates of injury, disability, and other chronic health problems for workers in public safety occupations compared with workers in other occupations.

Findings and Recommendations

The findings of the study were grouped into four separate categories: characterizing the central occupational health risks to different public safety occupations; describing current efforts at improving safety and identifying areas that represent the most promising targets for reform; comparing the self-reported health of public safety employees with that of workers in non-safety occupations; and examining differences in work-related disability claim rates of public safety employees and non-safety employees by age.

The key findings and recommendations included:

- There is a need for better surveillance of injury data, particularly for injuries to law enforcement and emergency medical personnel.
- The design and targeting of safety and health promotion efforts could also be improved with better monitoring of the types of situations and causes of injury that lead to the most severe and disabling injuries.
There is a need to reduce strains, sprains and musculoskeletal disorders among safety employees, which are by far the leading cause of nonfatal injuries.

Training, increased information analysis and sharing, strong safety messages from department leadership, and improvements to protective equipment were areas identified as good tools for improving safety of public safety employees.

Both firefighters and police officers become more susceptible to disability as they age. Policies designed to reduce the rate of disability retirement may be most effective if focused on either preventing injuries among older safety employees or taking steps to alleviating the impact of injuries on their ability to work.

For further Information …

SPECIAL REPORT: LIENS

Background

A perennial problem for the Division of Workers' Compensation (DWC) is the backlog of lien claims filed at Workers’ Compensation Appeals Board (WCAB) offices. Most liens are for medical treatment and medical-legal expenses. Liens are also filed to obtain reimbursement for other expenses.

In 1997, the Commission on Health and Safety and Workers' Compensation (CHSWC) convened several roundtable meetings on the WCAB lien backlog that was delaying the processing of cases filed by injured workers in many WCAB district offices. Commission staff also visited DWC district offices and found that in many instances, liens for payments made over ten years ago were being filed on workers’ compensation cases. In other instances, liens on the same case were not being heard at the same time, leading to costly notification and scheduling, churning of cases, and delays in resolution.

After an extensive study of the lien claim backlog in some WCAB district offices and several lien resolution roundtable sessions attended by interested members of the workers’ compensation community, CHSWC recommended that statutory limitations be placed on the filing of lien claims. Assembly Bill (AB) 749 signed in 2002 made the following changes with respect to liens:

- Labor Code Section 4903.5 provides that no liens for medical or medical-legal expenses may be filed more than six months after a final decision on the merits of the injured worker's claim, five years after the injury, or one year from the date the services were provided, whichever is later.

- An exception is made in the case of health care providers and other entities that provided medical benefits on a nonindustrial basis. They may file a lien claim within six months after they know that an industrial injury is being claimed.

In 2003, Senate Bill (SB) 228 added Labor Code Section 4903.05, requiring a $100 filing fee for each medical lien filed beginning in 2004, with exceptions for certain publicly funded programs. Effective July 1, 2006, budget trailer bill language in AB 1806 repealed the lien filing fee and added Section 4903.6 to deter the filing of premature and potentially unnecessary liens at DWC district offices.

Number of Liens Filed, 2000 - 2007
**Current Status of Liens**

As shown in the chart above, the number of liens has increased by 111 percent between 2000 and 2003, decreased by 47 percent between 2003 and 2006, and increased again by 84 percent between 2006 and 2007.

A sample of data obtained from DWC indicates that 82 percent of the liens filed are for medical issues. These may include medical-legal, medical treatment on denied claims and on accepted claims where the doctor or the treatment was not authorized, and billing disputes over items such as outpatient costs.

The chart below shows that the number of lien decisions regarding liens filed on WCAB cases has also grown. The number of lien decisions increased by over 130 percent between 2000 and 2007, resulting in an expenditure of DWC staff resources on the resolution of those liens. Filing, processing, and adjudicating liens place an enormous burden on the already strained workers' compensation courts.

**DWC Lien Decisions**

![DWC Lien Decisions Chart]

Data Source: DWC

**CHSWC Recommendation**

CHSWC recommends that a stakeholder roundtable again be convened to identify ways to reduce the number of disputes that legitimately necessitate liens and to deter the filing of unnecessary liens.

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60 Data provided by DWC. Edex Filings.
PROJECTS AND STUDIES

Introduction

In response to its Labor Code mandate, the Commission on Health and Safety and Workers' Compensation (CHSWC) has engaged in many studies to examine the health and safety and workers' compensation systems in California. CHSWC has concentrated these efforts on areas that are most critical and of most concern to the community.

CHSWC studies are conducted by staff and independent researchers under contract with the State of California. Advisory Committees are composed of interested members of the workers' compensation community and the public who provide comments, suggestions, data and feedback.

Studies were initially formed to evaluate changes to the system after the implementation of workers' compensation legislative reforms in the early 1990s and to assess the impact on workers and employers. While that focus continues, the scope of CHSWC projects has also evolved in response to findings in the initial studies and to concerns and interests expressed by the Legislature and the health and safety and workers' compensation community.

This report contains synopses of current and recently completed projects and studies followed by an overview of all CHSWC projects and studies. These projects are categorized as follows:

I. Permanent Disability and Temporary Disability
II. Return to Work
III. Return to Work and Disability Management
IV. Medical Care
V. Worker's Compensation Reforms
VI. Fraud
VII. Insurance Industry
VIII. Information for Workers and Employers
IX. Occupational Safety and Health
SYNOPSIS OF CURRENT CHSWC PROJECTS AND STUDIES

PERMANENT DISABILITY

This section starts with a discussion of the comprehensive evaluation of permanent disability (PD) by the Commission on Health and Safety and Worker's Compensation (CHSWC) and continues with descriptions of CHSWC’s other ongoing studies.

**Background**

The most extensive and potentially far-reaching effort undertaken by CHSWC is the ongoing study of workers’ compensation PD in California. The CHSWC study incorporates public discussions with studies by RAND and other independent research organizations. The CHSWC study deals with major policy issues regarding the way that California workers are compensated for PD incurred on the job.

The evaluation of PD is one of the most difficult tasks of the workers’ compensation system, often leading to disputes and litigation. The manner in which California rates and compensates injured workers for temporary disability (TD) and permanent partial disability (PPD) has enormous impact on the adequacy of injured workers’ benefits, the ability of injured workers to return to gainful employment, the smooth operation of the Division of Workers’ Compensation (DWC) adjudication system, and the cost of the workers’ compensation system to employers.

CHSWC’s PD project was originally conceived as having two phases. The focus of the first phase was to measure the long-term earnings losses and other outcomes for workers with PD claims. The focus of the second phase was intended to refine these measures and, at the same time, provide policymakers with suggestions for reforms intended to improve outcomes for injured workers at reasonable cost to employers. The project has become an ongoing effort to evaluate the effects of changes in the system and provide continuing information to policymakers contemplating further changes.

**Permanent Disability – Phase 1**

**Initial Wage Loss Study**

The initial report from the CHSWC study of PD, “Compensating Permanent Workplace Injuries: A Study of the California System,” examines earnings losses and the replacement of earnings losses for workers with PPD claims at insured firms in California in 1991-92. The main findings of this report include:

- PPD claimants experienced large and sustained earnings losses over the five years following injury. These losses amounted to approximately 40 percent of the earnings these workers would have made if injury had not occurred.
- Workers’ compensation benefits replaced only 40 percent of pre-tax earnings losses and only 50 percent of after-tax earnings losses.
- Losses are largely driven by lower employment rates among PPD claimants over the years following injury.
- Earnings losses and disability ratings are not closely related, particularly for low-rated claims. Replacement rates, the fraction of losses that are compensated by benefits, were lowest for the lowest-rated claims.

**Status:** Completed.
For further information …


“Findings and Recommendations on California’s Permanent Partial Disability System-Executive Summary,” RAND (1997)
http://www.dir.ca.gov/CHSWC/Reports/PPDFindingsAndRecommendations.pdf

Policy Advisory Committee

A CHSWC Permanent Disability Policy Advisory Committee was established to review the RAND report and the community’s responses and to recommend further action. The committee began meeting in November 1997.

The CHSWC Policy Advisory Committee raised additional questions about the wage loss study and other areas of the RAND report.

The workers’ compensation community wanted additional information on how other factors, such as demographics and local economic conditions, affected the outcomes of the wage loss study. Observations were also made about the initial study parameters, as the study lacked data on employees of self-insured employers and data beyond the 1991-1993 period.

The Permanent Disability Policy Advisory Committee urged CHSWC to study those issues further, and CHSWC voted to continue the comprehensive evaluation of workers’ compensation PD. Continuation of the evaluation of PD includes the following projects.

Enhancement of the Wage Loss Study to Include Self-Insureds

Stakeholders objected to the 1998 report, “Compensating Permanent Workplace Injuries: A Study of the California System,” because they believed that self-insured employers, which account for one-third of claims in California (an estimate that CHSWC in 2008 has revised to 30 percent, including self-insured employers and the State), would have better outcomes for PPD claimants. Stakeholders felt that since self-insured employers are larger and higher-paying firms and since they directly bear the full cost of their workers’ compensation claims, they would likely have more programs to encourage return to work (RTW) and a more motivated workforce.

Private Self-Insureds

The report entitled “Permanent Disability at Private, Self-Insured Firms” was released in April 2001. This report includes an unprecedented data-collection effort on PD claims at self-insured firms in California. The findings of this report include:

- Better RTW at self-insured firms led to a lower proportion of earnings lost by PPD claimants. During the five years after injury, self-insured claimants lost a total of 23 percent of both pre- and post-tax earnings, compared to the insured claimants’ proportional losses of about 32 percent.
Since workers at self-insured firms have higher wages, they are more likely to have weekly wages that exceed the maximum temporary disability (TD) payment. Therefore, workers’ compensation benefits replaced a smaller fraction of losses at self-insured firms. Workers at these self-insured firms experienced lower five-year wage-replacement rates (48 percent) than workers at insured firms (53 percent).

At both insured and self-insured firms, replacement rates were very low for workers with the lowest indemnity claims. At the self-insured and insured firms, claimants with total indemnity falling below the 20th percentile had 14 percent and 11 percent of their lost earnings replaced by benefits, respectively.

PPD claimants with high pre-injury earnings and high indemnity claims experienced large dollar losses that were not compensated by benefits.

Status: Completed.

For further information …

http://www.dir.ca.gov/CHSWC/Reports/PD-Study.pdf

Permanent Disability – Phase 2

Legislation Is Based on Permanent Disability Interim Report

The multi-year study of PD was nearing its conclusion when a crisis in the worker’s compensation system precipitated a series of reforms affecting the four major types of benefits: medical treatment; TD; PD; and vocational rehabilitation. The PD reform was enacted by Senate Bill (SB) 899 in 2004. The amended Labor Code Section 4660 called for a revision of the PD rating schedule (PDRS) with explicit reference to an interim report from the nearly completed study. The final report was published in 2005, containing a thorough review of PD compensation, including the underlying rationale for PD compensation, the measurement of wage loss, and the measurement of how well the California system was meeting its goals.

The final report observed that the California PDRS had come to be regarded as costly, inequitable, inconsistent, and prone to disputes. Workers who sustained similar earnings losses for different types of injuries received different amounts of compensation. The CHSWC “Permanent Disability Study” by RAND consisted of a detailed analysis of the PDRS in order to provide empirical findings that could guide a revision that would be consistent with the economic losses experienced by permanently disabled workers. The study empirically identified the components of the schedule that contribute to inconsistency and made recommendations to reduce them.

The CHSWC study by RAND recommended:

- Basing PD ratings on a more objective method of evaluation, such as the American Medical Association Guidelines to the Evaluation of Permanent Impairment, fifth edition (AMA Guides).
- Adjusting PD ratings to ensure that ratings were proportional to wage losses across different types of injury.

Status: Completed.
Legislative Changes and Administrative Implementation

With the enactment of Senate Bill (SB) 899 in 2004, the Governor and the Legislature intended to enact a PD rating system that would promote “consistency, uniformity, and objectivity.” The legislation carried out recommendations that emerged from CHSWC studies and included other changes as well. SB 899 made changes to:

- The goal of the rating schedule, giving consideration to diminished future earning capacity in place of consideration to diminished ability to compete in an open labor market (Section 4660(a)), as well as promoting consistency, uniformity and objectivity (Section 4660(d)).

- The criteria for medical evaluations using the AMA Guides in place of the often subjective criteria traditionally used in California (Section 4660(b)(1)).

- The adjustment factors to be included in the Schedule for Rating Permanent Disabilities, specifying that diminished future earning capacity be a numeric formula based on average long-term loss of income according to empirical studies (Section 4660(b)(2)).

- The apportionment of disability between industrial injuries and other causes when a disability is caused by the combination of two or more injuries or diseases (Sections 4663 and 4664).

- The number of weeks of PD benefits payable for each percentage point of permanent partial disability (PPD), reducing payments by up to 15 weeks on all awards of less than 70 percent PPD (Section 4658(d)(1)).

- The dollar amount of weekly PD benefits depending on whether the employer offers to continue to employ the permanently disabled worker, if the employer has 50 or more employees (Section 4658(d)(2) and (d)(3)).

Implementation of SB 899 required the Administrative Director (AD) of the Division of Workers’ Compensation (DWC) to adopt a revised PDRS. At the request of the AD, RAND prepared a separate report which quantified the ratio of average PD ratings to average proportional earnings losses for each of 23 injury categories in the RAND data. The AD employed those ratios in the development of the new PDRS effective January 1, 2005.

For further information …


http://www.dir.ca.gov/dwc/PDR.pdf

61 Labor Code Section 4660(d).
Permanent Disability Rating Schedule Analysis

The Legislature requested that CHSWC report on the impact of the change in the PDRS, as well as how the schedule could now be amended in compliance with Labor Code Section 4660(b)(2), which requires the use of findings from the RAND report and other available empirical studies of diminished future earning capacity.

In response to this legislative request, CHSWC developed a paper that evaluated the impact of the changes in the PDRS using data from the Disability Evaluation Unit (DEU) that did not exist when the latest reform was adopted.

Findings

- At the time the 2005 schedule was adopted, adequate empirical studies did not exist to permit accurate calculation of the relationship between impairments evaluated according to the AMA Guides and diminished future earning capacity.

- The 2005 schedule reduced the average PD rating (rated percentage of disability) in rated cases by about 43 percent for unrepresented cases and by about 40 percent for represented cases.

- The legislative and administrative changes reduced PD compensation by about two-thirds, with about half of that reduction attributable to lower ratings under the 2005 PDRS compared to the previous rating schedule.

- Revisions of the schedule can be formulated immediately and revised periodically. (See CHSWC study “Permanent Disability Rating Schedule Analysis.”)

The CHSWC “Permanent Disability” report provides a methodology for updating the PDRS to obtain more consistent ratings for all types of injuries. The report recommends a new mathematic formula using administrative data from DWC and the latest available wage loss data to make all ratings calculations consistent. The ratings are then entered into the existing system to calculate the level of benefits. An important recommendation in the report is that periodic revision to the rating schedule be adopted such that any future trends in medical impairments and earnings losses can be detected and incorporated in the formula.

The report also suggests that, beyond using a consistent methodology, overall levels of ratings and compensation should be considered a separate public policy issue. The report acknowledges that issues of benefit adequacy and affordability are issues for policymakers to debate. Subsequent unpublished work has suggested that the goal of equity across types of injuries can be achieved through amendments to the PDRS as contemplated in the CHSWC report, but the goal of benefit adequacy may require a combination of legislative action and amendments to the PDRS.

Status: Completed. CHSWC voted on February 9, 2006, to approve and release the report “Permanent Disability Rating Schedule Analysis.”

For further information ...

“Permanent Disability Rating Schedule Analysis” (February 23, 2006).
Continuing Review

CHSWC continues to evaluate the patterns of ratings, using data provided by the Disability Evaluation Unit (DEU) and analysis by the University of California (UC), Berkeley. CHSWC continues to examine data on wage losses of workers with permanent disabilities, with data and analysis provided by RAND. Incomplete results indicate that any changes to PD rating and compensation may need to involve more than just changes to the multipliers that are used in the PDRS. Legislative changes to the compensation may be required. The analysis further calls into question the empirical justification for the existing structure, in which the compensation rises geometrically as ratings increase. Data suggest that the relationship between average ratings and average proportional earnings losses is more nearly a straight line than a geometric curve. Modeling done by UC Berkeley enables policymakers to weigh the impacts of changes that may be considered in the compensation structure. Additional information will become available through a study of return to work, which is due for release in December 2009.
PERMANENT DISABILITY

APPORTIONMENT

Understanding the Effect of Senate Bill 899 on the Law of Apportionment

Background

Apportionment is the process in which an overall permanent disability (PD) that was caused at least in part by an industrial injury is separated into the components that are and are not compensable results of that injury. Senate Bill (SB) 899, signed into law by Governor Schwarzenegger on April 19, 2005, profoundly changed the law of apportionment. Decades of interpretation of the old law of apportionment are called into question, with some principles still being applicable and others being reversed. The Commission on Health and Safety and Workers’ Compensation (CHSWC) report provides information on the effect of SB 899 on the prior law of apportionment, how apportionment is likely to be affected by the American Medical Association *Guides to the Evaluation of Permanent Impairment*, fifth edition (AMA Guides), and what the key issues are that remain to be resolved. A summary of the report follows.

Repeal of Pre-existing Disease and Previous Permanent Disability or Impairment Language

SB 899 repealed Labor Code Section 4663 which provided that if a pre-existing disease were aggravated by a compensable injury, compensation was allowed only for the portion of the disability due to the aggravation reasonably attributed to the injury. SB 899 also repealed Labor Code Section 4750 which provided that an employee “suffering from a previous PD or physical impairment” could not receive compensation for a subsequent injury in excess of the compensation allowed for the subsequent injury “when considered by itself and not in conjunction with or in relation to the previous disability or impairment” and that the employer was not liable “for the combined disability, but only for that portion due to the later injury as though no prior disability or impairment had existed.”

Apportionment by Causation

To replace the repealed sections, SB 899 re-enacted Section 4663 in an extensively revised form and added a new Section 4664. The revised Section 4663 provides that “apportionment of permanent disability shall be based on causation.” Apportionment is determined by the approximate percentage of the PD caused by the direct result of the industrial injury and by the approximate percentage of the PD caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. A PD evaluation is not considered complete unless it includes an apportionment determination. Labor Code Section 4664(a) was added to emphasize that the employer is only liable for the percentage of PD “directly caused” by the injury. The repealed sections do not appear inconsistent with the new sections, but the case law interpreting the repealed sections considerably limited their application.

The problem faced by members of the workers' compensation community is how the authors of this legislation intended permanent disabilities to be apportioned under the new law. The final Senate floor analysis says only that it was intended to "replace present law on apportionment with the statement that apportionment of permanent disability is based on causation." It is clear, however, that the announced purpose of SB 899 was to reduce the cost of providing workers' compensation.

Status

In process. At its April 27, 2007 meeting, CHSWC approved the release of the draft report on apportionment for public comment. At its August 9, 2007 meeting, the Commission received a verbal update on a key judicial interpretation. The report requires updating to reflect subsequent several judicial interpretations.
RETURN-TO-WORK

Return-to-Work Study

Background

Several provisions of recent workers’ compensation legislation, Assembly Bill (AB) 227, Senate Bill (SB) 228 and SB 899, included important statutory and regulatory changes meant to encourage return to work (RTW) at the at-injury employer. Studying the impact of these changes is important for understanding how to construct appropriate incentives for both employers and employees. The significance of the research extends beyond California because the innovations in the recent reform legislation may offer a model for other states to follow when reforming their systems.

Thorough evaluations are critical for improving California’s workers’ compensation system, lowering employer costs related to temporary disability (TD) and permanent disability (PD), lowering employers’ indirect costs, such as hiring and training, and reducing workers’ wage losses associated with TD and PD.

In response to the need for further research and analysis, the Commission on Health and Safety and Workers’ Compensation (CHSWC) contracted with RAND to study the impact of recent RTW and vocational rehabilitation reforms on employer costs and injured worker outcomes.

Objectives and Scope of the Study

The purpose and objectives of the RTW study are to comply with the request by Assembly Member Keene and Assembly Member Vargas to evaluate RTW efforts in California in light of the changes caused by current legislation, SB 899.

The study will include an evaluation of the current state of RTW and vocational rehabilitation or the supplemental job displacement benefit (SJDB) for injured workers in California, and will identify issues, evaluate the impact of recent legislative changes, and make recommendations for how to construct appropriate incentives for both employers and employees.

The study shall focus on, but not be limited to, all of the following important research questions that involve evaluation of the recent legislation on RTW:

- What has been or will be the impact of the 15 percent “bump up, bump down” (increase, decrease) on disability benefits, the subsidy program for workplace modifications by small businesses, and the SJDB voucher program (which replaced the old vocational rehabilitation benefits) on the likelihood that a permanently disabled worker returns to work at the at-injury employer? With what frequency are these incentives applied?

- Have the reforms led to a change in the duration of cases that we see on TD, with or without ever receiving PD benefits? If so, what are the implications for injured worker outcomes and employer costs?

- After the reforms, are there workers who remain out of work for a substantial period without receiving permanent partial disability (PPD)? If so, how long do they remain on TD, and what is the likelihood that they eventually return to work? Are these workers effectively targeted by RTW programs?
• What impact have the reforms had on employer efforts to promote RTW? Have the reforms made it more cost-effective to implement a formal RTW program?

• Are there other steps that policymakers in California can and should take to improve RTW outcomes for injured workers?

• Will educational vouchers in place of vocational rehabilitation services improve worker outcomes while lowering employer costs?

Study information will be organized around five central themes:

• Evaluation of the trends in use of various programs affecting RTW.

• Evaluation of the impact of the reforms on the adoption of RTW programs by employers.

• Estimation of the impact of the reforms on the duration of work absences due to workplace disabilities.

• Review of the changes in the distribution of TD and PD benefits received.

• Assessment of the overall impact of these reforms on workers’ compensation benefit adequacy and affordability in California.

Preliminary Findings

The preliminary findings of the study show that:

• RTW has improved, and the most severely injured workers have seen the biggest improvement.

• The improvement in RTW has lead to a decline in proportional earnings losses.

• The gains in RTW, which started prior to the 2004 workers’ compensation reforms, may have coincided with the first cases coming out of the 2001 expansion of the Fair Employment and Housing Act (FEHA).

Status: In process. A draft report is expected in 2010.
RETURN TO WORK

Return-to-Work Best Practices

Background

Employers often adopt programs that are designed to improve return to work (RTW) of injured employees in order to manage their workers’ compensation costs. Policymakers may wish to encourage increased emphasis on RTW by employers as a means to improve outcomes for injured workers and curb system costs; however, much is still unknown about the effectiveness of employer RTW initiatives.

Description

This project used data from a survey of RTW practices from a sample of 40 large, private self-insured California employers and examined their impact on the duration of injury-related absences. The data include detailed information about the efforts to improve RTW which is useful to understand the nature of policies in place, the activities taken, and the type of coordination with medical providers.

The study will cover the following topics:

- How effective are employer practices to improve RTW?
- How much do employers and workers benefit in the long run?

Objectives

The objectives of this project are to:

- Provide information on the most effective RTW practices of California employers. This information is intended to assist employers and employees to determine which RTW practices may be applicable to their needs.
- Help policymakers evaluate the merits of employer-based initiatives as a tool for improving RTW.

Findings

Preliminary findings of the study suggest that:

- Employer-based RTW programs improve employment outcomes of injured workers.
- Most of the gains in RTW accrue to workers who experience more severe, permanently disabling injuries.
- RTW programs have a much bigger impact on male workers, likely due to higher injury rates and more dangerous jobs.
- Investments in RTW programs appear to be cost-effective.

Status  The draft working paper is expected in 2010.
RETURN TO WORK

Return-to-Work/FEHA/ADA Advisory Group Meeting and Handbook

Background

Return to work after an injury or illness is important for employers and workers and their families in the State of California. Efforts need to be made to reduce litigation, reduce friction, and provide information to employers, particularly small employers who have the most difficult time complying with requirements regarding return to work. Improved information for all system participants about the requirements of the Fair Employment and Housing Act (FEHA) and the Americans with Disabilities Act (ADA) will be critical to efforts to improve return to work in California.

Return to work is a key issue for 2009 for the Division of Workers’ Compensation (DWC) and for employers and the public sector. For employers, return to work is a complicated area for human resources and workers’ compensation professionals. In the public sector, it is challenging to identify how benefits are delivered and coordinated in cases involving job accommodations, as well as how these issues relate to conditions in the economy.

Description

This project developed through discussion about introducing legislation to develop guidebooks, and it was determined that authority already exists within the Department of Industrial Relations (DIR). Several stakeholders have requested information to help workers and employers meet their responsibilities under FEHA and ADA. The director of DIR requested that the Commission on Health and Safety and Workers’ Compensation (CHSWC) work with the Department of Fair Employment and Housing (DFEH) and partner with DWC on a new handbook on return to work, FEHA and ADA. The Commission voted at its November 6, 2008 meeting to proceed with this project. This is a multi-agency effort to improve return to work and improve information for workers and employers in order to reduce confusion and litigation.

Advisory Group Meeting

CHSWC convened the Return-to-Work/FEHA/ADA Advisory Group on December 9, 2008, to discuss how to improve return to work and improve information for workers and employers in order to reduce confusion and litigation.

The Advisory Group emphasized that there is a need for a new and better approach to return to work, especially with an aging workforce and the economy shedding jobs. Public policy is emphasizing that employers bring people back to work. The system in place now has to be reformed to be an affirmative approach, rather than the defensive posture created by the workers’ compensation system, with FEHA as the umbrella.

Project Team

Christine Baker
CHSWC
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Members

Cathy Aguilar
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Department of Fair Employment and Housing
Scott Hauge
Small Business California, Cal-Insurance
Nanette Goldberg Hauser
Southern California Edison
Lori Kammerer
Small Business California
Recommendations for the new Return-to-Work/FEHA/ADA Handbook and next steps included:

- Provide an informational piece that explains to employers, employees, clinicians and other interested parties how various benefits interact with one another.
- Present best practices for bringing an injured employee back to work including FEHA and workers’ compensation and workers’ compensation and human resources, and how to make them compatible with the required interactive process.
- Emphasize the economic necessity of keeping Californians working safely and productively; emphasize the importance of being proactive and not waiting until there is an investigation in process, and the importance of having a timely, cordial, well-documented engagement with the employee.
- Clarify roles and responsibilities: employers have the privilege and duty to define the essential functions for all jobs; employers have the right to ask for medical information; employees have the duty to bring relevant information to the table to protect their own health and productivity; clinicians have the responsibility to comment on capacity, or what the patient can safely do between now and the next visit, and they should not define accommodations but should have information about work requirements.
- Provide a tool kit including: common timeframes, common vocabulary, and common requirements for the different processes; a model interactive process; sample notifications; and a list of available resources.
- Develop strategies for dissemination, particularly co-branding with other organizations serving small businesses such as: Small Business California; Chambers of Commerce; local and state agencies; joint powers authorities (JPAs); and others. These organizations would promote the handbook and facilitate translation into multiple languages.

**Members (contd.)**

- Doug Kim
  - California Applicants’ Attorneys Association
- Sean McNally
  - Grimmway Farms
- Robin Nagel
  - Kaiser Permanente
- Carrie Nevans
  - Division of Workers’ Compensation
- Michael Nolan
  - California Workers’ Compensation Institute
- Pearl Phoenix
  - Zenith Insurance
- Seth Seabury, Ph.D.
  - RAND Corporation
- Herbert Yarbrough
  - Department of Fair Employment and Housing
- Mark Webb
  - Employers Direct

**Status:** In process.

**For further information ...**


RETURN TO WORK

Return-to-Work Reimbursement Program

Background and Legislative History

In November 2008, at the request of the Acting Administrative Director (AD) of the Division of Workers’ Compensation (DWC), the Commission on Health and Safety and Workers’ Compensation (CHSWC) voted to conduct a study of the Return-to-Work Reimbursement Program established in former Labor Code Section 139.48.

Section 139.48 of the Labor Code as amended by Senate Bill (SB) 899 (Poochigian, 2004), requires the AD to establish a Return-to-Work Program to promote the early and sustained return to work of injured employees. The program reimburses employers for expenses to modify the workplace to accommodate injured employees. It is available to private employers with 50 or fewer full-time employees that seek reimbursement of expenses to accommodate an employee with a work-related injury or illness occurring on or after July 1, 2004. As originally enacted, the program was to sunset on January 1, 2009. Pursuant to a 2008 budget trailer bill, Assembly Bill (AB) 1389, the sunset has been extended to January 1, 2010.

Reimbursement is paid from the Workers’ Compensation Return-to-Work Fund, which is funded by penalties collected pursuant to Labor Code Section 5814.6 (administrative penalties for unreasonable delay) and by transfers into the Fund from the Workers’ Compensation Administration Revolving Fund (WCARF) established pursuant to Labor Code Section 62.5 (user funding).

Description

The CHSWC report, “Recommendations for the Return-to-Work Program Established in Labor Code Section 139.48,” summarizes information provided by the DWC Retraining and Return-to-Work (RRTW) Unit describing employers’ applications for workplace modification expense reimbursement and approvals and denials of those applications. It also discusses rates of participation by eligible employers and potential future funding mechanisms. The report describes the operation of the program in the period August 18, 2006, to December 15, 2008. It discusses rates of participation by employers, awareness of the program among small employers, and possible future funding.

Findings and Recommendations

The Return-to-Work Program established in Labor Code Section 139.48 has been underutilized, probably because most small employers who qualify for the program were unaware of it.

Recommendations to increase utilization and cost-effectiveness of the Return-to-Work Program established in Labor Code Section 139.48 are either to:

- Conduct extensive outreach to inform small employers about the program and by streamlining the process to apply for reimbursement; or
- Consider eliminating the program and replacing it with another program that more directly assists injured workers who are unable to return to their previous jobs.

Increasing Utilization and Cost-Effectiveness

Most of 50 respondents to a questionnaire distributed by Small Business California made recommendations on how small employers could be made aware of the program. Sources of information
they identified included employer organizations, trade groups, workers’ compensation insurers and brokers, state agencies, city business licensing offices, and new media. Methods of communication suggested included email messages with links to further information online, bulletins, newsletters, written notices, regular mail, meetings, seminars and training classes.

Based on these recommendations, the RRTW Unit of the DWC could prepare articles and notices about the program and coordinate with the sources listed above to disseminate the information widely among small employers. They could also offer to prepare additional materials as needed and make presentations in employer and trade-affiliated seminars and training classes that small employers attend.

In addition, California could standardize the information provided to small employers about this program by including information about the program on the employer portion of the Workers’ Compensation Claim Form (DWC-1) or by requiring workers’ compensation insurers to notify their employers about the program when sending premium invoices.

Utilization may also increase if the application process is streamlined. More than two-thirds of the employers that applied for reimbursement from the RRTW Unit were denied for a variety of reasons, most due to incomplete understanding about the application process or about the program itself, and several because of an unnecessary requirement to submit a Notice of Offer of Modified or Alternative Work, which was used to deny applications.

Replacing the Program

Alternatively, the Return-to-Work Reimbursement Program could be eliminated due to high administrative costs relative to the amounts reimbursable to employers. User funding could then be reduced by the amounts that fund the Workers’ Compensation Return-to-Work Fund.

Status: Complete.

For further information …


RETURN TO WORK AND DISABILITY MANAGEMENT

International Forum on Disability Management 2010

**Background**

As part of its commitment to disability management, the Commission on Health and Safety and Workers’ Compensation (CHSWC) and the Department of Industrial Relations (DIR) are collaborating with the International Association of Industrial Accident Boards and Commissions (IAIABC) to host the International Forum on Disability Management (IFDM) 2010, in Los Angeles. The Forum will be devoted to multinational dialogue on disability management. Held biennially since 2002, IFDM is the only global conference dedicated to in-depth discussion of problems, trends and best practices in disability management. A major goal of IFDM is to bring key policymakers into the discussion and be an agent of change.

**Description**

IFDM 2010 is expected to bring together over 500 attendees, representing over 25 countries, from the health, safety, and workers’ compensation communities.

The purpose of IFDM 2010 is to bring together policymakers, such as legislators and heads of the executive branches, dynamic leaders in labor, business and insurance, and experts in disability management, including people mastering personal disability. Representatives of organizations with an interest in disability issues and a commitment to more effective systems for overcoming barriers to the rehabilitation and full integration of workers with disabilities in gainful employment will participate in presentations, discussions and workshops.

The goals of the conference include:

- Highlight how disability management benefits, workers, businesses and society.
- Offer convincing evidence that disability management processes are being widely adopted and are successfully helping disabled individuals find and maintain gainful employment.
- Identify the effects of periods of economic crisis on disability management in both industrialized and non-industrialized economies.
- Identify public policy and institutional changes that industrializing economies can feasibly use to manage disability in their workforce.
- Highlight success stories for large, medium-size and small employers in disability management, including prevention and stay-at-work and return-to-work programs.
- Acquaint participants with leading international experts on disability management through presentations and informal networking.
- Share best practices for gaining stakeholder cooperation and achieving measurable gains in disability management.
• Provide a forum for sharing different models of government safety net programs and incentives.

• Identify disability management performance metrics, data gathering, analysis, interpretation, reporting and dissemination that lead to better disability management among employers and regulatory agencies.

• Persuade government decision-makers that public policy initiatives, with multi-stakeholder support, have made significant and practically achievable gains in assisting disabled individuals find and maintain gainful employment.

Key topics will conclude:

• A global perspective: successful partnership in disability management; quantifying the value of disability management; overview of global trends in the workplace.

• The new paradigm: changing social attitudes toward disability management.

• Next steps in moving disability management forward.

• The government’s role in disability management; models from around the world.

• The state and disability management; lessons learned from government initiatives and reforms.

• Emerging economies and disability management.

• Legal aspects of disability management.

• Using research and information to guide public policy decisions on disability management.

• Innovative programs in workplace health and safety: an employer perspective.

• Identifying resources to assist in the development and promotion of disability management programs for employers.

• Measuring the value of disability management programs for employers and insurers.

• Measuring the success of disability management certification programs.

• Psychological well-being: addressing the mental barriers to return to work.

• Medical issues in disability management.

• Advances in medical technology and the impact on disability management.
• Disability management techniques to deal with specific medical conditions: chronic disease; depression; cancer; traumatic brain injury; post-traumatic stress syndrome.

• Success stories, case studies and solutions for stakeholders.

• Disability management for special populations.

• Special problems in workforces with large migratory and minority culture segments.

• Evaluating the impact of incentives on the development and implementation of workplace disability management programs.

• Integration of wellness, disability and absence management programs.

• Opportunities and barriers to safe, early and sustainable return to work.

Status: In process.

For further information …

International Forum on Disability Management (IFDM) 2010
www.ifdm2010.org

Commission on Health and Safety and Workers’ Compensation
www.dir.ca.gov/chswc

International Association of Accident Boards and Commissions
www.iaiabc.org
RETURN TO WORK AND DISABILITY MANAGEMENT

California Consortium to Promote Stay at Work-Return to Work

Background

In June 2007, the Commission on Health and Safety and Workers’ Compensation (CHSWC) participated in a Stay at Work (SAW)-Return to Work (RTW) Northern California Summit titled, “Preventing Needless Work Disability by Helping People Stay Employed.” The American College of Occupational and Environmental Medicine (ACOEM) guideline of the same title (advocating effective SAW-RTW processes) was featured and launched breakout discussions focusing on specific recommendations of the guideline among employer, labor, insurer and medical provider stakeholders, and other interested participants. (See http://www.acoem.org/guidelines.aspx?id=566.)

In 2008 and 2009, CHSWC continued to participate in the California Consortium to Promote SAW-RTW (http://www.CASAWRTW.org). This voluntary, multi-disciplinary group of stakeholders was created to continue the initial work of the Summit. CHSWC supports the following disability management definition and goals/objectives of the California SAW-RTW Consortium.

Disability Management

- Disability management, featuring strategies for preventing needless work disability, is an issue of high priority in the United States and the global economy. These strategies comprise some of the most effective means of reducing costs to employers while improving the health and productivity of their workforces.

- Disability management involves key stakeholders concerned with the human and fiscal challenges of work disability: employers of all sizes, both public and private; workers; health care providers; risk managers; labor unions; jurisdictional and local government agencies; the insurance industry; policymakers; and the public. These and other stakeholders are active in the health and safety and workers’ compensation communities of California, as well as in the workplace, labor and disability insurance arena beyond the statutory boundaries defining workers’ compensation (occupational injury and illness.)

Goals/Objectives of the California SAW-RTW Consortium

Vision

"The Vision of the California Consortium to Promote SAW-RTW is to establish in the minds of employers, employees, health care providers, carriers and policymakers the salutary effects of productive employment and the relationship of ongoing employment to health maintenance, disability prevention and accommodation."
Mission

"The California Consortium to Promote SAW-RTW will provide resources and strategies for interested stakeholders to ensure that more California employees stay at and/or return to work."

Ongoing Objectives of the California Consortium

- Promote discussion of the health benefits of productive employment and the relationship of sustained employment to disability prevention and (fulfillment of) statutory requirements for the interactive process for reasonable accommodation under state and Federal laws.

- Discuss incentives for large, medium-size and small employers and for workers to develop and implement effective disability management, including prevention, SAW and RTW programs.

- Assist stakeholders by identifying available resources and service providers in order to help large, medium-size and small employers, health care providers, and labor representatives implement and manage prevention, SAW, RTW and temporary transitional work programs.

- Share effective practices for gaining stakeholder engagement and cooperation as well as for demonstrating measurable fiscal value to stakeholders through disability management.

- Optimize decision-making for the development and implementation of disability management programs through the provision of accessible, evidence-based data and information.

- Determine and implement disability management performance metrics, data gathering, analysis, interpretation, reporting and dissemination that both demonstrate and continuously improve quality in effective disability management.

Status: Ongoing.

For further information …

California Consortium to Promote Stay-at-Work (SAW)-Return-to-Work (RTW)
http://www.CASAWRTW.org
MEDICAL CARE

Medical Study of Impact of Recent Reforms

A Commission on Health and Safety and Workers’ Compensation (CHSWC) study by RAND will evaluate recent legislative changes affecting medical treatment provided to workers who have sustained industrial injuries and illnesses in California. The study will also provide technical assistance in evaluating potential legislative and administrative refinements to the current system, including ways payment incentives might be used to improve the quality of care provided to injured workers.

Background

A series of legislative changes affecting medical care provided to California’s injured workers has been enacted over the past few years to address medical utilization and cost issues. While there is evidence that these changes are reducing medical expenses, the impact of these changes on access, quality and outcomes is unknown. The study will evaluate the impact of the changes both on an individual provision-by-provision basis and in combination. The topics for evaluation include: adoption of the Medicare-based fee schedule; hospital emergency department services furnished to injured workers; and pay for performance. The study will evaluate the impact of the new provisions on cost, quality and access by injured workers to appropriate and timely medical care and will identify issues and address areas of potential concern.

Senate Bills (SB) 228 and 899 made a number of changes that affect how medical-necessity determinations are made for medical care furnished to injured workers. Most notably, the changes included: the treating physician presumption was repealed; presumption was extended to the utilization schedule issued by the Administrative Director (AD) of the Division of Workers’ Compensation (DWC) (i.e., the ACOEM Guidelines); limits were placed on the number of chiropractic, physical therapy and occupational therapy visits per occupational injury; new utilization review (UR) requirements were established; and new appeals processes were created.

The AD of the DWC maintains an Official Medical Fee Schedule (OMFS) that establishes the maximum allowable fees for most medical services. On January 1, 2004, the OMFS was revised to provide for annual updates for acute care inpatient stays based on the Medicare payment system that included an additional pass-through for the cost of devices and instrumentation used in complex spinal surgery. A study funded by CHSWC and conducted by RAND examined the California OMFS payments for inpatient hospital services, facility services for ambulatory surgery, and physician and other practitioner services.

Under SB 228, the OMFS for services other than physician services furnished to injured workers is linked to Medicare fee schedules or, in the case of pharmaceuticals, Medi-Cal. The aggregate payment for each type of service (e.g., inpatient hospital services, outpatient hospital services) is limited to 120 percent of the amount payable.
under Medicare for comparable services. For most services other than physician services, fee schedules tied to 120 percent of the amounts payable under Medicare were implemented in 2004. Physician services were reduced 5 percent but not below the amount payable under Medicare. The study evaluates the impact of the fee schedule changes on access and cost. In addition, any issues of concern that are identified are assessed, and options and recommendations for addressing them are indicated.

As part of the study, CHSWC and RAND are working with the DWC to examine the following issues using the Workers’ Compensation Information System (WCIS) data:

- Processes used to form medical networks, including the considerations affecting the employer decision to establish a medical provider network (MPN), the strategies used to form the network (pre-existing or new, narrow or broad), quality assurance and enrollment processes, profiling, and fee discounting, etc.
- Generation of aggregate payment information by type of service for MPN and non-MPN care.
- Development of measures that could be used in an ongoing system of monitoring of the cost and quality of care provided to injured workers.

**Status:** In process.

*For further information …*


“Inpatient Hospital Services: An Update on Services Provided Under California’s Workers’ Compensation Program,” RAND (January 2009).
[http://www.dir.ca.gov/chswc/Reports/CHSWC_InpatientHospitalServices.pdf](http://www.dir.ca.gov/chswc/Reports/CHSWC_InpatientHospitalServices.pdf)

“Ambulatory Surgery Facility Services Provided to California’s Injured Workers,” RAND (March 2009).

“Hospital Emergency Department Services Furnished Under California’s Workers’ Compensation Program,” RAND (April 2009).
[http://www.dir.ca.gov/chswc/Reports/](http://www.dir.ca.gov/chswc/Reports/)

“Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California’s Workers’ Compensation Program,” RAND (July 2009).
[http://www.dir.ca.gov/chswc/Reports/](http://www.dir.ca.gov/chswc/Reports/)

“Pay-for-Performance in California’s Workers’ Compensation Medical Treatment System,” RAND (August 2007).

“Impact of Physician-Dispensing of Repackaged Drugs on California Workers’ Compensation, Employers’ Cost, and Workers’ Access to Quality Care” (July 2006).
[http://www.dir.ca.gov/CHSWC/Reports/Physician-Dispensend-Pharmaceuticals.pdf](http://www.dir.ca.gov/CHSWC/Reports/Physician-Dispensend-Pharmaceuticals.pdf)
MEDICAL CARE

Quality-of-Care Indicators: A Demonstration Project

Background

Ensuring that workers receive high-quality medical care would benefit both workers and employers. Better medical care would enable workers to make faster and more complete recoveries and reduce time off work which drives economic losses for injured workers. From the employers’ perspective, a lack of a recovery can create a need for more medical care over time, thereby increasing medical costs. Reducing temporary disability (TD) and permanent disability (PD) would decrease economic losses for employees.

The Commission on Health and Safety and Workers’ Compensation (CHSWC) demonstration project by RAND, the “Quality of Medical Care in Workers’ Compensation: Developing General Indicators for Carpal Tunnel Syndrome,” would attempt to suggest a mechanism for monitoring and improving the quality of care provided to injured workers.

Description

A recent landmark study by RAND found that across all health care settings, adults in the U.S. receive only about half of the care recommended by published literature and experts. Researchers also found that quality-of-care problems are pervasive for back and joint injuries, for which a third to half of U.S. patients do not receive appropriate care. The poor-quality care generally provided for back and joint injuries suggests that many injured workers probably also do not receive the appropriate care.

The goal of the project was to demonstrate quality measurement in a workers’ compensation setting and involved four objectives:

- Develop quality-of-care measures for carpal tunnel syndrome (CTS).
- Pilot test the measure in workers’ compensation provider and payor organizations.
- Place measures and supporting tools in the public domain.
- Use the measures to assess quality of care for a larger population of patients.

Conclusions

Conclusions based on the study include that:

- Quality of care is important in workers’ compensation settings and quality measures are needed.
- Provider organizations can use the CTS measures and tools developed by the study to monitor quality of care.
- Payors could assess the appropriateness of future surgeries for CTS using the algorithm developed in the study.

Status: Results of the study were presented at the April 30, 2009 Commission meeting.
MEDICAL CARE

Occupational and Non-Occupational Integrated Care

**Background**

Group health costs have been rising much more quickly than inflation and wages. Costs have been rising even more quickly for treatment of occupational injuries in the California’s workers’ compensation system. This creates major financial challenges for employers, especially those in industries with already high workers’ compensation costs. Furthermore, group health care and workers’ compensation medical care are typically delivered through separate provider systems, resulting in unnecessary, duplicative and contraindicated treatment, and inefficient administration.

Integration of group health and workers’ compensation medical care is an alternative to two separate systems of medical care. The basic concept of occupational and non-occupational integrated care (ONIC) is having the same physician or medical group treat all conditions, both occupational and non-occupational, regardless of the cause of injury and illness. Moving beyond this basic concept, the insurance products could also be integrated. An integrated system could offer savings on medical utilization, unit pricing and administrative expenses while potentially offering improvements in the quality of care. A secondary advantage of integration could be expanding access to affordable medical insurance.

**Description**

**Phase One: Partnerships**

The initial phase of this project involved a partnership of the Commission on Health and Safety and Workers’ Compensation (CHSWC), the California HealthCare Foundation (CHCF), the University of California (UC), Berkeley, DMS Facility Services, and the Service Employees International Union (SEIU) Local 1877 in a pilot program of integrated occupational and non-occupational medical care. The pilot is part of a carve-out agreement and uses Kaiser Permanente for delivery of both workers’ compensation medical care and group health benefits. The goal of the pilot is to identify areas of administrative savings and ways to reduce litigation. UC Berkeley is conducting data analysis for pricing issues and developing the evaluation strategy.

Savings are expected in medical utilization, indemnity costs, and administration. Medical services are expected to be delivered with fewer delays and disputes, enabling injured employees to recover more fully and return to work sooner.

**Phase Two: Evaluating the Potential for Savings Under Integration**

The current phase of the integration of care project involves a partnership between CHSWC, CHCF and UC Berkeley. Led by Frank Neuhauser at UC Berkeley, the project team is calculating the administrative and overhead cost of delivering occupational medical care under workers’ compensation insurance. The administrative costs are carefully segregated into loss adjustment expense, underwriting expenses and profit. Each of these cost categories from workers’ compensation is then compared to the counterpart in private health insurance.

This study confirms that workers’ compensation has administrative costs several times higher than private health insurance and that integration offers opportunities for substantial savings as discussed below.
**Administrative Costs of Insurance**

- In California, based on review of all rate filings by insurers between 1999 and 2009, the administrative cost of delivering medical treatment for occupational injuries and illnesses through workers’ compensation insurance is between 52 percent and 57 percent of insurance premiums.

- A review of aggregate data on 37 other states finds similar, or possibly higher, administrative costs for workers’ compensation.

**Savings Under 24-hour Care**

- Integrating occupational and non-occupational medical treatment under the more efficient health insurance system would reduce administrative costs and produce large one-time savings from switching insurance models.

- Nationally, savings in the first ten years would be between $490 billion and $560 billion.

- In California, integration would produce savings in the first ten years of $100 billion to $120 billion.

**Next Steps**

- The working paper is now available. CHSWC and CHCF will aid in the dissemination of draft materials for public comment.

- CHSWC will create an Advisory Group to discuss the findings of the study.

- The National Academy of Social Insurance (NASI) is interested in hosting a national conference in 2010 on the issue of integration, focusing on the California example.

**Status:** Ongoing.

*For further information …*


“Integrating Group Health and Workers’ Compensation Medical Care Factsheet” (2008).
http://www.dir.ca.gov/chswc/Reports/CHSWC_IntegrationofCareFactsheet.pdf

WORKERS’ COMPENSATION REFORMS

Medical-Legal Study

Background

Reform legislation changes to medical-legal evaluations were intended to reduce both the cost and the frequency of litigation, which drive up the price of workers’ compensation insurance for employers and lead to long delays in case resolution and the delivery of benefits to injured workers.

In 1995, the Commission on Health and Safety and Workers’ Compensation (CHSWC) initiated a project to determine the impact of the workers’ compensation reform legislation on workers’ compensation medical-legal evaluations. CHSWC contracted with the Survey Research Center (SRC) at the University of California (UC), Berkeley to carry out this study.

Description

The study analysis is based upon the Permanent Disability Claim Survey, a set of data created each year by the Workers’ Compensation Insurance Rating Bureau (WCIRB) at the request of the Legislature to evaluate the 1989 reforms. WCIRB data summarize accident claim activity, including such measures and elements as disability rating, the type and cost of specialty examinations, zip codes to facilitate regional analysis, and whether the case was settled and, if so, the method of settlement employed.

Findings

The study determined that a substantial decline in total medical-legal costs occurred during the 1990s. The decline in total medical-legal costs for insurers results from significant decreases in total number of permanent partial disability (PPD) claims and in the average number of medical-legal evaluations per claim. The source of savings can be attributed in equal proportion to the reduction in the number of evaluations performed per claim and the decline in PPD claim frequency. Starting in 2005, there was a significant increase in average cost of a medical-legal evaluation component of the total medical-legal cost.

Status: The medical-legal study was initiated in 1995 and is ongoing.

Advisory Committee

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WCIRB
Larry Law
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Karen Yifru
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Project Team

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FRAUD

Anti-Fraud Studies and Activities

This section describes the findings from Commission on Health and Safety and Workers’ Compensation (CHSWC) studies on fraud and fraud measurements.

Background

The California State Auditor Report on Workers’ Compensation Fraud in 2004 indicated that:

- Over 30 million dollars a year are spent on anti-fraud activities.
- Baselines for measuring the level of fraud need to be developed to evaluate if anti-fraud efforts have reduced the overall cost that fraud adds to the system by as much or more than what is spent annually to fight it.
- Efforts to detect and prevent workers’ compensation fraud need to be adequate.
- Cooperation between agencies to improve efforts to detect and prevent workers’ compensation fraud is critical.

At the December 10, 2004 meeting of the Commission, William Zachry, Chair of the Fraud Assessment Commission (FAC), requested that CHSWC assist FAC with anti-fraud research.

On February 4, 2005, a working group met and decided that FAC and CHSWC would partner with agencies, including the California Department of Insurance (CDI), to put together a study design on how to measure workers’ compensation medical provider fraud and other types of suspected workers’ compensation fraud in California and then would issue a request for proposal (RFP) on the study.

Funds were allocated by FAC in 2006 to conduct a study of medical overpayments and underpayments as a way to benchmark medical provider fraud and develop detection and measurement methods. A Request for Proposal (RFP) was made public in May 2006, and proposals were submitted in June 2006. Navigant Consulting was selected to conduct the Medical Payment Accuracy Study.

In addition to that joint project with CDI, CHSWC has been conducting complementary studies that address other issues of suspected fraud and non-compliance, as well as the measurement of their magnitude and type. CHSWC relies on partnerships and stakeholder experts for review of results and proposed recommendations. The following is a brief review of recent fraud studies and their objectives. A separate “Special Report: Fraud Studies” provides more detail on these studies and activities.

Description

The objectives of the fraud studies include:

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<th>Project Team</th>
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<td>William Zachry</td>
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<td>Fraud Assessment Commission</td>
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<td>Christine Baker</td>
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<td>D. Lachlan Taylor</td>
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<td>CHSWC</td>
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<td>Irina Nemirovsky</td>
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<td>Les Boden, Ph.D.</td>
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<td>Paula Douglass</td>
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<td>Donna Gallagher</td>
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<td>Frank Neuhauser</td>
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<td>Catherine Sreckovich</td>
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<td>Navigant Consulting</td>
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• Determine the extent of workers’ compensation medical overpayments and underpayments of all types, including suspected fraud, waste, abuse, and billing and processing errors in order to allocate the appropriate level of resources to detect and evaluate suspected medical provider fraud in California. This study was carried out jointly by FAC and CHSWC. (See “List of Projects and Studies.”)

• Estimate the percent or number of uninsured employers.

• Identify uninsured employers operating in the underground or “gray” economy.

• Determine under-reporting of injuries.

• Determine misreporting of payroll and estimate the degree of premium avoidance by insured employers.

• Estimate the degree of misreporting of split class codes, when lower-wage worker payrolls are reported as higher-wage ones in order to take advantage of the lower premiums in the higher-wage class codes. (See “List of Projects and Studies.”)
FRAUD

Underreporting of Injuries: “Reporting of Workers’ Compensation Injuries in California: How Many are Missed?”

Background

Underreporting of occupational injuries and illnesses may occur in response to increases in premium costs. Such underreporting is often proposed as a partial explanation for the continuing decline in occupational incidence rates. The Commission on Health and Safety and Workers’ Compensation (CHSWC) contracted with Boston University to conduct this injury reporting study, using a large sample of Workers’ Compensation Information System (WCIS) data and Bureau of Labor Statistics (BLS) data and applying a capture-recapture analysis methodology.

Objectives

The purpose of the study was to:

- Describe the proportion of injuries and illnesses that are underreported and the demographic, work and employer characteristics of underreported injuries and illnesses.
- Describe the nature of non-reported injuries/illnesses and the reasons for non-reporting.
- Provide improved estimates of incidence and underreporting for all cases involving more than three days off work or permanent partial disability.

The approach of the study was to:

- Use individual workplace injury reports to workers’ compensation agencies and BLS data to measure underreporting. Specifically, the research procedure is to:
  - Collect BLS and worker’s compensation injury data.
  - Use both sources to improve injury estimates.
  - Match individual injury records.
  - Obtain the number of injuries reported to either workers’ compensation agencies or BLS.
  - Estimate the number reported to neither workers’ compensation agencies nor BLS.

Participating states were California, Minnesota, New Mexico, Oregon, Washington, West Virginia and Wisconsin.

The data sources for this study were:

- State Workers’ Compensation Databases:
  - Focus on lost-time injuries.
  - First and subsequent reports.
BLS Annual Survey of Injuries and Illnesses:
- Stratified probability sample of employers.
- Based on OSHA 300 injury reports.
- Provides state and national estimates of non-fatal injury incidence.

Findings
- The most conservative estimate of reporting of workplace injuries in California suggests that 21 percent to 25 percent of lost-time injuries go unreported to WCIS. A less conservative estimate of underreporting implies that 40 percent of lost-time injuries went unreported.
- Reasonable alternate scenarios allow for the likelihood that reporting an injury to BLS increases the likelihood that it will be reported to WCIS. Under these circumstances, researchers estimate that only about 2/3 of injuries are reported to WCIS. This incomplete reporting places California in the middle of the seven states researchers studied.
- There appears to have been an increase in reporting from injuries occurring in 2003 to injuries between July 2004 and June 2005. This suggests that the 2004 reforms probably did not lead to a decline in the reporting of injuries to WCIS. Researchers do not know whether this increase is a random fluctuation or a stable change.
- From a policy perspective, benefit payment is at least as important as injury reporting. Researchers do not know how many workers receive benefits for injuries that go unreported to WCIS. It seems likely that benefits have been paid but not reported in many cases; however, evidence about this is inadequate to support an estimate.
- Injured workers with unreported injuries may be eligible for workers’ compensation benefits but receive none. In this case, the unpaid workers’ compensation benefits pose a burden to the injured workers and their families, health insurance programs, and public and private disability programs.

Recommendations
- CHSWC, the Division of Workers' Compensation (DWC), the California Department of Public Health (CDPH), the Division of Labor Statistics and Research (DLSR), and Cal/OSHA should convene an interagency underreporting task force to develop a plan for improving WCIS reporting. This would include identifying late reporting, but also identifying employers, insurers and third-party administrators (TPAs) that do not report compensated injuries. In doing so, these agencies should convene an interagency underreporting task force to develop a plan for improving WCIS reporting. This task force could include not only knowledgeable people from these agencies, but also people involved in other relevant activities, like California's reporting to the BLS survey and planning for the California Trauma Registry.

Specific recommendations include:
- DWC could strengthen its efforts to identify problem areas in reporting of compensated injuries. This would include identifying late reporting, but also identifying employers, insurers, and TPAs that do not report compensated injuries. In doing so, DWC may identify problems in the way reporting systems work, in addition to identifying noncompliance with reporting requirements.
PROJECTS AND STUDIES

- DWC and Cal/OSHA could consider collaborating to identify employers who underreport injuries. Employers who engage in substantial underreporting to either system could be given substantial penalties, and the program and penalties could be publicized. DWC could also consider penalties for late reporting to WCIS. If current laws and regulations are inadequate to support such a program, this could be addressed.

- DWC could begin an inquiry into the 40-50 percent of reported claims that lack information about benefit payments. DWC could draw a random sample of such cases with dates of injury at least three years in the past from a subset of claims administrators for insurers, TPAs and self-insured employers. Initially, the claims administrators might be chosen because they have a relatively high proportion of cases lacking benefit reports. DWC could submit the sample to the trading partners and request up-to-date information on benefit payments and claim status. From this information and discussions with trading partners, DWC may be able to diagnose systematic problems and develop solutions.

- California collects data on hospital and emergency room discharges and from ambulatory surgery clinics through Medical Information Reporting for California (MIRCal). DIR might explore whether these data could be used to look for unreported workplace injuries and illnesses. The data contain diagnosis and social security number of the patient and identify the expected source of payment. They do not identify the employer. If WCIS data included state Employment Development Department (EDD) account numbers (EANs), cross-matching with EDD wage files to determine the employer would be easier and more accurate. It is not known if there are any legal issues precluding this use of MIRCal data.

- CHSWC could explore linking other state occupational safety and health information systems with WCIS data to determine whether injuries and illnesses have been reported and compensated where appropriate.

- The Department of Industrial Relations (DIR) could explore automating the doctor’s first report of occupational injury or illness and requiring all doctor’s first reports to be electronically transmitted. For example, reports could be filled out on the Internet and automatically transmitted to DIR. These reports could be compared with WCIS files to determine where underreporting occurs.

- DWC may want to consider rejecting reports of injury with invalid or incorrect EINs. These numbers can be valuable for potential uses of WCIS, including but not limited to the underreporting issue.

- DWC should consider adding the state EAN as a required field in the First Report of Injury. This would allow easier and more accurate linkage with EDD wage files and other state data collected from employers.

- California has recently added workers’ compensation questions to the State’s Behavioral Risk Factor Surveillance System (BRFSS) survey. This could be used as another way to determine the extent of workers’ compensation underreporting. Over time, it could be used to determine whether reporting is improving.

Status: Completed.

For further information …

“Reporting Workers’ Compensation Injuries in California: How Many are Missed?” (August 2008).
FRAUD

Premium Avoidance by Insured Employers

Background

In the absence of auditing or accountability, an employer seeking to minimize insurance costs has incentives to misreport payroll for different types of employees. If employers do misreport payroll, it would be expected to be more prevalent during periods when costs are high. Consequently, employers would report less payroll as workers’ compensation costs as a percentage of payroll increase. The Commission on Health and Safety and Workers’ Compensation (CHSWC) contracted with University of California (UC), Berkeley to estimate the magnitude of misreported payroll in the system.

Objectives

The purpose of the study is to determine the extent of underreporting by:

- Examining the reporting behavior of employers’ reported payroll for premium calculation compared to actual payroll.

- Comparing any underreporting to premium rates in order to determine possible trends and relationships in underreporting/misreporting.

- Describing reporting behaviors in low-risk, low-premium classes and high-risk, high-premium classes at different premium rate levels in history.

The approach of the study is to analyze:

- Changes in reported exposure and premium rates over time, by different employers and by different risk and premium classes, using Workers’ Compensation Insurance Rating Bureau (WCIRB) data and reported wages from the Current Population Survey (CPS), a Census Bureau survey.

- Whether misreporting changes results in unfairly high premium rates for honest employers.

- The extent to which experience modifications (Ex-mods) correct for misreporting.

Findings

From 1997 to 2005 (the most recent data available at publication), there was a substantial underreporting of premium by employers. Underreporting ranges from a low of 4 percent in 1997, when rates were substantially lower, to an excess of 10 percent in 2004, when rates were several times higher than 1997. This amounts to about $15 billion of underreported payroll in 1997 and to $60 billion in payroll in 2004.

Between $15 and $60 billion of payroll annually is underreported over this period for employers that should be insured for workers’ compensation insurance. This includes the underground economy and underreporting by employers that do have insurance. The result is that premium rates are likely to be unfairly high for honest employers who probably face rates three to 10 times higher in the high-risk class codes than they would face under full reporting. Underreporting also affects the competitiveness of honest employers. There are only limited incentives for insurers to accurately monitor underreporting, and underreporting is probably offset by the higher premium rates that are observed.
Possible next steps include:

- Consider ways to improve auditing incentives and behavior:
  - Have “Test Audit” program conducted by an independent auditing entity.
  - Open audit results to public access at insurer level.
  - WCIRB to report at least direction of test audit errors.
  - Increase civil penalties for under- and misreporting.

- Consider ways to improve reporting incentives and behavior:
  - Allow insurers access to employer reporting to the Employment Development Department (EDD) for tax and unemployment insurance (UI).
  - Employers identify individual workers in high-risk classes.
  - Integrate occupational and non-occupational healthcare.

**Status:** Completed.

For further information …


http://www.dir.ca.gov/chswc/allreports.html
FRAUD

Uninsured Employers Benefits Trust Fund

Background

All employers in California except the State are required to provide workers’ compensation coverage for their employees through the purchase of workers’ compensation insurance or by being certified by the State as permissibly self-insured. However, not all employers comply with the law to obtain workers’ compensation coverage for their employees.

The Uninsured Employers Benefits Trust Fund (UEBTF) was established to provide for the payment of workers’ compensation benefits to injured employees of illegally uninsured employers. Labor Code Sections 3710 through 3732 describe the operation of the Fund, and Labor Code Section 62.5 describes the funding mechanism for UEBTF.

Description

UEBTF is administered by the director of the Department of Industrial Relations (DIR). Funding comes from assessments on all insured and self-insured employers annually, from fines and penalties imposed on illegally uninsured employers when they get caught, and from recoveries from illegally uninsured employers when UEBTF has paid benefits and is able to obtain reimbursement from responsible employers.

Concerns have been raised about UEBTF from both employers and workers. Law-abiding employers are concerned about cost shifting to the UEBTF by illegally uninsured employers. Workers are concerned about the difficulties in obtaining benefits from UEBTF.

Findings

Past findings include:

- Identifying and locating uninsured employers along with proper enforcement would reduce the costs to stakeholders in the workers’ compensation system.

- The surest way to reduce the long-term cost of UEBTF is to reduce the prevalence of illegally uninsured employers. In a Commission on Health and Safety and Workers’ Compensation (CHSWC) 1998 study on illegally uninsured employers, the rate of uninsured employers was found to be 9 percent of the system as a whole. For new employers and in the targeted industry of auto/truck repair, 15 percent and 20 percent, respectively, were uninsured.

- Labor Code Section 90.3 provided for a program to identify illegally uninsured employers through targeting and data matching. Due to lack of resources, this program was never implemented. In 2007, Senate Bill (SB) 869 was signed into law and set forth administrative funding as well as mandatory reporting on the program’s performance.

- There is a lack of knowledge of UEBTF and civil procedure in the workers’ compensation community.

- Unrepresented applicants lack easy access to UEBTF. Of some 1,800 claims filed during the 2007-2008 fiscal year, only four or five were filed by unrepresented applicants according to UEBTF. Injured workers will probably continue to require attorneys if they wish to pursue any of the additional remedies available against illegally uninsured employers.

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• Applicants’ attorneys have consistently complained about the many technicalities and formalities with which they must comply to file a valid claim. The process cannot be greatly streamlined because it is necessary to build a case that can ultimately lead to a civil judgment against the illegally uninsured employer.

• Medical providers incur increased losses on liens while waiting to get paid.
• UEBTF does not get involved early enough in the claims.
• According to UEBTF, it learns of a claim on an average of ten months after the injury.
• Frequently, the claim is not promptly pursued by the injured worker because the employer pays bills directly for a while.
• Other times, the injured worker goes without treatment until a critical situation arises or he or she initially receives treatment from Medi-Cal or another program.

Recommendations
Past recommendations include:

• Publicize and enforce the workers’ compensation coverage requirement.
• Provide workers’ compensation coverage information.
• Improve methods to help workers access benefits from UEBTF.
• Encourage reporting of suspected illegally uninsured employers.
• Protect and improve UEBTF.
• Further educate the workers’ compensation community.

Recent Initiatives and Outcomes
• In collaboration with CHSWC, the Division of Workers’ Compensation (DWC) initiated in late May 2009 a pilot enhanced customer service initiative in one Information & Assistance (I&A) Office to assist unrepresented injured workers in properly identifying employers and serving papers. The pilot will formally review results after one year, but has already reported positive outcomes. DWC released updated Guides for filing UEBTF claims in May 2009 to clarify and streamline instructions.
• CHSWC has funded the development of a UEBTF booklet in simple language for use by uninsured workers, and it is being translated into Spanish.
• Progress is being made in following the requirements of Labor Code Section 90.3, as evidenced by the Division of Labor Standards Enforcement (DLSE) release in June 2009 of the first report required by Labor Code Section 90.3.

Status: In process

For further information …

FRAUD

Uninsured Employers Benefits Trust Fund Educational Booklet

Background

Injured workers whose employers are illegally uninsured or whose employers do not provide information about their insurance face significant hurdles in requesting workers’ compensation benefits, either from the employer or from the Uninsured Employers Benefits Trust Fund (UEBTF). It is often difficult or impossible to determine the legal name and address of the employer, obtain coverage information from the Workers’ Compensation Insurance Rating Bureau (WCIRB) because of the difficulties naming the employer, and find and properly serve the employer because the employer is avoiding service of process.

Objectives and Scope

Injured workers, legal services organizations, and agencies that investigate workers’ compensation fraud have expressed a need for these workers to receive help and support in following the steps described above. The Division of Workers’ Compensation (DWC) has produced basic materials on steps to take in a UEBTF case. Further educational work is needed to clarify and fully explain the procedural steps set forth in these materials with easy-to-understand terminology and examples. Funding has been approved for University of California (UC), Berkeley staff to assist the Commission on Health and Safety and Workers’ Compensation (CHSWC) in developing a fully designed educational booklet based on DWC materials and advisory input from members of the workers’ compensation community.

This project is being coordinated with the Commission’s project to streamline the UEBTF process and offer additional services to injured workers of uninsured employers and to pilot these services with the Information & Assistance office in Salinas. The booklet was drafted based on the design of the pilot. It is being revised to incorporate comments from the Legal Unit of the Office of the Director of Industrial Relations (DIR). It will then be distributed to other advisors for their review and comment.

The booklet will be available online and distributed at I&A Offices; a Spanish version will also be available.

Status: In process.

For further information …

http://www.dir.ca.gov/CHSWC/Reports/UEBTF-Final.pdf
FRAUD

Uninsured Employers Operating in the Underground or “Gray” Economy

Background

An unknown fraction of employers operate partially or entirely outside the standard economy, going uncovered for workers’ compensation insurance as well as committing other wage and tax violations. Honest employers, workers, state social programs, the state general fund, and the federal government all suffer the consequences of fraudulent underground activity. Despite the important and extensive impact the underground economy has on honest employers and their workers, there are almost no useful estimates of the extent of the underground economy, the amount of premium and taxes avoided, or the differential impact on employers by industry. The main reason for this lack of information is that by operating underground, these employers remain outside most mechanisms used to track and measure economic activity.

Underground or “gray” economy employers may represent a major fraction of the uninsured employer population. Often, these employers are only identified when a worker files a claim with the Uninsured Employers Benefit Trust Fund (UEBTF).\(^6\)

Objectives

The purpose of the study is to:

- Examine the impact of the enforcement mechanisms already in place to deter underground activity.
- Estimate the impact of enforcement mechanisms (sweeps, fines, etc.) on reported employment, reported payroll and related taxes, workers’ compensation coverage, and worker safety.
- Examine the incentives related to fines and penalties imposed during enforcement.
- Propose how enforcement procedures could increase compliance.
- Propose how enforcement procedures could measure the underground economy and progress towards better compliance.

The main approach of the study is to:

- Identify the population of all employers, industries and geographic areas subject to enforcement sweeps and other systematic enforcement efforts.
- Identify comparable groups of employers by industry and geography, but not affected by the specific, systematic enforcement.
- Compare the affected employers with the comparison not-affected employers and measure the change, if any, in the compliance with:
  - Workers’ compensation coverage.
  - Payroll reporting.
  - Tax payments.

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\(^6\) UEBTF is also still commonly called the Uninsured Employers Fund (UEF).
• Other labor and wage regulations.

In addition, the study will:

• Compare various types of enforcement (industry-based, geography-based, community-state partnerships, etc.) and evaluate which approaches are most cost-effective.

• Develop recommendations on refining enforcement and penalty assessment strategies.

Status: In process.
INSURANCE INDUSTRY

Insolvent Insurers

Background

Since insurance rates were partially deregulated in 1995, the California workers' compensation system has been very volatile. For reasons that go beyond price deregulation, there have been dramatic swings in workers' compensation prices and insurer underwriting profits, and a substantial number of insurers, including some of the largest market participants, have failed.

Pursuant to Senate Bill (SB) 316, which was signed into law in 2007, the Commission on Health and Safety and Workers' Compensation (CHSWC) conducted the CHSWC/RAND/Navigant Consulting study, “The Insurance Insolvency Study: California’s Volatile Workers’ Compensation Insurance Market, Problems and Recommendations for Change.” This study identifies and examines factors that contributed to increased market volatility and the large number of insolvencies following price deregulation. It also examines the regulatory system for overseeing the workers' compensation market and how the California Department of Insurance (CDI) responded to the market turmoil that followed the move to open rating. Based on the findings, recommendations are made that aim to reduce the volatility of the market and the frequency of insolvencies while realizing the benefits of a competitive market.

Description

The purpose of this report is to identify the different factors that contributed to increased market volatility and the large number of insolvencies following price deregulation and to suggest policy changes to reduce the severity of these problems in the future. Findings and recommendations are based on information obtained through interviews with a wide range of interested parties, detailed examination of eight insurer groups that became solvent and eight insurance groups that survived, a review of previous studies, and an analysis of data from the Workers' Compensation Insurance Rating Bureau (WCIRB) and CDI on the overall market.

Findings

Several key factors contributed to the insolvencies and volatility over the past 15 years: inaccurate projections of claim costs; pricing below expected costs; reinsurance contracts that gave insurers and reinsurers insufficient stake in the profitability of the policies they wrote; managing general agents who had little financial interest in the ultimately profitability of policies; under-reserving by insurers; and insurer surplus and capital that were inadequate to provide a cushion against adverse events.

Based on the findings, policy recommendations will be presented in the study that could reduce the volatility of the market and the frequency of insolvencies while realizing the benefits of a competitive market.

Status: The report was released for public comment in December 2009.
INSURANCE INDUSTRY

Claims Adjuster and Bill Reviewer Training

Background

At the November 6, 2008 meeting of the Commission on Health and Safety and Workers’ Compensation (CHSWC), the Commission instructed staff to review the regulation, compliance and enforcement of claims adjuster and bill reviewer training and certification. This paper reviews the existing rules and oversight process.

At the December 12, 2008 CHSWC meeting, the draft report which reviewed regulation, compliance and enforcement of claims adjuster and bill review training and certification was presented and approved for distribution for public comment and feedback. The Commission also requested that CHSWC staff hold an Advisory Group meeting to look further into the oversight process for claims adjuster and bill reviewer certification.

The report, “Revised Claims Adjuster and Bill Reviewer Training and Certification by Insurers Report,” updates the December 2008 report and includes information from the Claims Adjuster and Bill Reviewer Training and Certification Advisory Group meeting.

Description

The California Department of Insurance (CDI) is directed by statute to require insurers to assure that the individuals responsible for handling their claims will meet a minimum standard of training or experience. “Insurer” is defined for this purpose to mean a workers’ compensation insurance carrier, a self-insured employer, or a third-party administrator (TPA) for a self-insured employer. The regulations allow those insurers to manage the training and to designate as trained or experienced the individuals who have received the required training, including continuing education.

Three different levels of claims adjusting responsibility may be designated, each with its own required training and post-designation continuing education. The levels are Claims Adjuster, Medical-Only Claims Adjuster, and Medical Bill Reviewer. After an individual has been designated as “trained” at one of these levels, the regulations require periodic post-designation training. There is also a provision for designation of “experienced” claims handlers in each level. The “experienced” designation served to grandfather in many working claims handlers at the time the new program took effect, and it serves to qualify individuals to supervise trainees handling claims prior to completing training. As an alternative to the specified claims adjusting experience, an individual may be designated as an Experienced Claims Adjuster after passing the comprehensive examination issued by the Department of Industrial Relations (DIR) to qualify as a self-insurance administrator.

The designation of a trained or experienced adjuster or reviewer is issued by the insurer whether or not the insurer is the direct employer. Records of training or experience must be obtained and retained by the insurer. The designation is portable with the individual. The only filings required with CDI are the insurer’s certification of the total numbers of persons adjusting its claims and the numbers of those persons who are designated as trained or experienced, as well as the insurer’s certification that the training complies with the requirements.

Insurers (as defined to include self-insured employers and third-party adjusters) are the regulated entities under this program; this is not an adjuster-licensing program. No penalties are prescribed for insurers who do not comply. CDI does not have jurisdiction over self-insured employers or their third-party adjusting agents. Both CDI and DIR are entitled to access to insurer (as defined) records of claims.
handlers’ training and experience, so verification of compliance is possible through one department if not the other.

At the request of the Commission at its December 12, 2008 meeting, CHSWC staff held an Advisory Group meeting on January 23, 2009, to look further into the oversight process for claims adjuster and bill reviewer certification. The key question for the Advisory Group was whether there is sufficient oversight of the program and if not, what enforcement needs to be implemented. Also discussed was whether this is a training issue or an area that might be best left to the courts to enforce through adjudication of benefits or penalties, case-by-case.

The conclusion to the December 2008 report is that the program is relatively new, and its strengths and weakness are not fully recognized yet. It is awkward for a single program to oversee the operations of both insurance carriers and self-insured employers because they are under the jurisdictions of different departments of state government. Mechanisms are available to encourage compliance.

**Recommendation**

The CHSWC staff recommendation based on discussion at the Advisory Group meeting was that any enforcement of claims adjuster and bill reviewer training should be the responsibility of the respective agencies currently responsible for self-insureds and their TPAs and for insurance companies.

For self-insureds and their TPAs, enforcement should be done by the Office of Self Insurance Plans (OSIP) and it should include confirming that the entities under its jurisdiction which are required to certify their claims adjuster and bill reviewer training have in fact submitted the required certifications to CDI. For insurance companies, CDI has advised that they are working to ensure complete compliance by the companies. The statute does not specifically provide enforcement powers, but the respective departments may consider judicious use of general oversight authority. A department can at least encourage compliance without need for statutory authority.

In addition, increased education and outreach should be implemented by DIR and CDI to improve compliance.

**Status:** Completed.

*For further information …*

“Revised Claims Adjuster and Bill Reviewer Training and Certification by Insurers Report” (April 2009).
INSURANCE INDUSTRY

Self Insurance Groups

Background

Self insurance groups (SIGs) in the private sector are a comparatively new phenomenon in California. Private sector employers in California must secure the payment of their workers’ compensation obligations either by obtaining workers’ compensation insurance or by obtaining from the State a certificate of consent to self-insure. Since the early years of the workers’ compensation system, individual employers with sufficient financial capacity have been able to obtain the State’s consent to self-insure. Public entities have also been permitted to self-insure, either individually or in groups called joint powers authorities (JPAs) for decades. Private group self insurance, however, was not authorized by statute until 1993, and the first private sector SIG in California was approved effective January 1, 2002.

By the end of 2007, SIGs reported over $5.2 billion in covered payroll, nearly 6 percent of the total payroll covered by all private sector self insurance. There were 28 active SIGs in California as of February 2009, ranging from groups of three members up to a group of 743 members. One SIG reported over $1.1 billion in covered payroll. In 2007, SIGs paid an aggregate of $21,610,856 in indemnity benefits and $28,786,674 in medical benefits. This growth has taken place under a statutory framework that added only a few words to the statutes governing individually self insured employers and under regulations that were likewise based largely on the regulations that were designed for individually self insured employers.

Description

Both the market for group self insurance and the regulatory oversight of group self insurance are now undergoing a first stage of maturation. Some SIGs are closing or undergoing changes as their business models prove to be poorly suited to the current economic climate. An extensive overhaul of the regulations was adopted effective March 2, 2009, after more than three years of work by the Department of Industrial Relations (DIR) and its Office of Self Insurance Plans (OSIP). At the same time, other states with longer histories have provided examples of what can go terribly wrong when SIGs are not adequately regulated and supervised.

In the context of these changes, and mindful of the widely publicized failure of several large self insurance trusts in the state of New York, Assembly Member Joe Coto, Chair of the California Assembly Insurance Committee, requested on October 6, 2008, that the Commission on Health and Safety and Workers’ Compensation (CHSWC) analyze the statutory and regulatory oversight of workers’ compensation self insurance groups and make recommendations to ensure the viability of these programs.

Status: Completed.

For further information …

“Report on Self Insurance Groups”
(December 2009).

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Sources: Office of Self Insurance Plans website and e-mail correspondence 1/8/2009.
INFORMATION FOR WORKERS AND EMPLOYERS

Return-to-Work Handbook

Background

The Commission on Health and Safety and Workers’ Compensation convened a Return-to-Work/FEHA/ADA Advisory Group on December 9, 2008, to discuss how to improve return to work and improve information for workers and employers in order to reduce confusion and litigation. The Advisory Group emphasized that there is a need for a new and better approach to return to work, especially with an aging workforce and the economy shedding jobs.

Objectives and Scope

The Advisory Group recommended that a new Return-to-Work/FEHA/ADA handbook be developed to address the recognized difficulties in simultaneously complying with both workers’ compensation and disability rights laws in California, especially for small employers.

The new handbook, *Helping Injured Employees Return to Work: Practical Guidance Under Workers’ Compensation and Disability Rights Laws in California*, includes discussion of:

- Legal requirements:
  - How does workers’ compensation law protect injured employees from discrimination?
  - What are employers’ obligations under the Fair Employment and Housing Act (FEHA)?

- Best practices in returning an injured employee to work:
  - How can employers comply with the requirements of the interactive process under FEHA?
  - What are the time frames for engaging in the interactive process and offering work?
  - Examples of return to work in construction and agriculture

- Establishing an effective return-to-work program:
  - How can employers carry out best practices?
  - What can be done to ensure that everyone assumes their roles and responsibilities?
  - Why should employers evaluate existing jobs and working conditions?

The handbook includes Appendix sections with additional resources on:

- Physician’s and insurer’s roles.
- Job accommodations.
- Workers’ compensation benefits, rights and procedures.
- Disability rights and procedures under FEHA.
• California workers’ compensation laws.

• California disability rights under FEHA.

The Handbook was undertaken to address the recognized difficulties in simultaneously complying with both workers’ compensation and disability rights laws in California, especially for small employers. Recommendations for the Handbook include:

• Provide an informational piece that explains to employers, employees, clinicians and other interested parties how various benefits interact with one another;

• Present best practices for bringing an injured employee back to work including FEHA and workers’ compensation and workers’ compensation and human resources, and how to make them compatible with the required interactive process.

• Clarify roles and responsibilities for employers, workers and clinicians.

• Provide a tool kit including: common timeframes, common vocabulary, and common requirements for the different return-to-work processes; a model interactive process; sample notifications; and a list of available resources.

• Develop strategies for dissemination, including working with organization that would promote the handbook and facilitate translation into multiple languages.

**Status:** In process.
OCCUPATIONAL SAFETY AND HEALTH

The Impact of Worker’s Compensation Experience Modification Rating (Ex-mod) and Firm Age on Safety Behavior and Risk

Background

At the request of the Commission on Health and Safety and Workers’ Compensation (CHSWC), Commission staff held a Health and Safety Research Advisory Committee meeting on November 19, 2007, in Oakland, to identify key health and safety areas where further research and study could help improve workplace health and safety in California. The Advisory Committee included stakeholders in the health, safety and workers’ compensation communities representing insured and self-insured employers, labor, health and safety researchers and state agencies.

One of the recommendations of the Health and Safety Research Advisory Committee was to rigorously identify the consequences of different:

- Safety policies and practices such as workers’ compensation experience modification (Ex-mod) rating.
- Workplace health and safety activities for different types of employers by size, age of firm and industry.

Two areas of research that warrant attention with respect to the above recommendations are how workplace safety behavior is affected by workers’ compensation experience modification rating (Ex-mod) and the safety risk and employer safety behavior within different age firms.

In addition to the above recommendations, the Experience Rating Task Force, established in 2007 in response to concerns expressed by the California Insurance Commissioner, made recommendations regarding research on workers’ compensation Ex-mod. The Task Force report suggested that research opportunities to “evaluate the effectiveness of experience rating as a safety incentive” should be undertaken “to the extent such research is likely to produce meaningful results relevant to potential future Rating Plan changes.”

Description

The study responds to the above research recommendations of the Experience Rating Task Force and the Health and Safety Research Advisory Committee. The study would evaluate:

- The impact of workers’ compensation Ex-mod on the safety behavior of small, medium-size and large employers.
- The safety risk of new firms versus older firms.

Objectives of the Study

Objectives of this project are to identify:

- Whether the application of and changes to workers’ compensation Ex-mod has an effect on the safety experience of small, medium-size and large employers in addition to its original purpose of addressing insurer underwriting concerns.
- Whether the application of and changes to workers’ compensation Ex-mod to medium-size and large employers has an effect on their safety experience.

- If employers’ performance now affects their premiums, but overall premiums are declining, would employers pay more or less attention to how to decrease their injury losses?

- Policy recommendations on improving the current workers’ compensation Ex-mod methodology.

- Whether new firms have a greater safety risk than older firms. The analysis will look at firms by payroll, size and rating class.

- Policy recommendations on safety interventions if new firms are determined to be more unsafe than older firms.

**Status:** In process.
OCCUPATIONAL SAFETY AND HEALTH

Evaluation of the Effectiveness of California's Injury and Illness Prevention Program and Compliance Officers' Inspections

Background

At the request of the Commission on Health and Safety and Workers' Compensation (CHSWC), Commission staff held a Health and Safety Research Advisory Committee meeting on November 19, 2007, in Oakland, to identify key health and safety areas where further research and study could help improve workplace health and safety in California. The Advisory Committee included stakeholders in the health, safety and workers' compensation communities representing insured and self-insured employers, labor, health and safety researchers and state agencies.

One of the recommendations of the Health and Safety Research Advisory Committee was to rigorously identify the consequences of different regulators' policies and practices with respect to job safety and health standards and enforcement through worksite inspections.

Description

The purpose of the study is to conduct research that addresses the above recommendation with respect to the effectiveness of the Injury and Illness Prevention Program (IIPP) standard and compliance officers' inspections at reducing injury and illness rates. The research can help to improve the ability of occupational health and safety agencies to prevent injuries, potentially preventing a significant number of injuries and illnesses. The study will identify the following:

- The effect of the adoption and enforcement of the IIPP regulations.
- The elements of the IIPP standard that may be most effective.
- Whether firms that comply with Section 3203 have lower injury and illness rates (and better experience modification ratings) than similar firms which do not.
- Whether compliance with Section 3203 leads to a reduction in injury and illness rates.
- Which provisions, if any, of Section 3203 are most closely associated with reductions in injury rates. The rule includes seven substantive provisions, each of which can be cited separately.
- Whether there is any relation between the stringency of enforcement of Section 3203 and reductions in injury rates.
- When controlling for other factors that affect inspection outcomes, whether the reductions in injury and illness rates vary depending on the particular compliance officer who carries out the inspection.
- Which characteristics of the more successful compliance officers and their inspection activities distinguish them from other compliance officers.
- What the policy implications are for the selection, training, and incentives for compliance officers.

Status: In process.

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<th>Project Team</th>
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OCCUPATIONAL SAFETY AND HEALTH

Firefighters Musculoskeletal Injuries

Background

Firefighting is a dangerous and difficult occupation that places considerable toll on the health and safety of workers. Policymakers and researchers have made efforts to understand the adverse conditions that arise at a fire ground and to devise policies and equipment that protect firefighters. However, because much of the attention has focused on monitoring and reducing fatalities and chronic diseases among firefighters, there is still much that is unknown about the causes and consequences of non-fatal acute injuries among firefighters.

In particular, musculoskeletal conditions account for a majority of all nonfatal injuries, dominate the medical costs of workers’ compensation claims, and are a leading contributor to disability retirements for firefighters. In this respect, firefighting appears similar to other occupations. Still, there are aspects of firefighting that could make firefighters particularly susceptible to work-related musculoskeletal injuries: the work is often physically strenuous; it often takes place under adverse conditions (poor visibility, wet surfaces); and it involves sudden bursts of activity following long periods of inactivity. On the other hand, firefighters are typically drawn from a set of physically more fit and healthier people than the general population, which could lead to fewer musculoskeletal injuries. In addition, the long shifts associated with firefighting lead to a considerable amount of time when firefighters are conducting normal life activities while technically working, leading some to wonder what fraction of injuries occur at work that would likely have otherwise occurred at home.

Given a lack of comprehensive data, however, it is unclear as to just how many California firefighters incur what types of such injuries and how often these injuries occur. Such information is essential in order to determine how best to protect against such injuries and safeguard firefighters when they do sustain these types of occupational injuries.

Description

At the request of Assembly Member Sandré R. Swanson, Chair, Assembly Committee on Labor and Employment to the Commission on Health and Safety and Workers’ Compensation (CHSWC), the musculoskeletal injury study will gather data and analyze the types, frequencies and treatments applied to major musculoskeletal injuries incurred by firefighters while performing their job-related duties. The objectives of this project include:

- What percentage of firefighter injuries are musculoskeletal injuries as compared to other job-related injuries.
- Based on the number of claims for musculoskeletal injuries, what percentage of those are ultimately determined to be compensable for the purposes of workers’ compensation.
- Of those injuries determined to be compensable under workers’ compensation, how many are subject to apportionment to other non-job-related causes; how does this affect compensation.
- How caps on the number of allowed physical therapy visits affect the recovery and subsequent employment outcomes of injured firefighters with musculoskeletal injuries.
- Policy recommendations on the prevention and compensation of these injuries.

Status: In process.
OCCUPATIONAL SAFETY AND HEALTH

Disability Retirement Benefits for Public Safety Officers

Background

The provision of public safety is one of the most important responsibilities of government. Workers charged with protecting the public routinely put their lives and well-being at risk. It is documented that, in general, public safety employees tend to have much higher-than-average rates of work-related injuries and illnesses, both fatal and non-fatal, as compared to other sectors. Because public safety occupations inherently entail significant risk and because of the social importance of the services these employees provide, public safety employees are usually rewarded with comparatively higher compensation in the event of a work-related injury.

The high incidence and high cost of injuries sustained by public safety employees raise a number of important policy questions. For instance, do workers’ compensation and disability retirement benefits provided to public safety employees adequately compensate them for disabling injuries? Could specific safety interventions reduce the frequency of injuries to public safety employees and thereby lower the cost of providing workers’ compensation and disability retirement benefits to these workers? What types of injuries do public safety employees suffer and at what ages, as compared to other public employees?

Description

The high rate of injury and disability sustained by vital public safety employees, particularly police and firefighters, is of great concern to the workers’ compensation community. In October 2004, Assembly Members Juan Vargas and Rick Keene requested that the Commission on Health and Safety and Workers’ Compensation (CHSWC) conduct a study of public sector injury prevention. In particular, they requested a comprehensive evaluation and recommendations on effective public safety employee injury and illness prevention measures.

In response to the above bi-partisan request, CHSWC contracted with RAND in September 2005 to conduct a study that will assist the Legislature in its goals to minimize injuries incurred by public safety employees and provide adequate workers’ compensation and disability benefits to those who are injured. The study addresses the following topics:

- Describe the incidence and types of injuries suffered by public safety employees and assess how the distribution of these injuries differs from that of other public (and potentially private) employees.

- Explore which aspects of public safety employment lead to the greatest injury and disability rates and whether specific interventions could reduce the risk of injury among those workers.

- Estimate the impact of disability on earnings of public safety employees and assess the adequacy of workers’ compensation and disability benefits provided to these injured workers.

- Examine the extent to which disability retirements for public safety employees have changed over time and what factors have contributed to any observed trends.

Project Team

Elyce Biddle
NIOSH

Seth Seabury, Ph.D.
RAND

Dave Loughran, Ph.D.
RAND

Tom LaTourrette, Ph.D.
RAND

CHSWC Staff

Christine Baker
D. Lachlan Taylor
Irina Nemirovsky
**Findings**

RAND has conducted in-depth discussions with members of eight California agencies covering fire/emergency-management services, law enforcement, and corrections. The key findings from these discussions included:

- There is a need for better surveillance of injury data, particularly for injuries to law enforcement and emergency medical personnel.

- The design and targeting of safety and health promotion efforts could also be improved with better monitoring of the types of situations and causes of injury that lead to the most severe and disabling injuries.

- There is a need to reduce strains, sprains and musculoskeletal disorders among public safety employees, which are by far the leading cause of nonfatal injuries.

- Training, increased information analysis and sharing, strong safety messages from department leadership, and improvements to protective equipment were areas identified as good tools for improving safety of public safety employees.

- Both firefighters and police officers become more susceptible to disability as they age. Policies designed to reduce the rate of disability retirement may be most effective if focused on either preventing injuries among older public safety employees or taking steps to alleviate the impact of injuries on their ability to work.

**Status.** A joint CHSWC/NIOSH report was completed in 2008.

For further information …


OCCUPATIONAL SAFETY AND HEALTH

Worker Occupational Safety and Health Training and Education Program

Background

Labor Code Section 6354.7 establishes a Workers’ Occupational Safety and Health Education Fund (WOSHEF) for the purpose of establishing and maintaining a statewide worker-training program. The Commission on Health and Safety and Workers’ Compensation (CHSWC) has developed the Worker Occupational Safety and Health Training and Education Program (WOSHTEP) to raise awareness and promote injury and illness prevention through training and dissemination of materials by a statewide network of providers. This program is designed to prepare workers in California to take a leadership role in health and safety programs at work.

Description

CHSWC has taken the following steps in implementing this program:

- **Prepared a Survey of State, National and International Worker Health and Safety Training Programs.** This survey includes websites and descriptions of available programs and lists courses for each program. The survey can be found as a link on CHSWC’s website at [http://www.dir.ca.gov/CHSWC/TrainingProgramsResources/Surveycover.html](http://www.dir.ca.gov/CHSWC/TrainingProgramsResources/Surveycover.html)

- **Created a labor-management Advisory Board to oversee program activities, which meets semi-annually.** The WOSHTEP Advisory Board consists of employers and workers or their representatives who assist in guiding development of curricula and broadening partnerships with worker-based organizations, labor studies programs, employers, insurance companies, and other stakeholders in the workers’ compensation community. The Advisory Board prepares an Annual Report on WOSHTEP.

- **Conducted needs assessments with stakeholders that will continue on an ongoing basis.** Needs assessments are conducted with workers and their representatives, employers, insurers, community-based organizations serving difficult-to-reach workers, and potential training providers.

- **Designed a core curriculum and supplemental training materials based on the results of the needs assessment.** This 24-hour Worker Occupational Safety and Health (WOSH) Specialist curriculum is aimed primarily at “workers who are able to train other workers and workers who have significant health and safety responsibilities, such as those serving on a health and safety committee or serving as a designated safety representative.” Participants who complete six core modules and three supplemental modules become WOSH Specialists. (See [http://www.dir.ca.gov/chswc/woshtep.html](http://www.dir.ca.gov/chswc/woshtep.html))

- **Developed a training-of-trainers curriculum to train a statewide network of trainers as mandated by the statute.** Training-of-trainers sessions are held in Northern, Central, and Southern California, and network trainers have been co-teaching with mentor trainers from the Labor Occupational Health Program (LOHP) at the University of California (UC), Berkeley and the Labor Occupational Safety and Health Program (LOSH) at University of California, Los Angeles (UCLA).
• **Created a Small Business Resources program component to target very small employers who do not have the resources to send employees to 24 hours of training.** Materials have been developed for small businesses across industries for the restaurant industry, and for the janitorial industry. Materials are in development for the dairy industry.

• **Created health and safety programs for young workers, including a Young Worker Leadership Academy.** Two Academies are offered annually, one in Northern and one in Southern California.

• **Established Resource Centers that house and distribute training materials and additional health and safety resources.** These Resource Centers are located at LOHP and LOSH and the Western Center for Agricultural Health and Safety (WCAHS) at UC Davis.

• **Prepared a Multilingual Health and Safety Resource Guide to Worker Training Materials on the Web for WOSHTEP.** This Guide, prepared by LOHP, is a collection of worker training materials, such as fact sheets, checklists and other educational resources that are available online. Information from the guide can be printed to distribute to workers participating in workplace injury and illness prevention programs. (See [http://www.dir.ca.gov/CHSWC/MultilingualGuide/MultilingualGuideMain.html](http://www.dir.ca.gov/CHSWC/MultilingualGuide/MultilingualGuideMain.html).)

**Next Steps**

CHSWC has assessed fees to California workers’ compensation insurance carriers pursuant to Labor Code Section 6354.7 for the next fiscal year. Next steps include:

• **Continued WOSH Specialist training by LOHP, WCAHS and LOSH** in a variety of industries for participants in diverse occupations and work settings. Courses are taught through community colleges, at employers’ places of business, and in many other settings. Courses are taught in English, Spanish and Chinese.

• **Continued Refresher trainings or courses** to update WOSH Specialists on health and safety information to assist them in carrying out activities they choose to do in their workplaces after completion of the WOSH Specialist training.

• **Continued Awareness Sessions** drawing on the WOSH Specialist curriculum to help promote awareness of and interest in the WOSH Specialist course and to provide injury and illness prevention education. These trainings are presented in English and Spanish.

• **Ongoing development of the statewide network of trainers** who will partner with mentor trainers from LOHP and LOSH to deliver WOSH Specialist courses.

• **Continued geographic expansion to the Central Valley and other areas of Northern and Southern California.** WCAHS has been identified as a Central Valley partner. The Center has hired staff and is conducting WOSHTEP activities under the direction of LOHP WOSHTEP staff. Expansion in Southern California includes San Diego and the Inland Empire.

• **Ongoing development of injury and illness prevention materials on** health and safety topics such as heat illness, motor vehicle safety, integration of wellness and occupational safety and health, and emergency preparedness.

• **Ongoing dissemination of health and safety material for small businesses** across industries and for restaurants, janitorial services companies, and the dairy industry.

• **Ongoing Young Worker Leadership Academies and young worker programs.**

• **Additional outreach to ensure wider use of Resource Centers** in Northern, Central and Southern California and wider distribution of multilingual resource training materials.

• **Ongoing evaluation of WOSHTEP** to identify accomplishments and outcomes.
WOSHTEP Advisory Board Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Position</th>
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<tbody>
<tr>
<td>Bob Balgenorth</td>
<td>State Building &amp; Construction Trades Council</td>
</tr>
<tr>
<td>Lisa Barbato</td>
<td>Service Employees International Union (SEIU) – United Healthcare West and Joint Employer Education Fund</td>
</tr>
<tr>
<td>Laura Boatman</td>
<td>State Building &amp; Construction Trades Council</td>
</tr>
<tr>
<td>Andrea Dehlendorf</td>
<td>Service Employees International Union</td>
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<tr>
<td>Marti Fisher</td>
<td>California Chamber of Commerce</td>
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<tr>
<td>Judith Freyman</td>
<td>ORC, Inc.</td>
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<tr>
<td>Simmi Gandhi</td>
<td>Garment Workers Center</td>
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<tr>
<td>Deborah Gold</td>
<td>California Division of Occupational Safety and Health</td>
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<tr>
<td>Scott Hauge</td>
<td>Small Business California</td>
</tr>
<tr>
<td>Jon Hughes</td>
<td>United Food and Commercial Workers Union (UFCW) Local 5</td>
</tr>
<tr>
<td>Bonnie Kolesar, ARM, CCSA</td>
<td>California Department of Corrections and Rehabilitation (CDCR)</td>
</tr>
<tr>
<td>Cynthia Leon</td>
<td>California Manufacturers &amp; Technology Association</td>
</tr>
<tr>
<td>Tom Rankin</td>
<td>State Fund, California, and formerly President, California Labor Federation (AFL-CIO)</td>
</tr>
<tr>
<td>Christina Vasquez</td>
<td>Union of Needletrades, Industrial and Textile Employees (UNITE HERE!)</td>
</tr>
<tr>
<td>Len Welsh</td>
<td>State of California Division of Occupational Safety and Health</td>
</tr>
<tr>
<td>Chad Wright</td>
<td>Laborers-Employers Cooperation and Education Trust</td>
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Advisory Board Ex-officio Members

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<thead>
<tr>
<th>Name</th>
<th>Organization/Position</th>
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<tbody>
<tr>
<td>Charles Boettger</td>
<td>Municipal Pooling Authority</td>
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<tr>
<td>Mary Deems</td>
<td>California Department of Public Health</td>
</tr>
<tr>
<td>Cindy Delgado</td>
<td>San Jose State University</td>
</tr>
<tr>
<td>Ken Helfrich</td>
<td>Employers Direct Insurance</td>
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<tr>
<td>Scott Henderson</td>
<td>Henderson Insurance Agency</td>
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<tr>
<td>Dori Rose Inda</td>
<td>Watsonville Law Center</td>
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<tr>
<td>Mark Jansen</td>
<td>Zenith Insurance</td>
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<tr>
<td>Chris P. Kaiser</td>
<td>State Compensation Insurance Fund</td>
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<tr>
<td>Dave Mack</td>
<td>Chubb Group of Insurance Companies</td>
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<tr>
<td>Michael Marsh</td>
<td>California Rural Legal Assistance</td>
</tr>
<tr>
<td>John McDowell</td>
<td>LA Trade Technical College, Labor Studies</td>
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<tr>
<td>Thomas Neale</td>
<td>Chubb &amp; Son</td>
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<tr>
<td>Fran Schreiberg</td>
<td>Kazan, McClain, Lyons, Greenwood &amp; Hailey</td>
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<tr>
<td>Bob Snyder</td>
<td>Liberty Mutual Insurance Group</td>
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<td>John Stassi</td>
<td>Food Service Insurance Managers</td>
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<td>Dave Strickland</td>
<td>Zurich Insurance</td>
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<td>Ed Walters</td>
<td>QBE the Americas</td>
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<td>Jim Zanotti</td>
<td>AIG</td>
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</table>
**Projects and Studies**

**Status:** Ongoing.

*For further information …*

- **WOSHTEP brochure and other WOSHTEP materials**
  [http://www.dir.ca.gov/chswc/WOSHTEP.html](http://www.dir.ca.gov/chswc/WOSHTEP.html)

- **Heat Hazards in Agriculture: A Guide for Employers to Carry Out Tailgate Training for Workers.**
  (In English and Spanish.)
  [http://www.dir.ca.gov/CHSWC/Reports/CHSWC_HeatAgricultureSpanish.pdf](http://www.dir.ca.gov/CHSWC/Reports/CHSWC_HeatAgricultureSpanish.pdf)


- **Small Business Health and Safety Materials (English and Spanish)**
  [http://www.dir.ca.gov/chswc/SBMRhealthandsafety.htm](http://www.dir.ca.gov/chswc/SBMRhealthandsafety.htm)

- **Health and Safety Training for Owners and Managers of Small Restaurants (English and Spanish)**
  [http://www.dir.ca.gov/chswc/SBMRMaterials.htm](http://www.dir.ca.gov/chswc/SBMRMaterials.htm)

- **Small Business: Janitorial Safety Resources (English and Spanish)**
  [http://www.dir.ca.gov/chswc/WOSHTEP/SBMR_Janitorial.htm](http://www.dir.ca.gov/chswc/WOSHTEP/SBMR_Janitorial.htm)

- **Motor Vehicle Safety Programs Fact Sheet**

- **“Teens Working in Agriculture: Activities for High School ESL Classes**
  [http://www.dir.ca.gov/chswc/woshtep.html](http://www.dir.ca.gov/chswc/woshtep.html)

- **“Teens Speak Out About Safety on the Job: Lessons Learned From the Young Worker Leadership Academy (2008).**
  [http://www.dir.ca.gov/chswc/WOSHTEP/Publications/TeensSpeakOut.pdf](http://www.dir.ca.gov/chswc/WOSHTEP/Publications/TeensSpeakOut.pdf)

- **“Summary of the July 16, 2008 Workplace Wellness Roundtable”, (December 2008).**

- **WOSHTEP Advisory Board Annual Reports:**
  - 2009 WOSHTEP Advisory Board Annual Report
  - 2008 WOSHTEP Advisory Board Annual Report
  - 2007 WOSHTEP Advisory Board Annual Report
  - 2006 WOSHTEP Advisory Board Annual Report
  - 2005 WOSHTEP Advisory Board Annual Report
  - 2004 WOSHTEP Advisory Board Annual Report
OCCUPATIONAL SAFETY AND HEALTH

California Partnership for Young Worker Health and Safety

Background

Over the past five years, an average of 48 teens have died each year in the United States as a result of work-related injuries, and an estimated 53,000 are injured severely enough to require treatment in hospital emergency rooms. Most of these injuries are preventable.

Description

The Commission on Health and Safety and Workers’ Compensation (CHSWC) continues to put California in the forefront as a nationwide leader in protecting and educating teen workers. Over the past several years, CHSWC has sponsored and convened the California Partnership for Young Worker Health and Safety, established by Assembly Bill (AB) 1599 in September 2000. The Partnership is coordinated by the Labor Occupational Health Program (LOHP) at the University of California (UC), Berkeley with key support from the Labor Occupational Safety and Health Program (LOSH) at the University of California, Los Angeles (UCLA), and other members of the Partnership. In addition to serving California, these efforts have inspired similar activity throughout the U.S.

The California Partnership for Young Worker Health and Safety is composed of agencies, and organizations dealing with youth employment and education issues, as well as others who can play a role in educating and protecting young workers. Members represent educators, parents, employers, youth training programs, governmental agencies and others.

The purpose of the Partnership is to identify potential strategies to:

- Reduce work-related injuries and illnesses among youth in the California workforce.
- Foster awareness and skills in health and safety that will remain with youth throughout their working lives and allow them to take an active role in shaping safe work environments.
- Promote positive, healthy employment for youth.

During the past year, the Partnership met twice. In addition, subcommittees held conference calls to develop and implement the following activities:

- Promote the eleventh annual California Safe Jobs for Youth Month public awareness campaign in May, which was established by former Governor Gray Davis’s proclamation starting in 1999. This year’s public awareness and education activities have included: a teen poster contest (with posters distributed to 1,000 schools and hundreds of other youth-serving organizations); a teen video public service announcement (PSA) contest, funded separately by the Department of Industrial Relations (DIR), with the winning PSA shown in movie theaters in several communities, and distribution of a resource kit to over 500 educators and community groups (by 450 downloads from the website and 50 hard copies requested to date).

In addition, ten youth teams that participated in the Young Worker Leadership Academies (see below) conducted activities in their communities to promote safe jobs for youth. These activities included: workshops conducted by teens at school and in the community for other students; development of materials for distribution at career centers and other work readiness programs; school-wide job fairs and lunchtime information-sharing events; and passage by the Sacramento City School Board of a policy requiring all youth who get work permits to receive the teen fact sheet and view a short video on workplace safety.
• **Support and conduct two Young Worker Leadership Academies.** Young Worker Leadership Academies (YWLAS) in 2009 were held in Berkeley in January and in Los Angeles in February. The Academies are part of the CHSWC Worker Occupational Safety and Health Training and Education Program (WOSHTEP) and are coordinated by LOHP and LOSH and supported by active participation by Partnership members. Young people from 11 different organizations around the State attended the Academies in 2009. The goals of each Academy were: to teach youth about workplace health and safety and their rights on the job; to help youth start thinking about ways to help ensure that young people do not get hurt on the job; and to provide a forum for these youth to plan for specific actions they can take in their own communities to promote young worker safety. Academy alumni youth led many of the activities at the Academies and developed their own outreach projects, including creating a radio PSA and planning and conducting a community event in Los Angeles.

• **Develop a guide for conducting a Young Worker Leadership Academy.** With additional funding from the California Wellness Foundation, LOSH and LOHP staff developed a 64-page guide, *Teens Speak Out for Safety on the Job*, to share the YWLA model with organizations in California, as well as nationwide. This new guide describes the YWLA process and includes all the teaching instructions, handouts and other materials needed to put on a YWLA. This model will be shared with organizations and agencies around the country through the national Young Worker Safety Resource Center. The guide has already been used by MassCOSH in Massachusetts to plan and conduct its own YWLA.

• **Identify and implement strategies for using the work permit system as a mechanism for educating teens, parents and employers about workplace safety and job rights.** Partnership members are developing a short quiz and other information for teens who apply for work permits. This information-dissemination and quiz will be pilot-tested with the Quick Permit Program used by the majority of school districts.

• **Make presentations at several prominent state and national meetings highlighting the innovative approaches being taken in California to protect young workers.** National annual meetings included those of the Young Worker Safety Resource Center and the American Public Health Association (APHA). With additional funding from federal OSHA, LOHP made presentations on the California Partnership model to statewide young worker coalitions in Oregon (sponsored by the University of Oregon) and New York (sponsored by NYCOSH).

• **Coordinate the provision of information and resources on young worker health and safety by Partnership members.** Over the past year, Partnership members with direct access to teachers, employers and youth jointly reached and served organizations and individuals throughout California with important health and safety information. Partnership members helped with promoting and recruiting for the YWLAS, the poster contest, the video PSA contest, and Safe Jobs for Youth month resources and activities, as well as with providing ongoing links to young worker health and safety information. Information and training were offered in both English and Spanish. In addition, the Partnership provides a space for youth to voice their opinion on young worker health and safety issues. Several youth have made presentations to Partnership members about their issues and concerns and their innovative ideas to help reduce young worker injuries and illnesses.

Partnership accomplishments include:

• More than 1,000 teachers, employers and youth received direct training or presentations.

• Approximately 4,500 teachers, employers and youth received written information, such as the fact sheets for teens and for employers, the Safe Jobs for Youth Month Resource Kit produced by LOHP, or articles in Partnership newsletters, such as that of the California Association of...
Work Experience Educators (CAWEE). In addition, CAWEE estimates that its own members reach approximately 15,000 students, parents and employers with workplace safety information. Thousands more received information through listserv postings, email announcements, radio and video PSAs, and posters.

- About 80 teachers, employers and youth received direct technical assistance via phone or via the [http://www.dir.ca.gov/youngworker/youngworkersmain.html](http://www.dir.ca.gov/youngworker/youngworkersmain.html) website.

- The [www.youngworkers.org](http://www.youngworkers.org) website averaged 110 unique visits per day (1.26 visits/visitor; 2.61 pages per visit, equaling an average of 361 pages visited/day) for a total of 40,000 unique visitors served during the year, or 132,000 pages visited. This is comparable to 2008. The most frequently visited pages, after the home page, were the teen info page (viewed 7200 times), the FAQs page (viewed 2600 times), and the employers page (viewed 2000 times). The most frequent downloads, after the poster and PSA contest materials, were the teen fact sheet (1500), components of the YWLA Guide (1000), and the safety orientation checklist for worksite supervisors (800).

- At least four newsletter, newspaper or web-based articles were published.

- Health and safety information continued to be integrated into ongoing statewide activities of many of the partners, including regular in-service training for work experience educators, widespread use of health and safety curricula in job training and work experience programs, and organizational links to the [http://www.youngworkers.org](http://www.youngworkers.org) website.

- Health and safety information continued to be integrated into ongoing statewide activities of many of the partners, including regular in-service training for work experience and WorkAbility educators, widespread use of health and safety curricula in job training and work experience programs, and organizational links to the [http://www.youngworkers.org](http://www.youngworkers.org) website.

In the coming year, priorities are to:

- Strengthen and expand youth involvement by holding two more YWLAs and exploring funding opportunities to hold YWLA reunions and other youth-led events in Northern, Central and Southern California.

- Continue to strengthen activities of Partnership members, with a focus on outreach and information tools for the employer community, including the small business restaurant safety training materials and the new health and safety resources for small businesses across industries which employ youth.

- Expand the membership of the Partnership to include greater representation from employers and youth organizations.

- Continue to share the California Partnership for Young Worker Health and Safety model with other states and assist them with replicating this model.
California Partnership for Young Worker Health and Safety

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Alameda County Office of Education

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Cal/OSHA

Gail Bateson
California Department of Public Health

Ken Born
California Department of Education

Ken Burt
California Teachers Association

Yvette Brittain
State Compensation Insurance Fund

Richard DaRosa
DIR, Cal/OSHA

Thomas Dinh
Department of Industrial Relations

Mary Jo Edmundson
California Association of Work Experience Educators

Lisa Elliott
New Ways to Work

Mario Feletto
DIR, Cal/OSHA

Susan Gard
DIR, Division of Workers’ Compensation

Fred Glass
California Federation of Teachers

Soteria Riester
California Teachers Association

Eric Rood
Dept. of Labor Standards Enforcement

Cory Sanfilippo
California Parent Teachers Association

Carol Smith
Dept. of Education

Krystl Tena
Watsonville Law Center

Rick Ullerich
DIR, Cal/OSHA

(continued)

David Lawrence
California Center for Childhood Injury Prevention

Adriana Iglesias
U.S. Dept. of Labor, Wage & Hour

Rubin Mayorga
U.S. Dept. of Labor, Wage & Hour

Charlene Mouille
New Ways to Work

Jim Muldavin
California Center for Civic Participation

Lee Pliscou
California Rural Legal Association

Cheryl Ramos
Unified School District, Vacaville

Eric Rood
Dept. of Labor Standards Enforcement

Cory Sanfilippo
California Parent Teachers Association

Carol Smith
Dept. of Education

Nance Steffen
Dept. of Labor Standards Enforcement

Krystal Tena
Watsonville Law Center

Linda Tubach
Collective Bargaining Education Project, UTLA

Rick Ullerich
DIR, Cal/OSHA
**Status**: Ongoing.

*For further information …*

Young Worker Website for information for teens, teen workers in agriculture, employers, parents and educators.
http://www.dir.ca.gov/YoungWorker/YoungWorkersMain.html
http://www.dir.ca.gov/chswc/woshtep.html
http://www.youngworkers.org

UCLA-LOSH Youth Project.
http://www.losh.ucla.edu

“Keeping California’s Youth Safe on the Job – Updated Recommendations of the California Partnership for Young Worker Health and Safety” (2004).
OCCUPATIONAL SAFETY AND HEALTH

Schools Injury and Illness Prevention Program Project

Background

Per the mandate set forth in the Labor Code, the Commission on Health and Safety and Workers' Compensation (CHSWC) is to assist inner-city schools or any school or district in establishing effective occupational injury and illness prevention programs (IIPPs). Priority shall be given to schools or districts with high risk.

Description

CHSWC has established a Schools IIPP model program, California’s School Action for Safety and Health (SASH) program, to help schools statewide improve their injury and illness prevention practices and resources. The program will include training and resources to enable schools or school districts to develop or improve IIPPs and to make other health and safety improvements that will help protect school or school district employees from injuries and illnesses on the job. The target audience will focus on K-12 schools and school districts at high risk of occupational injury and illness, including, but not limited to, the Youth Authority overseen by the California Department of Corrections and Rehabilitation (CDCR).

On June 27, 2008, CHSWC hosted a roundtable discussion that brought together representatives from schools and school districts, the Governor’s Office of Homeland Security, labor, and school-related agencies and organizations in California. (See list of participants on the next page.) The objectives of the meeting were to determine how best to structure and implement the model program including a training program for schools or school districts with the priority training going to schools or school districts with high incidence rates and a pilot with schools from around the State.

A second Advisory Group meeting was held on June 30, 2009, to provide feedback on the project.

The SASH program includes: a needs assessment conducted to determine the types of training and resources; development of materials and resources; implementation with a pilot group; and evaluation. A final report will detail successful IIPP improvements achieved, barriers encountered, and recommendations for the future. Further development of the model program would include: expanding partnerships with key constituents throughout the State; expanding the target population statewide; developing a network of expert trainers; ensuring that measures of accountability are applied; and institutionalizing the program by identifying continuing health and safety education opportunities for schools.

Project Team

CHSWC
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Irina Nemirovsky
Nabeela Khan
Denise Vargas
Selma Meyerowitz
Nurgul Toktogonova

UC Berkeley-LOHP
Robin Baker
Helen Chan
Robin Dewey
Laura Stock

UCLA-LOSH
Linda Delp, Ph.D.
**Status:** In process.

*For further information …*

“Summary of June 27, 2008 Schools Injury and Illness Prevention Program Roundtable” (December 2008).
http://www.dir.ca.gov/chswc/Reports/CHSWC_SummarySchoolsInjuryIllnessPreventionProgramRoundtable.pdf
OCCUPATIONAL SAFETY AND HEALTH

Workplace Wellness: How to Address Both Occupational and Lifestyle Issues on the Job

Background

Integration of wellness and occupational health and safety has become a key focus of efforts by employers of large, medium-size and small businesses and labor. Efforts to develop an integrated approach to health promotion and occupational health and safety programs have focused on research and public health literature, as well as best practices of wellness programs implemented by employers.

Description

On July 16, 2008, the Commission on Health and Safety and Workers’ Compensation (CHSWC) hosted a Workplace Wellness Roundtable facilitated by the University of California (UC), Berkeley’s Labor Occupational Health Program (LOHP). Participants included representatives from employers of large, medium-size and small businesses, labor, research organizations, and state agencies. (See list of participants that follows.) The purpose of the Workplace Wellness Roundtable was to begin a dialogue about strategic approaches, both short-term and long-term, to integrating workplace wellness and occupational health and safety programs in California. Attendees were encouraged to share experience with workplace wellness initiatives and programs and to reflect on how these ideas relate to their own organizations.

Objectives

The objectives for the Roundtable were to:

- Develop a general understanding of what constitutes an integrated approach to health promotion and occupational health and safety programs.
- Explore barriers to integration of workplace health promotion and workplace health and safety programs.
- Discuss strategies for overcoming challenges to integration of programs.
- Identify strategies and resources for promoting more and better programs that address workplace health in a holistic manner for employers of large, medium-size and small businesses.

Booklet on Integrating Wellness and Occupational Health and Safety Programs

As a result of the Roundtable, a booklet, The Whole Worker: Integrating Wellness & Occupational Health and Safety Programs, is being developed. The booklet addresses the central role that the workplace plays in the health of most Americans. Average working American adults spend more than half their waking lives at work. In order to fully address health, what happens inside and outside the workplace has to be a key focus.

Many employers are required by OSHA law to provide safe and healthy workplaces. Consequently, many employers are voluntarily establishing wellness or health promotion programs to address employee health. They view the workplace as an opportunity to engage workers in efforts to prevent
disease, promote better overall health, and possibly lower costs and increase morale and productivity. There is evidence that wellness programs that emphasize correcting workplace hazards show greater participation rates than those that focus only on individual behavior change and have a greater chance of success if integration with occupational health and safety is a priority.

The objectives of the booklet are to:

- Develop a general understanding of what constitutes an integrated approach to health promotion and occupational health and safety programs.
- Explore barriers to integration of workplace health promotion and workplace health and safety programs.
- Identify strategies for overcoming challenges to integration of programs.
- Identify resources for promoting programs that address worker health in a holistic fashion.

The booklet provides examples of specific wellness/health promotion programs and discusses their effectiveness. It also presents a Checklist and a Planning Worksheet for integrating workplace wellness programs and occupational health and safety, as well as a List of Resource Organizations and a bibliography of publications related to wellness and occupational health and safety.

**Status:** The final version of the booklet is expected in 2010.

*For further information...*

“Summary of the July 16, 2008 Workplace Wellness Roundtable” (December 2008).
http://www.dir.ca.gov/chswc/Reports/CHSWC_SummaryWorkplaceWellnessRoundtable.pdf
Wellness Workplace Advisory Group

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SEIU UHW West & Joint Employer Education Fund

Charles Boettger
Municipal Pooling Authority

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Small Business California

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State Building & Construction Trades Council

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San Francisco Labor Council

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Harvard School of Public Health

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Building Skills Partnership, SEIU 1877

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UC Berkeley, Health Services

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OCCUPATIONAL SAFETY AND HEALTH

Experimental Evidence on the Causal Effect of Cal/OSHA Inspections on Workplace Employees and Employers

Background

Little is known about the relationship between health and safety inspections, voluntary programs and consultations, and improvements in workplace health and safety and overall business and employee success over time. In fact, OSHA is considered by some a controversial agency in large part because of doubts about its effectiveness in reducing workplace injuries and illnesses, and in part because of concerns about the cost of OSHA inspections and other enforcement activities. This project seeks to evaluate Cal/OSHA’s Targeted Inspections, Voluntary Programs, and Consultations. The Commission on Health and Safety and Workers’ Compensation (CHSWC) is working with the University of California (UC), Berkeley and Harvard University researchers to analyze these relationships and assist in obtaining data.

Objectives and Scope of Study

This research project will evaluate the extent to which Cal/OSHA’s inspections (particularly randomized inspections in high hazard industries), voluntary programs, and consultations affect organizational and employee outcomes. Outcomes to be analyzed include injury rates, worker’s compensation costs, company survival, sales, employment and wages. This study will use the randomized nature of some Cal/OSHA inspections to provide the best estimates of the causal effects of Cal/OSHA inspections on workers and employers.

Studies will individually examine:

- Randomized inspections.
- Voluntary programs (partnership programs).
- Consultations based on high experience modification (Ex-mod) rates.

The studies will link data from Cal/OSHA inspections Institute for the Management of Information Systems (IMIS), Dun & Bradstreet (D&B) data on businesses, and Workers’ Compensation Insurance Rating Bureau (WCIRB) data on injury rates and payroll from 1993 to 2006 to give a picture of a range of performance outcomes over time. The results should also help Cal/OSHA improve how it targets random inspections, pointing out which inspections had the largest benefits to workers. More broadly, these results will be of substantial interest to policymakers, employers and workers in California.

Status: In process.

Project Team

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CHSWC Staff
Christine Baker
D. Lachlan Taylor
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I. PERMANENT DISABILITY AND TEMPORARY DISABILITY STUDIES

Permanent Disability Schedule Analysis
Status: Completed
CHSWC Reports:
- Memorandum to Christine Baker, Executive Officer of CHSWC regarding “Analysis of Ratings Under the New PD Schedule Through June 2007” (August 2007).
  http://www.dir.ca.gov/chswc/Reports/memo_on_new_ratings_through_june_30_07_revised_aug_9.pdf
- Memorandum to Christine Baker, Executive Officer of CHSWC regarding “Analysis of ratings under the new PD schedule, through January 2007” (February 2007).

Impact of Changes to the Temporary Disability Benefits
Status: In Process
CHSWC Memorandum:
“Evaluate and Identify Impact of Changes to the Temporary Disability Benefit” (2007).
http://www.dir.ca.gov/CHSWC/Reports/Memo_On_TD_Benefits_Beyond_2Years.pdf

Initial Wage Loss Analyses
Status: Completed
CHSWC Reports:
  http://www.rand.org/pubs/monograph_reports/MR920
  http://www.dir.ca.gov/CHSWC/Reports/PPDFindingsAndRecommendations.pdf

Enhancement of Wage Loss Analysis – Private Self-Insured Employers
Status: Completed
CHSWC Report:
http://www.dir.ca.gov/CHSWC/Reports/PD-Study.pdf

Enhancement of Wage Loss Analysis – Public Self-insured Employers
Status: In process

Impact of Local Economic Conditions on Wage Loss
Status: Completed
CHSWC Report:
http://www.dir.ca.gov/CHSWC/Reports/TrendsInEarningsLoss-EcoCondition.pdf
PERMANENT DISABILITY AND TEMPORARY DISABILITY STUDIES (continued)

Permanent Disability Rating Tool
Status: Completed
CHSWC Reports:

Apportionment
Status: Completed
CHSWC Reports:

II. RETURN TO WORK

International Forum on Disability Management (IFDM) 2010
Status: In process.
Information and Call for Papers: http://www.dir.ca.gov/chswc/Conferences/IFDM/IFDM.html
For further information…
See the project synopsis in the “Projects and Studies” section.

Return-to-Work Program Established in Labor Code Section 139.48
Status: Completed
CHSWC Reports:
For further information…
See the project synopsis in the “Projects and Studies” section.

RTW/FEHA/ADA – Coordination and Interaction
Status: Completed
CHSWC Report:
For further information…
See the project synopsis in the “Projects and Studies” section.
RETURN TO WORK (continued)

Evaluation of Return-to-Work Reforms
   Status: In process
   For further information…
   See the project synopsis in the “Projects and Studies” section.

Return-to-Work Roundtable
   Status: Completed
   CHSWC Report:
   http://www.dir.ca.gov/CHSWC/Reports/ReturnToWorkRoundtable-Final.pdf

Assembly Bill 1987 and Return to Work
   Status: Completed
   CHSWC Report:
   “AB 1987 and Return-to-Work Incentives and Alternatives” (April 2006).

Best Practices Encouraging Return to Work
   Status: In process
   For further information …
   See the project synopsis in the “Projects and Studies” section.

Review of Literature on Modified Work
   Status: Completed
   CHSWC Report:
   “Does Modified Work Facilitate Return to Work for Temporarily or Permanently Disabled Workers?” (August 1997).
   http://www.dir.ca.gov/CHSWC/Modified_Work_Krause.html

Policies and Strategies to Help Injured Workers Return to Sustained Employment
   Status: Completed
   CHSWC Report:
   “Return to Work in California: Listening to Stakeholders’ Voices” (July 2001).
   http://www.dir.ca.gov/CHSWC/RTWinCA0701.html

Primary Treating Physician Effectiveness in Return to Work (RTW) After Low-Back Injuries
   Status: First phase: Completed
   Second phase: In process
   CHSWC Report:
   http://journals.lww.com/joem/Abstract/2000/03000/Physical_Workplace_Factors_and_Return_to_Work.15.aspx

Predictors and Measures of Return to Work
   Status: Completed
   CHSWC Report:
   http://www.dir.ca.gov/chswc/Determinants.pdf
III. WORKERS’ COMPENSATION REFORMS

Evaluation of System Changes
Status: In process
CHSWC Summary:
“CHSWC Summary of System Changes in California Workers’ Compensation” (February 2008).
http://www.dir.ca.gov/Chswc/Reports/CHSWCRptonSummarySystemChangesDRAFTFeb%202008.pdf

Assembly Bill 749 Analysis
Status: Completed
CHSWC Summaries:
“CHSWC and AB 749 as Amended” (October 2002).
http://www.dir.ca.gov/CHSWC/749Report/AB749asamended112202.html
“CHSWC and AB 749” (February 2002).
http://www.dir.ca.gov/CHSWC/ab749.html

Assembly Bill 227 and Senate Bill 228 Analysis
Status: Completed
CHSWC Summary:
“Reforms of 2003, AB 227” (October 2003).
“Reforms of 2003, SB 228” (October 2003).

Senate Bill 899 Analysis
Status: Completed
CHSWC Summaries:
http://www.dir.ca.gov/CHSWC/Summary-of-SB899.doc
“Section-by-Section Review of SB 899” (2004).
http://www.dir.ca.gov/CHSWC/Section-by-section-Review-of-SB899.doc

Evaluation of the Division of Workers’ Compensation (DWC) Audit Function
(Special Study at the Request of the Legislature)
Status: Completed
CHSWC Reports:
http://www.dir.ca.gov/CHSWC/FinalAuditReport.html
“CHSWC Study of the Division of Workers’ Compensation Audit Function” (December 1998)
http://www.dir.ca.gov/CHSWC/AuditSummaryCover.html

Medical-Legal Study
Status: Ongoing
CHSWC Reports:
“Evaluating the Reforms of the Medical-Legal Process Using the WCIRB Permanent Disability Survey” (July 1997).
http://www.dir.ca.gov/CHSWC/DisabilityReport/data_and_methodology.html
“Evaluating the Reforms of the Medical-Legal Process Using the WCIRB Permanent Disability Survey” Executive Summary (July 1997).
http://www.dir.ca.gov/CHSWC/DisabilitySummary/execsummary.html

For further information …
See the project synopsis in the “Projects and Studies” section.
WORKERS’ COMPENSATION REFORMS (continued)

Vocational Rehabilitation Study
Status: Completed
CHSWC Reports:
“Vocational Rehabilitation Reform Evaluation” (March 2000).
http://www.dir.ca.gov/CHSWC/rehab/rehabcover.html

Evaluation of Treating Physician Reports and Presumption
Status: Completed
CHSWC Report:
http://www.dir.ca.gov/CHSWC/Report99/TPhysician.html

Update of Treating Physician Reports and Presumption Study
Status: Completed
CHSWC Report:
http://www.dir.ca.gov/CHSWC/CHSWCLegalDecAffectMedTreatPractice/ptpfinalrpt.html

Status: Completed
CHSWC Reports:
http://www.dir.ca.gov/CHSWC/LC5814Cvr.html
“Background Paper on Labor Code Section 5814” (February 1999).
http://www.dir.ca.gov/CHSWC/LC5814.htm

“Baseball Arbitration” Provisions of Labor Code Section 4065
Status: Completed
CHSWC Report:
http://www.dir.ca.gov/chswc/Baseballarbfinal%27rptcover.htm

CHSWC Response to Questions from the Assembly Committee on Insurance
Status: Completed
CHSWC Report:
“CHSWC Response to Questions from the Assembly Committee on Insurance” (2001).

Evaluation of Workers’ Compensation Cost and Benefit Changes Since the Beginning of the Reforms
(Special Study at the Request of the Legislature)
Status: Completed
CHSWC Report:
“Workers’ Compensation Costs and Benefits After the Implementation of Reform Legislation” (August 1999).
http://www.dir.ca.gov/chswc/Report.htm
“Executive Summary Impact of the 1993 Reforms on Payments of Temporary and Permanent Disability” (August 1999).
http://www.dir.ca.gov/chswc/ExecutiveSummary.htm
WORKERS’ COMPENSATION REFORMS (continued)

http://www.dir.ca.gov/chswc/Summary.htm

Cost Trends 1985-2005
Status: Completed
NASI Brief:

Temporary Disability Payments Beyond the Two-Year Restriction
Status: Completed
CHSWC Memorandum:
“Impact of Relaxing Restrictions on Eligibility for Temporary Disability Payments Beyond the Current Two Years From Commencement of Benefit Payment” (January 2007).
http://www.dir.ca.gov/CHSWC/Reports/Memo_On_TD_Benefits_Beyond_2Years.pdf

IV. OCCUPATIONAL SAFETY AND HEALTH

The Experience Modification (Ex-mod) Rating and Safety Behavior
Status: In process
For further information …
See the project synopsis in the “Projects and Studies” section.

The Injury and Illness Prevention Program (IIPP) Requirement and Cal/OSHA Inspections
Status: In process
For further information …
See the project synopsis in the “Projects and Studies” section.

Research Agenda for Improving Workplace Health and Safety in California
CHSWC Report:
“Research Agenda for Improving Workplace Health and Safety in California” (February 2008).

California Occupational Safety and Health Programs
Status: Completed
CHSWC Report:
“Background Report on California Occupational Safety and Health Programs” (February 2008).
http://www.dir.ca.gov/CHSWC/reports/CHSWCBackgroundReportonCaliforniaHealthsafetyProgramsFeb2008.pdf

ISO 9001
Status: Completed
CHSWC Report:
OCCUPATIONAL SAFETY AND HEALTH (continued)

Cal/OSHA Inspections and Safety Outcomes
Status: In process
For further information …
See the project synopsis in the “Projects and Studies” section.

Disability Retirement Benefits for Public Safety Officers
Status: Completed
CHSWC Report:
For further information …
See the project synopsis in the “Projects and Studies” section.

Schools Injury and Illness Prevention Program Project
Status: In process
CHSWC Report:
“Summary of the June 29, 2008 Schools Injury and Illness Prevention Program Roundtable” (December 2008).
http://www.dir.ca.gov/chswc/Reports/CHSWC_SummarySchoolsInjuryIllnessPreventionProgramRoundtable.pdf
For further information …
See the project synopsis in the “Projects and Studies” section.

The Relationship Between Employer Health-Promotion Measures and Workplace Injury and Illness Prevention: A CHSWC-NIOSH Study
Status: In process

Project: Worker Occupational Safety and Health Training and Education Program (WOSHTEP)
Status: Ongoing
CHSWC Reports and Materials:
WOSHTEP Brochure
“2009 WOSHTEP Advisory Board Annual Report”
“2008 WOSHTEP Advisory Board Annual Report”
“2007 WOSHTEP Advisory Board Annual Report”
“2006 WOSHTEP Advisory Board Annual Report”
“2005 WOSHTEP Advisory Board Annual Report”
“2004 WOSHTEP Advisory Board Annual Report”
“State, National and International Safety and Health Training Program Resources” (2003)
http://www.dir.ca.gov/CHSWC/TrainingProgramsResources/Surveycover.html
http://www.dir.ca.gov/CHSWC/MultilingualGuide/MultilingualGuideMain.html
**PROJECTS AND STUDIES**

**OCCUPATIONAL SAFETY AND HEALTH (continued)**

http://www.dir.ca.gov/chswc/Reports/CHSWC_HeatAgricultureSpanish.pdf

“Small Business Health and Safety Training Materials (General)” (July 2009).
http://www.dir.ca.gov/chswc/SBMRhealthandsafety.htm

http://www.dir.ca.gov/chswc/SBMRMaterials.htm (English and Spanish)

http://www.dir.ca.gov/chswc/WOSHTEP/SBMR_Janitorial.htm (English and Spanish)

Motor Vehicle Safety Programs Fact Sheet
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/MotorVehicleSafety.pdf

Teens Working in Agriculture: Activities for High School ESL Classes
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/ESLCurriculumActivitiesBooklet.pdf


*For further information …*  
See the project synopsis in the “Projects and Studies” section.

**Workplace Wellness**

**Status:** Ongoing

**CHSWC Report:**

“Summary of the July 16, 2008 Workplace Wellness Roundtable” (December 2008).
http://www.dir.ca.gov/chswc/Reports/CHSWC_SummaryWorkplaceWellnessRoundtable.pdf

*For further information …*  
See the project synopsis in the “Projects and Studies” section.

**Low-Wage Workers - Barriers to Occupational Health**

**Status:** Completed

**CHSWC Report:**

“Barriers to Occupational Health Services for Low-Wage Workers in California” (April 2006).
http://www.dir.ca.gov/CHSWC/Reports/Barriers_To_OHS.pdf

**California Partnership for Young Worker Health and Safety**

**Status:** Ongoing

**CHSWC Report:**

http://www.dir.ca.gov/chswc/studgrp.html

www.youngworkers.org for the California Partnership for Young Worker Health and Safety, providing information for teens, teen workers in agriculture, employers, and educators.

*For further information …*  
See the project synopsis in the “Projects and Studies” section.

**Project: Child Labor Photography Exhibit and Teen Workshops**

**Status:** Presented in 2004, 2005 and 2006.
V. WORKERS' COMPENSATION ADMINISTRATION

Selected Indicators in Workers’ Compensation
Status: Completed
CHSWC Reports:
“Selected Indicators in Workers’ Compensation: A Report Card for Californians” (December 2006).

The System of Access to Benefits for Injured Employees When Employer May Not Be Insured
Status: Completed
CHSWC Report:
http://www.dir.ca.gov/CHSWC/Reports/UEBTF-Final.pdf

Electronic Deposit of Benefits
Status: Completed
CHSWC Report:
“Costs and Benefits of Implementing Electronic Deposit for Unemployment and Disability Benefits in the State of California” (November 2004).
http://www.dir.ca.gov/chswc/chswc_accessstofunds.pdf/

Workers’ Compensation Court Management and Judicial Function Study
Status: Completed
CHSWC Reports:
http://www.dir.ca.gov/CHSWC/Reports/ImprovingDisputeResolution-Summary.pdf
http://www.dir.ca.gov/CHSWC/Reports/ImprovingDisputeResolution.pdf

Court Technology Project
Status: Completed
CHSWC Reports:
“Briefing on the Use of Technology in the Courts” (2003).

Final Offer Arbitration in Determining a Permanent Disability Rating Under Labor Code 4065
Status: Completed
CHSWC Reports:
http://www.dir.ca.gov/chswc/BasebalArbFfinal.htm

Local Forms and Procedures – Labor Code Section 5500.3
Status: Completed
For further information …
WORKERS’ COMPENSATION ADMINISTRATION (continued)

Profile of Division of Workers’ Compensation (DWC) District Office Operations
Status: Completed
For further information …

CHSWC Roundtable on Division of Workers’ Compensation (DWC) Lien Workload
Status: Completed
For further information …

Evaluation of the DWC Audit Function
(Special Study at the Request of the Legislature)
Status: Completed
CHSWC Reports:
http://www.dir.ca.gov/chswc/FinalAuditReport.html
“Executive Summary - CHSWC Study of the Division of Workers' Compensation Audit Function” (December 1998).
http://www.dir.ca.gov/chswc/AuditSummaryCover.html
“Project Description Study of Workers Compensation Audit Function” (1998).
http://www.dir.ca.gov/chswc/Auditfunctiondesc.html

VI. INFORMATION FOR WORKERS AND EMPLOYERS

Uninsured Employers Benefits Trust Fund Educational Booklet
Status: In process
For further information …
See the project synopsis in the “Projects and Studies” section.

Workers’ Compensation and Disability Rights Laws in California: RTW, FEHA, and the Interactive Process
Status: In process
For further information …
See the project synopsis in the “Projects and Studies” section.

Medical Booklet and Fact Sheet
Status: Completed
CHSWC Booklet and Fact Sheet:
The Basics About Medical Care for Injured Workers (2006).
http://www.dir.ca.gov/CHSWC/Reports/MedicalCareFactsheet.pdf
Getting Appropriate Medical Care for Your Injury (2006).
http://www.dir.ca.gov/CHSWC/Reports/MedicalCareBooklet.pdf

Benefit Notices Simplification Project
Status: Completed
CHSWC Reports:
“Project to Improve Laws and Regulations Governing Information for Workers Recommendations: Information for Injured Workers” (May 2000).
http://www.dir.ca.gov/CHSWC/IWCover.html
http://www.dir.ca.gov/CHSWC/navigate/navigate.html
INFORMATION FOR WORKERS AND EMPLOYERS (continued)

Workers’ Compensation Information Prototype Materials
Status: Completed
CHSWC Report, Fact Sheets and Video:
“Project to Augment, Evaluate, and Encourage Distribution of the Prototype Educational Materials for Workers” (2000).

Workers’ Compensation Fact Sheets and a Video, “Introduction to Workers’ Compensation”
http://www.dir.ca.gov/chswc/EduMaterials.html

Consolidating and Coordinating Information for Injured Workers
Status: English and Spanish versions completed.
CHSWC Reports:
http://www.dir.ca.gov/CHSWC/Reports/WorkersCompGuidebook-3rdEd.pdf (English)
http://www.dir.ca.gov/CHSWC/Reports/GuidebookSpanishforInjuredWorkers2006.pdf (Spanish)
“Workers Compensation Update: Predesignating a Medical Group” (March 2007).
http://www.dir.ca.gov/chswc/Reports/WorkersCompUpdateMarch2007d.pdf

Workers’ Compensation Medical Care in California Fact Sheets
Status: Completed
Fact Sheets:
“Workers’ Compensation Medical Care in California: Quality of Care, Costs, Access to Care, System Overview” (August 2003).
http://www.dir.ca.gov/chswc/CHSWC_WCFactSheets.htm

Workers’ Compensation Carve-Out Booklet
Status: Completed
CHSWC Report:
http://www.dir.ca.gov/CHSWC/carve-out1.pdf

Workers’ Compensation Carve-Out Guidebook
Status: Completed
CHSWC Report:
www.dir.ca.gov/CHSWC/CARVEOUTSGuidebook2004.doc

Carve-Outs – Alternative Workers’ Compensation Systems
Status: Completed
CHSWC Report:
Carve-outs in Workers’ Compensation: An Analysis of Experience in the California Construction Industry (September 1999).
http://www.dir.ca.gov/CHSWC/CarveOutReport/Carveoutcover.html
VII. MEDICAL CARE

Medical Study of Impact of Recent Reforms

Status: In process
CHSWC Report:

Medical Care Provided California’s Injured Workers

Status: Completed
CHSWC Report:
“Medical Care Provided California’s Injured Workers: An Overview of the Issues,” RAND (September 2007).
http://www.dir.ca.gov/chswc/CHSWC_MedCareProvidedCAIWs.pdf

Quality-of-Care Indicators: A Demonstration Project Using Carpal Tunnel Syndrome

Status: In process
For further information …
See the project synopsis in the “Projects and Studies” section.

CHSWC Study on Spinal Surgery Second-Opinion Process

Status: Completed
CHSWC Report:
http://www.dir.ca.gov/chswc/Reports/SSSOP-Final.pdf

State Disability Insurance Integration Project

Status: In process
CHSWC Report:

Medical Treatment Study

Status: In process.
CHSWC Report:
“Inpatient Hospital Services: An Update on Services Provided Under California’s Workers’ Compensation Program Report,” RAND (January 2009).
http://www.dir.ca.gov/chswc/Reports/CHSWC_InpatientHospitalServices.pdf
“Inpatient Hospital Fee Schedule and Outpatient Surgery Study,” RAND (February 2002)
http://www.dir.ca.gov/CHSWC/HospitalFeeSchedule2002/HospfeeschedulePage1.html
“Ambulatory Surgery Facility Services Provided to California’s Injured Workers,” RAND (March 2009).
“Hospital Emergency Department Services Furnished Under California’s Workers’ Compensation Program,” RAND (April 2009).
“Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California’s Workers’ Compensation Program,” RAND (July 2009).

For further information …
See the project synopsis in the “Projects and Studies” section.
MEDICAL CARE (continued)

CHSWC Study on Medical Treatment Protocols

Status: Completed  
CHSWC Reports:
  http://www.dir.ca.gov/CHSWC/Reports/Eval_med_tx_guideline_summary.pdf Summary  
- “Updated and Revised CHSWC Recommendations to DWC on Workers’ Compensation Medical Treatment Guidelines” (April 2006).  
  http://www.dir.ca.gov/CHSWC/Reports/Medical_Treatment_Recommendations_Final_040606.pdf  
- “CHSWC Recommendations to DWC on Workers’ Compensation Medical Treatment Guidelines” (November 2004).  
  http://www.dir.ca.gov/CHSWC/Reports/Recohswctreat.pdf  
  http://www.dir.ca.gov/CHSWC/ACOEMGuideline.pdf

Health Care Organizations

Status: Completed  
CHSWC Staff Report:

Repackaged Drugs Study

Status: Completed  
CHSWC Issue Paper:
- “Paying for Repackaged Drugs Under the California Workers’ Compensation Official Medical Fee Schedule” (May 2005).  

Pharmacy Reporting Impact Study

Status: Completed  
CHSWC Report:
- “Impact of Physician-Dispensing of Repackaged Drugs on California Workers’ Compensation, Employers’ Cost, and Workers’ Access to Quality Care” (July 2006).  
  http://www.dir.ca.gov/CHSWC/Reports/Physician-Dispensed-Pharmaceuticals.pdf

Workers’ Compensation Pharmaceutical Costs Study

Status: Completed  
CHSWC Reports:
- “Study of the Cost of Pharmaceuticals in Workers’ Compensation” (June 2000).  
  http://www.dir.ca.gov/CHSWC/Pharmacy/pharmacover.html  
- “Study of the Cost of Pharmaceuticals in Workers’ Compensation,” Executive Summary (June 2000).  
  http://www.dir.ca.gov/CHSWC/Pharmacy/ExecSumPharmaRpt.html

Payment for Hardware Study

Status: Completed  
CHSWC Report:
- “Payment for Hardware Used in Complex Spinal Procedures Under California’s Official Medical Fee Schedule for Injured Workers,” RAND (September 2005).  
  http://www.dir.ca.gov/CHSWC/Hardware_comp9.pdf
**MEDICAL CARE (continued)**

**Burn Diagnosis-Related Groups (DRGs) Study**  
*Status:* Completed  
*CHSWC Report:*  
“Payments for Burn Patients under California’s Official Medical Fee Schedule for Injured Workers,” RAND (May 2005).  

**California Research Colloquium on Workers’ Compensation Medical Benefit Delivery and Return to Work**  
*Status:* Completed  
*CHSWC Report:*  

**Integrating Occupational and Non-Occupational Integrated Care (ONIC) Medical Treatment**  
*Status:* In Process  
*For further information …*  
See the project synopsis in the “Projects and Studies” section.  

**Occupational and Non-Occupational Integrated Care (ONIC) Roundtables**  
*Status:* Completed  
*CHSWC Report:*  
“Summary of Occupational and Non-Occupational Integrated Care Roundtables” (December 2008).  

**CHSWC Study on 24-Hour Care**  
*Status:* Completed  
*CHSWC Reports:*  
“24-Hour Care Roundtable,” Summary (December 2006).  
[http://www.dir.ca.gov/CHSWC/Reports/24-Hour-Care-Final.pdf](http://www.dir.ca.gov/CHSWC/Reports/24-Hour-Care-Final.pdf)  
“Assessment of 24-Hour Care Options for California” (2004).  
[http://www.dir.ca.gov/CHSWC/Reports/24HourCare.pdf](http://www.dir.ca.gov/CHSWC/Reports/24HourCare.pdf)  
“CHSWC Background Paper: Twenty-four Hour Care” (October 2003).  
[http://www.dir.ca.gov/CHSWC/CHSWC_24hCare.pdf](http://www.dir.ca.gov/CHSWC/CHSWC_24hCare.pdf)  
*For further information …*  
See the project synopsis in the “Projects and Studies” section.  

**Workers’ Compensation Medical Billing Process**  
*Status:* Completed  
*For further information …*  
*CHSWC Background Paper:*  
“Background Information on Workers’ Compensation Medical Billing Process, Prepared for the Honorable Richard Alarcón, Chair, California Senate Committee on Labor and Industrial Relations” (2003).
MEDICAL CARE (continued)

Workers’ Compensation Medical Payment Systems
Status: Completed
CHSWC Staff Reports:
http://www.dir.ca.gov/CHSWC/CHSWC_WCMedicalPaymentSystem/CHSWC_WCMedicalPaymentSystem.pdf
http://www.dir.ca.gov/CHSWC/Reports/AdoptingMedicareFeeSchedules-summary.pdf

VIII. COMMUNITY CONCERNS

Analysis of WCIRB Pure Premium Rates
Status: Completed
CHSWC Report:
“Analysis of Proposed WCIRB 2009 Pure Premium Rates Submitted to the California Department of Insurance” (September 2008).

Public Access to Workers’ Compensation Insurance Coverage Information
Status: Completed
CHSWC Reports:
“Workers’ Compensation Compliance and Proof of Coverage” (February 2006).
http://www.dir.ca.gov/CHSWC/Papers/ProofOfCoverage2006.pdf
http://www.dir.ca.gov/CHSWC/ProofofCoverage.pdf

DWC Workers’ Compensation Audits
Status: In process
CHSWC Report:
“Draft CHSWC Response to Community Concerns Regarding DWC Workers’ Compensation Audits” (February 2007).
http://www.dir.ca.gov/CHSWC/Reports/DWC_Audits_022107.pdf

U.S. Longshore and Harbor Workers’ Compensation Market in California
Status: Completed
CHSWC Report:
http://www.dir.ca.gov/CHSWC/USLongshoreAndHarborPaper.pdf

Benefit Simulation Model
Status: Completed

Workers’ Compensation and the California Economy
Status: Completed
CHSWC Report:
“Update – Workers’ Compensation and the California Economy” (April 2000).
http://www.dir.ca.gov/CHSWC/CalEconomy/CalEconomyCover.html
COMMUNITY CONCERNS (continued)

Evaluation of Workers’ Compensation Cost and Benefit Changes Since the Beginning of the 1989 and 1993 Reforms
(Special Study at the Request of the Legislature)
Status: Completed
CHSWC Reports:
“Workers’ Compensation Costs and Benefits After the Implementation of Reform Legislation” (August 1999).
http://www.dir.ca.gov/CHSWC/Report.htm
“Executive Summary Impact of the 1993 Reforms on Payments of Temporary and Permanent Disability” (August 1999).
http://www.dir.ca.gov/CHSWC/ExecutiveSummary.htm
http://www.dir.ca.gov/CHSWC/Summary.htm

Workers’ Compensation Anti-fraud Activities
Status: Completed
CHSWC/Fraud Assessment Commission (FAC) Study
“Workers’ Compensation Medical Payment Accuracy Study” (June 2008).
CHSWC Reports:
“Reporting Workers’ Compensation Injuries in California: How Many are Missed?” (August, 2008)
“Split Class Codes: Evidence of Fraudulent Payroll Reporting” (August 2007).
http://www.dir.ca.gov/CHSWC/Fraud/Fraudreport.html
“Report on the Campaign Against Workers' Compensation Fraud” (May 2000).
http://www.dir.ca.gov/CHSWC/Fraud/Fraudcover.html
http://www.dir.ca.gov/CHSWC/Finalfraudreport0801.html

For further information …
See the project synopsis in the “Projects and Studies” section and the “Special Report: Fraud Studies.”

Underground Economy Study
Status: In process
For further information …
See the project synopsis in the “Projects and Studies” section and the “Special Report: Fraud Studies.”

Injury Reporting Study
Status: In process
COMMUNITY CONCERNS (continued)

Illegally Uninsured Employers Study
Status: Completed
CHSWC Reports:
http://www.dir.ca.gov/CHSWC/Reports/UEBTF-Final.pdf
http://www.dir.ca.gov/CHSWC/uefcover.html

IX. INSURANCE INDUSTRY AND COVERAGE

Insurance Insolvency Study
Status: In process.
For information …
See the project synopsis in the “Projects and Studies” section.

Self Insurance Groups
Status: Completed
CHSWC Reports:

Training of Claim Adjusters and Bill Reviewers
Status: Completed
CHSWC Report:
“Revised Claims Adjuster and Bill Reviewer Training and Certification by Insurers Report” (April 2009).
For further information …
See the project synopsis in the “Projects and Studies” section.

Proof of Coverage
Status: Completed
CHSWC Background Paper:
“Workers’ Compensation Compliance and Proof of Coverage” (February 2006).
http://www.dir.ca.gov/CHSWC/Papers/ProofOfCoverage2006.pdf

State of the California Workers’ Compensation Insurance Industry
Status: Completed
CHSWC Background Papers:
http://www.dir.ca.gov/CHSWC/StateInsuranceIndustry2002/Stateinsuranceindustry042002.html
X. CHSWC ISSUE PAPERS

Study of Labor Code Section 132a
Status: Completed
CHSWC Memorandum:
http://www.dir.ca.gov/chswc/Lauher132aUpdate.pdf

Information on Industrial Medical Council (IMC) Disciplinary Actions Taken on Qualified Medical Evaluators (QMEs)
Status: Completed
CHSWC Background Paper:
“Recommendations for Improvement of the IMC’s Protection of Injured Workers and Regulation of QMEs” (July 2003).

CHSWC White Paper on Cost/Benefit of Implementing Electronic Deposit for Unemployment and Disability Benefits in the State of California
Status: Completed
CHSWC Paper:
http://www.dir.ca.gov/CHSWC/CHSWC_AccesstoFunds.pdf or http://www.dir.ca.gov/chswc/CHSWC_Accessstofunds.doc
For further information …
See the project synopsis in the “Projects and Studies” section.

Strategic Plan
Status: Completed
CHSWC Report:
“CHSWC Strategic Plan” (November 2002).

XI. DISASTER PREPAREDNESS AND TERRORISM

Impact of Terrorism on Workers’ Compensation
Status: Completed
CHSWC Issue Paper:
http://www.dir.ca.gov/CHSWC/Reports/ImpactTerrorism-WC.pdf

Forum on Catastrophe Preparedness: Partnering to Protect Workplaces (April 2006)
Status: Completed
CHSWC Staff Report:
http://www.dir.ca.gov/chswc/forum2006.html
CHSWC PARTNERSHIPS WITH THE COMMUNITY

Introduction

Since its inception, the Commission on Health and Safety and Workers’ Compensation (CHSWC) has been working closely with the health and safety and workers’ compensation community including employers, employees, labor organizations, injured worker groups, insurers, attorneys, medical and rehabilitation providers, administrators, educators, researchers, government agencies, and members of the public.

In certain studies and projects, CHSWC partners with other state agencies or other organizations in studies and projects of mutual interest. Key partnerships include:

Return-to-Work/FEHA/ADA Process and Handbook for Injured Workers

*Partnership with the California Department of Industrial Relations, the Department of Fair Employment and Housing and the University of California, Berkeley*

CHSWC has partnered with the California Department of Industrial Relations (DIR), the Department of Fair Employment and Housing (DFEH), and the University of California (UC), Berkeley to support efforts to reduce litigation, reduce friction and provide information to employers, particularly small employers who have the most difficult time complying with requirements regarding return to work, by providing improved information for all system participants about the requirements of the Fair Employment and Housing Act (FEHA) and the Americans with Disabilities Act (ADA).

A handbook *Helping Injured Workers Return to Work: Practical Guidance Under Workers’ Compensation and Disability Rights Laws in California* has been developed. The handbook provides an overview of the laws which govern an injured employee’s right to continue working and the employer’s obligations to accommodate the employer: workers’ compensation law, Labor Code Section 132a, which protects the employee from discriminatory treatment; and disability rights law under FEHA, which requires the employer to engage in a timely, good faith, interactive process to find a reasonable accommodation for the employee’s disability. This handbook is especially geared for small employers and their employees.

The handbook includes additional resources in Appendix sections for physicians and insurers and for employers and employees to design, implement and participate in an effective return-to-work program. Also included is a list of state agencies that administer workers’ compensation and disability rights laws.

Customer Service Initiative

*Partnership with Division of Workers’ Compensation and Workers’ Compensation Enforcement Collaborative*

CHSWC has partnered with the Division of Workers’ Compensation (DWC) and the Watsonville-based Workers’ Compensation Enforcement Collaborative (WCEC) to overcome hurdles faced by injured workers seeking benefits when their employers are illegally uninsured. In late May 2009, a pilot-enhanced customer service initiative in one Information & Assistance (I&A) Office in Salinas, in Northern California, was launched to assist unrepresented (in pro per) injured workers in properly identifying employers and serving papers.

In addition to CHSWC and the Department of Industrial Relations (DIR) and its divisions, members of the WCEC include: the Watsonville Law Center; the Department of Insurance (CDI) Fraud Division; the San Francisco, Santa Cruz and Monterey County Offices of the District Attorney; the Fraud Assessment Commission; Kaiser Permanente; the UC Berkeley Institute for Research on Labor & Employment; the Workers’ Compensation Insurance Rating Bureau (WCIRB); Salud Para La Gente; Worksafe!; La Raza Centro Legal; California Rural Legal Assistance (CRLA); and the California Applicants’ Attorneys Association (CAAAA).
Injured workers face unique barriers in pursuing claims where the employer is uninsured. Accessing the Uninsured Employers Benefits Trust Fund (UEBTF) is procedurally complicated, especially for unrepresented injured workers. Before UEBTF can be joined in a case, the employer must be correctly identified using the legal name and then be served notice of a claim in order to establish the court’s jurisdiction. The process discourages attorneys and deters most injured workers without attorneys. With stakeholder input from the community, CHSWC has published useful guides for injured workers, and it has reported on various barriers to the workers’ compensation systems for low-wage workers and other categories of workers with a view to improving access to the workers’ compensation system for all injured workers. In particular, CHSWC has reported on UEBTF, including a review of the statutory provisions and DWC guidance materials that detail the required steps in filing a UEBTF claim. In addition, CHSWC has funded a user’s guide to be developed and based on the experience of the pilot.

The customer service initiative was developed to test whether more assistance is needed or is productive in assisting injured workers. In the pilot, the role of the Information and Assistance (I&A) Officer is expanded to assisting injured workers by:

- Helping to correctly name the employer, possibly collecting several business names that the employer uses and helping to verify insurance coverage information from the employer, as well as using the correct legal name.
- If the employer is suspected to be uninsured: arranging for service of process to establish personal jurisdiction over the employer; assisting in joining UEBTF; requesting benefits from UEBTF; obtaining a Workers’ Compensation Appeals Board (WCAB) hearing (filing a Declaration of Readiness to Proceed, Application for Discretionary Payments); and reporting suspected fraud (suspected misdemeanor or felony crimes) to the Division of Labor Standards Enforcement (DLSE).

Once the unique requirements of a UEBTF claim have been completed, the I&A process reverts to normal customer service in the provision of information and assistance.

The expectation is that rededicated efforts to provide customer service in UEBTF cases will demonstrate practices that are productive in strengthening the workers’ compensation system. Feedback from I&A Officers will be critical and will be documented for reporting purposes. The additional assistance to be provided by I&A Officers requires additional training, including additional investigative expertise that is already available within DIR.

This initiative began in Salinas, California I&A Office on June 1, 2009, and will continue for one year. The pilot will review results after one year, but it has already reported positive outcomes. If successful, the initiative may be replicated throughout the State, provided there are available resources.

Quality-of-Care Indicators Study
Partnership with RAND and Zenith Insurance Company

CHSWC partnered with RAND and Zenith Insurance Company on a demonstration project that suggests a mechanism for monitoring and improving the quality of care provided to injured workers.

The goal of the study was to demonstrate quality measurement in workers’ compensation. The objectives were to:

- Develop quality-of-care measures for carpal tunnel syndrome (CTS).
- Pilot test the measure in workers’ compensation provider and payor organizations.
- Place measures and supporting tools in the public domain.
- Use the measures to assess quality of care for a larger population of patients.
Public-private partnerships made the study possible. Funding support was provided by the Commission and Zenith Insurance. The Commission also provided essential technical assistance in developing the project. Partners-in-kind included Kaiser Permanente Northern California Regional Occupational Health and the California State Compensation Insurance Fund (State Fund), which have been involved in pilot testing.

**Occupational and Non-Occupational Integrated Medical Care Pilot Project**

*Partnership with the California HealthCare Foundation, University of California, Berkeley, DMS Facility Services, and the Service Employees International Union Local 1877*

The California HealthCare Foundation (CHCF) awarded a grant to CHSWC to develop a proposal to integrate occupational and non-occupational medical treatment, an alternative that could offer savings on medical utilization, unit pricing, and administrative expenses while potentially offering improvements in the quality of health care. As a secondary advantage, the project is expected to expand access to affordable medical insurance.

The Service Employees International Union (SEIU) Local 1877 requested assistance from CHSWC and the University of California (UC), Berkeley with negotiating a collective bargaining agreement that would integrate both occupational and non-occupational medical treatment under the union’s Taft-Hartley Health and Welfare Trust. A pilot program integrating occupational and non-occupational care began in February 2008 between DMS Facility Services, a unionized employer with employees throughout California, and SEIU 1877. The pilot is part of a carve-out agreement. The pilot uses Kaiser Permanente for delivery of both workers’ compensation medical care and group health benefits. The goal of the pilot is to identify areas of administrative savings and ways to reduce litigation. UC Berkeley is conducting data analysis for pricing issues and developing the evaluation strategy.

The project team is calculating the administrative and overhead cost of delivering occupational care under workers’ compensation, comparing each cost category from workers’ compensation to the counterpart in private health insurance, and calculating the total amount that could potentially be saved if occupational medical treatment and insurance were completely integrated under group health.

CHSWC will host a series of roundtable discussions of the results and the opportunities and challenges of implementing an integrated occupational and non-occupational medical treatment and insurance product. Comments from these roundtables will be included in the final report.

In addition, the National Academy of Social Insurance (NASI) will hold a national conference in November 2009 on the issue of integration, which will focus on the California example.

**International Forum on Disability Management 2010**

*Partnership with the Department of Industrial Relations and the International Association of Industrial Accident Boards and Commissions*

CHSWC is partnering with the Department of Industrial Relations (DIR) and the International Association of Industrial Accident Boards and Commissions (IAIABC) on the International Forum on Disability Management (IFDM) 2010. The biennial Forum, which was last held in Berlin, Germany, September 22-24, 2008, will be held in Los Angeles, California, September 20-22, 2010. The purpose of the Forum is to share information about disability management and to identify barriers and ways to overcome barriers in disability management systems. Participants will develop policy recommendations to improve management of occupational disabilities by government, employers and service support organizations.

IFDM 2010 will bring together attendees from across the world who represent the health, safety, medical and workers’ compensation communities. The diverse audience will include employers, workers, disability management practitioners, healthcare providers, advocates for full employment with disabilities, policymakers, such as legislators and heads of the executive branches, dynamic leaders in labor, business and insurance, and experts in disability management, including people mastering personal disabilities. Representatives of organizations with an interest in disability issues and a commitment to
more effective systems for overcoming barriers to the rehabilitation and full integration of workers with disabilities in gainful employment will participate in the discussion.

The IFDM 2010 Advisory Committee includes representatives from the following national and international agencies and organizations: National Institute for Occupational Safety and Health; National Institute for Disability Management and Research; Cornell University, International Labor Relations (ILR) School; Griffith Health Executive, Griffith University, Gold Coast Campus; Association of Workers’ Compensation Boards of Canada; Council on Employee Health & Productivity, National Business Group on Health; Baylor School of Medicine; Health Sciences Programs, College of Arts, Social and Health Sciences, University of Northern British Columbia; Eur., Federal Ministry of Labour and Social Affairs; World Institute on Disability; German Social Accident Insurance; International Labour Organization; Kaiser Foundation Health Plan, Inc.; California Consortium to Promote Stay-at-Work-Return-to-Work; U.S. Government Accountability Office, Education, Workforce, and Income Security Team; The Netherlands Organisation for Applied Scientific Research; RAND Corporation; Unum; and the Yukon Workers’ Compensation Health and Safety Board; Disability Management Employer Coalition.

Key topics will include:

- A Global Perspective on Disability Management: successful partnerships in disability management; an overview of global trends in the workplace; the impact of the economic downturn.
- The New Paradigm: changing social attitudes toward disability management; the next steps in moving disability management forward.
- The Government’s Role in Disability Management: models from around the world; the State and disability management; lessons learned from government initiatives and reforms.
- Emerging Economies and Disability Management.
- The Legal Aspects of Disability Management.
- Using Research and Information to Guide Public Policy Decisions on Disability Management: measuring the value of disability management programs for employers and for insurers; measuring the success of disability management certification programs; identifying resources to assist in the development and promotion of disability management programs for employers; evaluating the impact of incentives on the development and implementation of workplace disability programs.
- Innovative Programs in Workplace Health & Safety: An Employer Perspective: integration of wellness, disability and absence management programs; opportunities and barriers to safe, early and sustainable return to work.
- Medical Issues in Disability Management: psychological well-being: addressing the mental barriers to return to work; advances in medical technology and the impact on disability management; disability management techniques to deal with specific medical conditions.
- Disability Management for Special Populations: special problems in workforces with large migratory and minority culture segments.
- Success Stories, Case Studies and Solutions for Stakeholders.


Northern California Summit and Consortium to Promote Stay-at-Work-Return-to-Work
Partnership with employers, medical providers, insurers, and non-profit disability organizations

CHSWC partnered with employers, medical providers, insurers, and non-profit disability organizations to plan the first Northern California Summit to Promote Stay-at-Work-Return-to-Work (SAW-RTW).

The Northern California summit of experts convened in Pleasanton, California, on June 21, 2007, to discuss reducing medically unnecessary time off work for injured or otherwise disabled employees. The goal of the summit was to advance toward sustained solutions for preventing needless time away from work and the realignments needed to meet this goal.

The Northern California Consortium to Promote SAW-RTW was developed following the June 2007 California Summit. Its mission is to provide resources and strategies for interested stakeholders to ensure that more California employees stay at work and/or return to work.
Consortium workgroups are addressing key SAW-RTW issues including: employer education; metrics and measuring results; web-accessible resources for clinicians; communications tools for employees, employers and physicians; and SAW-RTW legislative activities.

The Consortium is also soliciting ongoing feedback from Summit participants about positive changes related to SAW-RTW in their organizations and posting that feedback along with resources on SAW-RTW on the Consortium’s website: http://www.casawrtw.org. The Consortium has also developed a Speakers Bureau for disseminating SAW-RTW information to interested stakeholders. It will participate in the International Forum on Disability Management (IFDM) 2010, September 20-22, in Los Angeles.

Health and Safety Research Agenda

**Partnership with employers, workers, and occupational health and safety governmental agencies and researchers**

CHSWC believes that it is important to conduct research that results in both knowledge and policies that will lead to elimination of workplace fatalities and reduction in injuries and make California workplaces and workers the safest, healthiest and most productive in the country. At its August 9, 2007 meeting, the Commission voted to convene a Health and Safety Advisory Committee.

CHSWC held a Health and Safety Advisory Committee meeting on November 19, 2007, with various stakeholders to develop a health and safety research agenda. A Health and Safety Research Agenda has been developed as a result of this meeting, and several health and safety studies are in process.

**Evaluation of the Effectiveness of California’s Injury and Illness Prevention Program and Compliance Officers’ Inspections**

**Partnership with RAND and the University of California, Berkeley**

One of the recommendations of the Health and Safety Research Advisory Committee was to rigorously identify the consequences of different regulators’ policies and practices with respect to job safety and health standards and enforcement through worksite inspections. CHSWC, RAND and the University of California (UC), Berkeley are conducting a study to address this recommendation with respect to the effectiveness of the Injury and Illness Prevention Plan (IIPP) Standard (Labor Code Section 3203) and the effectiveness of compliance officers’ inspections at reducing injury and illness rates. This research could help to improve the ability of occupational health and safety agencies to prevent injuries, potentially preventing a significant number of injuries and illnesses. The study will identify the following:

- Whether firms that comply with Labor Code Section 3203 have lower injury and illness rates (and better experience modification factors) than similar firms which do not.
- Whether firms which improve their compliance with Section 3203 experience reductions in injury and illness rates.
- Which provisions, if any, of Labor Code Section 3203 are most closely associated with reductions in injury rates. The rule includes seven substantive provisions, each of which can be cited separately.
- Whether there is any relation between the stringency of enforcement of Labor Code Section 3203 and reductions in injury rates.
- When controlling for other factors that affect inspection outcomes, whether the reductions in injury and illness rates vary depending on the particular compliance officer who carries out the inspection.
CHSWC PARTNERSHIPS WITH THE COMMUNITY

- Which characteristics of the more successful compliance officers and their inspection activities distinguish them from other compliance officers.

- What the policy implications are for selection, training, and incentives for compliance officers.

The Impact of Worker’s Compensation Experience Modification Rating (Ex-mod) and Firm Age on Safety Behavior and Risk

Partnership with RAND and the University of California, Berkeley

One of the recommendations of the Health and Safety Research Advisory Committee was to rigorously identify the consequences of different safety policies and practices such as workers’ compensation experience rating and workplace health and safety activities for different types of employers by size, age of firm, and industry.

Two areas of research that warrant attention with respect to the above recommendation are how workplace safety behavior is affected by workers’ compensation experience modification (Ex-mod) rating and the safety risk and employer safety behavior within different age firms.

Overlapping recommendations have come from the Experience Rating Task Force, established in 2007 in response to concerns expressed by the California Insurance Commissioner. Its report suggested that research opportunities to “evaluate the effectiveness of experience rating as a safety incentive” should be undertaken “to the extent such research is likely to produce meaningful results relevant to potential future Rating Plan changes.”

The study responds to the above research recommendations of the Experience Rating Task Force and the Health and Safety Research Advisory Committee and will evaluate the impact of workers’ compensation Ex-mod rating on the safety behavior of small employers and medium-size and large employers, as well as the safety risk of new firms versus older firms. The objectives of this project are to identify:

- Whether the application of and changes to workers’ compensation Ex-mod rating has an effect on the safety experience of small, medium-size, and large employers in addition to its original purpose of addressing insurer underwriting concerns.

- Whether the application of and changes to workers’ compensation Ex-mod rating to medium-size and large employers have an effect on their safety experience.

- Whether if employers’ performance now affects their premiums but overall premiums are declining, employers would pay more or less attention to how to decrease their injury losses.

- Policy recommendations on improving the current workers’ compensation Ex-mod rating methodology.

- Whether new firms have a greater safety risk than older firms. The analysis will look at firms by payroll, size and rating class.

- Policy recommendations on safety interventions if new firms are determined to be more unsafe than older firms.
**CHSWC PARTNERSHIPS WITH THE COMMUNITY**

**Heat Illness: Heat Hazards in Agriculture, A Guide for Employers to Carry Out Tailgate Training for Workers**

*Partnership with Department of Industrial Relations, Cal/OSHA Consultation*

CHSWC has developed a training guide in English and Spanish on heat illness in response to recent California summers that have shown that the risk of heat illness is one of the most serious challenges to the safety and health of farm workers. This training guide helps employers plan how to prevent heat illness among the crew and provide training to workers.

The training guide includes the following tools for the supervisor or crew leader to use:

- A checklist to inspect the worksite and think about heat hazards before the training is held.
- Complete instructions for teaching workers about heat hazards.
- A daily checklist to make sure all appropriate precautions are in place each work day.
- A Cal/OSHA factsheet that reviews some of the key information about heat illness, to read as needed.
- An easy-to-read factsheet that can be copied and distributed to workers.

The training is designed to be 45 minutes long and can be carried out by a supervisor or crew leader in three 15-minute sessions as tailgate meetings before the work shift or during shade breaks. Workers must get all the information before starting work and again during a heat wave. The guide emphasizes the requirements laid out in the Cal/OSHA heat stress standard, General Industry Safety Order (GISO) 3395.

This guide was developed by the [Labor Occupational Health Program (LOHP)](https://lohp.berkeley.edu), UC Berkeley, for CHSWC and is part of the [Worker Occupational Safety and Health Training and Education Program (WOSHTEP)](https://woshtep.ucdavis.edu), which is administered by CHSWC in the Department of Industrial Relations through interagency agreements with LOHP, the Western Center for Agricultural Health and Safety (WCAHS) at UC Davis, and the [Labor Occupational Safety and Health Program (LOSH)](https://losh.ucla.edu) at the University of California, Los Angeles (UCLA).

**Injury and Illness Prevention Training for Return to Work**

*Partnership with the Division of Workers’ Compensation*

CHSWC has partnered with the Division of Workers’ Compensation (DWC) to provide training for the Retraining and Return-to-Work (RRTW) Unit based on materials from the Commission’s Worker Occupational Safety and Health Training and Education Program (WOSHTEP). The RRTWU is providing direct service to employers to assist with making accommodations for injured workers to facilitate their return to work. Knowledge of WOSHTEP materials which focus on analyzing the causes of injuries and illnesses and ways to prevent them will help RRTW Unit staff make recommendations to employers on-site and at Small Business Association meetings, Chamber of Commerce meetings and Expos. CHSWC will help publicize the RRTW Unit’s “Bring ‘em Back Program” by distributing DWC materials at training sessions and conferences.

**Schools Injury and Illness Prevention Program**

*Partnership with representatives from schools and school districts, the Governor’s Office of Homeland Security, labor, and state and school-related agencies and organizations in California*

Per the mandate set forth in the Labor Code, CHSWC will assist inner-city schools or any school district in establishing effective occupational injury and illness prevention programs (IIPPs). CHSWC has established a Schools IIPP model program to help schools statewide improve their injury and illness prevention practices and resources. The program will include training and resources to enable schools or school districts to develop or improve IIPPs and make other health and safety improvements that will help protect school employees from injuries and illnesses on the job. The target audience will focus on K-12 schools and school districts at high risk of occupational injury and illness.
On June 27, 2008, CHSWC hosted a roundtable discussion that brought together representatives from schools and school districts, the Governor's Office of Homeland Security, labor, and school-related agencies and organizations in California. The objectives of the meeting were to determine how best to structure and implement the model program, School Action for Safety and Health (SASH), including a training program for schools or school districts with the priority training going to schools or school districts with high incidence rates and a pilot with schools from around the State to improve their injury and illness prevention strategies.

The SASH program includes training and resources to enable schools or school districts to develop or improve IIPPs and to make other health and safety improvements that will help protect school or school district employees from injuries and illnesses on the job. The program includes a needs assessment conducted to determine the types of training and resources that will be most effective, development of materials and resources, implementation with a pilot group, and evaluation.

On June 30, 2009, CHSWC hosted a second roundtable discussion that brought together representatives from schools and school districts, labor, and school-related agencies and organizations in California to discuss the results of the needs assessment and to provide feedback on the proposed program outline and resources.

A final report will detail successful IIPP improvements achieved, barriers encountered, and recommendations for the future. Further development of the model program would include expanding partnerships with key constituents throughout the State, expanding the target population statewide, developing a network of expert trainers, ensuring that measures of accountability are applied, and institutionalizing the program by identifying ongoing health and safety education opportunities for schools.

Workplace Wellness: How to Address Both Occupational and Lifestyle Issues on the Job

Integration of wellness and occupational health and safety has become a key focus by employers of small, medium-size and large businesses and labor. Efforts being made to develop an integrated approach to health promotion and occupational health and safety programs have focused on research and public health literature, as well as best practices of wellness programs implemented by employers.

On July 16, 2008, CHSWC hosted a Workplace Wellness Roundtable including participants from employers, labor, research organizations, and state agencies. The purpose of the Workplace Wellness Roundtable was to begin a dialogue about strategic approaches, both short-term and long-term, to integrating workplace wellness and occupational health and safety programs in California. As a result of recommendations from Roundtable participants, a booklet on integration of workplace wellness and occupational health and safety programs in California is under development.

The workplace wellness booklet, *The Whole Worker -- Integrating Wellness & Occupational Health and Safety Programs: A Guide for Effective Practices*, will help to: develop a general understanding of what constitutes an integrated approach to health promotion and occupational health and safety programs; explore barriers and strategies to overcome barriers to integration of workplace health promotion and workplace health and safety programs; and identify resources for promoting more and more effective programs that address worker health in a holistic fashion.
Health and Safety Training and Resources for Small Businesses Across Industries  
*Partnership with the State Compensation Insurance Fund*

Health and safety resources for small businesses across industries have been developed in English and Spanish through the Worker Occupational Safety and Health Training and Education Program (WOSHTEP). CHSWC has partnered with the State Compensation Insurance Fund (State Fund) to implement training and disseminate health and safety information to small businesses throughout the State of California. Through WOSHTEP, health and safety resources have been developed for the restaurant industry and the janitorial industry, and materials for the dairy industry are under development.

**Health and Safety Training for Small Business Restaurant Owners**  
*Partnership with the State Compensation Insurance Fund and the California Restaurant Association*

CHSWC has partnered with the State Compensation Insurance Fund (State Fund) and with the California Restaurant Association (CRA) to provide health and safety trainings to small business restaurant owners and managers throughout California through WOSHTEP. Preliminary findings from the evaluation of these trainings have been positive.

**Health and Safety Training and Resources for the Janitorial Industry**  
*Partnership with the State Compensation Fund and the Service Employees International Union Local 1877*

Health and safety training and resources have been developed for the janitorial industry through WOSHTEP. CHSWC has partnered with the State Compensation Insurance Fund (State Fund) and the Building Skills Partnership, a program of the Leadership Training & Education Fund between the California Janitors’ Union, SEIU 1877, and employers to provide health and safety training to small businesses within the janitorial industry.

**Integration of Worker Health and Safety Education into Building Trades Apprenticeship Programs**  
*Partnership with the State Building and Construction Trades Council of California (SBTC) (with 13 member unions) and the California Apprenticeship Coordinators Association (CACA)*

The construction industry had the largest number of work-related deaths (1,239) in 2006, compared to all industries (5,840). This, combined with the fast growth of the industry, makes the provision of worker training on injury and illness prevention a priority for governments, unions and other occupational safety and health agencies. Union apprenticeship training programs provide a potential avenue to integrate worker health and safety education. CHSWC has contracted with the UCLA Labor Occupational Safety and Health Program (LOSH) to address worker injuries and illnesses in the construction industry by bringing together the resources of WOSHTEP and those offered by apprenticeship and pre-apprenticeship programs.

A needs assessment was conducted to determine whether any or all of the following are feasible: increase the capacity of the building trades to address workplace health and safety; include occupational health and safety education in apprenticeship and pre-apprenticeship programs to reach vulnerable workers before they enter the workforce; and/or develop the capacity of apprenticeship and pre-apprenticeship instructors to teach health and safety using effective adult education techniques.

The needs assessment revealed opportunities to adapt construction-related health and safety materials that are currently part of the WOSHTEP curriculum for apprenticeship programs. Findings included that: WOSHTEP materials be shortened to be appropriate for the building trades and should include worker safety in green construction; adapted materials could be delivered to apprentices during orientations to their apprenticeship programs, in the classroom, or on-the-job at tailgate safety training; apprenticeship
instructors, senior apprentices or journeymen could present training modules; and adapted training could be presented to journeymen as part of their refreshers, upgrades or supervisory training.

Offering adapted WOSHTEP curriculum would: meet the needs of building trade workers for health and safety education in apprenticeship and pre-apprenticeship programs; build the capacity of apprenticeship and pre-apprenticeship instructors to teach health and safety using effective adult education techniques; and support efforts to reduce injuries and illnesses on the job by reaching vulnerable workers before they enter the workforce.

**Implications of Developments in Workers’ Compensation for Social Security Disability Insurance**

**Partnership with the National Academy of Social Insurance and the Social Security Administration**

CHSWC will partner with the National Academy of Social Insurance (NASI) and the Social Security Administration (SSA) in November 2009 to host a seminar to enhance understanding of policy and administrative issues relating to the fit between workers’ compensation and social security disability insurance (SSDI). Key topics will include how to improve coordination between the two programs and better serve disabled workers. Sessions will focus on: priorities in social security disability programs and policy; national trends in workers’ compensation; the California experience – growth and retrenchment; social security disability insurance and the offset; pathways from workers’ compensation to SSDI; how injured workers learn about SSDI; and California innovations in return to work.
CHSWC AND THE COMMUNITY

For Information about the Commission on Health and Safety and Workers’ Compensation (CHSWC) and its activities:

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- What’s New
- Research Studies and Reports
- Information Bulletins
- Commission Members
- Meeting Schedules and Minutes
- DIR Young Workers Website
- Information for Workers and Employers
- WOSHTEP
  - Conferences
- Public Comments and Feedback
- Resources

CHSWC Publications

In addition to the many reports listed in the CHSWC Projects and Studies section of this report, CHSWC has published:

CHSWC Annual Reports
1994 through 2009

CHSWC Strategic Plan 2002
Community Activities

CHSWC is pleased to report that its members and staff have had the privilege of participating in several activities of the health and safety and workers’ compensation community.

California Coalition of Workers’ Compensation
7th Annual Conference

California Workers’ Comp Forum
Executive Officer presentation (Northern CA)

Department of Industrial Relations
Division of Workers’ Compensation
16th Annual Conference

Disability Management Employer Coalition
Executive Officer presentation

International Association of Industrial Accident Boards and Commissions
95th Annual Convention
All Committee Conference
Executive Committee Meeting

International Disability Management Standards Council
Executive Officer presentation

International Forum on Disability Management
Advisory Committee Meeting

National Academy of Social Insurance
2009 Board Meeting
Executive Officer Co-chair: Implications of Developments in Workers’ Compensation for Social Security Disability Insurance Seminar

National Institute for Occupational Safety and Health
Workers’ Compensation Data Workshop

RAND Corporation
Board Meeting

Ryan Associates, National Association of Occupational Health Professionals
23rd Annual National Conference

State Compensation Insurance Fund
Board Meeting
Executive Officer presentation

U.S. Department of Labor, Bureau of Labor Statistics
Workers’ Compensation Data Workshop

University of California Office of the President
Executive Officer presentation

Woodland Healthcare
Executive Officer presentation
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Workers’ Compensation Research Institute
Advisory Meeting

Workers’ Compensation Insurance Rating Bureau
Claims Subcommittee meeting
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ENDNOTES (See “System Costs and Benefits Overview”).

i. CHSWC estimate based on Employment Development Department report, as above, showing 1,304,291 businesses. Of these, 893,427 were businesses with 0 to 4 employees. For this estimate, half of those businesses are assumed to have no employees subject to workers’ compensation. 1,304,291 – (893,427/2) = 857,578. http://www.labormarketinfo.edd.ca.gov/?pageid=138


iii. The latest year for which Workers’ Compensation Information System (WCIS) reports are reasonably complete. Data are from the Division of Workers’ Compensation (DWC) report from the WCIS database, “Workers’ Compensation Claims (in 000’s) by Market Share with Eight Year History and Cumulative Totals, 2000-2008,” May 5, 2009, http://www.dir.ca.gov/dwc/WCIS/WCC-MarketShare.pdf. Due to delayed reporting, the number of claims reported to WCIS for a given year may grow by more than 5 percent between the second and the fourth years after the end of the accident year. Boden, Leslie I. and Al Ozonoff, “Reporting Workers’ Compensation Injuries in California: How Many are Missed?” (2008). CHSWC Report.

iv. Data for 2006 are from the Division of Workers’ Compensation report from the WCIS database, “Workers’ Compensation Claims (in 000’s) by Market Share with Eight Year History and Cumulative Totals, 2000-2007,” April 25, 2008. From 2002 through 2006, the average shares varied by no more than =0.5/-0.4 for the insured share, =0.7/-0.5 for the self-insured share, and =/-0.2 for the State. CHSWC omits the years 2000 and 2001 from these averages because reasonably complete reporting was not achieved until mid-2001.