California Commission on Health and Safety and Workers' Compensation

CHSWC 2010 Annual Report

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Department of Industrial Relations

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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 state agencies, foundations, and the health and safety and 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
Serving all Californians

- Created by the 1993 workers' compensation reform legislation.
- Composed of eight members appointed by the Governor, Senate and Assembly to represent employers and labor.
- Charged with examining the health and safety and workers' compensation systems in California and with recommending administrative or legislative modifications to improve their operation.
- Established to conduct a continuing examination of the workers' compensation system and of the State's activities to prevent industrial injuries and occupational diseases and to examine those programs in other states.
- Works with the entire health and safety and workers' compensation community – employees, employers, labor organizations, injured worker groups, insurers, attorneys, medical and disability providers, administrators, educators, researchers, government agencies, and members of the public.
- Brings together a wide variety of perspectives, knowledge, and concerns about various health and safety and workers' compensation programs critical to all Californians.
- Serves as a forum whereby the community may come together, raise issues, identify problems, and work together to develop solutions.
- Contracts with independent research organizations for projects and studies designed to evaluate critical areas of key programs. This is done to ensure objectivity and incorporate a balance of viewpoints and to produce the highest-quality analyses and evaluation.

CHSWC Members Representing Employers

Catherine Aguilar

Catherine (Cathy) Aguilar 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 the 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 Insurers' 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

CHSWC Members Representing Employers

Kristen Schwenkmeyer

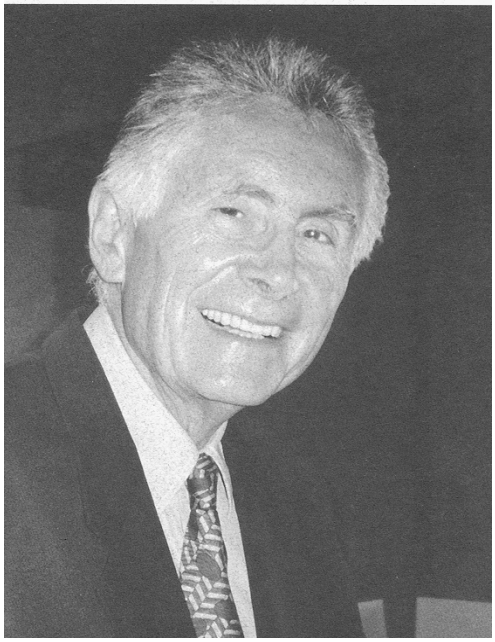
Kristen Schwenkmeyer is secretary-treasurer of Gordon & Schwenkmeyer, a telemarketing firm she started with Mike Gordon in March of 1985. Her primary responsibilities include overall administration of operations, budgeting and personnel for a staff of over 700.

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

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

CHSWC Members Representing Labor

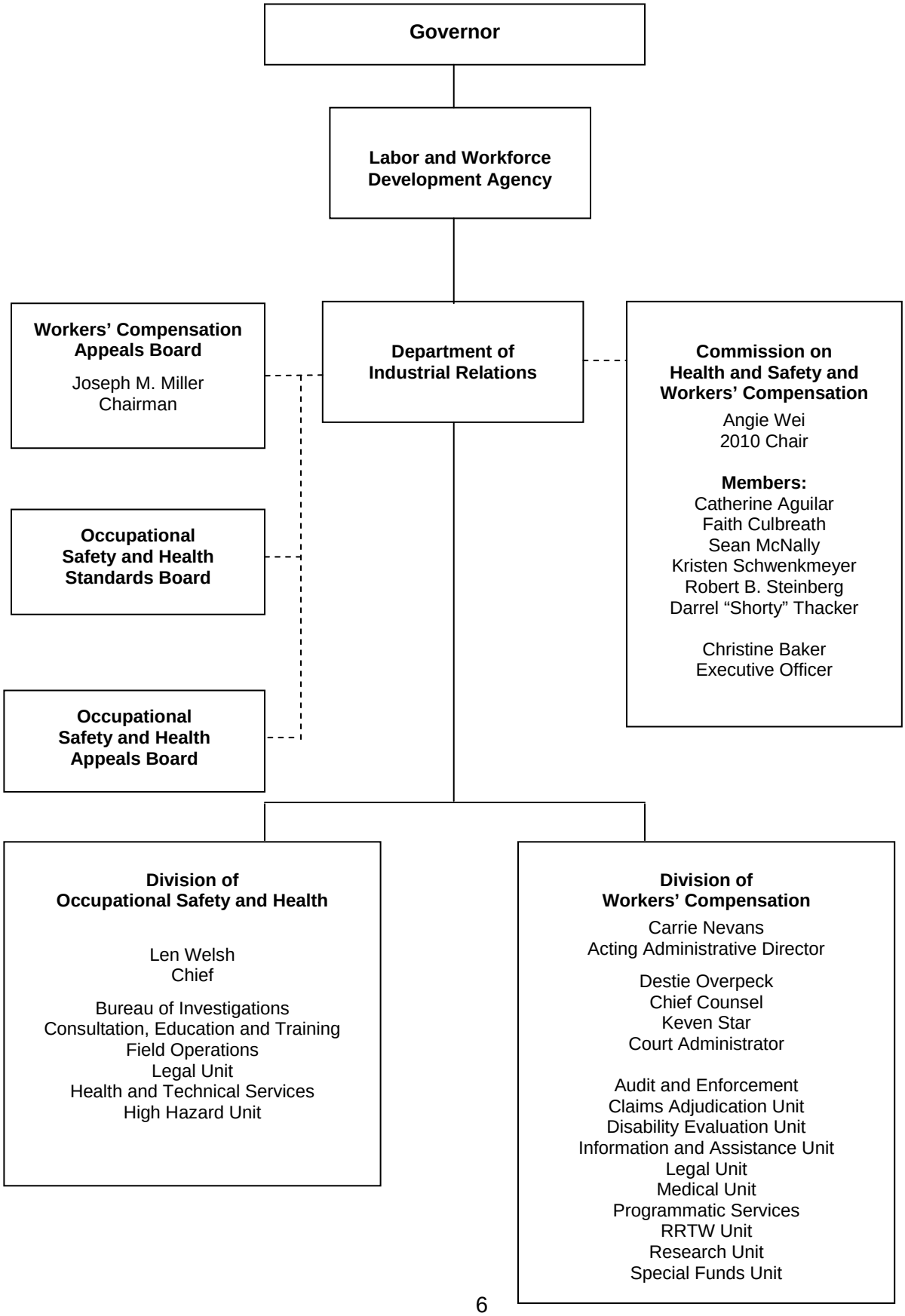
Angie Wei

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

State of California Health and Safety and Workers' Compensation Functions



CHSWC RECOMMENDATIONS

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

Permanent Disability

An increase in permanent disability (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 employers are confronted with judicial interpretations permitting liberal interpretation of the AMA *Guides to the Evaluation of Permanent Impairment* and establishing parameters rebuttal of the 2005 permanent disability rating schedule.

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 also disproportional to losses across the range of pre-injury earnings because the weekly maximum payment (usually $230 per week, based on two-thirds of wages up to $345) 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 primarily to the lower range of ratings and to workers whose pre-injury wages were more than $345 per week.

Recommendation

CHSWC recommends that PD compensation be increased, and at the same time, that legislation be enacted to improve the consistency of impairment ratings under the AMA *Guides* and to make the rating schedule conclusive for all or most cases. CHSWC recommends that, when PD compensation is increased, the increase should be in the form of a higher maximum weekly rate, while the number of weeks of benefits for each percent of rated disability should be revised to make compensation more nearly proportional to the average losses associated with the PD rating.

RETURN TO WORK

The 2003 and 2004 reforms contained three major provisions aimed at improving return to work (RTW): tiered PD benefits; the supplemental job displacement benefit (SJDB); and the RTW Reimbursement Program for smaller employers. The RTW Reimbursement Program was not cost-effective, and the Legislature did not extend the program after December 31, 2009. The tiered PD and the SJDB programs are not well coordinated, and neither one is performing as originally intended. They may nevertheless serve a purpose, even if only as an indirect way to increase PD compensation until that issue is addressed directly.

RTW rates have improved from the low point reached in 2003. Empirical evidence cannot single out the cause of the improvement. Possible factors are changes to the California Fair Employment and Housing Act (FEHA) enacted in 2000, changes in workers' compensation medical treatment laws enacted in 2003, the repeal of vocational rehabilitation for injuries occurring after 2003, and changes in RTW incentives enacted in 2003 and 2004.

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.
- Consider eliminating SJDB and tiered TD benefits; if these are retained then coordinate the timelines for eligibility determinations and of timing of notices
- Consider modifying SJDB and tiered PD eligibility to meet public policy goals in cases of seasonal and temporary employment, as well as general and special employment.
- Continue to support and further the discussion on the problems, trends and best practices of disability management.

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 Administrative Director (AD) of the Division of Workers' Compensation (DWC) was required by statute enacted in 2003 to adopt a medical treatment utilization schedule (MTUS) in consultation with CHSWC. DWC is continuing to augment and update the MTUS.

Recommendations

- Use stakeholder discussions and research to identify reasons for deviations from the guidelines so that inappropriate deviations can be minimized.
- 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. In its filing for January 2011, WCIRB reported that average medical severity increased by 6.1 percent in 2008-09, suggesting that the rate of growth has slowed.

Recommendations

- Conduct further studies which are needed to determine what is driving medical costs.
- The AD should continue the process of adopting a physician fee schedule based on the Resource Based Relative Value Scale (RBRVS). A goal should be to arrive at a single conversion factor after a reasonable transition period.
- The AD should continue the process of revising the fee schedule to eliminate the duplication of reimbursements for the cost of implantable spinal hardware that result from the existing pass-through of spinal hardware costs in addition to diagnostic related group (DRG)-based facility fees which already include consideration for such costs.
- 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 continue the process of revising the fee schedule for Ambulatory Surgery Centers (ASCs). Any allowance above 120 percent of the Medicare ASC fee should only be based on insufficient access to services demonstrated by access studies in accordance with Labor Code Section 5307.2 and not based on speculative arguments. The AD should adopt definitions of ASCs eligible for payment of facility fees to be more similar to the requirements of Medicare or other payors.
- 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.
- To enable improved monitoring of MPN performance, amend the Workers' Compensation Information System (WCIS) reporting requirements to identify the MPN if treatment is furnished through an MPN.

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 the result of a UR. A medical-legal evaluation is performed by an Agreed Medical Evaluator (AME) if the worker is represented and the parties agree, otherwise by a Qualified Medical Evaluator (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. In addition, problems exist with the consistency of reports because the outcome of the evaluation is significantly influenced by the selection of the evaluating physician. All of these problems contribute to increased frictional costs and delays in resolving disputes and delivering benefits to injured workers.

Recommendation

Provide continuing training, monitoring, and oversight of QMEs with the goals of obtaining complete reports and consistent evaluations in compliance with legal requirements.

- Seek ways to attract and retain physicians to serve as QMEs, particularly in specialties where the demand is greatest.

REDUCTIONS IN ADMINISTRATIVE COSTS

Liens

The number of liens filed per year has dropped since the introduction of the Electronic Adjudication Management System (EAMS) in August 2008. It is growing as people become more familiar with the new filing procedures. The volume of liens overwhelms the court system and creates an environment where overbilling, underpayment, and all manner of bad faith conduct can thrive. Filing, processing, and adjudicating liens place an enormous burden on the already strained workers' compensation courts and an administrative burden on the parties. Courts are seeing backlogs both in the processing liens into the system and getting the disputes resolved.

Recommendations

- Make resources available to enforce existing penalties and incentives for appropriate payments.
- Modify existing statute to require a clear explanation of payment or nonpayment of medical bills.
- Enact a meaningful statute of limitations to bar stale lien claims.
- Enact a filing fee to discourage frivolous claims, assessable as a cost to discourage frivolous disputes.
- Establish an administrative process to resolve fee schedule disputes, subject to limited judicial review.

Additional recommendations and discussion may be found in the CHSWC report on liens expected for publication in January, 2011.

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) Fraud Task Force Report May 2008. 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. Despite this, 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 to make recommendations.

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 2009 follow-on study to CHSWC's 2007 study found that between $15 and $68 billion of payroll annually are under-reported. 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.
- 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.

Definition of First Aid

Injuries that do not require treatment beyond first aid do not necessitate an employer report of injury for worker's compensation or a Cal/OSHA log. The definitions of first aid for those two purposes are different, however, resulting in a degree of uncertainty about when a minor injury is reportable. Even criminal evasion of workers' compensation obligations may hide behind that uncertainty. Employers have

identified the conflicting definitions as a barrier to compliance, and prosecutors have identified the conflicting definitions as a barrier to prosecution of willful violations. The definition of first aid is only pertinent to reporting requirements, so a change in the definition would not change an injured workers' right to receive treatment.

Recommendation

CHSWC recommends that the definition of first aid for purposes of workers' compensation reporting be amended to align with the definition used for Cal/OSHA purposes.

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.
- Make information available in 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. Assembly Bill (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 was published in 2009.

Recommendations

Findings from the CHSWC/RAND study identified six key factors that contributed to the insolvencies and volatility over the past 15 years:

- Inaccurate projections of claim costs.
- Pricing below projected 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 ultimate profitability of policies.
- Under-reserving for claim costs by insurers.
- Insurer surplus and capital that were inadequate to provide a cushion against adverse events.

CHSWC considers the first key factor, inaccurate projections of claims costs, to be the most important, and the one which remains a concern whether in a hard or soft market. The other factors to a large extent were unique to the price competitive environment at the time and the new, uncharted or inexperienced environment surrounding the introduction of the open rating system in California.

Related to inaccurate projections of claim costs, RAND identified a problem at the Workers' Compensation Insurance Rating Bureau (WCIRB) in that it does not have direct access to transaction-level data on claims payments in order to better detect and then project more accurate claim costs. According to RAND, WCIRB is developing plans to collect transaction-level data directly from insurers in the future.

CHSWC supports a recommendation that helps WCIRB collect and analyze transaction-level data from insurers.

RAND made six recommendations aimed at improving the reliability of projecting costs which are noted below. The first three recommendations aim to make the system more predictable and the next three help WCIRB, CDI and insurers do a better job of predicting costs:

- Increase clarity of legislative intent.
- Expeditiously release guidance and regulation on issues when there are important disagreements among stakeholders.
- Review the Workers' Compensation Appeals Board (WCAB) system.
- Explore the most appropriate way for WCIRB to take advantage of transaction-level data.
- Increase the comprehensiveness of data provided to WCIRB.
- Fast-track analyses of the impact of important legislative and judicial opinions.

CHSWC acknowledges that many of these recommendations highlight the importance of the insurance regulators to do more, but they also highlight the responsibility of the Department of Industrial Relations (DIR) and the Legislature to help create an environment where WCIRB and CDI are not engaged in a guessing game as to the real and potential cost drivers in the system, as well as when those cost drivers will actually take effect.

Overall, CHSWC supports the four themes underlying the RAND recommendations, those of predictability, transparency, incentives, and CDI oversight.

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, 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 as a precondition to obtaining benefits from UEBTF.

Recommendations

- Continue to expand the pilot project conducted by the Salinas Information & Assistance (I&A) office to assist injured workers in identifying insurers or identifying and serving uninsured employers. The project has already expanded to the Anaheim I&A office, and the experience of these two offices may inform further expansion statewide.
- 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, encourage medical providers to report suspected uninsured employers to CDI on the FD-1 fraud form.
    - Revise the FD-1 form to make it more suitable for reporting uninsured employers and employer or insurer fraud, not just claimant fraud.
    - 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 and more clearly report the results of that program annually.

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 report on the promptness of first payment. This was a simple way to motivate claims administrators to improve their compliance with legal requirements. If the confidentiality of individually identifiable information (defined by Labor Code Section 138.7 to include information identifiable to an individual insurance company or employer) is an obstacle to the publication of this report, then the Legislature should enact an exception to authorize the publication of the promptness of payment report.
- DWC should require electronic filing, rather than paper filing with the DIR Division of Labor Statistics and Research (DLSR), of 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 and improve the availability of data for monitoring system performance.
- DWC should implement expeditiously the following regulations to:
    - Update medical cost reporting.
    - Implement electronic billing.
    - Update coding for doctors' services to the codes in Medicare's 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.
- The Legislature could enact the statutory amendments necessary for the AD to carry out a simplification of benefit notices, as described in the July 2010 CHSWC report on benefit notices and recommendations.
- Review EAMS performance and proceed with revisions as necessary. One example known to CHSWC is the inability of EAMS to recognize amended liens, forcing all liens to be entered as original even if they are amendments.
- Enforce compliance with EAMS filing requirements. One example known to CHSWC is the continued filing of liens on incompatible forms, which defeats the automated data acquisition functionality of EAMS.

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 a statewide program that deserves continued support by employers and the health and safety and workers' compensation community.

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 2011, the following projects and studies by leading researchers in the country will continue:

- 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 (IIPP) and Compliance Officers' Inspections.
- Experimental Evidence on the Causal Effect of Cal/OSHA Inspections on Workplace Employees and Employers.

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.

INTEGRATION OF WORKERS' COMPENSATION MEDICAL CARE WITH OTHER SYSTEMS

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 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.
- Evaluate the impact of MediCare's implementation of its secondary payor rights with regard to settlements of workers' compensation claims, and examine alternative ways to coordinate benefits between the two systems.

SPECIAL REPORT: 2010 LEGISLATION AND REGULATIONS ON HEALTH AND SAFETY AND WORKERS' COMPENSATION

This Special Report outlines the 2010 legislation and regulations on health and safety and workers' compensation.

HEALTH AND SAFETY

Health and Safety Legislation

The following describes the health and safety bill that was signed into law in 2010, as reported on the website of the Legislative Counsel of California at www.leginfo.ca.gov.

AB 2774 – Assembly Member Swanson
Repeals and adds Section 6432 of the Labor Code, relating to employment.
Occupational safety and health.
Status: Enrolled 9/3/10 and Chaptered 9/30/10.

Existing law requires an employer to provide employees with a safe workplace and authorizes the Division of Occupational Safety and Health (DOSH) within the Department of Industrial Relations (DIR) to enforce health and safety standards in places of employment and to investigate and to issue a citation and impose civil penalties when an employer commits a serious violation that causes an employee to suffer or potentially suffer, among other things, "serious injury or illness" or "serious physical harm."

This bill would establish a rebuttable presumption as to when an employer commits a serious violation of these provisions and would define serious physical harm, as specified. The bill would also establish new procedures and standards for an investigation and the determination by the division of a serious violation by an employer which causes harm or exposes an employee to the risk of harm.

Health and Safety Regulations

The regulatory activities of DOSH and the Occupational Safety and Health Standards Board (OSHSB) 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.

Proposed DOSH regulations can be found online at:
http://www.dir.ca.gov/dosh/doshreg/mainregs.html

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.

In 2010, the Occupational Safety & Health Standards Board (OSHSB) launched the Title 8 index at:
http://www.dir.ca.gov/title8/index/t8index.html

Occupational Safety and Health Standards Board approved standards are at:
http://www.dir.ca.gov/OSHSB/apprvd.html

The latest formal OSHSB rulemaking updates are available at:
http://www.dir.ca.gov/OSHSB/proposedregulations.html

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
Labor Code Section 142.3 **Momentary Contact Devices for Portable Power Driven Augers (Kill Switches)**	**Status: Regulations completed. Filed with Secretary of State December 2, 2009. Effective January 1, 2010.** *8 CCR 4086* All portable pipe threading/cutting machines, portable power-driven augers (earth drills), and portable power drives shall be permanently equipped with a momentary contact device. http://www.dir.ca.gov/oshsb/Kill_Switches.html
Labor Code Section 142.3 **Pressurized Worksite Operations**	**Status: Regulations completed. Filed with Secretary of State March 10, 2010. Effective April 9, 2010.** *8 CCR Sections 6070, 6074, 6075, 6080, 6085, 6087, 6089, 6090, 6100, 6115, and 6120, and Appendices A and B.* Adoption of new (Navy) decompression tables, oxygen concentration and monitoring, fire prevention in handling of oxygen, and retention of a supervising physician who provides medical supervision of employees employed in compressed air work. http://www.dir.ca.gov/oshsb/Pressurized_Worksites.html
Labor Code Section 142.3 **Spreaders for Self-Feed Circular Ripsaws**	**Status: Regulations completed. Filed with Secretary of State March 24, 2010. Effective April 23, 2010.** *8 CCR 4301* *General Industry Safety Orders* In addition to guards over blades as specified in Section 4296, feed rolls shall be protected by a hood or guard to prevent the hands of the operator from coming in contact with the in-running rolls at any point. Every self-feed circular ripsaw shall be equipped with an anti-kickback device installed on the infeed side. http://www.dir.ca.gov/oshsb/Ripsaw_Spreaders.html

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
Labor Code Section 142.3 **Low-Voltage Electrical Safety Orders--Addendum**	**Status: Regulations completed. Filed with Secretary of State April 6, 2010. Effective May 6, 2010.** *8 CCR 2305.2 (incl. 2395.6), 2340.16, 2360.3, 2405.4, 2534.8* Addresses ambiguous, obsolete, overlapping, conflicting, and/or unnecessary standards outside of those covered by the counterpart federal standard. http://www.dir.ca.gov/oshsb/LVESO_Addendum.html
Labor Code Section 142.3 **Hot Pipes and Hot Surfaces**	**Status: Regulations completed. Filed with Secretary of State May 5, 2010. Effective June 4, 2010.** *8 CCR 3308* *General Industry Safety Orders* Pipes or other exposed surfaces having an external surface temperature of 140 degrees F (60 degrees C) or higher and located within 7 feet measured vertically from floor or working level or within 15 inches measured horizontally from stairways, ramps or fixed ladders shall be covered with a thermal insulating material or otherwise guarded against contact. This order does not apply to operations where the nature of the work or the size of the parts makes guarding or insulating impracticable. http://www.dir.ca.gov/oshsb/Hot_Surfaces.html
Labor Code Section 142.3 **Traffic Control--Number of Flaggers**	**Status: Regulations completed. Filed with Secretary of State May 25, 2010. Effective June 24, 2010.** *8 CCR 1599.* (a) A flagger or flaggers shall be utilized at locations on a construction site where barricades and warning signs cannot control the moving traffic. Unless this section provides differently, the number of flaggers required and matters regarding the deployment of the flagger or flaggers shall be according to the California Manual on Uniform Traffic Control Devices for Streets and Highways, September 26, 2006, published by the State Department of Transportation (the Manual), which is herein incorporated by reference. (b) When a flagger or flaggers are required, they shall be placed in relation to the equipment or operation so as to give effective warning.

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
	(c) Placement of warning signs shall be according to the "Manual." ***** (g) Flaggers shall be trained in the proper fundamentals of flagging moving traffic before being assigned as flaggers. Signaling directions used by flaggers shall conform to the "Manual." The training and instructions shall be based on the "Manual" and work site conditions and also include the following: http://www.dir.ca.gov/oshsb/Flaggers.html
Labor Code Section 142.3 **Acetylene.**	**Status: Regulations completed. Filed with Secretary of State July 1, 2010. Effective July 1, 2010.** *8 CCR 4650, 4797,4823.* §4650. Storage, Handling, and Use of Cylinders. (t) Cylinders. Employers must ensure that the in-plant transfer, handling, storage, and the use of acetylene in cylinders comply with the provisions of CGA G-1-2003 Acetylene, Eleventh Edition, which is hereby incorporated by reference. (u) When flammable gas lines or other parts of equipment are being purged of air or gas, open lights or other sources of ignition shall not be permitted near uncapped openings. §4797. Approval and Marking. (a) Employers must ensure that facilities, equipment, structures, or installations used to generate acetylene or to charge (fill) acetylene cylinders comply with the provisions of NFPA 51A Standard for Acetylene Cylinder Charging Plants 2006 Edition which is hereby incorporated by reference. (b) When employers can demonstrate that the facilities, equipment, structures, or installations used to generate acetylene or to charge (fill) of acetylene cylinders were constructed or installed prior to February 16, 2006, these employers may comply with the provisions of NFPA 51A Standard for Acetylene Cylinder Charging Plants, 2001 Edition which is hereby incorporated by reference. (c) The provisions of subsection (b) also apply when the facilities, equipment, structures, or installations were approved for construction or installation prior to February 16, 2006, but constructed and installed on or after that date.

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
	(d) Auxiliary apparatus such as blowpipes (torches), regulators (pressure-reducing valves), compressors and booster systems, flame arresters and gages shall be approved. (See Section 3206) (e) Equipment shall be installed and used only in the service for which it is approved. §4823. Acetylene Piping. (a) Employers must comply with NFPA 51A Standard for Acetylene Cylinder Charging Plants 2006 Edition which is hereby incorporated by reference. (b) When employers can demonstrate that the facilities, equipment, structures, or installations used to generate acetylene or to charge (fill) acetylene cylinders were installed prior to February 16, 2006, these employers may comply with the provisions of NFPA 51A Standard for Acetylene Cylinder Charging Plants, 2001 Edition which is hereby incorporated by reference. (c) The provisions of subsection (b) also apply when the facilities, equipment, structures, or installations used to generate acetylene or to charge (fill) acetylene cylinders were approved for construction or installation prior to February 16, 2006, but constructed and installed on or after that date. NOTE: For additional information on acetylene piping systems, see CGA G-1.2-2006, Acetylene Metering and Piping, Third Edition. http://www.dir.ca.gov/oshsb/Acetylene.html
Labor Code Section 142.3 **Haulage and Earth Moving, General. Use of High Visibility Apparel--Private Roads and Off-Highway Situations**	**Status: Regulations completed. Filed with Secretary of State June 2, 2010. Effective July 2, 2010.** *8 CCR 1590.* (a) Private Roadways and Off-Highway Conditions. ***** (5) Employees (on foot), such as grade-checkers, surveyors and others exposed to the hazard of vehicular traffic, shall wear high-visibility safety apparel in accordance with the requirements of Sections 1598 and 1599 of these Orders. http://www.dir.ca.gov/oshsb/HVA2010.html

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
Labor Code Section 142.3 **Airborne Contaminants**	**Status: Regulations completed. Filed with Secretary of State February 3, 2010. Effective August 3, 2010.** *8 CCR 5155* Specifies several types of airborne exposure limits, requirements for control of skin and eye contact, workplace environmental monitoring through measurement or calculation, and medical surveillance requirements. Related to several dilutants, solvents, explosives, nickel compounds, coal dust, ceramic fibers, and vinyl chemicals. http://www.dir.ca.gov/oshsb/airborne_contaminants09.html
Labor Code Section 142.3 **Loading Explosive Materials-General.**	**Status: Regulations completed. Filed with Secretary of State July 22, 2010. Effective August 21, 2010.** *8 CCR 5278.* ***** (d) Loading operations shall be carried on with the smallest practical number of persons and explosive materials loading equipment present and no one but the loading crew, inspection personnel, and authorized supervisory personnel shall be allowed within 50 feet of the loading area. (1) At locations where a 50-foot minimum distance cannot be maintained, an alternative plan shall be submitted to the Division for approval 30 days prior to the anticipated start of work. The Division shall give written notice of receipt to the applicant within 7 days. Notice of approval/disapproval, shall be given within 15 days of receipt of the application. The Division may shorten the 30-day notification requirement where construction has commenced and unexpected site and/or emergency conditions requiring blasting occur. (2) The Division shall approve the alternative plan if the following elements are satisfied: (A) All blasting operations will be conducted using low-sensitivity explosive materials. (B) All blasting operations will be conducted using initiation systems which cannot be affected by stray current or radio frequency energy. (C) A lightning and electric storm-detection system and written plan of action are provided to the Division. The plan shall include provisions for a detection system capable of warning the loading crew when a storm is 100 miles away. When a storm is detected 50 miles from the

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
	loading operation, the storm's movement is to be monitored. When a storm is detected at 25 miles from the loading operation, loading operations will be discontinued, and all persons in the blast area withdrawn to a safe location. (D) K-rails, barriers, traffic control systems or natural terrain shall be used to prevent entry by vehicular traffic into the loading site. ***** (o) Except as provided in Section 5278(w), holes to be blasted shall be charged as near to blasting time as practical and such holes shall be blasted as soon as possible after charging has been completed. (1) No explosive materials shall be left unattended at the blast site. (2) Loaded holes shall not be left unattended except as permitted in Section 5278(w). (3) No one but the attendant(s) (see CCR, Title 8, Section 3207 for the definition of Qualified Person, Attendant or Operator), the loading/detonation crew, inspection personnel, and authorized supervisory personnel shall be allowed within 50 feet of the loaded holes. (A) At locations where 50-foot minimum distance cannot be maintained, an approved alternative plan pursuant to the requirements in subsection (d) shall be implemented. ***** (w) Loaded holes intended for geophysical operations: (1) Shall be attended; or (2) May be left unattended, but only where the loaded explosives, if detonated, will not cause injuries and where the loaded explosives are: (A) Anchored, tamped or stemmed so that the charge cannot be removed; or (B) Left so that the detonator leads are inaccessible to or concealed from unauthorized persons. (3) No one but the attendant(s), the loading/detonation crew, inspection personnel, and authorized supervisory personnel shall be allowed within 50 feet of the loaded holes. (A) At locations where the 50-foot minimum distance cannot be maintained, an approved alternative plan pursuant to the requirements in subsection (d) shall be implemented. http://www.dir.ca.gov/oshsb/Loading_Explosives.html

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
Labor Code Section 142.3 **Rollover Protective Structures for Ride-On Power Lawn Mowers**	**Status: Regulations completed. Filed with Secretary of State August 3, 2010. Effective September 2, 2010.** *8 CCR 3563 and 3651* Standards requirements for different dates of manufacture, labeling, uses of seat belts and protective structures, prohibited use guidelines and training. http://www.dir.ca.gov/oshsb/Lawn_Mower_ROPS.html
Labor Code Section 142.3 **Heat Illness Prevention**	**Status: Regulations completed. Filed with Secretary of State October 5, 2010. Effective November 4, 2010.** *8 CCR 3395* The Heat Illness Prevention Standard was amended and definitions were updated. The modifications address high-heat procedure requirements for five industries, clarification of the shade requirement including temperature triggers, and the provision for flexibility to employers under this requirement. http://www.dir.ca.gov/oshsb/Heat_Illness.html
Labor Code Section 142.3 **Update of Welding Fire Prevention and Suppression Procedures and Methods**	**Status: Regulations completed. Filed with Secretary of State August 30, 2010. Effective September 29, 2010.** *8 CCR 4848* ***** (b) Welding blankets, curtains and pads shall be approved for their intended use in accordance with Section 3206 of these Orders. http://www.dir.ca.gov/oshsb/Welding_Update.html
Labor Code Section 142.3 **Pile Driving and Pile Extraction**	**Status: Public hearing May 20, 2010. Proposed for adoption September 16, 2010.** *8 CCR 1600-1601* http://www.dir.ca.gov/oshsb/Pile_Driving.html

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
Labor Code Section 142.3 **Scaffold Plank Design Requirements**	**Status: Public hearing June 17, 2010. 15-Day Notice issued Comments due 8/26/2010.** *8 CCR 1504, 1637, 3622* http://www.dir.ca.gov/oshsb/Scaffold_Planks.html
Labor Code Section 142.3 **Other Confined Space Operations**	**Status: Regulations completed. Filed with Secretary of State August 30, 2010. Effective September 29, 2010.** *8 CCR 5158* ***** (e) Confined Space Operations. (1) Entry Into and Work Within Confined Spaces. The requirements of this subsection apply to entry into and work within a confined space whenever an atmosphere free of dangerous air contamination, oxygen enrichment and/or oxygen deficiency cannot be ensured through the implementation of the applicable provisions of subsection (d), or whenever, due to the existence of an emergency, it is not feasible to ensure the removal of dangerous air contamination, oxygen enrichment and/or an oxygen deficiency through the implementation of the applicable provisions of subsection (d). ****** (D) At least one employee shall stand by on the outside of the confined space ready to give assistance in case of emergency. At least one additional employee who may have other duties shall be within sight or call of the standby employee(s). 1. The standby employee shall have appropriate, approved, respiratory protective equipment, including an independent source of breathing air which conforms with Section 5144(e)(i), available for immediate use. ****** http://www.dir.ca.gov/oshsb/Confined_Spaces.html

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
Labor Code Section 142.3 **Employee Notification Regarding Chromium (VI) Exposure Determinations**	**Status: Regulations completed. Filed with Secretary of State September 13, 2010. Effective September 13, 2010.** *8 CCR 1532.2, 5206, 8359* Amends Section 1532.2 as follows: Section 1532.2. Chromium (VI). ****** (d) Exposure determination. ****** (4) Employee notification of determination results. (A) Where the exposure determination indicates that employee exposure exceeds the PEL, as soon as possible but not more than 5 working days later <u>after making an exposure determination in accordance with subsections (d)(2) or (d)(3),</u> the employer shall either post the results in an appropriate location that is accessible to all affected employees or shall notify each affected employee individually in writing of the results. ****** Amends Section 5206 as follows: Section 5206. Chromium (VI). ****** (d) Exposure determination. ****** (4) Employee notification of determination results. (A) Where the exposure determination indicates that employee exposure exceeds the PEL, within 15 working days <u>after making an exposure determination in accordance with subsections (d)(2) or (d)(3),</u> the employer shall either post the results in an appropriate location that is accessible to all affected employees or shall notify each affected employee individually in writing of the results. ****** http://www.dir.ca.gov/oshsb/Chromium_IV.html

2010 OSHSB and DOSH Regulations	Status of Regulations (as of November, 2010)
Labor Code Section 142.3 **Maximum Allowable Load**	**Status: Public hearing August 19, 2010. Comments due by November 1, 2010.** *8 CCR 1709* http://www.dir.ca.gov/oshsb/Max_Load.html
Labor Code Section 142.3 **Definitions of "Manifold" and "Header"**	**Status: Public hearing August 19, 2010.** *8 CCR 1742* http://www.dir.ca.gov/oshsb/Manifold.html
Labor Code Section 142.3 **Occupational Exposures to Food Flavorings Containing Diacetyl**	**Status: Comments due by August 20, 2010.** *8 CCR Section 5197* http://www.dir.ca.gov/oshsb/Diacetyl.html
Labor Code Section 142.3 **Underground Electrical Vaults--Headroom Clearance**	**Status: Public hearing September 16, 2010.** *8 CCR 2813* http://www.dir.ca.gov/oshsb/Underground_Vaults.html
Labor Code Section 142.3 **Firing of Explosive Materials (Blasting Operations)**	**Status: Meeting on October 21, 2010.** *8 CCR Section 5291*
Labor Code Section 142.3 **Machinery and Equipment**	**Status: Meeting on November 18, 2010.** *8 CCR Section 3328*
Labor Code Section 142.3 **Elevating Employees with Lift Trucks**	**Status: Meeting on December 16, 2010.** *8 CCR Section 3657*

WORKERS' COMPENSATION

Workers' Compensation Legislation

The following describes the workers' compensation bills that were signed into law in 2010, as reported on the website of the Legislative Counsel of California at www.leginfo.ca.gov.

AB 586 - Assembly Member Ma
Amends Section 4850 of the Labor Code, relating to workers' compensation, and declares the urgency thereof, to take effect immediately.
Workers' compensation: employees of the City and County of San Francisco: leaves of absence.
Status: Enrolled 7/6/10 and Chaptered 7/15/10

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.

This bill amends Labor Code 4850 to correct a drafting error in AB 1227, enacted last year to expand the number of public safety officers eligible for "4850" leaves of absence after a work injury. Under 4850, officers receive salary continuation in lieu of temporary disability or maintenance allowance payments for the period of the disability (but not exceeding one year), or until an earlier date when he or she is retired on a permanent disability pension and actually receives disability pension payments or advanced disability pension payments. This bill extends the 4850 benefits to certain public safety employees of the City and County of San Francisco. This was an urgency measure and took effect July 15, 2010.

AB 1696 - Assembly Member Bill Berryhill
Amends Section 4703.5 of the Labor Code, relating to workers' compensation.
Death benefits: payment duration.
Status: Enrolled 8/25/10 and Chaptered 9/27/10

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation that generally requires employers to secure the payment of workers' compensation for injuries incurred by their employees that arise out of, and in the course of, employment.

Existing law provides certain methods for determining workers' compensation benefits payable to a worker or his or her dependents for purposes of temporary disability, permanent total disability, permanent partial disability, and in the case of death.

Existing law provides that totally dependent minor children of a deceased worker shall receive death benefits until the youngest child attains 18 years of age, or until the death of a child physically or mentally incapacitated from earning at a weekly rate of at least $224.

This bill extends death benefits until the youngest child attains 19 years of age if the child is still attending high school and is receiving the benefits as a child of certain public employees killed in the performance of duty.

AB 2253 – Assembly Member Coto
Amends Section 3212.1 of the Labor Code, relating to workers' compensation.
Workers' compensation: cancer presumption.
Status: Enrolled 9/26/10 and Chaptered 9/30/10

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment.

Existing law requires an employer to provide, or pay for all reasonable costs of, medical services necessary to care for or relieve work-related injuries. Existing law further provides that in the case of active firefighting members of certain state and local fire departments and in the case of certain peace officers, a compensable injury includes cancer that develops or manifests itself during the period when the firefighter or peace officer demonstrates that he or she was exposed, while in the service of the public agency, to a known carcinogen, as defined, and the carcinogen is reasonably linked to the disabling cancer.

Existing law establishes a presumption that the cancer in these cases is presumed to arise out of, and in the course of, employment, unless the presumption is controverted by evidence that the primary site of the cancer has been established and that the carcinogen to which the member has demonstrated exposure is not reasonably linked to the disabling cancer.

Existing law extends this presumption to a member following termination of service for a period of 3 calendar months for each full year of the requisite service, but not to exceed 60 months in any circumstance, commencing with the last date actually worked in the specified capacity.

This bill provides that the above-described presumption shall be extended to a member following termination of service for a period of 3 calendar months, but not to exceed 120 months in any circumstance, commencing with the last date actually worked in the specified capacity.

AB 2305 – Assembly Member Knight (Principal coauthor: Senator Runner)
Amends Section 7125 of the Business and Professions Code, and to amend Section 11665 of the Insurance Code, relating to contractors.
Contractors: workers' compensation insurance coverage.
Status: Enrolled 9/3/10 and Chaptered 9/28/10

Existing law requires private employers to secure the payment of compensation by obtaining and maintaining workers' compensation insurance or to self-insure as an individual employer or as one employer in a group of employers. The Contractors' State License Law requires every licensed contractor to have on file at all times with the Contractors' State License Board a current and valid Certificate of Workers' Compensation Insurance or Certification of Self-Insurance, or a statement certifying that he or she has no employees and is not required to obtain or maintain workers' compensation insurance coverage. Existing law, until January 1, 2011, requires a contractor with a C-39 roofing classification to obtain and maintain workers' compensation insurance even if he or she has no employees. Failure to comply with this requirement results in the automatic suspension of the license. However, with respect to a license that was active on January 1, 2007, and included a C-39 roofing classification, existing law, until January 1, 2011, requires the registrar of contractors, in lieu of suspending the license, to remove the C-39 roofing classification from the license if the contractor does not have workers' compensation insurance coverage.

This bill extends the operation of those provisions until January 1, 2013, with respect to a license that is active on January 1, 2011, with a C-39 roofing classification. The bill requires the suspension of any license that, after January 1, 2011, is active and has had the C-39 roofing classification removed, if the licensee is found by the registrar of contractors to have employees and to lack a valid Certificate of Workers' Compensation Insurance or Certification of Self-Insurance.

Existing law requires an insurer who issues a workers' compensation insurance policy to a roofing contractor holding a C-39 license from the Contractors' State License Board to perform an annual payroll audit for the contractor. Existing law requires the Insurance Commissioner to direct the rating organization designated as his or her statistical agent to compile pertinent statistical data on those holding C-39 licenses on an annual basis and to provide a report to the commissioner each year. Existing law provides that these provisions are inoperative and repealed on January 1, 2011.

This bill extends the operation of these provisions until January 1, 2013. The bill requires the report provided to the commissioner each year to also be provided to the Legislature, as specified.

AB 2404 – Assembly Member Hill
Amends Sections 481 and 730 of the Insurance Code, relating to insurance.
Insurance.
Enrolled 9/8/10 and Chaptered 9/27/10

Existing law requires that unless the insurance contract provides otherwise, an insured person is entitled to a return of his or her premium if the policy is canceled, rejected, surrendered, or rescinded, as provided.

This bill requires that any insurance policy that includes a provision to refund a premium other than on a pro rata basis, including the assessment of cancellation fees, disclose that fact in writing, including the actual or maximum fees or penalties applied, which would be permitted to be stated in the form of percentages of the premium. The disclosure is required to be made prior to, or concurrent with, the application and prior to each renewal, as provided. The disclosure is not required if the policy provision permits, but does not require, the insurer to refund a premium other than on a pro rata basis, and the insurer refunds the premium on a pro rata basis. If an application is made by telephone, the disclosure is not required to be mailed to the applicant or insured within 5 business days. The disclosure requirements apply prospectively and only to policies issued or renewed on or after January 1, 2012. This bill does not require any additional disclosure of a fee or penalty for early cancellation if that disclosure is required by any other provision of law.

Existing law requires the Insurance Commissioner to conduct an examination of the business and affairs of insurers admitted in this state at least once every 5 years. In scheduling and determining the nature, scope, and frequency of the examinations, the commissioner is required to consider the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, market analysis results, including consumer complaint analysis, evaluation of ongoing regulatory activities, analysis of data derived from industry surveys or interrogatories, and other criteria as set forth in the Examiner's Handbook or in the Market Regulation Handbook adopted by the National Association of Insurance Commissioners that are in effect at the time of the examination.

This bill authorizes the commissioner to postpone a market conduct examination, otherwise required, for up to 3 years if information derived from a market analysis indicates that the prior examination of the insurer resulted in no significant negative findings, the number of consumer complaints received by the insurer is in the lowest quartile of complaints, on a ratio basis, for insurers in that line of business, and the market analysis identifies no other issues of significant concern.

AB 2538 – Assembly Member Niello
Amends Sections 1755, 1757, 2124, 2626, and 2629 of, and to add Section 1755.1 to, the Unemployment Insurance Code, relating to unemployment insurance.
Unemployment insurance: eligibility for benefits: notification.
Enrolled 8/16/10 and Chaptered 9/27/10

This bill includes a technical amendment relating to workers' compensation. It repeals obsolete references in two sections of law (Unemployment Insurance Code Sections 2626 and 2629) that formerly determined eligibility for, and the amount of, disability insurance benefits in connection with people who were covered under the workers' compensation program. Other aspects of the bill do not relate to workers' compensation.

AB 2772 - Committee on Labor and Employment (Swanson, Chair)
Amends Section 98.2 of the Labor Code, relating to employment.
Labor Commissioner: appeals.
Status: Enrolled 7/06/10 and Chaptered 7/15/10.

Existing law authorizes the Labor Commissioner to investigate employee complaints and hold administrative hearings to decide disputes over unpaid wages and other issues between employers and

employees. Existing law also permits a party who loses at an administrative hearing conducted by the Labor Commissioner to file an appeal in the superior court. An employer filing an appeal must post a bond with the court in the amount of the judgment rendered in the administrative hearing.

This bill expressly states that an employer wishing to appeal an administrative judgment must first post a bond.

AB 2780 - Assembly Member Solorio
Amends, repeals, and adds Section 138.7 of the Labor Code, relating to workers' compensation, and declaring the urgency thereof, to take effect immediately.
Workers' compensation: individually identifiable information.
Status: Enrolled 9/15/10 and Chaptered 9/30/10.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. Existing law provides that when benefits are provided or will be provided to a beneficiary under the Medi-Cal program because of an injury for which another person or insurance carrier is liable, the Director of Health Care Services may recover from that person or carrier the reasonable value of benefits so provided.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment.

Existing law provides that a person or public or private entity who is not a party to a claim for workers' compensation benefits may not obtain individually identifiable information, as defined, that is obtained or maintained by the Division of Workers' Compensation of the Department of Industrial Relations on that claim, except as specified.

This bill, until January 1, 2017, authorizes the State Department of Health Care Services to obtain and use individually identifiable information for the purposes of seeking recovery of Medi-Cal costs incurred by the state for treatment provided to injured workers that should have been incurred by employers and insurance carriers pursuant to the above-described authority of the Director of Health Care Services to recover the value of the benefits for which another person or carrier is liable.

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

AB 2781 – Assembly Insurance Committee
Amends Sections 1063.1 and 1063.75 of the Insurance Code, relating to insurance.
Committee on Insurance. Insurance: Guarantee Association.
Status: Enrolled 8/6/10 and Chaptered 8/13/10.

Existing law establishes the California Insurance Guarantee Association to provide coverage against losses arising from the failure of an insolvent property, casualty, or workers' compensation insurer to discharge its obligations under its insurance policies. The association is managed by a board of governors appointed by the commissioner, the President pro Tempore of the Senate, and the Speaker of the Assembly.

Existing law defines the term "insolvent insurer" to mean an insurer that was a member insurer of the association, as specified, either at the time the policy was issued or when the insured event occurred, and against which an order of liquidation or receivership with a finding of insolvency has been entered by a court of competent jurisdiction, or, in the case of the State Compensation Insurance Fund, if a finding of insolvency is made by a duly enacted legislative measure.

This bill deletes an order of receivership as a qualification for being an insolvent insurer.

Existing law provides that any bonds to provide funds to the California Insurance Guarantee Association under specified statutory authority for covered claim obligations for workers' compensation claims shall be issued, as specified, prior to January 1, 2011.

This bill extends the date for bonds to be issued to provide funds for covered claim obligations for workers' compensation claims, as specified, to January 1, 2013.

SB 156 - Senator Wright
Adds Section 1879.1 to the Insurance Code, relating to insurance fraud.
Insurance: fraud prevention and detection.
Status: Enrolled 8/23/10 and Chaptered 9/27/10.

Existing law generally provides for the prevention, detection, and investigation of insurance fraud. Existing law requires insurers to disclose to an authorized governmental agency information relative to incidents of workers' compensation fraud, as specified.

This bill authorizes the Department of Insurance to convene meetings with insurance companies to discuss specific information concerning suspected, anticipated, or completed acts of insurance fraud and would protect a person sharing information pursuant to that authorization from civil liability for libel, slander, or any other relevant cause of action, as specified.

SB 1072 - Senator Calderon
Amends Section 19605.73 of, to add Sections 19601.02, 19605.74, and 19642.1 to, and to add Article 9.1 (commencing with Section 19604.5) to Chapter 4 of Division 8 of, the Business and Professions Code, relating to horse racing.
Horse racing: statewide marketing organization: Breeders' Cup promotion: wagering deduction: exchange wagering.
Status: Enrolled 9/8/10 and Chaptered 9/12/10.

Existing law permits racing associations, fairs, and the organization responsible for contracting with racing associations and fairs with respect to the conduct of racing meetings, to form a private, statewide marketing organization to market and promote thoroughbred and fair horse racing, and to obtain, provide, or defray the cost of workers' compensation coverage for stable employees and jockeys of thoroughbred trainers. Existing law requires the marketing organization to annually submit to the California Horse Racing Board a statewide marketing and promotion plan and a thoroughbred trainers' workers' compensation defrayal plan for thoroughbred and fair horse racing. Existing law requires 0.4 percent of the amount handled by each satellite wagering facility to be distributed to the marketing organization for the promotion of thoroughbred and fair horse racing, and to defray the cost of workers' compensation insurance, as specified. Existing law repeals these provisions on January 1, 2011.

This bill extends the operation of these provisions until January 1, 2014, when they would be repealed.

SB 1254 - Senator Leno
Adds Section 7127 to the Business and Professions Code, and amends Section 830.3 of the Penal Code, relating to contractors.
Contractors: workers' compensation insurance coverage.
Status: Enrolled 9/8/10 and Chaptered 9/30/10.

Existing law requires private employers to secure the payment of compensation by obtaining and maintaining workers' compensation insurance or to self-insure as an individual employer or as one employer in a group of employers. The Contractors' State License Law requires every licensed contractor to have on file at all times with the Contractors' State License Board a current and valid Certificate of Workers' Compensation Insurance or Certification of Self-Insurance, or a statement certifying that he or she has no employees and is not required to obtain or maintain workers' compensation insurance coverage.

This bill authorizes the registrar of contractors to issue a stop order, effective immediately upon service, to any licensed or unlicensed contractor who as an employer has failed to secure workers' compensation insurance coverage for his or her employees. The bill makes a failure to comply with the stop order a crime, thereby imposing a state-mandated local program. The bill sets forth specified procedures for the payment of employees during a work stoppage subject to a stop order, as specified, and for an employer to request a hearing to protest a stop order. Upon that request, the bill requires the registrar of contractors to hold a hearing to affirm or dismiss the stop order and issue and serve on all parties to the hearing a written notice of findings and those findings. The bill authorizes a writ of mandate to be taken from the findings to the appropriate superior court, as specified. Existing law authorizes the Director of Consumer Affairs to designate 3 persons as peace officers to be assigned to the special investigations unit of the board.

This bill authorizes the director to designate 12 persons as peace officers for assignment to the special investigations unit of the board.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill provides that no reimbursement is required by this act for a specified reason.

SB 1407 - Committee on Banking, Finance and Insurance
Amends Section 11797 of the Insurance Code, relating to insurance.
State Compensation Insurance Fund: investments.
Status: Enrolled 9/8/10 and Chaptered 9/30/10.

Existing law creates the State Compensation Insurance Fund administered by a board of directors for the purpose of transacting workers' compensation insurance, and insurance against the expense of defending any suit for serious and willful misconduct, against an employer or his or her agent, and insurance to employees and other persons of the compensation fixed by the workers' compensation laws for employees and their dependents. Existing law requires the board of directors to invest and reinvest, from time to time, all moneys in the State Compensation Insurance Fund in excess of current requirements, in the same manner as is authorized in certain provisions applicable to private insurance carriers.

This bill expands the board's choices for the investment of excess moneys by allowing the board to invest or reinvest in additional investments in the same manner as provided for private insurance carriers, including, but not limited to, interest bearing obligations issued by a non-affiliate institution, all deposits and debt obligations of banks or savings and loan associations whose accounts are insured by an agency or instrumentality of the federal government, and bonds issued by any county, municipality, or school district in this state to represent assessments for local improvements authorized by law.

The bill incorporates additional changes to Section 11797 of the Insurance Code, proposed by AB 1873 of the 2009-10 Regular Session, to be operative only if both bills are chaptered and become effective on or before January 1, 2011, and this bill is chaptered last.

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 on the following pages. 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.html.

In July 2009, DWC announced a 12-point plan to monitor and help control medical costs. DWC proposed to update regulations on treatment guidelines, providing a network option, simplifying medical provider network (MPN) rules, improving medical cost reporting, implementing electronic billing, creating pharmacy networks, streamlining requests for medical authorization, updating ambulatory surgical center fees, eliminating the spinal hardware pass-through, streamlining utilization review, updating coding for doctor payments, and considering creation of a drug formulary, as part of a 12-point plan.
http://www.dir.ca.gov/dwc/dwc_newslines/2009/Newsline_53-09.html

Much work on this plan took place during 2010, and updates related to the 12-point plan and other regulations are listed below.

12-Point Plan as launched in July 2009	Status as of November 2010
1. Tightening treatment guidelines: Updated Medical Treatment Utilization Schedule (MTUS) includes guidelines for compounded topical drugs	✓ complete Revised MTUS became effective 7/18/09.
2. Providing a network option: Reducing the Health Care Organization (HCO) fees will make HCOs more on par with Medical Provider Networks (MPNs) and give employers another option for choosing a network of doctors and eliminating utilization review costs	✓ complete The regulations took effect 1/1/10.
3. Simplifying MPN rules: Updating the Medical Provider Networks (MPN) rules to streamline the notice requirements	✓ Regulations approved on 8/9/10 and took effect 10/9/10.
4. Improving medical cost reporting: The Workers' Compensation Information System (WCIS) regulations will be updated to clarify medical lien reporting, which will allow DWC to better monitor medical costs	✓ complete but not yet effective Regulations approved on 11/15/10 and become effective on 11/15/11
5. Implementing electronic billing: Medical e-billing regulations will encourage electronic billing and faster payments to physicians	Public hearings held on 4/23 and 4/26/10. 1st 15- day public comment period will issue by 11/30/10.
6. Creating pharmacy networks: Will allow employers to contain pharmacy costs, which are rising at a higher rate than other medical costs	Advisory group held in the fall of 2009. Informal forum was open until 3/17/2010.
7. Streamlining requests for medical authorization: Revise physician reporting forms so it is clear when a physician is requesting medical treatment	Proposed draft regulations were posted on the public forum for comments until 4/5/10. A revised version was posted on the forum on 9/23/10.
8. Ambulatory surgical center fees: Reduce ambulatory surgical center fees by adjusting Medicare's outpatient fee schedule multiplier	Stakeholder meeting held on 5/27/10. Proposed draft regulations posted on DWC forum for comment on 8/10/10.
9. Reducing duplicate payment for spinal hardware pass-through: Amend OMFS to reduce duplicate payment for spinal hardware pass-through	Informal stakeholder meeting held 1/19/10. Draft language was posted on the forum from 6/8 – 6/22/10.
10. Streamlining utilization review (UR): Amending the UR regulations to streamline procedures and reduce administrative costs	Stakeholder meeting was held on 4/8/10. Draft amended regulations posted on the forum on 9/23/10.
11. Updating coding for doctor payments: Converting from the current physician fee schedule to a Resource Based Relative Value Scale (RBRVS) system	Draft regulations and the supplemental Lewin report were posted on the public forum for comments until 4/5/10. A revised version was posted on the forum from 7/6 through 7/20/10. A stakeholder meeting was held on 8/17/10.
12. Considering creation of a drug formulary: Consider an additional revision to the MTUS	The next MTUS update will address chronic pain and opiods.

Source: DIR

DWC Regulations	Status of Regulations (as of November, 2010)
Labor Code Section 5307.1 **Physician Fee Schedule** As of January 1, 2006, the Administrative Director (AD) will have the authority to adopt an Official Medical Fee Schedule (OMFS) for physician services.	**Status: Pre-rulemaking public comment – July 10, 2010; a stakeholder meeting was held on August 17, 2010.** *8 CCR Sections 9789.12.4, 9789.13.2 and 9789.14.1* http://www.dir.ca.gov/dwc/DWCWCABForum/dwc_PhysicianFeeSchedule.htm The Division of Workers' Compensation (DWC) new draft regulations propose adopting the resource based relative value scale (RBRVS), as well as ground rules relating to calculation of fees.
Labor Code Section 5307.1 **Ambulance fee schedule** Administrative Director (AD) shall adopt and revise periodically an Official Medical Fee Schedule (OMFS). In 2003, the Administrative Director adopted regulation 9789.70, effective January 1, 2004, which provided that the maximum fees for ambulance services were 120 percent of the fee prescribed in the relevant Medicare payment system, and which provided that for services not covered by the Medicare payment system, the maximum fee was the fee specified in the 2003 OMFS.	**Status: Filed with Secretary of State - July 13, 2010. Effective - July 13, 2010.** http://www.dir.ca.gov/dwc/DWCPropRegs/Ambulance_regulations/Ambulance_Regulations.htm *8 CCR Section 9789.70* Regulation clarifies that the section does not apply to services provided by air ambulance providers which are air carriers as defined by the federal Airline Deregulation Act of 1978, as amended.
Labor Code Section 4603.4 **Electronic and standard medical billing** Administrative Director (AD) must adopt regulations by January 1, 2005, and the regulations must mandate that employers accept electronic claims for payment of medical services on or before July 1, 2006. The amendment also stated that payment for medical treatment provided or authorized by the treating physician shall be paid within 15 working days of electronic receipt of a billing for services at or below the fees set forth in the Official Medical Fee Schedule.	**Status: 45-day comment period - April 26, 2010.** http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm *8 CCR Sections 9792.5, 9792.5.0, 9792.5.1, 9792.5.2 and 9792.5.3* The Administrative Director (AD) now proposes to amend and adopt administrative regulations governing electronic and standardized medical treatment billing. These regulations implement, interpret, and make specific sections 4600, 4603.2 and 4603.4 of the Labor Code.

DWC Regulations	Status of Regulations (as of November, 2010)
Labor Code Section 138.6 **Workers' compensation information system (WCIS)** Administrative Director (AD) is required to develop a cost-efficient workers' compensation information system (WCIS) to manage operations, evaluate the benefit delivery system, measure adequacy of indemnity payments, and provide statistical data for research of the workers' compensation system.	**Status: 1st 15-day comment period - June 10, 2010; 2nd 15-day comment period – August 10 through August 26, 2010.** http://www.dir.ca.gov/dwc/DWCPropRegs/WCIS_Regs/WCIS_Regulations.htm *8 CCR Sections 9701-9702* Eliminates unnecessary data elements, adds relevant data elements, corrects errors in the text of the regulation, adds lien payment data elements for medical bill payment reporting, and updates the two California-specific implementation guides.
Labor Code Section 5318 **Inpatient Hospital Fee Schedule; spinal surgery using implantable hardware** A separate reimbursement for implantable medical devices, hardware, and instrumentation for certain diagnostic related groups (DRGs). The statute also provides that the pass-through section would only be operative until the Administrative Director (AD) adopts a regulation specifying separate reimbursement, if any, for implantable medical hardware or instrumentation for complex spinal surgeries.	**Status: Pre-rulemaking public comment – June 22, 2010.** http://www.dir.ca.gov/dwc/dwc_newslines/2010/Newsline_32-10.pdf *8 CCR Sections 9789.20 et seq. and new section 9789.25* The proposed revisions to the Inpatient Hospital Fee Schedule regulations provide hospitals with an annual choice in how they would be reimbursed for complex spinal surgery using implantable hardware.
Labor Code Sections 4603.5, 5307.1, and 5307.3 **Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers** Labor Code Section 5307.1 requires that the Official Medical Fee Schedule (OMFS) for Ambulatory Surgery Centers (ASCs) be based on the fee-related structure and rules of the Medicare program. The Labor Code caps the aggregate allowances for ASCs at 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department (HOPD) setting.	**Status: Pre-rulemaking public comment – August 24, 2010.** http://www.dir.ca.gov/dwc/dwcRulemaking.html *8 CCR Sections 9789.30, 9789.31, 9789.32, 9789.33, 9789.36, 9789.37, 9789.38, and 9789.39* Proposes to revise the ambulatory surgical center fee schedule by modifying the multiplier for ambulatory surgical center facility fees to 100 percent of the Medicare outpatient fee schedule or 102 percent multiplier that includes an extra 2 percent reimbursement for high-cost outlier cases.

Assembly Bill 1073

AB 1073 Mandates/Tasks	Status of Regulations (as of November, 2010)
Labor Code Sections (LC§§) 5307.27, 4604.5 **Medical Treatment Utilization Schedule –** Chronic pain medical treatment guidelines, postsurgical treatment guidelines evidence-based reviews, chronic pain medical treatment guidelines, DWC's and official diagnostic groups' (ODGs') references, and postsurgical treatment guidelines ODG's references.	***Status:*** **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 *8 CCR Sections 9792.20 - 9792.26* The Medical Treatment Utilization Schedule (MTUS) was amended and definitions were updated. 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). 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; chronic pain guidelines are similarly defined and addressed for chronic pain management and treatment.

Senate Bill 899

SB 899 Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §§4600.3 et seq,, 4600.5, 4600.6 and 4600.7 **Health Care Organizations (HCOs)**	***Status:*** **Regulations completed. Filed with Secretary of State November 4, 2009. Effective January 1, 2010** http://www.dir.ca.gov/dwc/DWCPropRegs/hco/HCO_Regulations.htm *8 CCR Sections 9771, 9778, 9779, 9779.5, and 9779.9* To reduce the certification application fee and recertification fee and remove redundant data collection requirements.

SB 899 Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §4616 et seq, 59, 124, 133, 138.3, 138.4, 139.6, 3550, 3551, 4603.5, and 5307.3. **Medical Provider Network (MPNs)**	***Status:*** **Regulations completed. Filed with Secretary of State August 9, 2010. Effective October 8, 2010.** http://www.dir.ca.gov/dwc/DWCPropRegs/MPN_Regulations/MPN_Regulations.htm *8 CCR Sections 9767.3, 9767.6, 9767.8, 9767.12, 9767.16, 9880, 9881, 9881.1, 10139* Amends 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 amend 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. Specifically, the regulations: • Allow MPN notices to be distributed electronically to all covered workers. • Eliminate the 14-day MPN implementation and change of MPN notice period. • Further define and streamline the MPN implementation notice. • Reduce distribution of both the Change of MPN notices and the Termination/Cessation of Use of MPN notices only to covered injured workers. • Eliminate only the filing of the Change of MPN notices with DWC. • Clarify material modifications that require filing with DWC. • Clarify provider listing requirements. • Require MPN notices to be in Spanish only where there are Spanish- speaking employees. • Require an MPN contact e-mail address to be included in notices. • Require access to the MPN contact through the toll-free number. • Update the Employee Poster and Notice of Potential Eligibility and DWC Claim Form 1.

SB 899 Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §4062.1 and LC §4062.2 **Qualified Medical Evaluator Procedures for Unrepresented Injured Workers and Procedures for Represented Injured Workers**	***Status:*** **Regulations completed. Filed with Secretary of State January 13, 2009. Effective February 17, 2009.** http://www.dir.ca.gov/dwc/DWCPropRegs/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 [Agreeed Medical Evaluator (AME) or QME Declaration of Service of Medical-Legal Report] are created.

SB 899 Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §4600 **Pre-Designation of Physician**	***Status:*** **Regulations completed. Effective March 14, 2006, and revised February 21, 2007, to comply with 2007 amendment to Labor Code §4600.** (SB 186 in 2009 removed the sunset date of this provision.) http://www.dir.ca.gov/DWC/DWCPropRegs/predesignation_Regulations/Predesignation_regulations.htm *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.

SB 899 Mandates/Tasks	Status of Regulations (as of November, 2010)
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/dwcpropregs/MPNReg.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."

SB 899 Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §4660 **Permanent Disability Rating Schedule Revision**	***Status:*** **Revised regulations in progress. Public hearings on 7/21/08 and 7/22/08. Time for completion of regulations elapsed.** ***Status:*** **Regulations Completed. Emergency regulations effective January 1, 2005. Permanent regulations effective June 10, 2005.** http://www.dir.ca.gov/dwc/dwcpropregs/PDRSRegs.htm *8 CCR Section 9725 et seq.* The Permanent Disability Rating Schedule (PDRS) adopts and incorporates the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment, 5th Edition*. 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.
LC §4660 **Permanent Disability Rating Schedule Revision (continued)**	**Effective May 2008: 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.

SB 899 Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §5814.6 **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 Section 5814.
LC §5814.6 **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.

Assembly Bill 227 and Senate Bill 228 – Official Medical Fee Schedule

AB 227 & SB 228 OMFS Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §5307.1 **Physician Fee Schedule** 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. As of January 1, 2006, the Administrative Director (AD) will have the authority to adopt an OMFS for physician services.	***Status*: Regulations revised effective February 15, 2007.** http://www.dir.ca.gov/DWC/OMFS9904.htm *8 CCR Section 9789.11* 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. The Administrative Director (AD) has not yet adopted the Medicare-based schedule for physicians. The Division of Workers' Compensation (DWC) new draft regulations propose adopting the resource based relative value scale (RBRV), as well as ground rules relating to calculation of fees. **Current Status: Pre-rulemaking public comment – July 10, 2010; a stakeholder meeting was held on August 17, 2010.** *8 CCR Sections 9789.12.4, 9789.13.2 and 9789.14.1* http://www.dir.ca.gov/dwc/DWCWCABFourm/dwc_PhysicianFeeSchedule.htm
LC §5307.1 **Pharmacy Fee Schedule** Administrative Director (AD) to adopt a new fee schedule for pharmaceuticals based on the Medi-Cal fee schedule.	***Status:* Regulations complete. Effective March 1, 2007.** http://www.dir.ca.gov/DWC/OMFS9904.htm *8 CCR Section 9789.40* 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.

AB 227 & SB 228 OMFS Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §5307.1 **Official Medical Fee Schedule Shall Be Adjusted** to conform to relevant Medicare/Medi-Cal changes within 60 days of changes (except specified inpatient changes)	***Status:* Statutes specify that changes can be implemented without regulations.** Updates to Medicare and Medi-Cal changes are implementeted by an "Order of the Administrative Director of the Division of Workers' Compensation." Update orders issued periodically as needed. The most recent orders issued are as follows: • Inpatient – update to conform to Medicare changes was adopted by Order, effective December 1, 2009. • Outpatient – update to conform to Medicare changes was adopted by Order, effective April 15, 2010. • Ambulance fees – update to conform to Medicare changes was adopted by Order, effective January 1, 2009. • Pathology and Clinical Laboratory – update to conform to Medicare changes was adopted by Order, effective January 1, 2010. • Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEPOS) – update to conform to Medicare changes was adopted by Order, effective July 1, 2010. http://www.dir.ca.gov/DWC/OMFS9904.htm
LC §5307.1 **Specified Schedules (Not in Fee Schedule until January 1, 2005)** (Skilled nursing facility, home health agency, inpatient for hospitals exempt from Medicare Prospective Payment System, outpatient renal dialysis)	***Status:* In process.** Expect to move forward on these in 2010. The Division of Workers' Compensation (DWC) is in the process of prioritizing the work.

Other Mandates of Assembly Bill 227 and Senate Bill 228

AB 227 & SB 228 Other Mandates/Tasks	**Status of Regulations (as of November, 2010)**
LC §4603.4 **Electronic Bill Payment Regulations** Regulations are required to be adopted by January 1, 2005, and to mandate acceptance of electronic bills by January 1, 2006.	***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. Public hearings held on April 23 and 26, 2010. Proposed regulations 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-$50,000.00 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** Statute codified old regulation providing extra payment for hardware/implantables until Administrative Director (AD) adopts reimbursement regulation.	***Status:* In process. Pre-rulemaking public comment – June 22, 2010** 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.

AB 227 & SB 228 Other Mandates/Tasks	Status of Regulations (as of November, 2010)
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 diagnositic 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

AB 749 Other Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §138.4 **Benefit Notices to Employees from Claims Administrators** Regulations are revised to reflect changes in this statute.	***Status:*** **Regulations completed. Effective April 9, 2008.** http://www.dir.ca.gov/dwc/DWCPropRegs/BenefitNoticeRegulations/BenefitNotice_regulations.htm *8 CCR Sections 9767.16, 9810, 9811, 9812, 9813, 9813.1, and 9813.2* 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.
LC §§139.48 and 139.49 **Return-to-Work Reimbursement Program/Study** *Sunset:* January 1, 2010	***Status:*** **Regulations completed. Effective August 18, 2006.** http://www.dir.ca.gov/dwc/DWCPropRegs/ReturnToWork_regulations/ReturnToWork_regulations.htm *8 CCR Sections 10004-10005* An eligible employer was entitled to reimbursement through this program for expenses incurred to make workplace modifications to accommodate an employee's return to modified or alternative work, up to the following maximum amounts: (1) $1,250 to accommodate each temporarily disabled employee, for expenses incurred in allowing such employee to perform modified or alternative work within physician-imposed temporary work restrictions; and (2) $2,500 to accommodate each permanently disabled employee, for expenses incurred in returning such employee to sustained modified or alternative work within physician-imposed permanent work restrictions; however, if an employer who has received reimbursement for a temporarily disabled employee under paragraph (1) is also requesting reimbursement for the same employee for accommodation of permanent disability, the maximum available reimbursement is $2,500. CHSWC completed a study about this program in April 2009. The program was repealed effective January 1, 2010.

AB 749 Other Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §3822 **Fraud Notice** (Annually to every employer, claims adjuster, third-party administrator, physician and attorney participating in workers' compensation)	***Status:*** **Completed for 2007. Completed for 2008. Completed for 2009.**
LC §4062.8 **Develop and Revise Educational Materials for Primary Treating Physicians and Chiropractors**	***Status:*** **Project in process.** 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.
LC §4600.2 **Pharmacy Contract Standards**	***Status:*** **Project 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. Stakeholder meeting held in fall of 2009. Draft regulations posted on forum for comments until April 5, 2010.
LC §4603.4 **Electronic Bill Payment Regulations**	***Status:*****. 45-day comment period - April 26, 2010** The Administrative Director (AD) now proposes to amend and adopt administrative regulations governing electronic and standardized medical treatment billing. These regulations implement, interpret, and make specific sections 4600, 4603.2 and 4603.4 of the Labor Code

Other Regulations

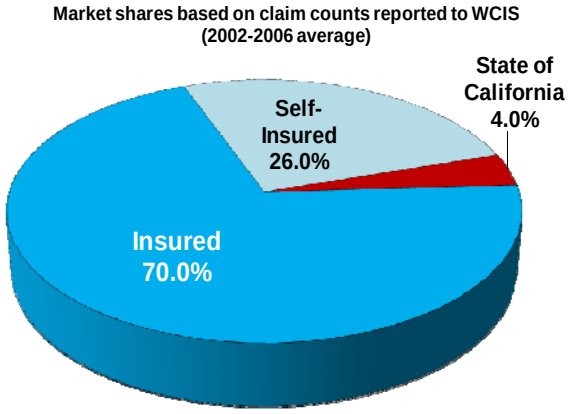
Other Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §138.6 **Workers' Compensation Information System** Implementation of the Workers' Compensation Information System (WCIS) mandated medical treatment and payment data collection.	***Status:*** **Regulations became effective April 21, 2006. Proposed updated regulations 2nd 15-day comment period closes August 26, 2010.** 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 April 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.
LC §123.6 **Ethical Standards for Workers' Compensation Administrative Law Judges**	***Status*****: Regulations completed. Filed with Secretary of State August 25, 2008. Effective September 24, 2008.** *8 CCR §§9720.1 et seq.*
LC §§133, 4603.5, 5307.3, 5307.4 **Americans with Disabilities Act – Access to DWC District Offices. New sections.**	***Status:*** **The proposed regulations were posted on the Division of Workers' Compensastion (DWC) Forum from July 13 to July 23, 2007. Notice of rulemaking will be issued in 2010.**

Other Mandates/Tasks	Status of Regulations (as of November, 2010)
LC §§127.5, 5300, 5307 **Workers' Compensation Appeals Board/Division of Workers' Compensation (WCAB/DWC) District Offices Regulations and Forms**	***Status:*** **Regulations became effective November 17, 2008.** *8 CCR §§ 10210 et seq.* http://www.dir.ca.gov/dwc/DWCPropRegs/EAMS_regulations/EAMS regulations.htm
LC §§4061.5, 4603.4, and 4610 **PR-2 Form - Primary Treating Physician's Progress Report, Functional Improvement Report, Request for Authorization Form**	***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 toward the end of 2010.** *8 CCR Sections 9785, 9785.2*
LC §127 **Fees for Copies of Documents**	***Status:*** **Revisions anticipated in 2010.** *8 CCR Section 9990*
LC §4659 **Commutation Tables for Permanent Disability**	***Status:*** **Need to hire actuary.** *8 CCR §§ 10169, 10169.1*

SYSTEM COSTS AND BENEFITS OVERVIEW

The California workers' compensation system covers 15,248,000 employees working for over 865,000 employers[i] in the State. These employees and employers generated a gross domestic product of $1,891,363,000,000 ($1.89 trillion) for 2009.[ii] A total of 533,600 occupational injuries and illnesses were reported for 2009,[iii] ranging from minor medical treatment cases up to catastrophic injuries and deaths. The total paid cost to employers for workers' compensation in 2009 was $13.3 billion. (See textbox on the next page.)[1]

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.[iv]



Data Source: DWC - WCIS

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 $9 billion, then the systemwide paid losses and expenses are estimated as:

$9 billion * 1.43 = $12.9 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.

[1] Endnotes i, ii, iii, and iv are at the end of this section.

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 2009 Calendar Year

A Claim Counts-based Estimate of Workers' Compensation System Size (Million $)

	Insured	***Self-Insured and the State****	***All Employers***
Indemnity*	$2,820	$1,213	$4,033
Medical*	$4,165	$1,791	$5,956
Changes to Total Reserves	-$95	-$41	-$136
Insurer Pre-Tax Underwriting Profit/Loss	-$1,487	N/A	-$1,487
Expenses (See Table below: Breakdown of Expenses)	$3,884	$1,087	$4,971
TOTAL for 2009	$9,287	$4,050	**$13,337**

*Include CIGA payments

Source for Insured figures above is WCIRB Losses and Expenses report June 2010. Self-insured and state expenses are calculated by CHSWC using 0.43 multiplier for equivalent cost components. The equivalent expense components are estimated as follows:

Breakdown of Expenses (Million $)	*Insured*	*Self-Insured and State*	*All Employers*
Loss Adjustment Expense	$1,883	$810	$2,693
Commissions and Brokerage	$696	N/A	$696
Other Acquisition Expenses	$485	N/A	$485
General Expenses	$645	$277	$922
Premium and Other Taxes	$175	N/A	$175
Total	$3,884	$1,087	**$4,971**

Estimate of Workers' Compensation System Size Based on Written Premium

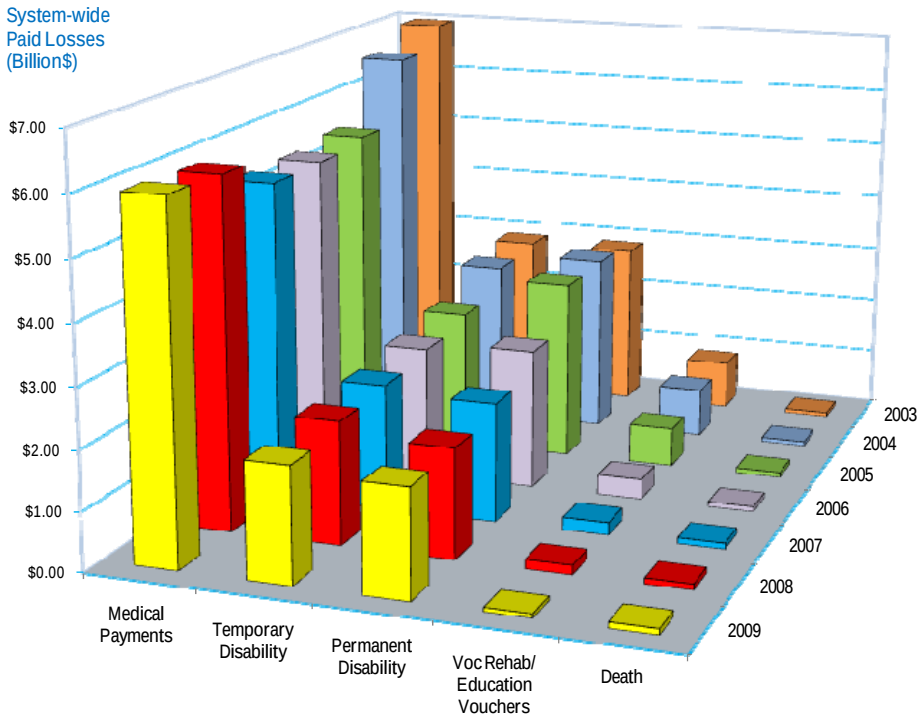
Another way to calculate systemwide costs for employers is by using written premium.

Written premium for insured employers = $8.9 billion in accident year 2009.[2]

$8.9 billion * 1.43 = $12.7 billion systemwide costs for employers.

[2] WCIRB Summary of September 30, 2010 Insurer Experience Report, December 9, 2010.

System-wide* paid benefits, by year and type of payment
(Billion $)



* System-wide amounts estimated at 1.43 times the amounts reported by insurers

Data Source: WCIRB

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

[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, 26 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 was published in December 2009.

Impact on Employer

Costs for insurance peaked at an average of $6.44 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 premium rate has dropped every year from 2003 to 2009 when it was $2.37, a decrease of 63 percent from the second half of 2003. From 2009 to 2010, the average premium rate increased 0.8 percent.

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:
  - Evidence-based medical treatment guidelines (e.g., ACOEM *Guidelines*).
  - Utilization review of medical treatment, systematically applying the guidelines.
  - A revised dispute resolution system using a qualified medical evaluator (QME) selected from a panel whenever an agreed medical evaluator (AME) is not used.
  - Standardized and transparent medical fee schedules.
  - New fee schedule for inpatient hospital, hospital outpatient departments, and ambulatory surgery centers based on the Medicare fee plus 20 percent.
  - A new fee schedule for pharmaceuticals based on the Medi-Cal Fee Schedule.
  - Caps on the number of chiropractic, physical therapy and occupational therapy visits per claim.
  - Employer control of medical care through medical provider networks (MPNs).
- Changes to indemnity benefits:
  - 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.
  - 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.
  - 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.
  - 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:
  - 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.
  - Apportionment to causation, the conclusive presumption that previously awarded disability, continues to exist for the purpose of apportionment from a subsequent award.
  - 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]

[4] WCIRB Summary of September 30, 2010, Insurer Experience Report, December 9, 2010.

- Medical paid costs went down 23 percent from their peak in 2003 to 2007, and then increased 10.6 percent from 2007 to 2009.
- 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 nine months of 2010 is 2 percent higher than that for the first nine months of 2009. The indemnity 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.

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[5] WCIRB Report WCIRB Legislative Cost Monitoring Report, October 9, 2008.
[6] WCIRB Summary of September 30, 2010, Insurer Experience Report, December 9, 2010.
[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 to allow designation of the medical group rather than just an individual physician. 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 outpatient 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). (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, the University of California (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 ambulatory surgery center (ASC) fees at the same rates as hospital outpatient surgical departments, even though ASCs have lower costs and are paid less than 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).

The Division of Workers' Compensation (DWC) provided information on claims denial rates for 2002 through 2009 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 2009, the data show a slight increase in claim denial rate.

Statewide Claims Denied[9]

Accident Year	Total Reported Claims	Claims Denied	Claim Denial Rate
2002	889,016	49,723	5.6%
2003	848,143	53,161	6.3%
2004	802,144	49,828	6.2%
2005	755,656	47,845	6.3%
2006	731,447	48,074	6.6%
2007	691,431	50,018	7.2%
2008	625,769	44,658	7.1%
2009	533,643	40,446	7.6%

Source: WCIRB

[9] Reported in WCIRB's 2008 Legislative Cost Monitoring Report. Based on DWC's WCIS records as of June 3, 2010.

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 return to work (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; however, many questions remain to be resolved.

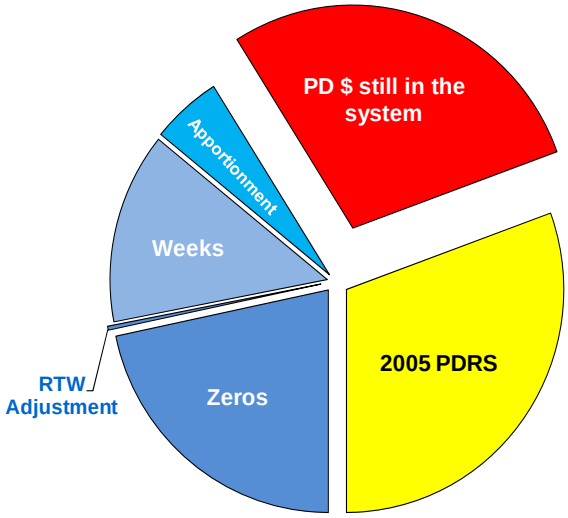
Combined Effects of Changes to Permanent Disability

The savings from the combined effects of changes to PD are approximately $3.5 billion per year.[10] 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 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.

Permanent Disability Reductions, Permanent Disability Remaining, per SB 899



Data Source: WCIRB
Calculations: CHSWC, UC Berkeley

[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.

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 unclear whether any of the direct approaches have improved California's RTW rate.

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. Results from the CHSWC/RAND study indicate that the improvement in RTW began before the workers' compensation reforms were enacted and may not obviously be 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.

Costs Paid by Insured Employers

In 2009, workers' compensation insurers earned $9.1 billion in premiums from California employers.[11]

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.

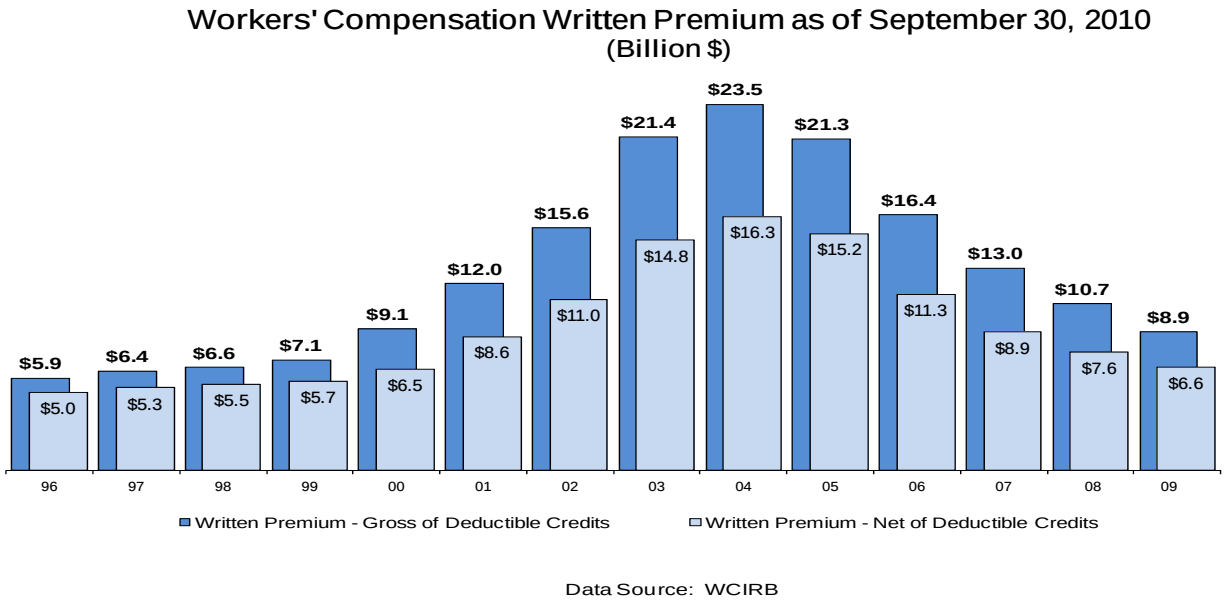
The California workers' compensation legislative reforms in the early 2000s, which were developed to control medical costs, update indemnity benefits and improve the assessment of PD, had significant impact on insurance costs.

As intended, these reforms reduced workers' compensation costs in California. It appears that the savings have been fully realized and the system may be returning 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.

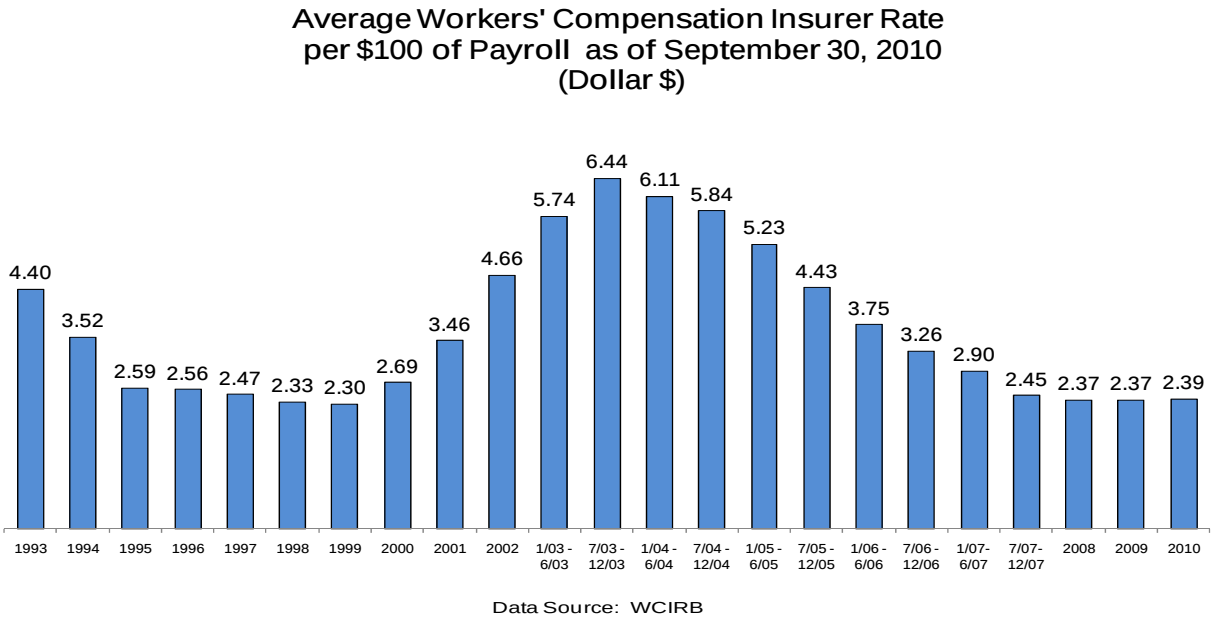
As shown in the following chart, workers' compensation written premium has undergone dramatic changes since 1996. Written premium increased slightly in the latter part of the 1990s, more than tripled from 1999 through 2004, and experienced a significant decline of over 60 percent from 2004 to 2009.



[11] Source: "2010 California's Workers' Compensation Losses and Expenses." WCIRB – June 22, 2010. 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.

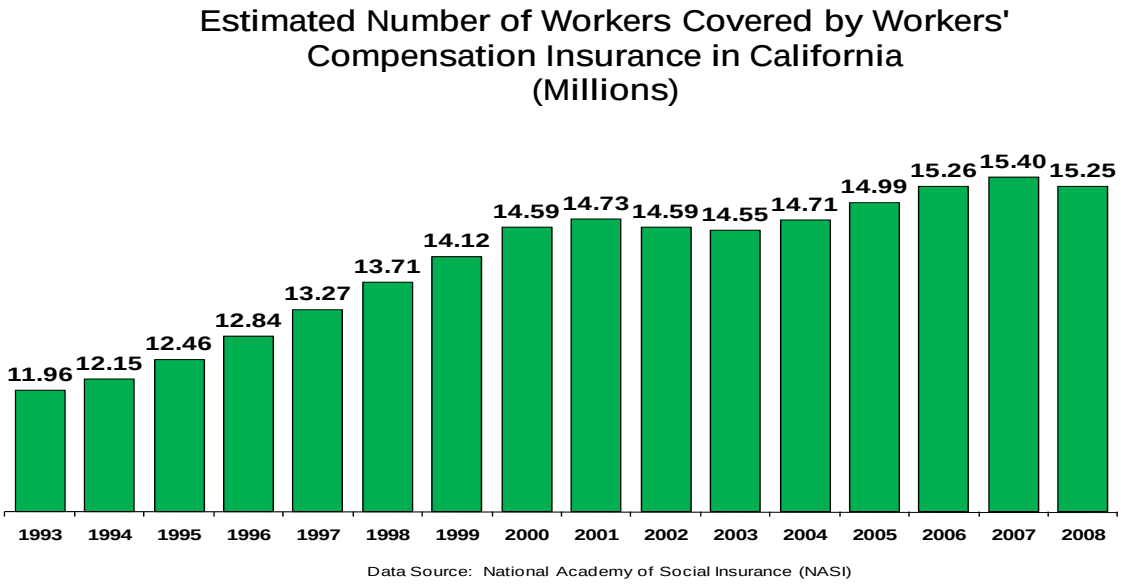
Workers' Compensation Average Premium Rate

The following chart shows the average workers' compensation premium rate per $100 of payroll. The average stabilized during the mid-to-late 1990s, and then rose significantly beginning in 2000 up to the second half of 2003. However, the average premium rate has dropped every year from the second half of 2003 to 2009 when it was $2.37, a decrease of 63 percent from the second half of 2003. From 2009 to 2010, the average premium rate increased 0.8 percent.



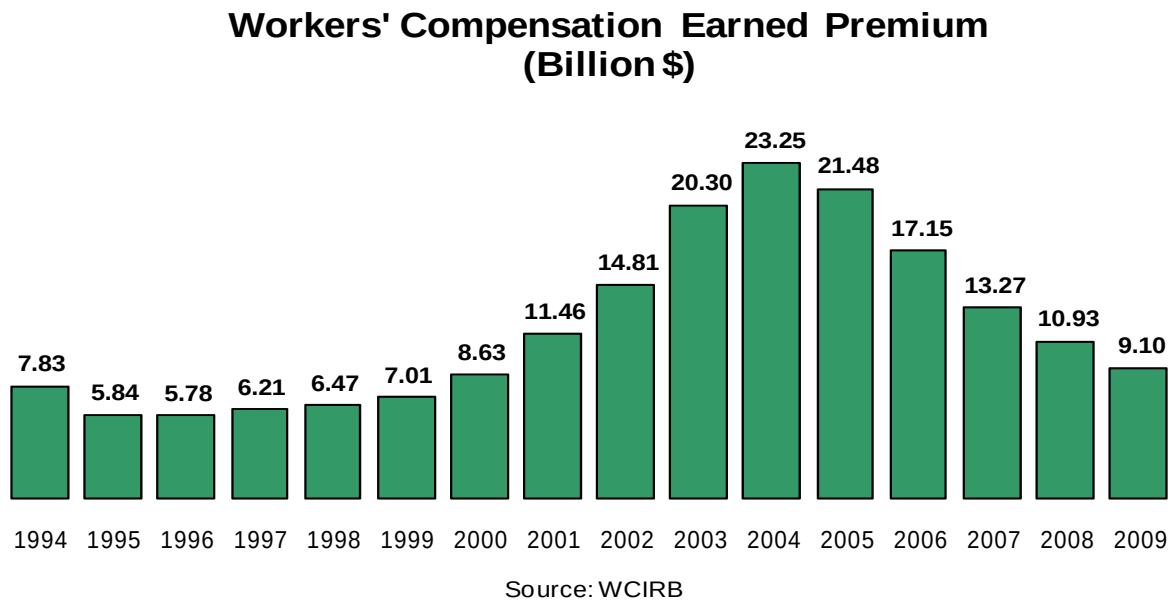
Workers Covered by Workers' Compensation Insurance

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, and then in 2008 returned to the 2006 level.



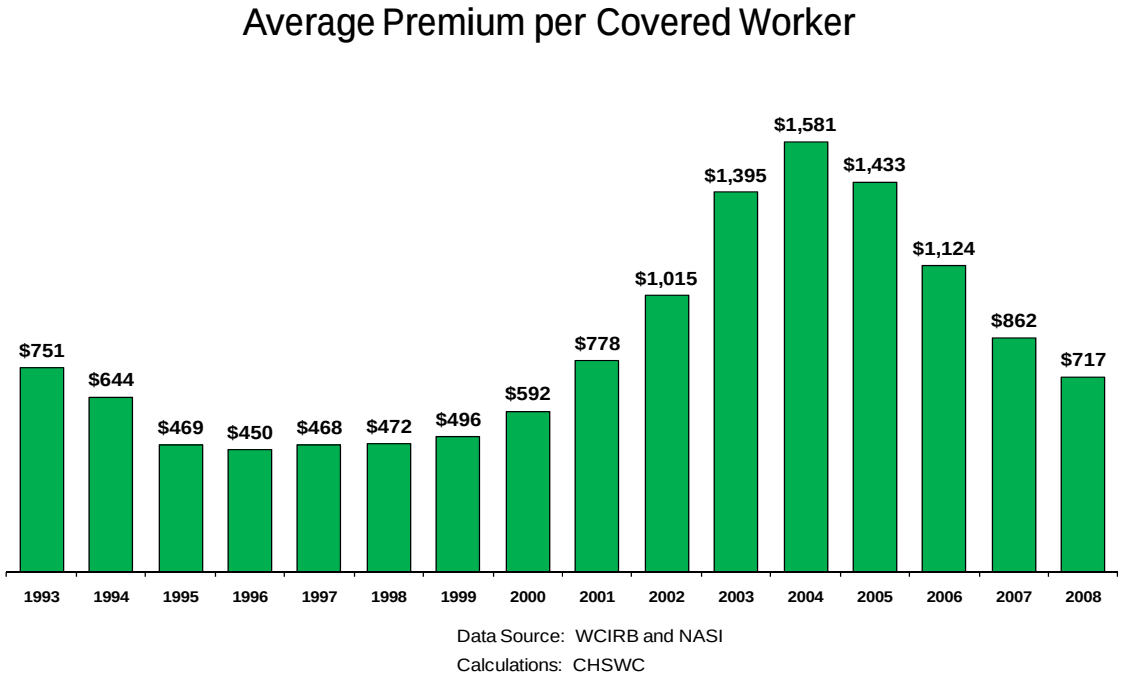
Total Earned Premium

WCIRB defines the earned premium as the portion of a premium that has been earned by the insurer for policy coverage already provided.



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 54.6 percent decrease in average earned premium per covered worker from 2004 to 2008.



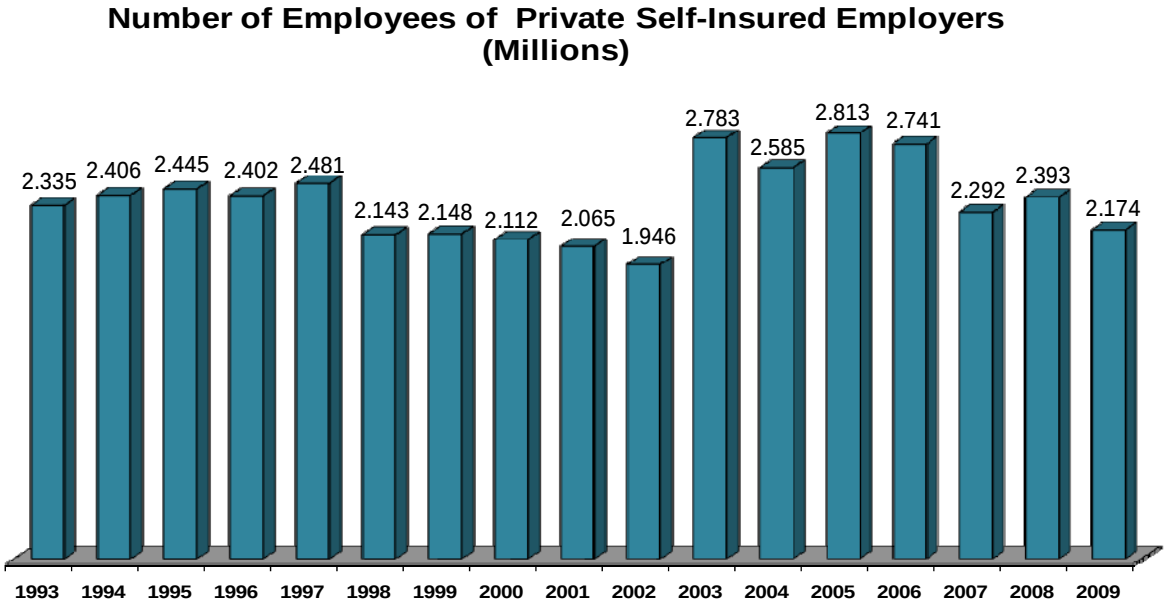
Costs Paid by Self-Insured Private and Public Employers

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 multiplier is 0.43, and the estimated cost to self-insured employers and the State for 2009 is $4.05 billion.

Private Self-Insured Employers[12]

Number of Employees

The following chart shows the number of employees working for private self-insured employers between 1993 and 2009. 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.



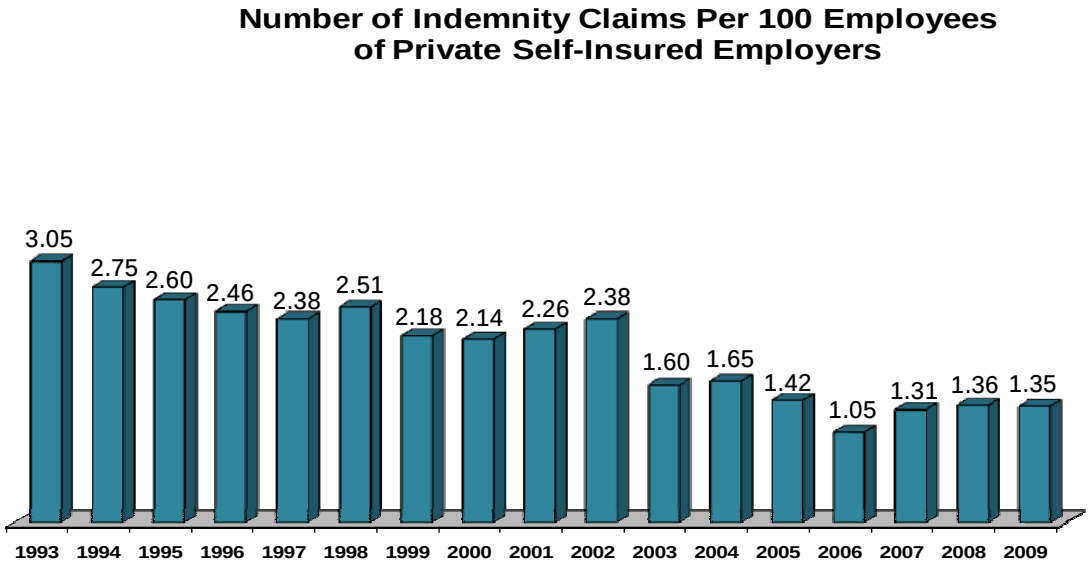
Data Source: DIR Self-Insurance Plans

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

[12] Data for private self-insured employers are from DIR's Office of Self Insurance Plans correspondence received by CHSWC in August 2010.

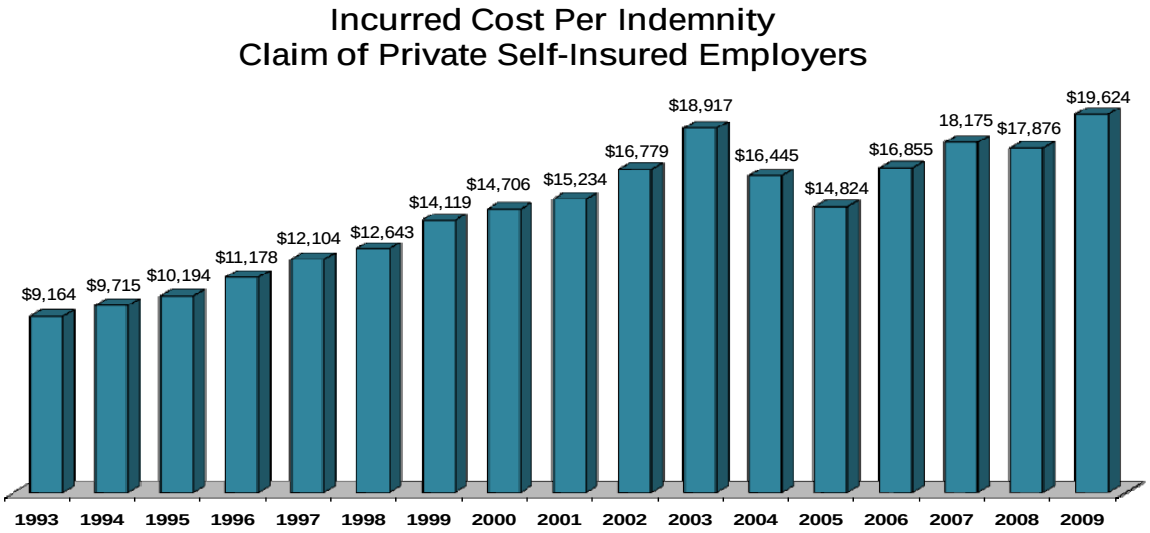
frequency. Smaller year-to-year variations, including a small upswing in 1998 and a two-year upward trend from 2000 through 2002, are not correlated with any short-term variations in the insured market.



Data Source: DIR Self-Insurance Plans

Incurred Cost per Indemnity Claim

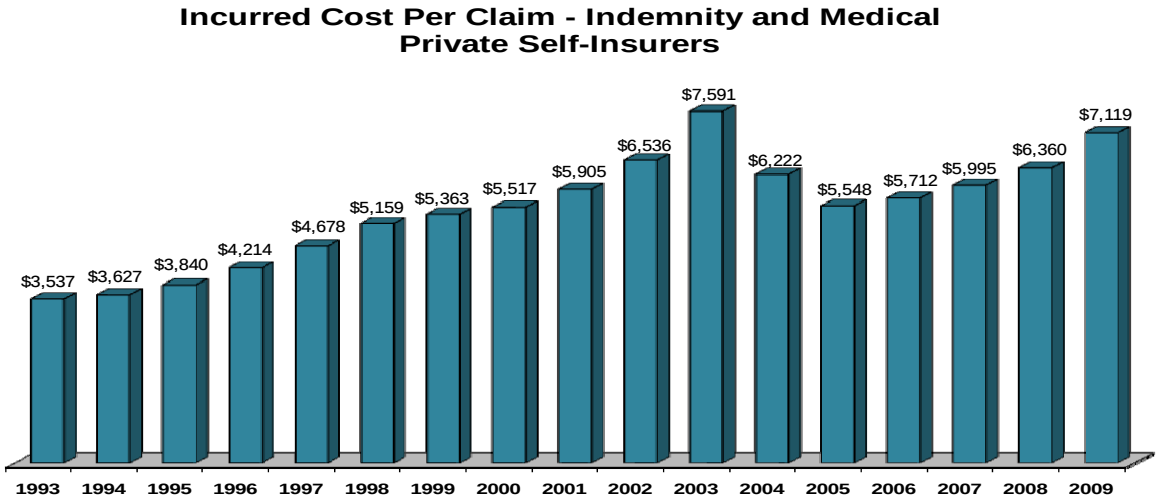
The following chart shows the incurred cost per indemnity claim for private self-insured employers, which has experienced changes similar to the changes for insurance companies. There has been a steady rise in the cost per indemnity claim until 2003, when the cost began to drop in response to the reforms 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.



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.

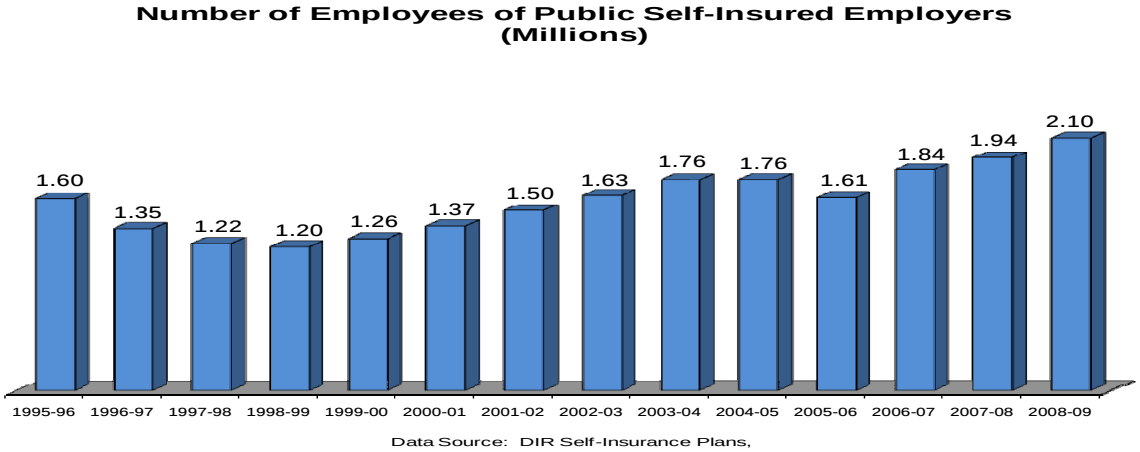


Data Source: DIR Self-Insurance Plans

Public Self-Insured Employers[13]

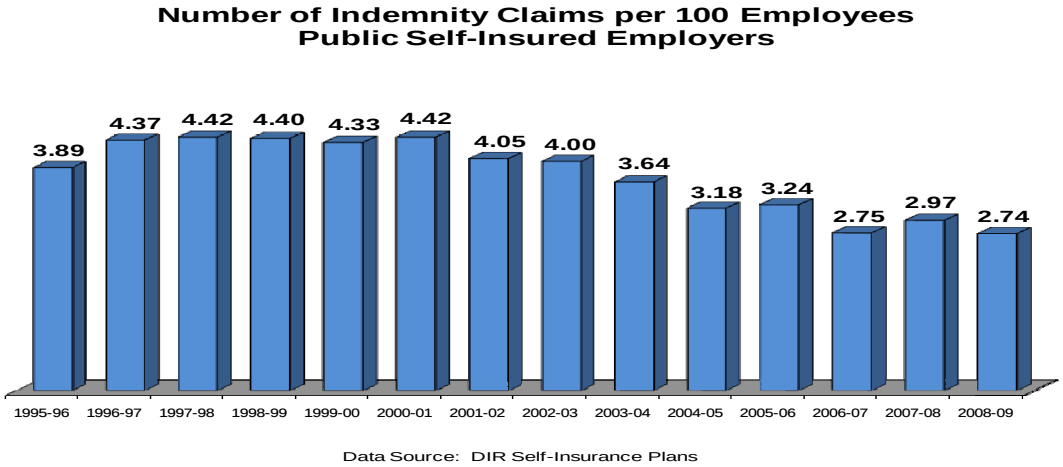
Number of Employees

The following chart shows the number of public self-insured employers between fiscal years 1995-1996 and 2008-2009. The number of public self-insured employers declined between 1995-1996 and 1998-1999. Between 1998-1999 and 2003-2004, the number of employees working for public self-insured employers grew by 46.7 percent, then leveled off between 2003-2004 and 2004-2005, declined between 2004-2005 and 2005-2006, and increased by 30 percent from 2005-2006 to 2008-2009.



Indemnity Claims

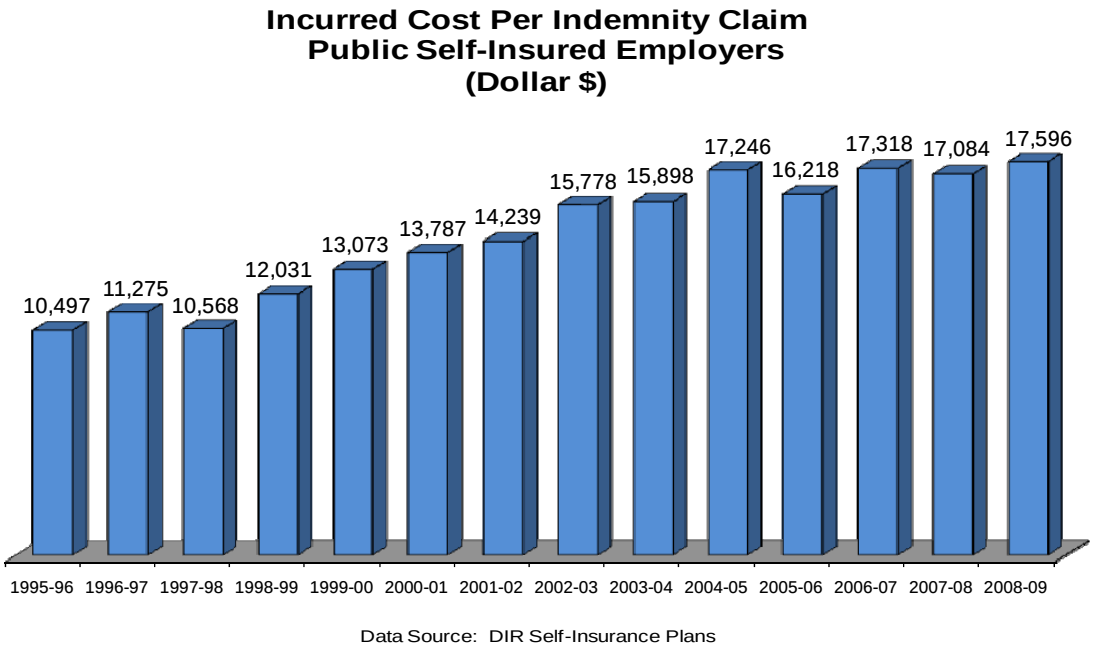
The number of indemnity claims by employees working for public self-insured employers remained steady between 1996-1997 to 2000-2001. Between 2000-2001 and 2004-2005, the number of indemnity claims decreased steadily, increased slightly between 2004-2005 and 2005-2006, then decreased again between 2005-2006 and 2006-2007 to the lowest level in the past 14 years, increased by 8 percent from 2006-2007 to 2007-2008, and then decreased again by 7.7 percent from 2007-2008 to 2008-2009. 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.



[13] Data for Public Self-Insured Employers are from DIR's Office of Self Insurance Plans correspondence received by CHSWC in September 2010.

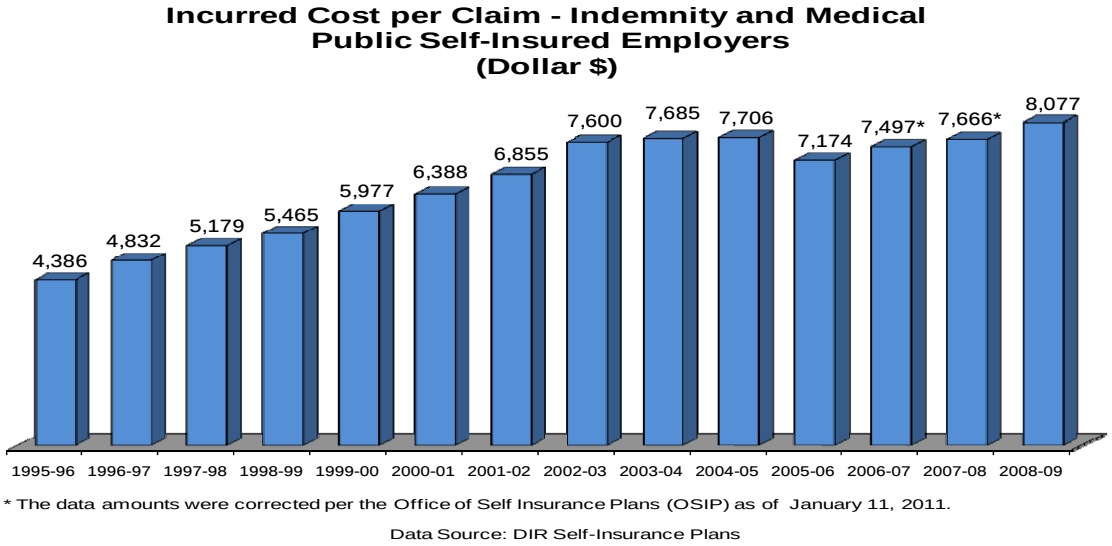
Incurred Cost per Claim

The following chart shows the incurred cost per indemnity claim for public self-insured employers. Between 1995-1996 and 2008-2009, the incurred cost per indemnity claim increased by about 68 percent from $10,497 to $17,596.



Incurred Cost per Indemnity and Medical Claim

The following chart shows the incurred cost per indemnity and medical claim for public self-insured employers. Between 1995-1996 and 2002-2003, the incurred cost per indemnity and medical claim nearly doubled, leveled off between 2003-2004 and 2004-2005, decreased by 7 percent between 2004-2005 and 2005-2006, and then increased by about 13 percent from 2005-2006 to 2008-2009.



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

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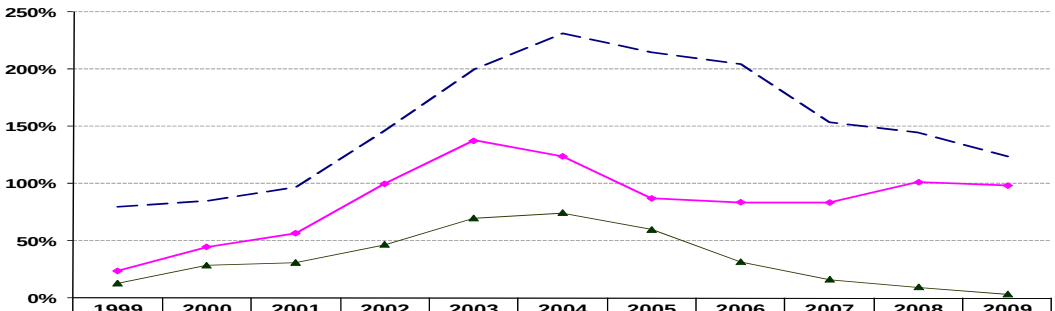
Workers' Compensation Costs Percent Growth by Year Compared With 1998



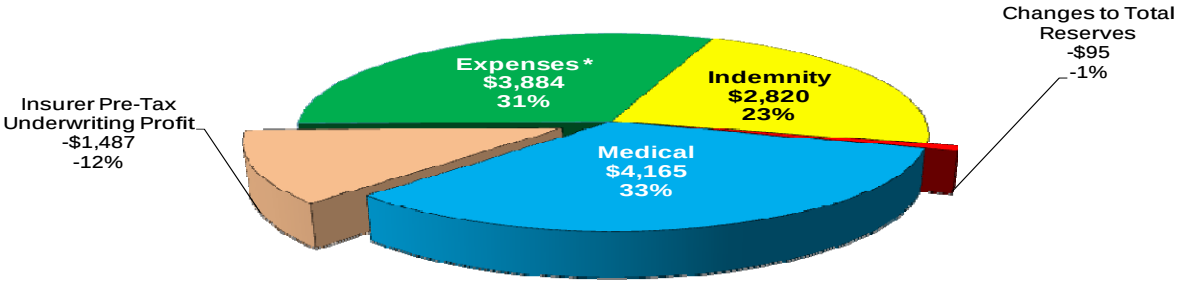
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Expenses	80%	85%	97%	146%	200%	231%	215%	204%	154%	145%	124%
Medical Paid	24%	45%	57%	100%	138%	124%	87%	84%	84%	101%	99%
Indemnity Paid	13%	29%	31%	47%	70%	75%	60%	32%	16%	9%	3%

Data Source: WCIRB

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, 2009 (Million $)



* 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

Indemnity Benefits (Thousand $)	2008	2009	Change
Temporary Disability	$2,075,473	$1,948,033	-$127,440
Permanent Total Disability	$146,811	$140,067	-$6,744
Permanent Partial Disability	$1,704,986	$1,675,724	-$29,262
Death	$99,319	$100,390	$1,071
Funeral Expenses	$2,217	$1,909	-$307
Life Pensions	$83,644	$96,804	$13,160
Voc Rehab/Non-transferable Education Voucher	$158,242	$69,990	-$88,252
Total	$4,270,692	$4,032,917	-$237,775

Paid by Insured Employers

Indemnity Benefits (Thousand $)	2008	2009	Change
Temporary Disability *	$1,451,380	$1,362,261	-$89,119
Permanent Total Disability *	$102,665	$97,949	-$4,716
Permanent Partial Disability *	$1,192,298	$1,171,835	-$20,463
Death *	$69,454	$70,203	$749
Funeral Expenses	$1,550	$1,335	-$215
Life Pensions	$58,492	$67,695	$9,203
Voc Rehab/Non-transferable Education Voucher *	$110,659	$48,944	-$61,715
Total	$2,986,498	$2,820,222	-$166,276

Paid by Self-Insured Employers and the State**

Indemnity Benefits (Thousand $)	2008	2009	Change
Temporary Disability	$624,093	$585,772	-$38,321
Permanent Total Disability	$44,146	$42,118	-$2,028
Permanent Partial Disability	$512,688	$503,889	-$8,799
Death	$29,865	$30,187	$322
Funeral Expenses	$667	$574	-$92
Life Pensions	$25,152	$29,109	$3,957
Voc Rehab/Non-transferable Education Voucher	$47,583	$21,046	-$26,537
Total	$1,284,194	$1,212,695	-$71,499

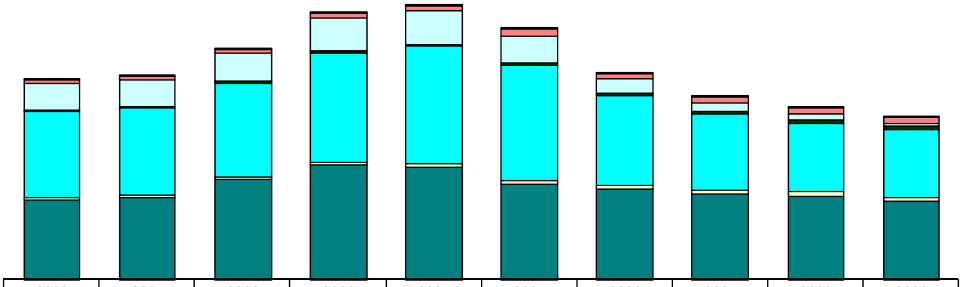
* Single Sum Settlement and Other Indemnity payments have been allocated to the benefit categories.

** 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 2000 levels. The permanent partial disability that peaked in 2004 saw one of the biggest declines after the reforms. The TD benefits began declining in 2005 despite the TD benefit increases of AB 749 and the impact of the two-year limit not taking effect until April 2006.

Workers' Compensation Paid Indemnity Benefit by Type
Systemwide Estimated Costs*
(Million $)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Funeral Expenses	$2.5	$2.3	$2.4	$2.1	$2.1	$2.0	$2.2	$1.9	$2.2	$1.9
Permanent Total Disability	$85.2	$86.5	$86.5	$101.9	$124.2	$161.3	$141.2	$132.0	$146.8	$140.1
Voc Rehab/ Education Vouchers	$660.8	$663.6	$707.2	$838.0	$838.4	$673.1	$347.1	$217.1	$158.2	$70.0
Life Pensions	$40.6	$39.5	$46.2	$47.5	$45.5	$59.9	$62.8	$72.0	$83.6	$96.8
Permanent Partial Disability	$2,145.6	$2,178.9	$2,330.7	$2,708.6	$2,923.4	$2,862.3	$2,242.3	$1,885.2	$1,705.0	$1,675.7
Death	$62.9	$66.0	$66.5	$66.8	$72.5	$85.2	$87.2	$97.4	$99.3	$100.4
Temporary Disability	$1,973.6	$2,028.5	$2,484.1	$2,857.8	$2,802.0	$2,384.8	$2,246.8	$2,126.5	$2,075.5	$1,948.0
Total	$4,971.3	$5,065.3	$5,723.5	$6,622.7	$6,808.0	$6,228.6	$5,129.6	$4,532.0	$4,270.7	$4,032.9

Data Source: WCIRB
Calculations: CHSWC

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 a supplemental job displacement benefit (SJDB). The vocational rehabilitation (VR) statutes are repealed entirely effective January 1, 2009. Consequently, the expenditures for VR are decreasing 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 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.

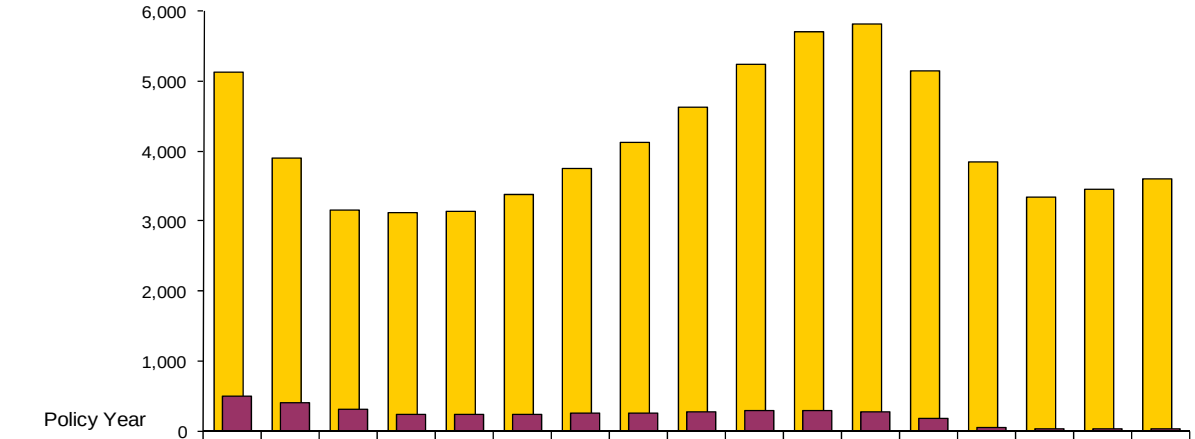
Table: Vocational Rehabilitation (VR) and Supplemental Job Displacement Benefit (SJDB) Vouchers Incurred Costs at Second/Third Report Level

Accident Year (AY)	Percent of Indemnity Claims with VR or SJDB Vouchers	Change from Average of AY 2001-03	VR and SJDB Vouchers Cost per VR & SJDB Vouchers Claim	Change from Average of AY 2001-03	VR and SJDB Vouchers Cost per Indemnity Claim	VR and SJDB Cost Level Change from Average of AY 2001-03
2001	**25.1%**	**-**	**$9,525**	**-**	**$2,387**	**-**
2002	**25.2%**	**-**	**$9,635**	**-**	**$2,426**	**-**
2003	**24.0%**	**-**	**$8,987**	**-**	**$2,158**	**-**
2004	**12.1%**	**-51%**	**$4,187**	**-55%**	**$505**	**-78%**
2005	**11.2%**	**-55%**	**$3,923**	**-58%**	**$441**	**-81%**

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 2007 on VR costs including SJDB vouchers (non-transferable educational vouchers) beginning from policy year 2003.

Vocational Rehabilitation Benefits and SJDB Vouchers* Compared with Total Incurred Losses, WCIRB 1st Report Level (Million $)



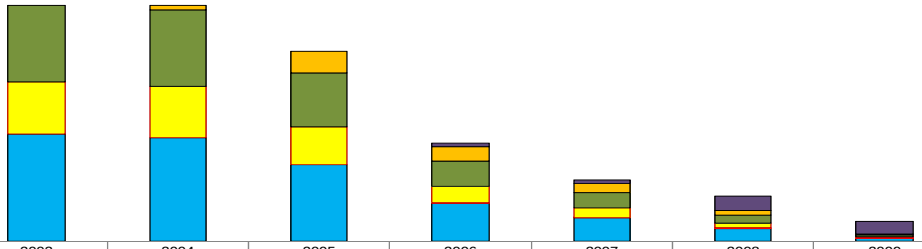
Policy Year	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total Incurred Losses	5,136	3,907	3,164	3,120	3,136	3,389	3,744	4,123	4,631	5,243	5,702	5,809	5,147	3,855	3,351	3,463	3,601
Voc Rehab Benefits **	508	404	308	246	236	241	253	261	278	292	291	275	177	49	38	38	40

* The Vocational Rehabilitation statutes are repealed entirely effective January 1, 2009, and replaced with Supplemental Job Displacement Benefits.
** Policy year 2003 "vocational rehabilitation benefits" contain a mix of vocational rehabilitation costs and non-transferable educational voucher costs. Policy year 2004 and later "vocational rehabilitation benefits" contain mainly non-transferable educational voucher costs.

Data Source: WCIRB

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 2003 through 2009.

Paid Vocational Rehabilitation Benefits and SJDB Vouchers (Million $)



	2003	2004	2005	2006	2007	2008	2009
Education Vouchers	N/A	N/A	N/A	8.004	8.598	35.054	31.087
V/R Settlement*	N/A	12.232	53.039	37.014	22.490	11.524	2.592
Education & Training	190.464	190.894	134.594	62.789	38.151	19.549	4.398
Evaluation	130.357	126.562	94.033	40.282	24.476	12.542	2.821
Other Voc. Rehab	N/A	N/A	N/A	0.612	0.949	2.716	1.461
Maintenance Allowance	265.167	256.572	189.050	94.025	57.131	29.274	6.585
Total	585.988	586.26	470.716	242.726	151.795	110.659	48.944

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

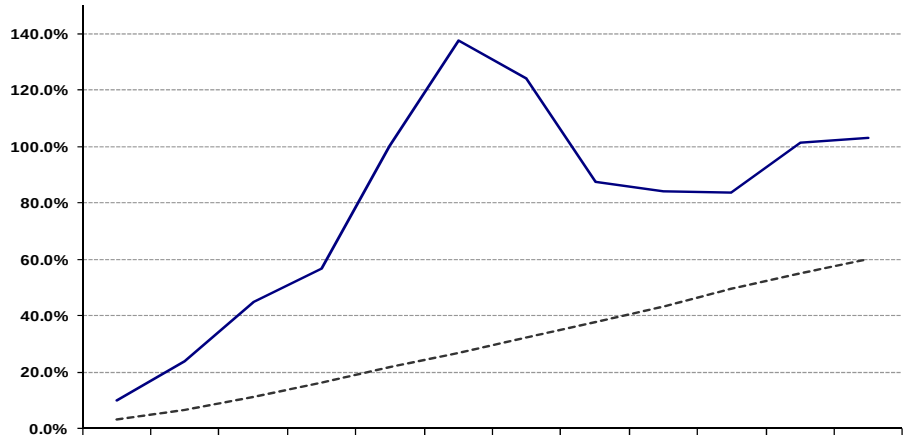
Data Source: WCIRB

Medical Benefits

Workers' Compensation Medical Costs vs. Medical Inflation

The following chart compares the percent growth of California's workers' compensation medical costs paid by insurers and self-insured employers in each consequtive year from 1997 with the percent growth of the medical component of the Consumer Price Index (CPI) in each consequtive year from 1997. The medical component of the CPI is also known as the "Medical CPI," an economic term used to describe price increases in health care services.

Growth of Workers' Compensation Medical Costs Compared to Growth of Medical Inflation since 1997



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Change in Workers' Comp Medical Costs as Compared to 1997	9.9%	23.7%	44.9%	56.8%	100.0%	137.8%	124.1%	87.3%	84.0%	83.7%	101.5%	103.2%
Change in Medical CPI as Compared to 1997	3.2%	6.8%	11.2%	16.3%	21.7%	26.6%	32.2%	37.8%	43.3%	49.6%	55.2%	60.1%

Data Source: WCIRB; Bureau of Labor Statistics

Distribution of Medical Benefits: Where Does the Workers' Compensation Dollar Go?

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

Systemwide Estimated Costs - Medical Benefits Paid

Medical Benefits (Thousand $)	2008	2009	Change
Physicians	$2,152,919	$2,102,400	-$50,519
Capitated Medical	$19,773	$4,969	-$14,803
Hospital	$1,569,319	$1,495,415	-$73,904
Pharmacy	$525,875	$485,628	-$40,247
Payments Made Directly to Patient	$943,538	$1,180,990	$237,452
Medical-Legal Evaluation	$289,112	$228,231	-$60,881
Medical Cost-Containment Programs*	$405,763	$458,632	$52,870
Total	$5,906,299	$5,956,266	$49,967

Paid by Insured Employers

Medical Benefits (Thousand $)	2008	2009	Change
Physicians	$1,505,538	$1,470,210	-$35,328
Capitated Medical	$13,827	$3,475	-$10,352
Hospital	$1,097,426	$1,045,745	-$51,681
Pharmacy	$367,745	$339,600	-$28,145
Payments Made Directly to Patient	$659,817	$825,867	$166,050
Medical-Legal Evaluation	$202,176	$159,602	-$42,574
Medical Cost-Containment Programs*	$283,750	$320,722	$36,972
Total	$4,130,279	$4,165,221	$34,942

Paid by Self-Insured Employers**

Medical Benefits (Thousand $)	2008	2009	Change
Physicians	$647,381	$632,190	-$15,191
Capitated Medical	$5,946	$1,494	-$4,451
Hospital	$471,893	$449,670	-$22,223
Pharmacy	$158,130	$146,028	-$12,102
Payments Made Directly to Patient	$283,721	$355,123	$71,402
Medical-Legal Evaluation	$86,936	$68,629	-$18,307
Medical Cost-Containment Programs*	$122,013	$137,910	$15,898
Total	$1,776,020	$1,791,045	$15,025

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

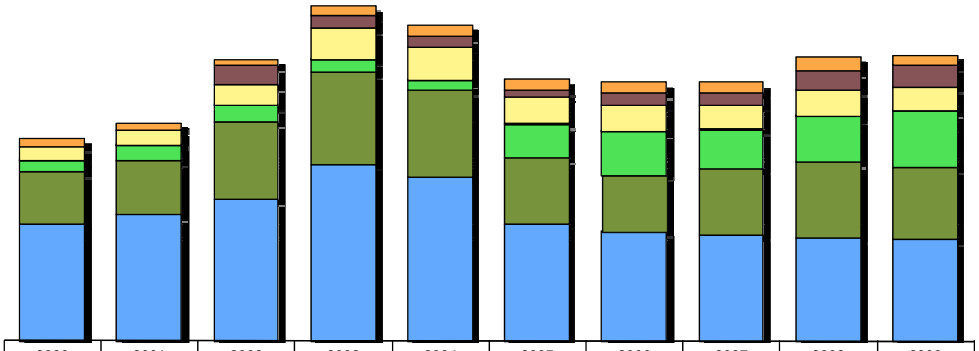
Trends in Paid Medical Benefits

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 and economic recession.

The cost of the total medical benefit increased by 65 percent from 2000 to 2003, decreased by 23 percent from 2003 to 2007, and then increased again by 11 percent from 2007 to 2009. Payments to physicians increased by 51 percent from 2000 to 2003, then dropped by 43 percent from 2003 to 2009. Pharmacy costs increased by 132 percent from 2000 through 2004, before declining by almost 30 percent from 2004 to 2009. Hospital costs increased by 78 percent from 2000 to 2003, declined by 39 percent from 2003 to 2006, and then increased by 28 percent in 2009. Direct payments to patients averaged $275 million from 2000 to 2004, increased sharply 3.3 times from 2004 to 2005, and then increased again 1.7 times from 2005 to 2009. Expenditures on medical cost-containment programs in 2005 were less than a third of what they were in 2002 and then increased again 3.6 times in 2009. Medical-legal evaluation costs decreased by 19 percent from 2000 to 2002, more than doubled between 2002 and 2008, and then decreased by 21 percent from 2008 to 2009.

The apparent increases in the medical payments made to injured workers and medical cost containment programs were in part the result of availability of more detailed reporting of payments into specific recipient/payee categories.

Workers' Compensation Paid Medical Benefits by Type
Systemwide Estimated Costs* (Million $)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Medical-Legal Evaluation	$157.0	$138.5	$127.4	$183.5	$229.4	$244.5	$231.8	$213.8	$289.1	$228.2
Med Cost Cntnmnt Prgrms	N/A	N/A	$408.2	$278.8	$222.8	$127.4	$250.2	$267.7	$405.8	$458.6
Pharmacy	$294.9	$320.8	$424.2	$651.4	$683.5	$559.1	$545.0	$497.1	$525.9	$485.6
Capitated Medical	$7.9	$6.5	$8.8	$13.0	$15.2	$32.6	$13.5	$11.6	$19.8	$5.0
Direct Payments to Patient	$241.5	$329.8	$340.2	$256.1	$207.6	$686.4	$899.6	$803.9	$943.5	$1,181.0
Hospital	$1,076.0	$1,111.6	$1,612.0	$1,917.8	$1,798.1	$1,374.2	$1,167.9	$1,381.9	$1,569.3	$1,495.4
Physicians	$2,437.2	$2,630.1	$2,943.4	$3,669.4	$3,414.8	$2,431.0	$2,285.0	$2,209.8	$2,152.9	$2,102.4
Total	$4,214.5	$4,537.3	$5,864.3	$6,970.0	$6,571.5	$5,452.9	$5,396.4	$5,385.8	$5,906.3	$5,956.3

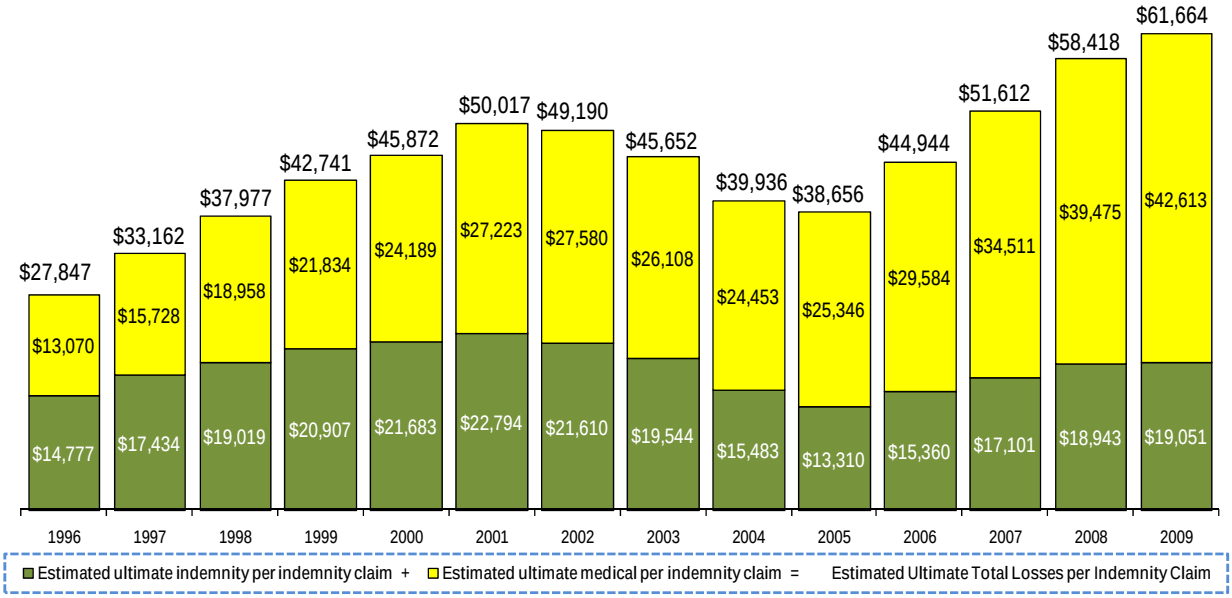
Source: WCIRB
Calculations: CHSWC

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 almost 23 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 about 60 percent between 2005 and 2009.

Estimated Ultimate Total Loss* per Indemnity Claim
as of September 30, 2010



*Excludes medical-only

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.

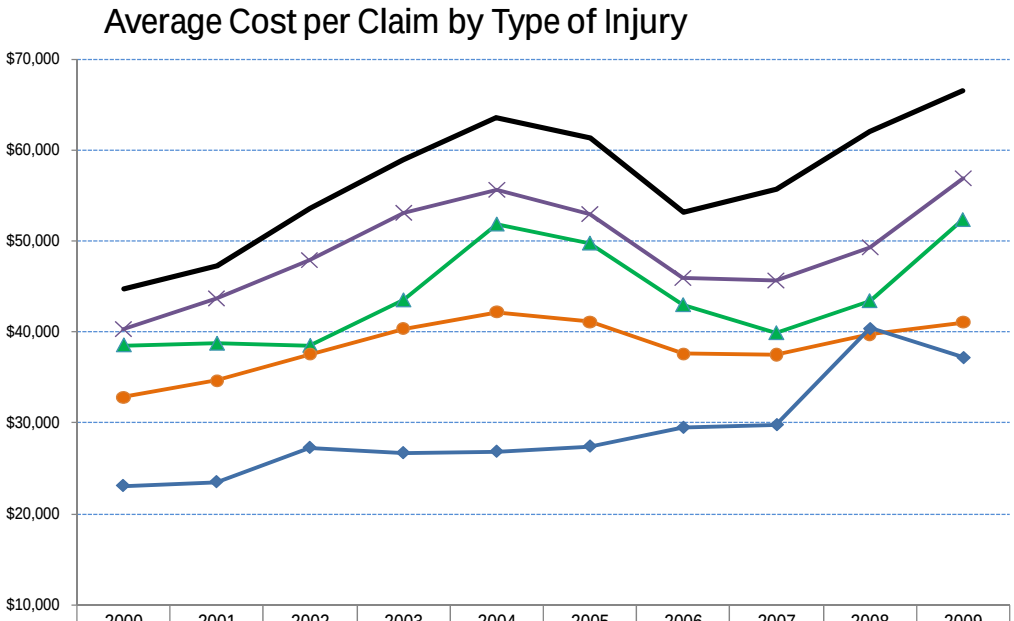
Average Cost per Claim by Type of Injury

As shown in the following chart, from 2000 to 2004, there was an increase in average costs of all types of injuries. The average cost of slip and fall injuries increased by 42 percent and the average cost of back injuries increased by 38 percent, followed by a 34.5 percent increase in the average cost of other cumulative injuries and a 28 percent increase in the average cost of carpal tunnel/repetitive motion injuries (RMI).

From 2004 to 2007, the average costs declined for all of the types of injuries shown below, with the exception of psychiatric and mental stress. The average cost of other cumulative injuries decreased by 23 percent, and the average cost of back injuries decreased by almost 18 percent, followed by a 12 percent decrease in the average cost of slip and fall injuries and an 11 percent decrease in the average cost of carpal tunnel/RMI injuries.

The average cost for all of the types of injuries shown below, with the exception of psychiatric and mental stress, increased between 2007 and 2009. The average cost of other cumulative injuries increased by 31 percent and the average cost of back injuries increased by 24.5 percent, followed by a 19 percent increase in the average cost of slip and fall injuries and a 9.5 percent increase in the average cost of carpal tunnel/RMI injuries.

Average costs of psychiatric and mental stress claims increased by 18 percent between 2000 and 2002, decreased by 2 percent between 2002 and 2003, and then increased by 51 percent from 2003 through 2008. From 2008 to 2009, the average costs of psychiatric and mental stress claims decreased again by 8 percent.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Slip and Fall	$44,689	$47,316	$53,576	$58,869	$63,581	$61,266	$53,121	$55,738	$62,004	$66,459
Back Injuries	$40,311	$43,739	$47,938	$53,049	$55,570	$52,955	$45,963	$45,698	$49,283	$56,874
Other Cumulative Injuries	$38,543	$38,721	$38,494	$43,507	$51,867	$49,773	$42,975	$39,880	$43,417	$52,364
Carpal Tunnel / RMI	$32,817	$34,627	$37,552	$40,349	$42,152	$41,108	$37,598	$37,500	$39,709	$41,064
Psychiatric and Mental Stress	$23,082	$23,505	$27,278	$26,706	$26,855	$27,427	$29,499	$29,798	$40,385	$37,188

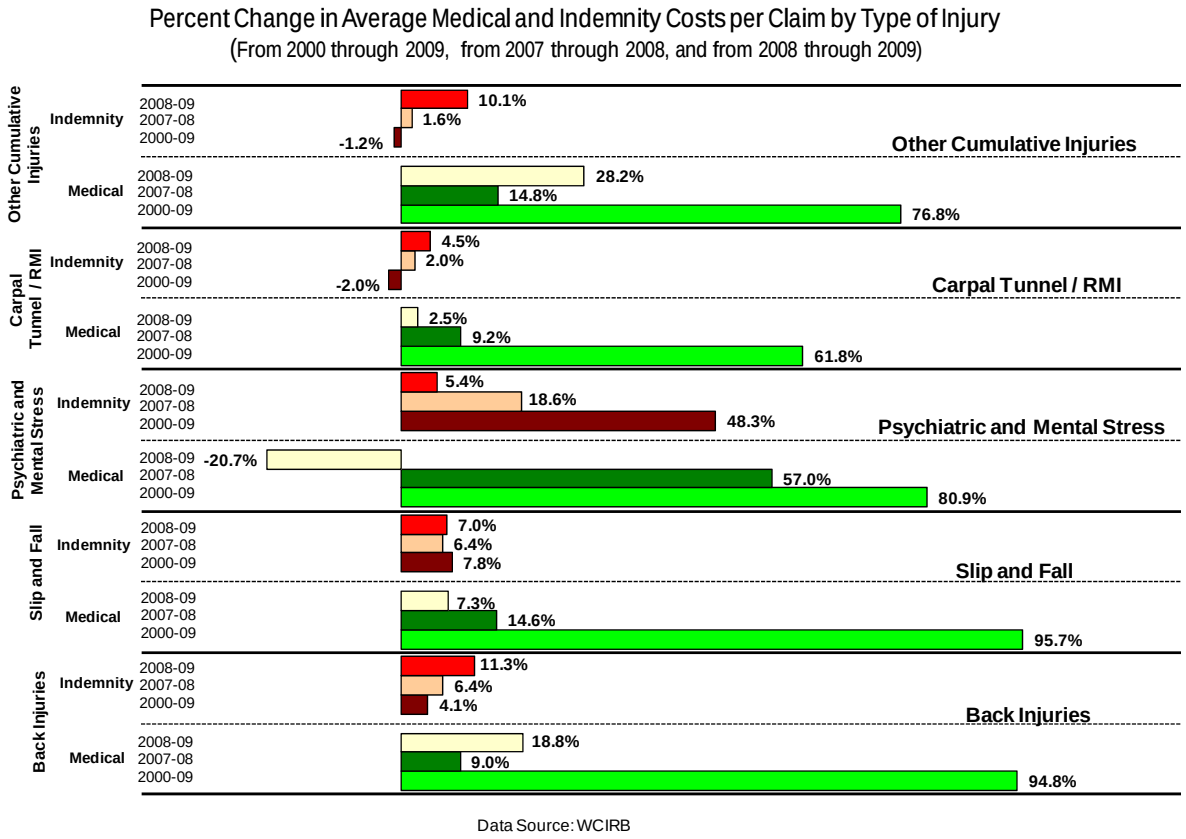
Data Source: WCIRB

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 2009 shows increases in medical costs for all these types of injury. The same trend for indemnity costs shows slight decreases for carpal tunnel/repetitive motion injury(RMI) and other cumulative injuries and increases for the psychiatric and mental stress, slips and falls, and back injuries as the result of increase in those indemnity costs for both the 2007-2008 and 2008-2009 periods.

From 2007 to 2008, medical costs increased for every type of injury. In the same year, indemnity costs showed increases for all types of injury as well.

From 2008 to 2009, medical costs increased for every type of injury except for psychiatric and mental stress, the largest being a 28 percent increase for other cumulative injuries. In the same year, indemnity costs increased for every type of injury, the largest being 11 percent for back injuries.



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 permanent disability (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 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. 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 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 2007, the average cost of medical-legal evaluations was $1,527, or more than double from the 2000 accident year, reaching the highest level since 1989. In the workers' compensation system, the medical-legal cost is reported as a component of medical cost and comprises from 2 to 5 percent of the paid medical cost. A decline in medical costs shortly after passage of major reform measures in 2003 and 2004, followed by an increase starting in 2006, raises the question of how much of the changes in medical costs is attributable to changes in medical-legal costs. The table below shows the share of medical-legal costs in workers' compensation medical costs paid from 1998 to 2009.

Table: Percent of Medical-Legal Evaluation Costs in Total Medical Costs

Calendar Year	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Percent of Medical-Legal Evaluation Costs in Total Medical Costs	4.6	3.7	3.6	3.0	2.2	2.6	3.5	4.8	4.3	4.8	4.9	3.8

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.

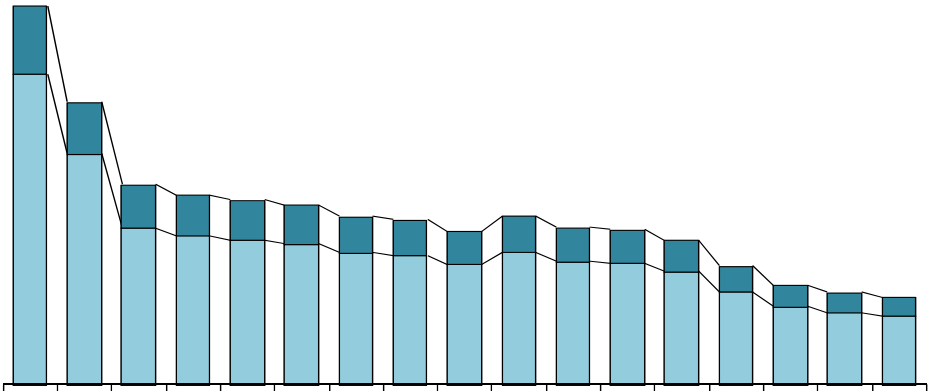
The medical-legal analysis that follows uses data from the WCIRB *Permanent Disability Survey*. Accident year 2007 is the latest year for which sufficiently mature data reports are available.

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, which 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 2007.

PPD Claims at Insured Employers by Year of Injury (Thousands)



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Major (PD rating of 25% or more)	33.7	25.5	21.4	20.3	19.8	19.2	18.0	17.6	16.4	18.0	16.8	16.6	15.5	12.7	10.7	9.9	9.4
Minor (PD rating less than 25%)	154.1	114.4	77.7	73.7	71.7	69.7	65.4	64.0	59.7	65.6	61.0	60.1	56.1	46.1	38.7	35.7	34.0
Total Claims	187.8	139.9	99.1	94.0	91.5	88.9	83.4	81.6	76.1	83.6	77.8	76.7	71.6	58.8	49.4	45.6	43.4

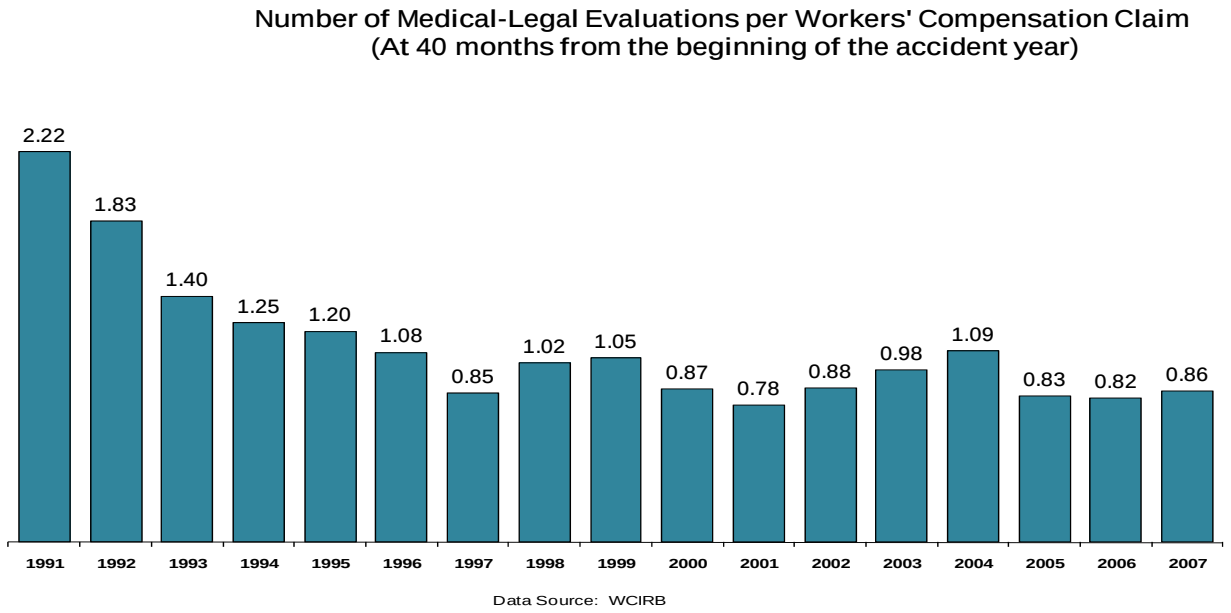
Data Source: WCIRB

Medical-Legal Evaluations per Claim

The following chart illustrates that the average number of medical-legal evaluations per claim declined from 2.22 evaluations in 1991 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).



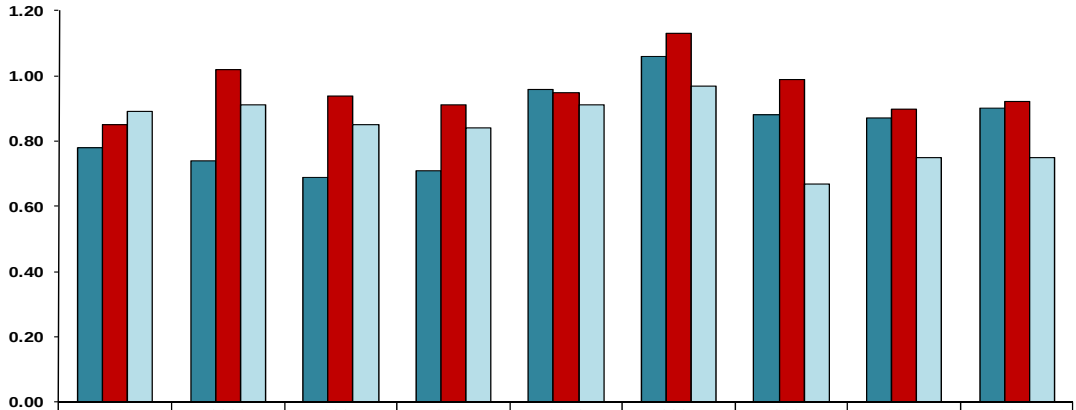
The change in the average number of evaluations between 1993 and 1994 was almost entirely the result of improvements that occurred during the course of 1993 calendar year claims. These results were based on smaller surveys done by WCIRB when the claims were less mature. These later data involving a larger 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 and 2007 accident years. 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 January 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 1999 and 2007 in different regions. 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. From 2005 to 2007, for the average number of evaluations per claim, there was a 12 percent increase in the Southern California region, a slight (2 percent) increase in Northern region, and 7 percent decrease in Central California region.



	1999	2000	2001	2002	2003	2004	2005	2006	2007
Northern California	0.78	0.74	0.69	0.71	0.96	1.06	0.88	0.87	0.90
Central California	0.85	1.02	0.94	0.91	0.95	1.13	0.99	0.90	0.92
Southern California	0.89	0.91	0.85	0.84	0.91	0.97	0.67	0.75	0.75

Data Source: WCIRB

Prior to 2003, 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 seven out of the nine years.

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.

Percentage of Medical-Legal Claims by Region[14]				
	2004 1st level	2005 1st level	2006 1st level	2007 1st level
South	58.10%	63.10%	61.80%	63.50%
Central	16.30%	13.50%	13.60%	12.50%
North	25.70%	23.40%	24.60%	24.00%

Average Cost per Medical-Legal Evaluation

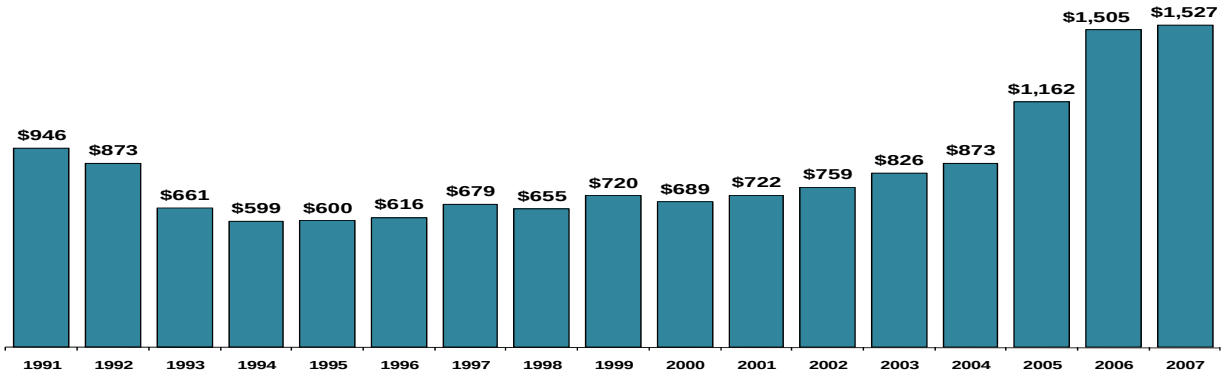
The average cost of a medical-legal evaluation per claim declined from 1991 to the mid-1990s and then increased from the mid-1990s to 2000 by 15 percent. Between 2000 and 2007, the average cost of a medical-legal evaluation more than doubled.

There are two reasons why the average cost per medical-legal evaluation declined from 1991 to 1995. First, substantial changes were made to the structure of the Medical-Legal Fee Schedule that reduced the

[14] Based on WCIRB's *PD Survey* random sample.

rates at which medical-legal evaluations are reimbursed. These restrictions were introduced in early 1993 and enforced at the beginning of August 1993. 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.

Average Cost of a Medical-Legal Evaluation
(Evaluated at 40 months of accident year)

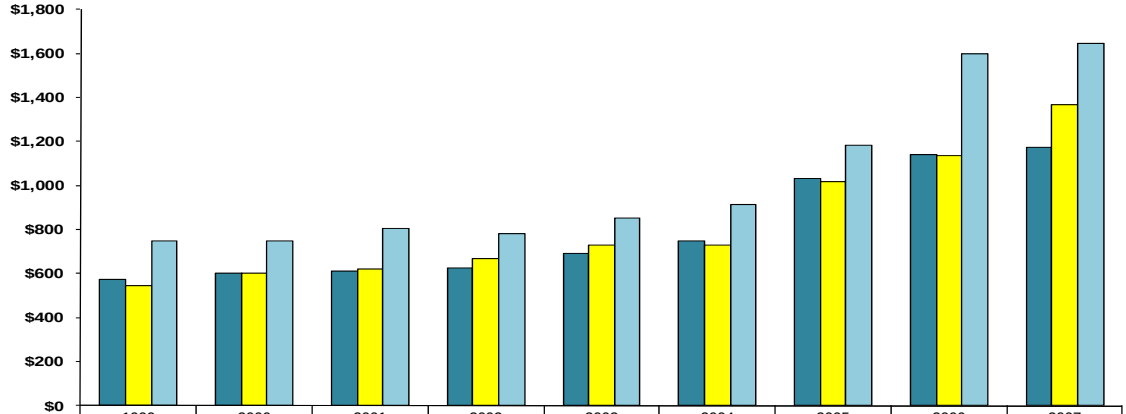


Data Source: WCIRB

In 2007, the average cost of a medical-legal evaluation increased by 75 percent compared to 2004 average medical-legal cost per evaluation and reached its highest level since 1991.

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.[15] 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.[16]

Average Cost of a Medical-Legal Evaluation by Region
(at 34 months after beginning of accident year)



	1999	2000	2001	2002	2003	2004	2005	2006	2007
Northern California	$574	$601	$613	$627	$693	$747	$1,033	$1,141	$1,171
Central California	$547	$604	$621	$670	$728	$728	$1,017	$1,136	$1,367
Southern California	$749	$746	$806	$783	$854	$914	$1,182	$1,598	$1,643

Data Source: WCIRB

[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.

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: 2000-2007

Region	Distribution of Medical-Legal Evaluations by Region in 2000	Distribution of Medical-Legal Evaluations by Region in 2007	Change in Average Cost 2000-2007	Contribution of Each Region to the Average Cost
Southern California	58.6%	58.0%	$1,042	73.5%
Central California	16.5%	14.0%	$763	13.0%
Northern California	24.5%	26.0%	$425	13.5%

Cost Drivers

The primary cost driver for California and its Southern region is not the price paid for specific types of evaluations.[17] 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.[18] 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[19]

Evaluation Type	Amount Presumed Reasonable
ML-101 Follow-up/ Supplemental	$250
ML-102 Basic	$500
ML-103 Complex	$750
ML-104 Extraordinary	$200/hour

.

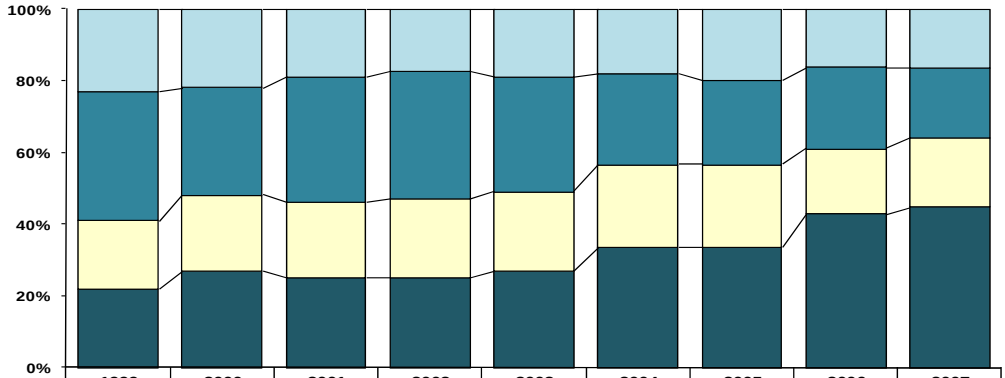
Table: Medical-Legal Evaluation Cost for Dates of Service on or After July 1, 2006

Evaluation Type	Amount Presumed Reasonable
ML-101 Follow-up/Supplemental	$62.50/15 minutes or $250/hr
ML-102 Basic	$625
ML-103 Complex	$937.50
ML-104 Extraordinary	$62.50/15 minutes or $250/hr

[17] An additional category "Other than ML-101, ML-102, ML-103, or ML-104" was included by WCIRB in types of evaluations for PD Survey 2007. This category comprises 2 percent of medical-legal claims.
[18] 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.
[19] 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.[20] Evaluations with "Extraordinary" complexity increased from 22 percent to 44.7 percent in the Southern California region and from 22 percent to 41 percent in all regions from 1999 to 2007.

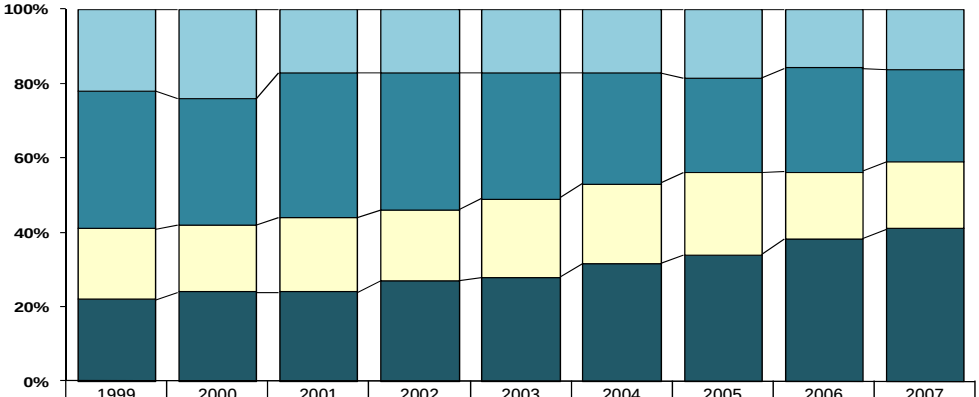
Distribution of Medical-Legal Evaluations by Type (Southern California)



	1999	2000	2001	2002	2003	2004	2005	2006	2007
ML - 101 Follow-up/ Supplemental	23%	22%	19%	18%	19%	18%	20%	16.3%	16.4%
ML - 102 Basic	36%	30%	35%	36%	32%	25.5%	23.5%	22.7%	19.6%
ML - 103 Complex	19%	21%	21%	22%	22%	23%	23%	18.2%	19.3%
ML - 104 Extraordinary	22%	27%	25%	25%	27%	33.5%	33.5%	42.8%	44.7%

Data Source: WCIRB

Distribution of Medical-Legal Evaluations by Type (California)



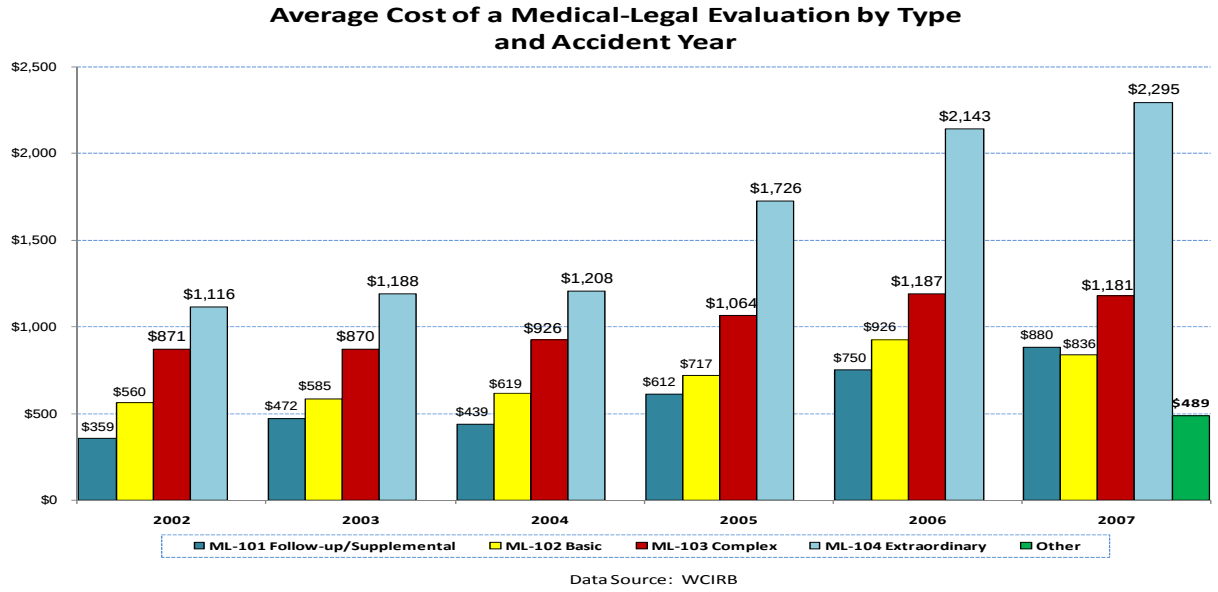
	1999	2000	2001	2002	2003	2004	2005	2006	2007
ML-101 Follow-up/Supplemental	22%	24%	17%	17%	17%	17%	18.5%	15.8%	16.2%
ML - 102 Basic	37%	34%	39%	37%	34%	30%	25.5%	28.0%	24.8%
ML - 103 Complex	19%	18%	20%	19%	21%	21.5%	22%	17.9%	18.0%
ML - 104 Extraordinary	22%	24%	24%	27%	28%	31.5%	34%	38.3%	41.0%

Data Source: WCIRB

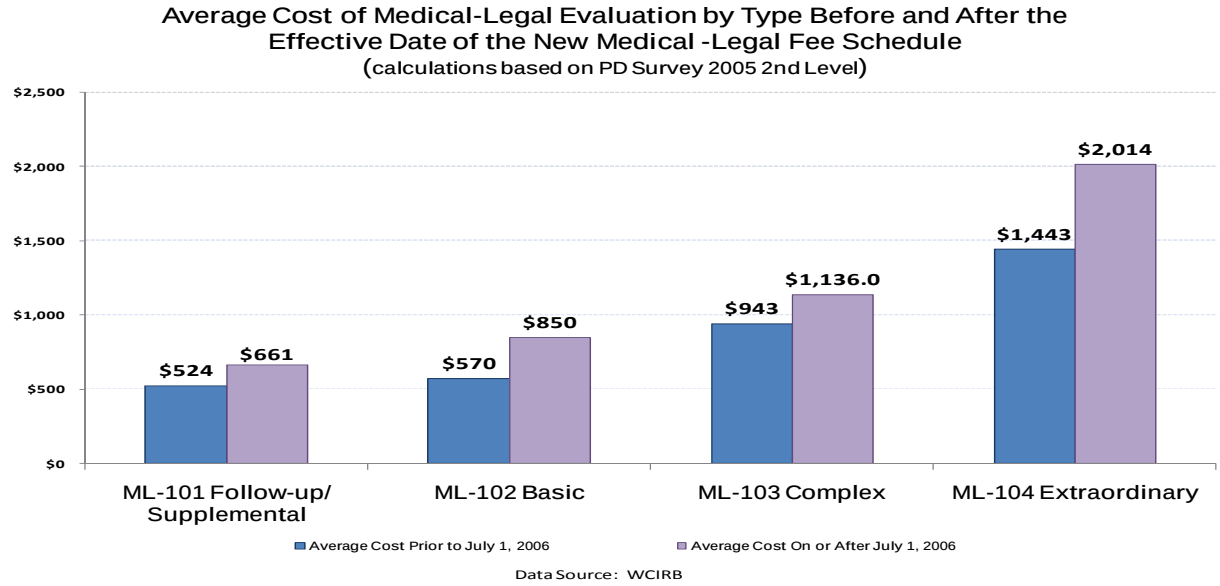
[20] Category "Other than ML-101, ML-102, ML-103, or ML-104" was excluded from two charts representing the distribution of medical-legal claims by type for comparability purposes.

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 was higher in the 2007 accident year sample compared to the 2002 accident year. The biggest increases are for the Complex and Extraordinary cases.

In addition, the medical-legal evaluations in 2007 accident year had both a higher average cost of Extraordinary evaluations ($2,295 and $1,116 respectively) and a higher share of Extraordinary evaluations (41 percent and 27 percent respectively) than in accident year 2002. In 2007, the pattern had changed. From 2002 to 2006, the average cost of a Basic medical-legal evaluation was higher than the average cost of a Follow-Up/Supplemental evaluation. However in 2007, the average cost of a Basic medical-legal evaluation became lower than the average cost of a Follow-up/Supplemental evaluation.



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.

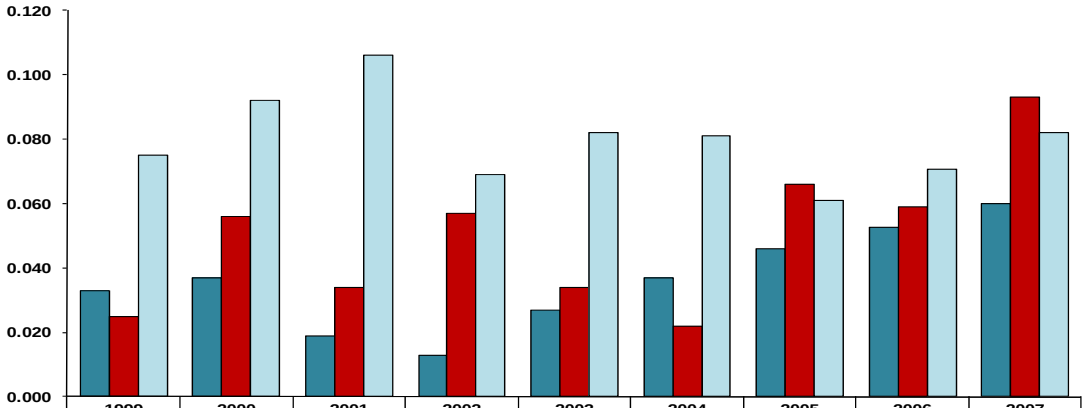


Psychiatric evaluations are nearly always billed under the ML-104 code that is the most expensive.

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 growing frequency of the most Complex evaluations in California could be an increase in psychiatric evaluations reflected in a growth of this type of evaluations from 6.4 percent of total medical-legal evaluations in the 2004 sample to 8.7 percent in the 2006 sample and to 10.2 percent in the 2007 sample. For the average number of psychiatric evaluations per report, the chart below indicates a 15.5 percent increase in the Southern California region, a 13.2 percent increase in the Northern California region, and a 57.6 percent increase in Central California region, from 2006 to 2007.

At the same time, the average cost of a psychiatric evaluation increased by 12.4 percent, from $2,545 in 2006 to $2,860 in 2007, exacerbating the effect of the increase in the number of psychiatric evaluations in all three regions.

Average Number of Psychiatric Evaluations per PPD Claim by Region



	1999	2000	2001	2002	2003	2004	2005	2006	2007
Northern California	0.033	0.037	0.019	0.013	0.027	0.037	0.046	0.053	0.060
Central California	0.025	0.056	0.034	0.057	0.034	0.022	0.066	0.059	0.093
Southern California	0.075	0.092	0.106	0.069	0.082	0.081	0.061	0.071	0.082

Data Source: WCIRB

According to WCIRB's estimates based on the PD Claim Survey, claims with psychiatric evaluations increased from 6.4 percent of all medical-legal evaluations in 2005 to 13.4 percent in 2009, and the cost of psychiatric evaluations as a percent of the cost of all medical-legal evaluations increased from 13.6 percent in 2005 to 25.7 percent in 2009.

The average cost of a psychiatric medical-legal evaluation was the highest in comparison to average costs of other medical-legal evaluations by physician type, averaging $3,057 in 2009, or almost twice as the average cost of all medical-legal evaluations, and showed 64.4 percent increases from its 2005 level. According to WCIRB's distribution of total workers' compensation medical costs paid by physician type, payments to psychiatrists increased from 1.4 percent in 2005 to 1.9 percent in 2009.

The recent data on the QME process presented in CHSWC studies in collaboration with UC Berkeley indicate a significant increase in the share of QME panels assigned to psychiatrist/psychologist specialties. The demand for psychiatric specialties as a part of all specialties increased from 6.5 percent in 2005 to 12.7 percent in 2010.

Both WCIRB and CHSWC/UC Berkeley data suggest that the frequency and related cost increases caused by psychiatric evaluations are likely to increase another 20 percent as the 2008 and 2009 PD Claim Survey data become available.

Total Medical-Legal Cost Calculation

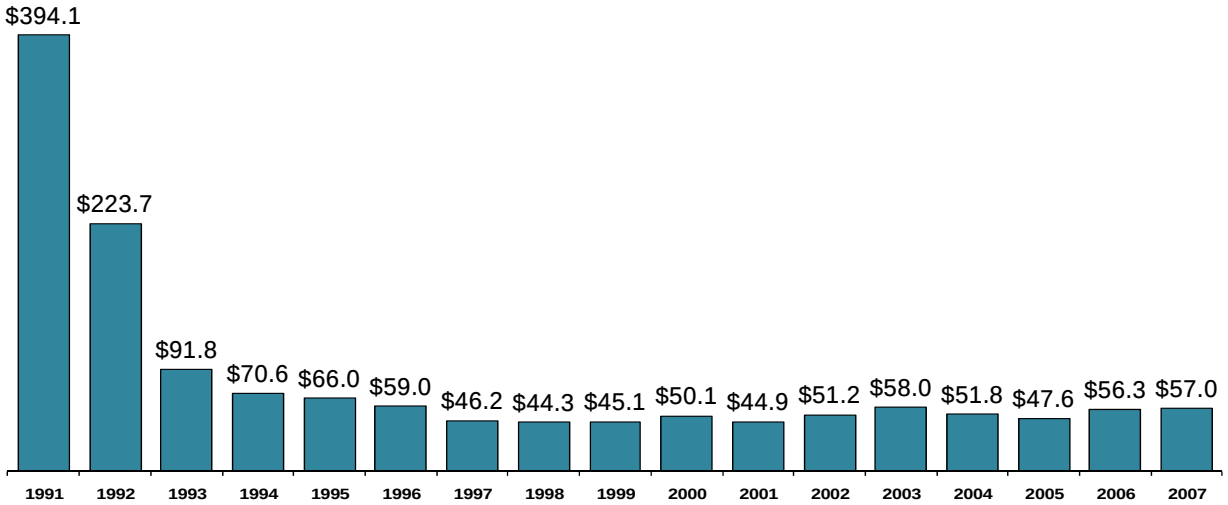
Total medical-legal costs are calculated by multiplying the number of permanent partial disability (PPD) claims by the average number of medical-legal evaluations per claim and by the average cost per medical-legal evaluation:

Total Medical-Legal Cost = Number of PPD Claims x Average **Evaluations**/Claim x 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 $394.1 million in 1991 to an estimated $57 million for injuries occurring in 2007. This is an 85.5 percent decline since 1991.

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

	1990	2007	Change 1990-2007
Number of PPD Claims	167.7	43.4	-74.1%
Number of evaluations per PPD Claims	2.53	0.86	-66.0%
Average Cost of Evaluation	$986	$1,527	+54.9%

ENDNOTES

i. CHSWC estimate based on Employment Development Department report, as above, showing 1,347,245 businesses. Of these, 964,862 were businesses with 0 to 4 employees. For this estimate, half of those businesses are assumed to have no employees subject to workers' compensation. 1,347,245– (964,862/2) = 864,814. http://www.labormarketinfo.edd.ca.gov/?pageid=138

ii. US Department of Commerce, Bureau of Economic Analysis, http://www.bea.gov/regional/gsp/, accessed June 2, 2009.

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, 2000-2009," June 3, 2010, 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.

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 Filings and 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
- Division of Labor Standards Enforcement (DLSE)
- Anti-Fraud Efforts

WCAB WORKLOAD

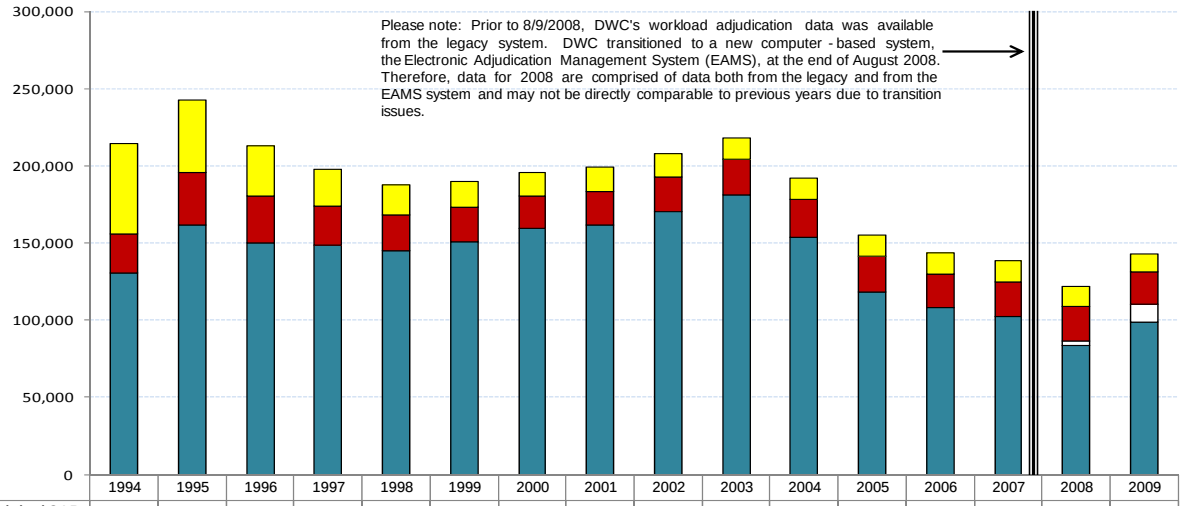
Division of Workers' Compensation Opening Documents

Three types of documents open a Workers' Compensation Appeals Board (WCAB) case. The graph on the next page 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).

Prior to August, 2008, Division of Workers' Compensation (DWC) workload adjudication data were available from the legacy system. At the end of August 2008, DWC transitioned to a new computer-based system, the Electronic Adjudication Management System (EAMS). 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.[21]

As the following graph shows, the total number of Opening Documents increased from 1994 to 1995, and then declined overall during the second part of 1990s, with a slight increase from 1998 to 1999. This increase from 1998 to 1999 continued over five years up to 2003. From 2003 to 2009, there was an overall decrease of 34 percent in the total number of Opening Documents.



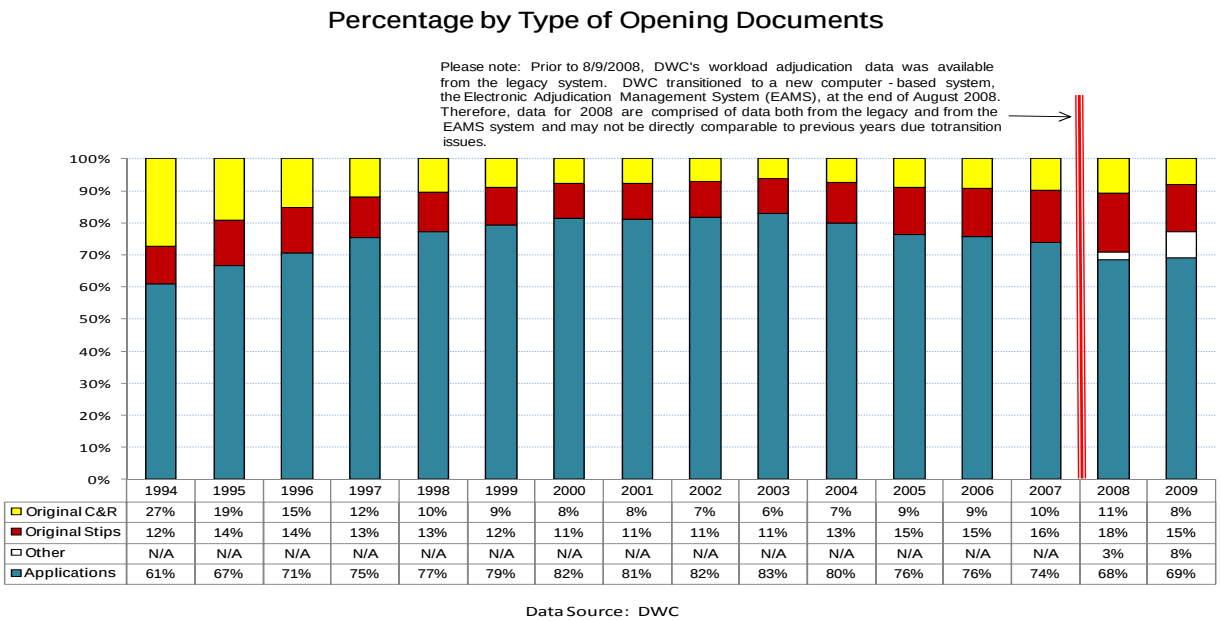
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Original C&R	58,191	46,777	32,223	23,344	19,526	16,809	14,884	15,374	14,729	13,665	14,115	13,868	13,156	13,602	13,297	11,705
Original Stips	25,650	34,056	30,143	25,467	23,578	22,394	21,288	22,052	22,972	23,600	24,281	23,015	21,723	22,513	22,246	20,767
Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3,136	11,558
Applications	130,217	161,724	150,344	148,787	144,855	150,612	159,467	161,469	169,996	180,782	153,625	118,524	108,313	102,498	83,528	99,012
Total	214,058	242,557	212,710	197,598	187,959	189,815	195,369	198,895	207,697	218,047	192,021	155,407	143,192	138,613	122,207	143,042

Data Source: DWC

Mix of DWC Opening Documents

As the graph on the next page shows, 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 1994 through 2003 and declining slightly from 2003 to 2007**.** The proportion of Original (case-opening) Stips averaged 12 percent from 1994 to 2003 and then increased from 2003 to 2007. The proportion of original C&Rs declined from 1994 to 2003 and then increased from 2003 to 2007.

[21] Analysis of trends for WCAB workload data include 2009 EAMS calendar year data only for aggregate numbers, but the same analysis for categories within major types of WCAB workload use only legacy data available through 2007. Analysis of trends using both EAMS and legacy data within major types of WCAB workload through 2009 was not possible due to several reasons, including the introduction of new categories in EAMS and the redefinition of previously existing categories.



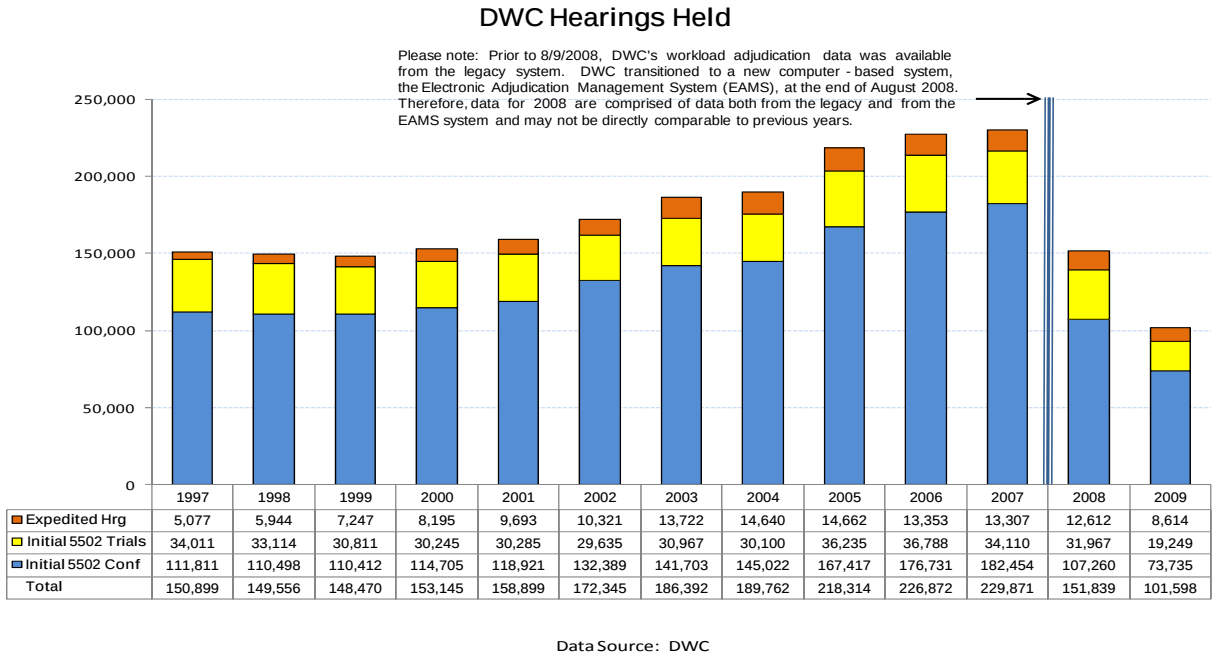
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Original C&R	27%	19%	15%	12%	10%	9%	8%	8%	7%	6%	7%	9%	9%	10%	11%	8%
Original Stips	12%	14%	14%	13%	13%	12%	11%	11%	11%	11%	13%	15%	15%	16%	18%	15%
Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3%	8%
Applications	61%	67%	71%	75%	77%	79%	82%	81%	82%	83%	80%	76%	76%	74%	68%	69%

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 2009. The total number of hearings held increased by 52 percent from 1997 to 2007 and then decreased by 56 percent from 2007 to 2009.

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.



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Expedited Hrg	5,077	5,944	7,247	8,195	9,693	10,321	13,722	14,640	14,662	13,353	13,307	12,612	8,614
Initial 5502 Trials	34,011	33,114	30,811	30,245	30,285	29,635	30,967	30,100	36,235	36,788	34,110	31,967	19,249
Initial 5502 Conf	111,811	110,498	110,412	114,705	118,921	132,389	141,703	145,022	167,417	176,731	182,454	107,260	73,735
Total	150,899	149,556	148,470	153,145	158,899	172,345	186,392	189,762	218,314	226,872	229,871	151,839	101,598

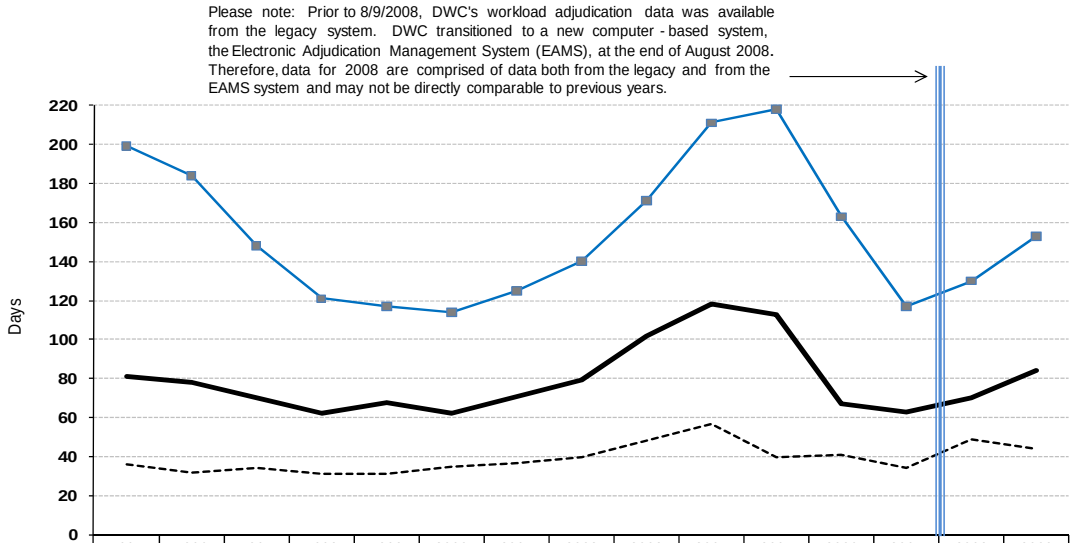
Timeliness of Hearings

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, and the average time for expedited hearings decreased by 15 percent.

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



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
First 5502 Conference	81	78	70	62	68	62	71	79	102	118	113	67	63	70	84
First 5502 Trial	199	184	148	121	117	114	125	140	171	211	218	163	117	130	153
Expedited Hearing	36	32	34	31	31	35	37	40	48	57	40	41	34	49	44

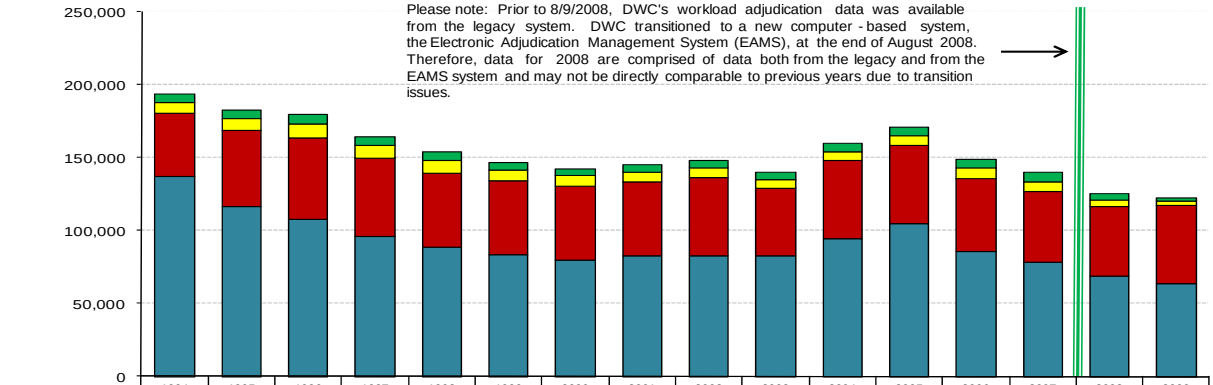
Source: DWC

Division of Workers' Compensation Decisions

DWC Case-Closing Decisions

As the chart on the next page shows, the number of decisions made by DWC that are considered to be case-closing declined overall during the second part of 1990s, increased slightly from 2000 to 2002, decreased in 2003, and then increased again between 2003 and 2005**.** In 2009, the total number of case-closing decisions decreased by 28 percent from its 2005 level.

DWC Case-Closing Decisions



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
F & O	5,877	6,043	6,780	6,261	6,021	5,205	4,606	4,470	4,866	4,677	5,221	5,873	5,883	6,331	4,666	2,499
F & A	7,560	7,890	9,450	8,656	8,290	7,487	7,313	6,786	6,996	5,910	5,989	6,634	7,265	6,865	4,475	3,124
Stipulation	43,318	52,537	56,368	53,863	51,074	50,371	50,223	51,113	53,640	46,248	54,216	53,889	49,748	48,469	48,140	53,721
C & R	137,162	116,485	107,407	95,760	88,501	83,512	80,039	82,506	82,433	83,060	94,153	104,829	85,641	78,120	68,444	63,298
Total Case Closing	193,917	182,955	180,005	164,540	153,886	146,575	142,181	144,875	147,935	139,895	159,579	171,225	148,537	139,785	125,726	122,642

Data Source: DWC

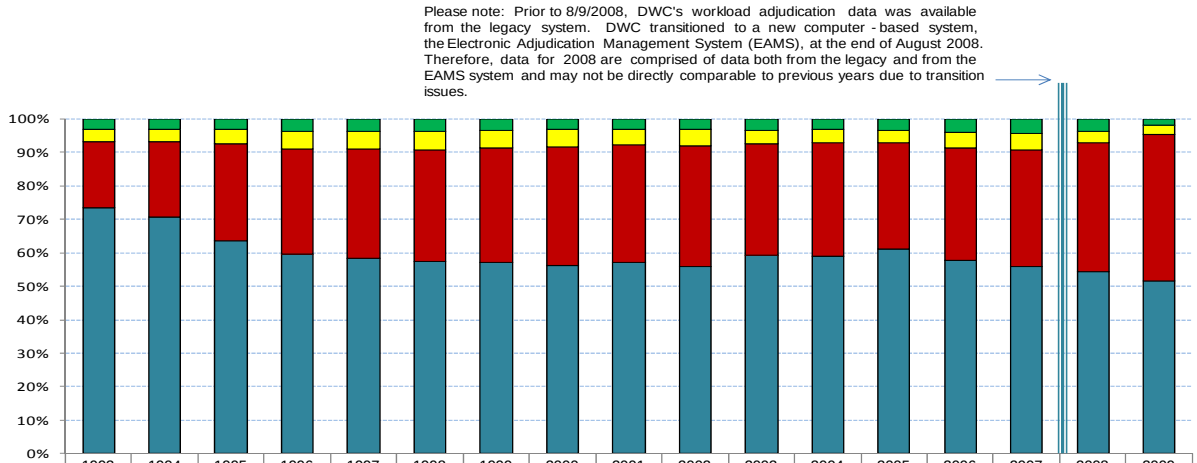
Mix of DWC Decisions

As shown on the previous charts and the chart below, 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 2007, there was an overall increase in proportion of Stips and overall decrease in proportion of C&Rs. 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: Percent Distribution by Type of Decisions



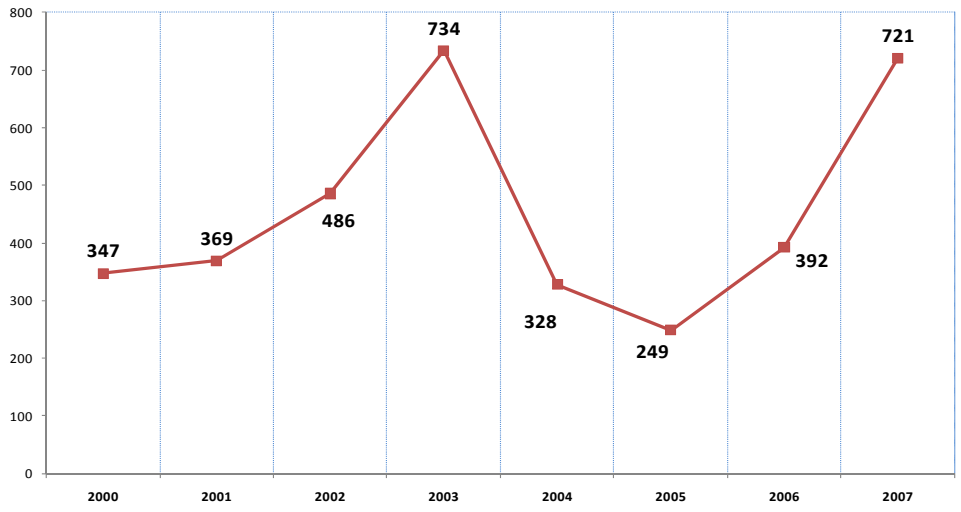
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
F & O	3.0%	3.0%	3.3%	3.8%	3.8%	3.9%	3.6%	3.2%	3.1%	3.3%	3.3%	3.3%	3.4%	4.0%	4.5%	3.7%	2.0%
F & A	3.9%	3.9%	4.3%	5.2%	5.3%	5.4%	5.1%	5.1%	4.7%	4.7%	4.2%	3.8%	3.9%	4.9%	4.9%	3.6%	2.5%
Stips	19.6%	22.3%	28.7%	31.3%	32.7%	33.2%	34.4%	35.3%	35.3%	36.3%	33.1%	34.0%	31.5%	33.5%	34.7%	38.3%	43.8%
C & R	73.5%	70.7%	63.7%	59.7%	58.2%	57.5%	57.0%	56.3%	56.9%	55.7%	59.4%	59.0%	61.2%	57.7%	55.9%	54.4%	51.6%

Data Source: DWC

Division of Workers' Compensation Lien Filings and Decisions

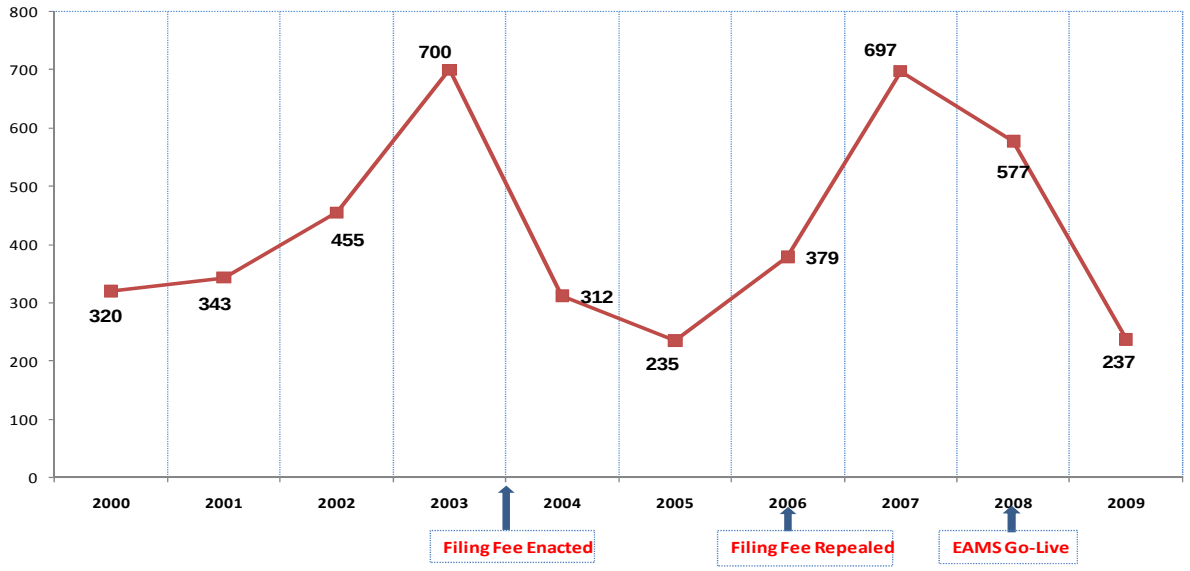
As shown in two charts below, the number of liens has increased by more than 110 percent between 2000 and 2003, decreased by 66 percent between 2003 and 2005, increased by more than 190 percent between 2005 and 2007, and decreased by 66 percent from 2007 to 2009.

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



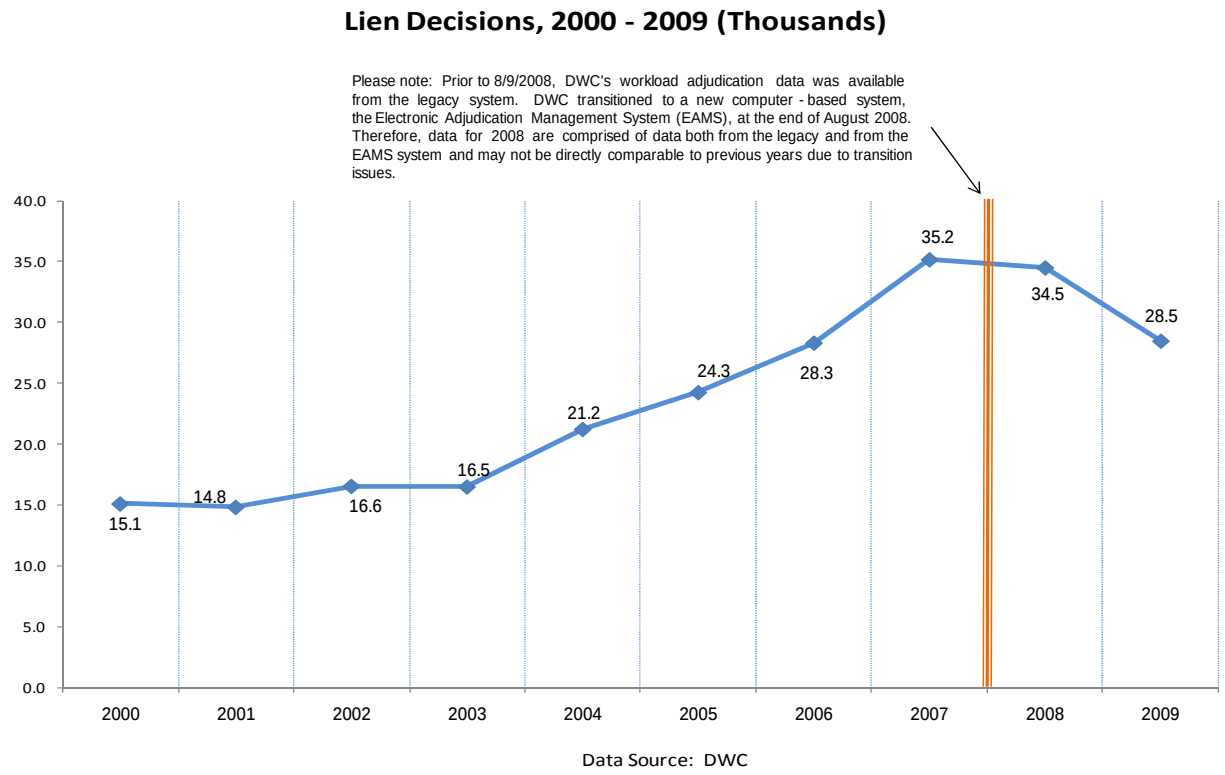
Data Source: DIR

Number of Liens Filed, 2000 - 2009 (Thousands)
EAMS*



* Please Note that data from Electronic Adjudication Management System (EAMS) do 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.



See "Report on Liens" (CHSWC, 2011) for a complete description**.**

VOCATIONAL REHABILITATION/SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

Assembly Bill (AB) 227 enacted in 2003, in combination with clean-up language in Senate Bill (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 are calendar year 2009 data for the vocational rehabilitation/SJDB program:

Closures by types and totals for January, 2009:

- Employee completed plan and returned to work = 1,129
- Employee completed plan and not working = 1,789
- Employee settled prospective vocational rehabilitation = 1,213

The Retraining & Return to Work Unit issued 9,794 determinations for calendar year 2009.

Open cases as of January 1, 2009 = 10,890, 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 regular, modified or alternative work position (post-2004 date of injury) for calendar year 2009 total = 15,547.

SJDB disputes for calendar year 2009 = 320.

Return to Work Unit also conducts educational workshops for employers, insurers, health care providers, employees and labor unions as well as partner with other agencies interested in promoting return to work and stay at work policies.

DIVISION OF WORKERS' COMPENSATION AUDIT AND ENFORCEMENT PROGRAM

Background

The 1989 California workers' compensation reform legislation established an audit function within the Division of Workers' Compensation (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 the Workers' Compensation Appeals Board (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 2009. 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

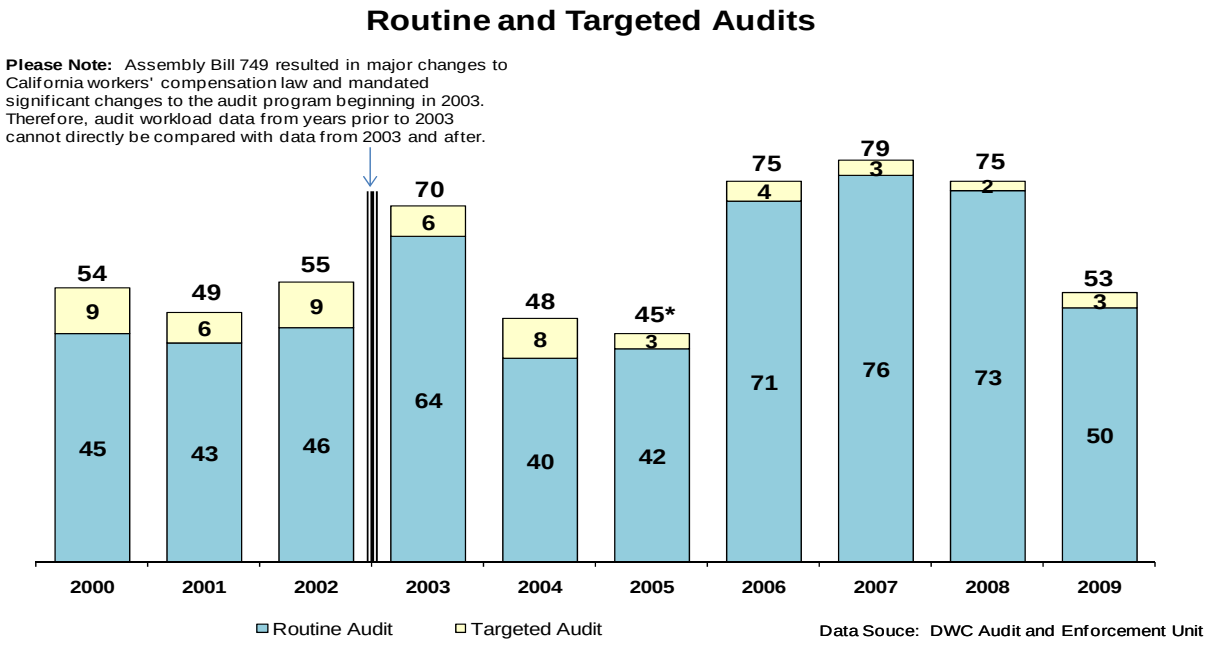
Audit subjects, including insurers, self-insured employers and third-party administrators, are selected randomly for routine audits.

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

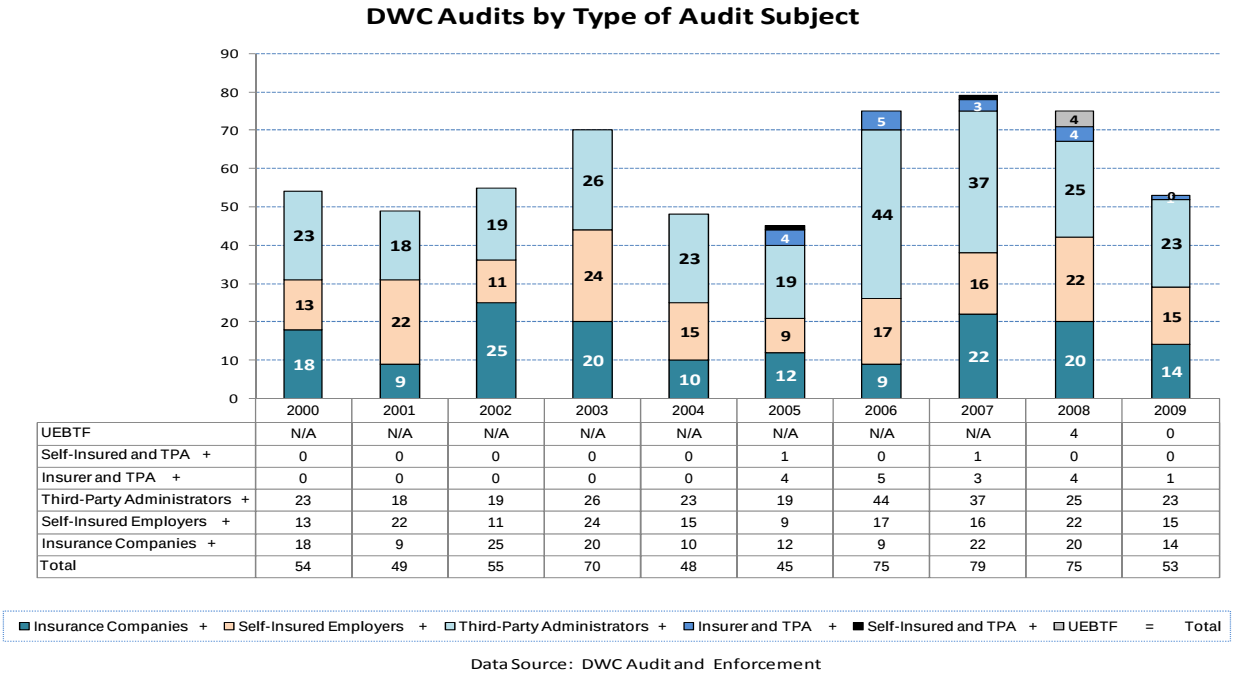
The following chart shows the number of routine audits and targeted audits and the total number of audits conducted each year.



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



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
UEBTF	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4	0
Self-Insured and TPA +	0	0	0	0	0	1	0	1	0	0
Insurer and TPA +	0	0	0	0	0	4	5	3	4	1
Third-Party Administrators +	23	18	19	26	23	19	44	37	25	23
Self-Insured Employers +	13	22	11	24	15	9	17	16	22	15
Insurance Companies +	18	9	25	20	10	12	9	22	20	14
Total	54	49	55	70	48	45	75	79	75	53

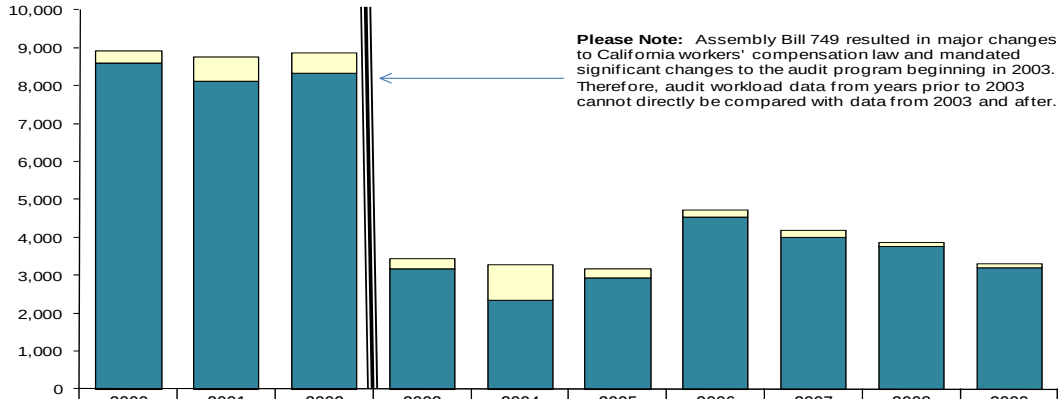
Selection of Files to be Audited

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



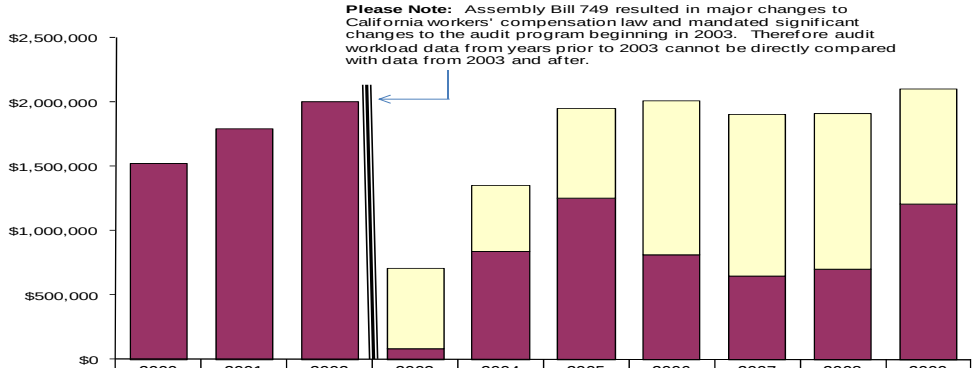
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Target	321	644	532	262	939	228	180	191	118	96
Random	8,600	8,105	8,329	3,163	2,337	2,940	4,538	4,004	3,755	3,208
Total Files Audited	8,921	8,749	8,861	3,425	3,276	3,168	4,718	4,195	3,873	3,304

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.

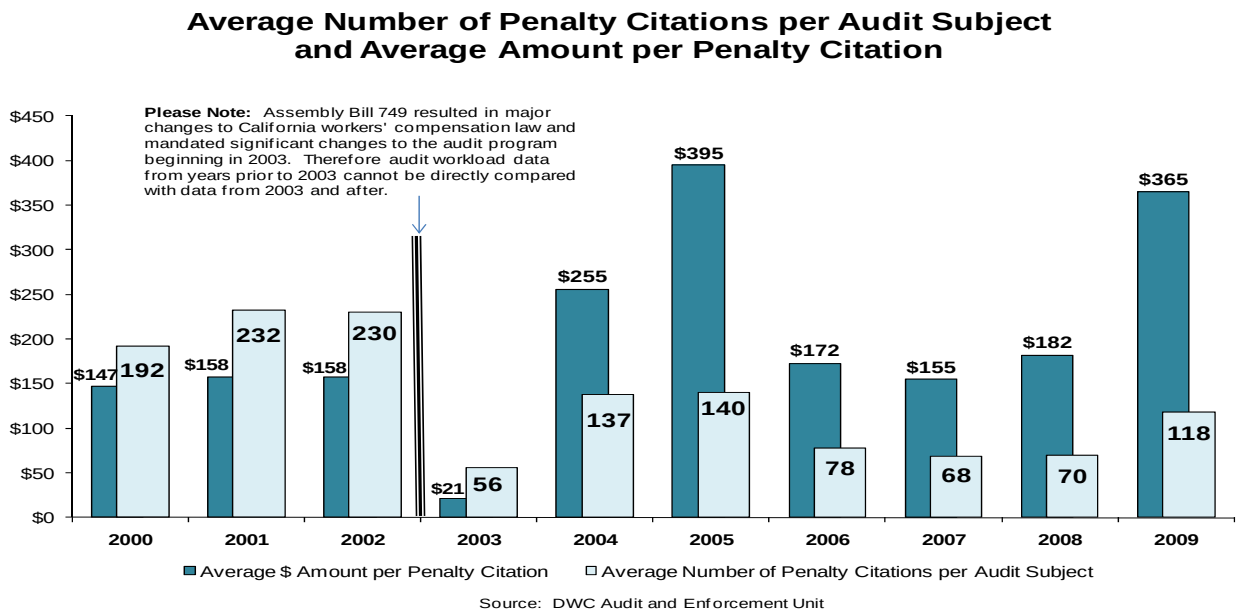
DWC Audit Unit - Administrative Penalties



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Assessable penalties waived per LC§129.5(c) and regulatory authority	N/A	N/A	N/A	$624,835	$518,605	$696,125	$1,200,80	$1,254,32	$1,210,17	$897,890
Total penalties Assessed	$1,524,47	$1,793,06	$2,004,89	$81,645	$835,988	$1,252,15	$811,146	$649,840	$703,295	$1,206,34

Source: DWC Audit and Enforcement Unit

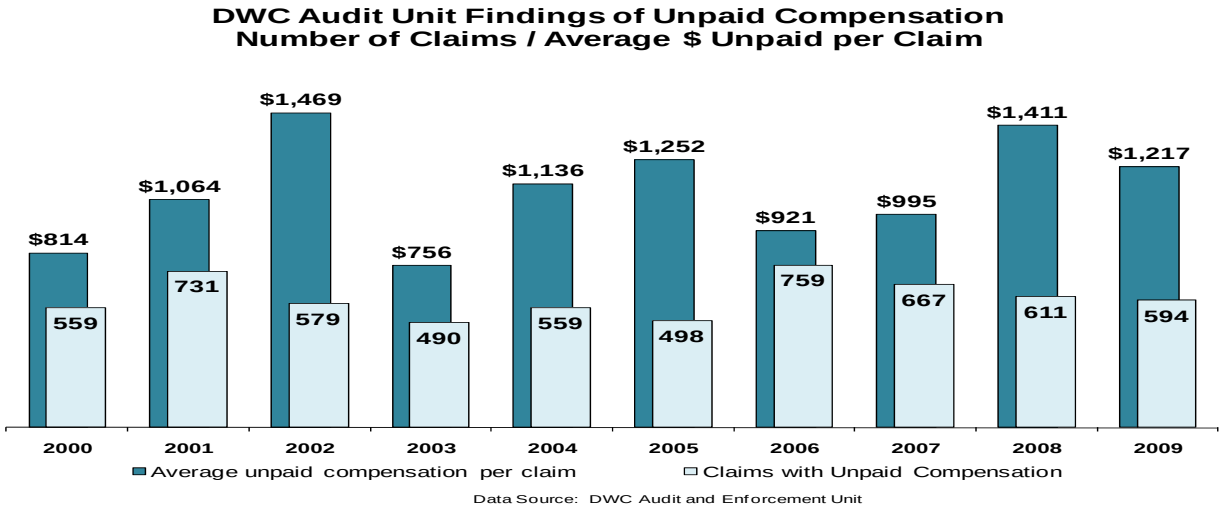
The following chart shows the average number of penalty citations per audit subject each year and the average dollar amount per penalty citation.



Unpaid Compensation Due To Claimants

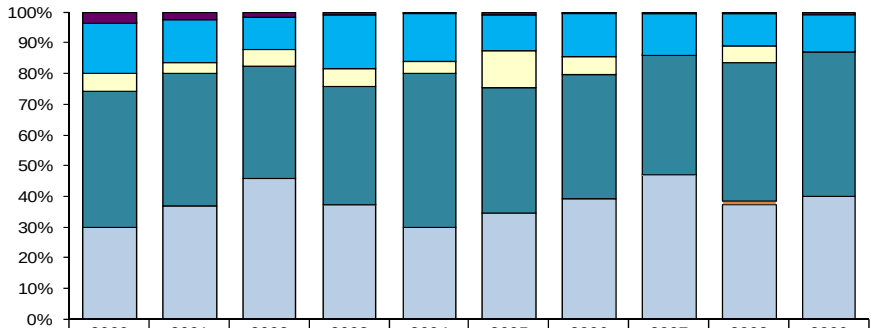
Audits identify claim files in which injured workers were owed unpaid compensation. The administrator is required to pay these employees within 15 days after receipt of a notice advising the administrator of the amount due, unless a written request for a conference is filed within 7 days of receipt of 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



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Interest and penalty and/or unreimbursed medical expenses	3.5%	2.5%	1.6%	0.8%	0.2%	0.8%	0.3%	0.4%	0.4%	0.8%
Self-imposed increases for late indemnity payments	16.5%	13.9%	10.7%	17.6%	16.0%	11.6%	14.2%	13.7%	10.6%	12.2%
Voc. Rehab Maintenance Allowance	5.9%	3.7%	5.2%	6.0%	3.8%	12.1%	5.9%	0.1%	5.3%	0.1%
Permanent Disability	44.5%	42.9%	36.6%	38.4%	50.0%	40.9%	40.3%	38.8%	45.4%	46.9%
Death Benefits	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.9%	0.0%
TD & salary continuation in lieu of TD	29.7%	36.9%	45.8%	37.1%	30.0%	34.5%	39.3%	46.7%	37.3%	40.0%

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

CHSWC "Report on the Division of Workers' Compensation Audit Function" (1998) http://www.dir.ca.gov/CHSWC/FinalAuditReport.html

DISABILITY EVALUATION UNIT

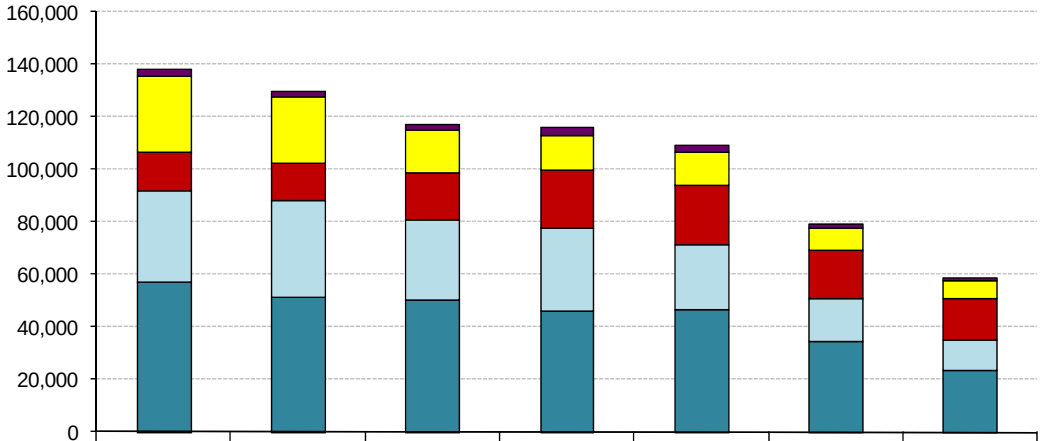
The DWC Disability Evaluation Unit (DEU) determines permanent disability (PD) ratings by assessing physical and mental impairments in accordance with the Permanent Disability Rating Schedule (PDRS). The ratings are used by workers' compensation judges, injured workers, and insurance claims administrators 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 two charts depict DEU's workload. The first chart shows the written ratings produced each year by type between 2003 and 2009. The second chart illustrates the total number of written and oral ratings between 2003 and 2007. From 2008, statistics on Oral Ratings are not maintained.

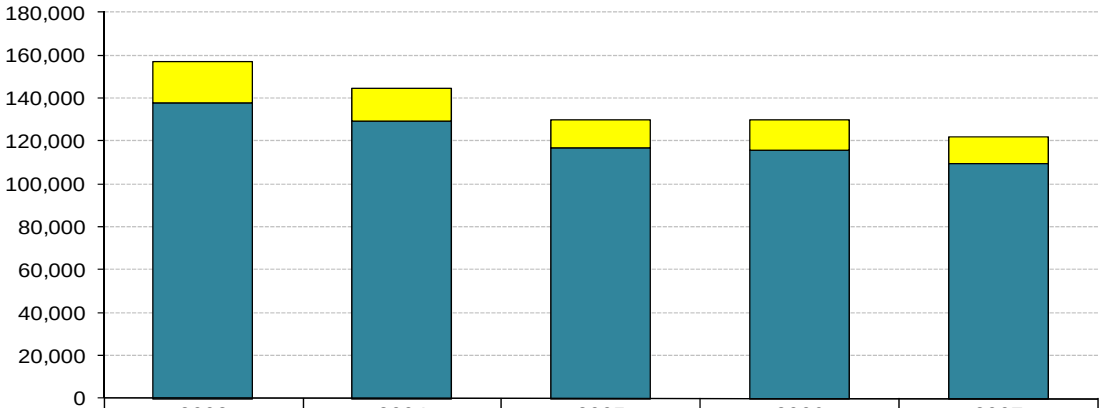
DEU Written Ratings 2003-2009



	2003	2004	2005	2006	2007	2008	2009
Formal Ratings	2,386	1,995	2,299	2,874	2,786	1,584	942
Summary - Treating Doctor	29,198	25,385	15,922	13,422	12,361	8,440	6,610
Summary - Panel QME	14,753	14,147	18,001	22,139	23,142	18,027	16,243
Consultative - Walk-In	34,369	36,563	30,553	31,181	24,528	16,383	11,065
Consultative - Other	57,367	51,442	50,275	46,210	46,530	34,607	23,682
Total Written Ratings	138,073	129,532	117,050	115,826	109,347	79,041	58,542

Data Source: DWC Disability Evaluation Unit

DEU Oral* and Written Ratings by Type 2003-2007



	2003	2004	2005	2006	2007
Oral Ratings	18,856	15,283	12,591	14,273	12,662
Written Ratings	138,073	129,532	117,050	115,826	109,347
Total Ratings	156,929	144,815	129,641	130,099	122,009

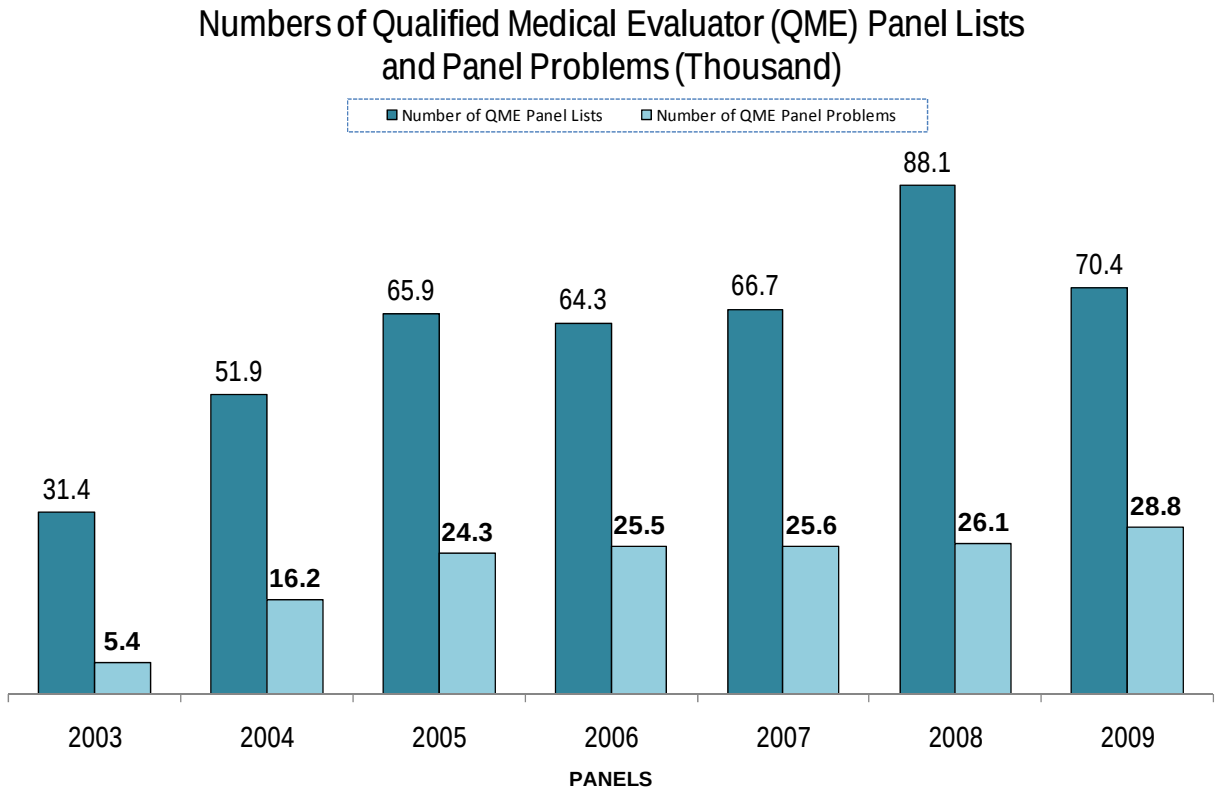
* From 2008, statistics on Oral Ratings are not mantained.

Source: DWC Disability Evaluation Unit

QUALIFIED MEDICAL EVALUATOR PANELS

DWC assigns panels composed of three Qualified Medical Evaluators (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 QME Panel Lists issued each year and 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.



Data Source: DWC

MEDICAL PROVIDER NETWORKS AND HEALTH CARE ORGANIZATIONS[22]

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,[23] 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 Senate Bill (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 the Division of Workers' Compensation (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.

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[22] The information in this section was provided by the DWC Medical Unit, with minor edits by CHSWC staff.

[23] Based on the WCIRB annual report *California Workers' Compensation Losses and Expenses* prepared pursuant to § 11759.1 of the California Insurance Code.

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 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

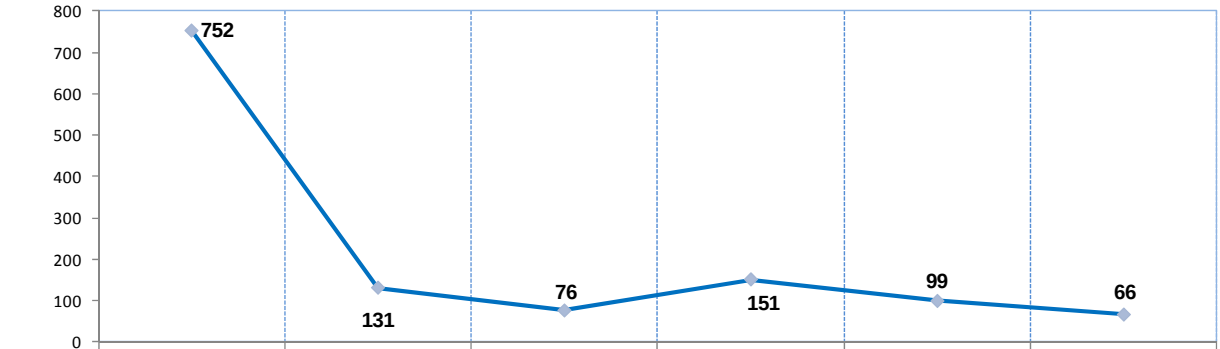
The Table below provides a summary of MPN program activities from the inception of the MPN program in November 1, 2004, to June 30, 2010. During this time, the MPN program received 1,660 MPN applications. Of these, 22 were ineligible as they were erroneously submitted by insured employers who under the MPN regulations are not eligible to set up an MPN. As of June 30, 2010, 1,519 applications were approved. Of these, 986 were approved under the emergency regulations and the remaining 533 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 twenty six (126) were withdrawn after approval and forty-six (46) 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. Thirty two (32) were terminated after approval. The reason for the termination was that the applicants decided to stop using the MPN.

Table: MPN Program Activities from November 1, 2004, to June 30, 2010

MPN Applications	Numbers
Received	1660
Approved	1519
Material Modifications	1954
Withdrawn	172
Revoked	17
Ineligible	22
Terminated	32

The chart below shows the time of receipt of MPN applications by month and year. The bulk of applications, 45.3 percent (752), were received in 2005. About 7.9 percent (131) were received in 2006, 4.6 percent (76) were received in 2007, 9.1 percent (151) were received in 2008, and 6.0 percent (99) were received in 2009.

Number of MPN Applications Received
by Month and Year of Receipt (Total = 1,660)

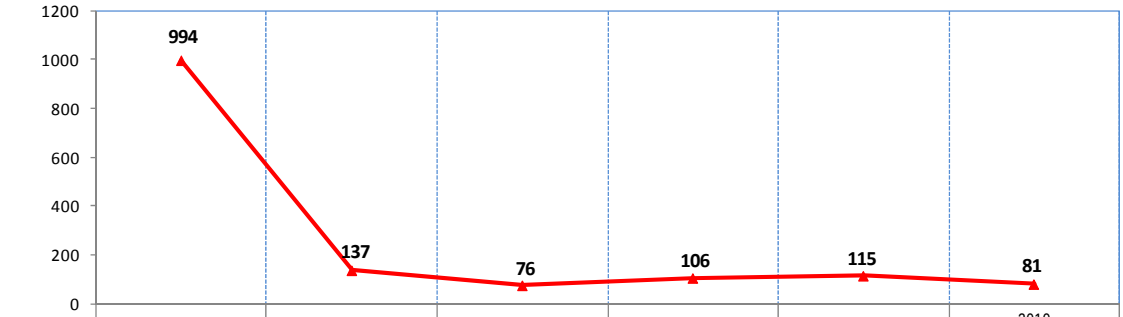


	2005	2006	2007	2008	2009	2010 (JAN-JUN)
JANUARY	175	28	3	15	11	4
FEBRUARY	168	14	6	9	12	7
MARCH	74	12	8	10	12	12
APRIL	95	9	5	10	9	10
MAY	64	18	4	4	7	13
JUNE	71	5	5	4	9	20
JULY	35	4	14	15	6	
AUGUST	12	7	5	6	1	
SEPTEMBER	20	18	3	18	8	
OCTOBER	13	5	7	33	2	
NOVEMBER	13	10	4	17	10	
DECEMBER	12	1	12	10	12	
TOTAL	752	131	76	151	99	66

Data Source: DWC

The chart below shows that 65.9 percent (994) of MPN applications were approved in 2005, while only 9.0 percent (137) were approved in 2006, 5.0 percent (76) were approved in 2007, 7.0 percent (106) were approved in 2008, and 7.6 percent (115) were approved in 2009.

Number of MPN Applications Approved by Month and Year(Total = 1,509)



	2005	2006	2007	2008	2009	2010 (JAN-JUN)
JANUARY	29	10	6	6	15	10
FEBRUARY	138	6	8	2	11	14
MARCH	288	18	11	10	10	9
APRIL	121	20	4	5	10	14
MAY	129	27	5	8	36	9
JUNE	71	10	6	17	9	25
JULY	89	9	7	9	5	
AUGUST	76	8	6	9	9	
SEPTEMBER	36	14	6	6	5	
OCTOBER	8	3	3	6	3	
NOVEMBER	0	2	10	14	0	
DECEMBER	9	10	4	14	2	
TOTAL	994	137	76	106	115	81

Data Source: DWC

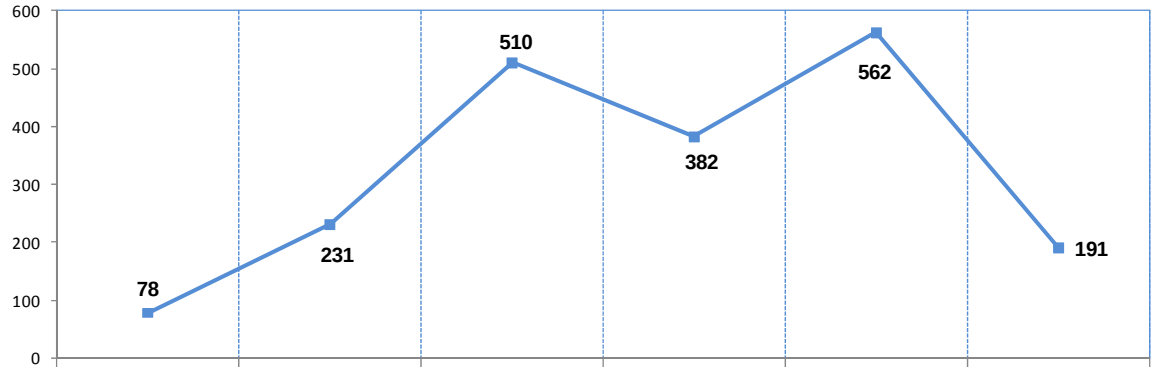
Material Modifications

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 June 30, 2010, 808 applicants have filed 1,954 material modifications with DWC. Some applicants have filed more than one material modification. Three hundred and sixty-two (362) applicants have filed two material modification filings and 296 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, 562 in 2009, and 191 from January through June 2010.

Number of MPN Material Modifications Received
by Month and Year (Total = 1,954)



	2005	2006	2007	2008	2009	2010 (JAN-JUN)
JANUARY		21	20	44	32	25
FEBRUARY	1	12	62	18	49	41
MARCH		13	12	41	52	21
APRIL	1	2	18	14	66	48
MAY		6	74	15	26	33
JUNE	7	9	72	13	40	23
JULY	2	5	40	35	47	
AUGUST	26	13	62	2	19	
SEPTEMBER	9	60	33	68	41	
OCTOBER	10	22	42	68	55	
NOVEMBER	11	44	22	55	60	
DECEMBER	11	24	53	9	75	
TOTAL	78	231	510	382	562	191

Data Source: DWC

MPN Applicants

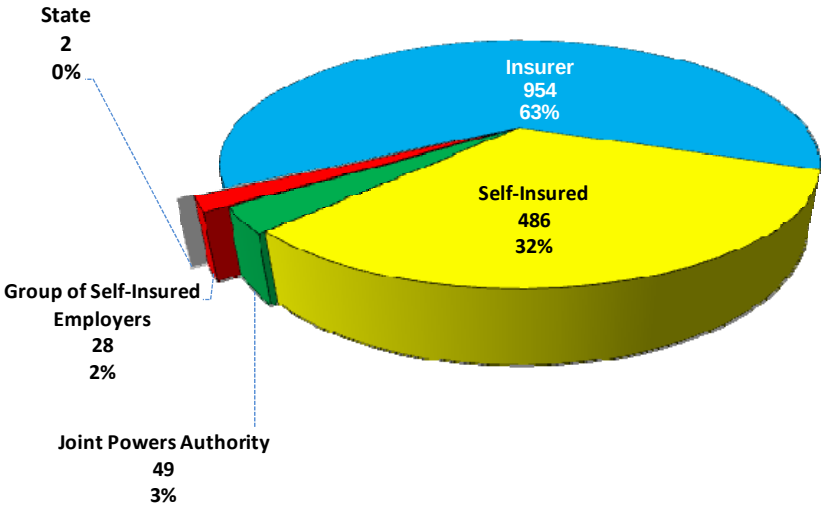
The table below shows the numbers of MPN applicants by type of applicant. The majority, 63 percent, of MPN applications were filed by insurers, followed by self-insured employers (32 percent) for the whole period from 2004 to 2010.

Table: Distribution of Approved MPN Applications by Type of Applicant (Total for all years = 1,519)

Type of Applicant	2004	2005	2006	2007	2008	2009	2010
Insurer	7	611	68	32	79	91	66
Self-Insured	3	346	55	37	22	16	7
Joint Powers Authority		33	4	4	3	2	3
Group of Self-Insured Employers		2	10	3	2	6	5
State		2					
Total	10	994	137	76	106	115	81

The chart below shows the distribution of MPN applicants by type.

Distribution of All Approved MPN Applications by Type of Applicant from 2004 to 2010 (Total = 1,519)



Data Source: DWC

HCO Networks

HCO networks are used by 664 (40.0 percent) of the approved MPNs. The distribution of MPNs by HCO is shown in the Table below. First Health HCO has 25.8 percent of the MPN market share followed by Corvel HCO, which has 7.4 percent, and Medex, which has 2.7 percent. There seems to be a decrease in the use of HCO networks for MPNs.

Table: Number of MPN Applicants Using HCO Networks

Name of HCO	Number	% Applications Received	% Applications Approved
CompAmerica (First Health)	429	25.8%	28.2%
Corvel	123	7.4%	8.1%
Medex	44	2.7%	2.9%
CompPartners	5	0.3%	0.3%
Net-Work	2	0.1%	0.1%
Intracorp	1	0.1%	0.1%
Promesa	1	0.1%	0.1%
Astrasano	3	0.2%	0.2%
Prudent Buyer (Blue Cross)	56	3.4%	3.7%
Total Using HCO	**664**	**40.0%**	**43.7%**

MPN applicants are allowed to have more than one MPN. As a result, 65.4 percent of applicants have more than one MPN, including 21.7 percent with 18 to 49 MPNs. (See Table, Distribution of Approved Applicants by Number of MPNs per Applicant, below.) The names of MPN applicants with 10 or more approved MPNs are shown in the Table (Names of MPN Applicants with 10 or More Approved MPNs) on the next page, ACE American Insurance Company leads with 49 MPNs followed by Zurich American Insurance Company with 36 MPNs, and American Home Assurance Company with 35 MPNs.

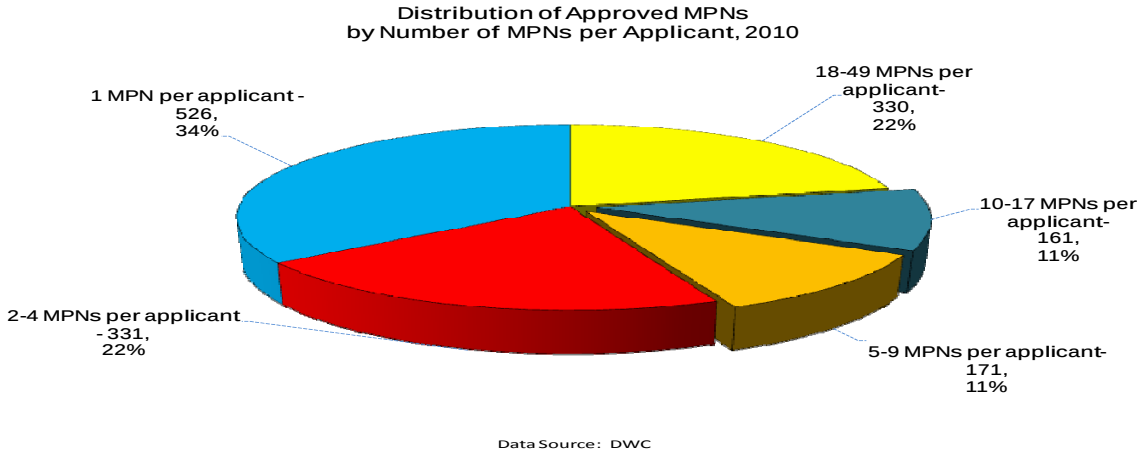


Table: Names of MPN Applicants with 10 or More Approved MPNs

Name of Applicant	Number of MPNs
ACE American Insurance Company	49
Zurich American Insurance Company	36
American Home Assurance Company	35
The Insurance Company of the State of Pennsylvania	29
Fidelity & Guaranty Insurance Company	28
National Union Fire Insurance Company of Pittsburgh, PA	26
Discover Property & Casualty Insurance Company	23
United States Fidelity and Guaranty Company	23
Fidelity & Guaranty Insurance Underwriters, Inc	22
Old Republic Insurance Company	22
New Hampshire Insurance Company	19
ARCH Insurance Company	18
Safety National Casualty Corporation	17
Commerce and Industry Insurance Company	17
American Zurich Insurance Company	16
XL Specialty Insurance Company	15
Hartford Insurance Company of the Midwest	15
Granite State Insurance Company	14
Chartis Property Casualty Company	14
Landmark Insurance Company	11
Continental Casualty Company (CNA)	11
American Guarantee & Liability Insurance Company	11
Hartford Accident & Indemnity Company	10
Greenwich Insurance Company	10

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 79.2 percent (1038) of approved MPN applicants. The total estimated number of covered employees, as reported by these MPN applicants, is 37,846,849. 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 5,000 is shown below. This list includes some large self-insured companies such as Albertsons, AT&T, Intel, Safeway, Home Depot, Target Corporation, Raley's, and Lowe's.

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 233 complaints. DWC has contacted the liaison of the MPNs and resolved and closed 210 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 233 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, June 2010

Name of Applicant	Name of MPN	Number of Covered employees
Regents of The University of California	Regents of The University of California MPN	189,925
Los Angeles Unified School District	Sedgwick CMS Extended Medical Provider Network	138,000
County of Los Angeles	CorVel HCO	94,000
California Farm Management-Self-Insured Group	WellComp Medical Provider Netowrk	81,351
Target Corporation	Target Medical Provider Network	75,300
California State Association of Counties - Excess Insurance Authority	EIA Medical Provider Network	74,882
Safeway, Inc.	Safeway Select MPN	60,000
Kelly Services, Inc	Kelly Services Medical Provider Network	58,500
San Diego/Imperial County Schools Joint Power Authority	Interplan through CompPartners	54,000
The Home Depot	The Home Depot Medical Provider Network	51,062
Target Corporation	Sedgwick CMS/Harbor Net-Target	50,000
San Diego County Schools JPACorVel	San Diego County Schools JPA MPN	42,000
K-Mart Corporation	Sedgwick CMS / Harbor Net - SHG	40,000
Macy's Inc.	Macy's Inc. Medical Provider Network	32,575
Self-Insured Schools of California	Self-Insured Schools of California/California Foundation for Medical Care Network	31,811
Pacific Bell Telephone Company	Sedgwick CMS Extended Medical Provider Network	31,500
Costco Wholesale	Costco MPN	31,000
Kaiser Foundation Hospitals, a California Corporation	Kaiser Permanente MPN	29,880
Auto Dealers Compensation of California, Inc.	Auto Dealers Compensation of California, Inc. Medical Provider Network	28,012
New Albertsons, Inc.(A SuperValu Company)	New Albertson's Inc. CA MPN	27,000
University of Southern California USC	Harbor MPN	26,634
Southern California Permanente Medical Group	Kaiser Permanente MPN	26,353
Kimco Staffing Services, Inc.	First Health CompAmerica Primary Network	26,000
Mainstay Business Solutions	WellComp Medical Provider Network	22,500
County of Orange	WellComp Medical Provider Network	22,000
County of Orange	Cambridge Orange County MPN	21,500
County of Orange	Intracorp	21,400
Pacific Gas and Electric Company	PG&E /Blue Cross Medical Provider Network	21,000
San Diego Unified School District	WellComp Medical Provider Network	20,762

Name of Applicant	Name of MPN	Number of Covered employees
Marriott International, Inc.	Marriott's Medical Provider Network	20,511
Manpower Inc.	Concentra MPN	20,320
Santa Clara County Schools Insurance Groups	PRIME Plus Medical Network	20,198
The County of Riverside	First Health Comp America Select	20,173
Walt Disney World Co (The Disneyland Resort Division)	Disneyland Resort Medical Provider Network	20,000
Sun Microsystems, Inc. (Sun)	First Health Network	20,000
City and County of San Francisco	City and County of San Francisco Medical Provider Network	20,000
California Farm Management Self-Insured Group	N/A	20,000
San Diego Unified School District	TRISTAR - CompAmerica Primary HCO	20,000
Schools Insurance Group	SIG MPN	19,600
Ventura County Schools Self-Funding Authority	WellComp Medical Provider Network	19,566
Manpower, Inc.	Sedgwick CMS MPN	19,000
Securitas Security Services USA, Inc.	Sedgwick CMS Extended MPN	19,000
County of Riverside	CorVel MPN/County of Riverside	19,000
Viacom International Services, Inc.	First Health Comp America HCO Select Network	18,913
Healthcare Industry Self-Insured Program	CorVel/Healthcare Industry Self-Insured Program	18,500
Countrywide Financial Corporation	Countrywide Network	18,000
Nordstrom Inc.	Nordstrom Medical Provider Network	17,000
Securitas Security Services USA, Inc.	Securitas Broadspire SNP	16,890
Hewlett Packard Company	Sedgwick CMS Extended Medical Provider Network	16,500
Victory Comp, Inc.	TRISTAR Specialty MPN	16,000
COP/CPB of the Church of Jesus Christ of the Latter-day Saints	Deseret MPN	16,000
Alameda County Schools Insurance Group	ACSIG/AccessMedical Provider Network	16,000
Cornerstone Comp, Inc.	TRISTAR Specialty MPN	16,000
Guardian Comp, Inc.	TRISTAR Specialty MPN	16,000
Quality Comp, Inc.,	TRISTAR Specialty MPN	16,000
Elite Golf Club Program, Inc.	TRISTAR Specialty MPN	16,000
American Building Maintenance (ABM)	ABM Network	15,800
Southern California Edison	SCE Select	15,514
Lowe's HIW, Inc.	Lowe's CA MPN	15,136
Federal Express Corporation	Intracorp	14,878
Schools Linked For Insurance Management (SLIM)	Prime Advantage Medical Network a	14,217
County of San Bernardino	CorVel MPN	14,000
The Walt Disney Company	The Liberty Mutual Group MPN	13,924
Alliance of Schools for Cooperative Insurance Programs	WellComp Medical Provider Network	13,764

Name of Applicant	Name of MPN	Number of Covered employees
Central Region School Insurance Group	WellComp Medical Provider Network	13,679
Riverside Schools Risk Management Authority	Prime Advantage Medical Network	13,610
Raley's	Raley's Quality Medical Provider Network	13,500
Lockheed Martin Corporation	INTRACORP/Lockheed Martin MPN	13,400
Intel Corporation	Broadspire MPN	13,223
Alameda County Schools Insurance Group	PRIME Plus Medical Provider Network	13,048
Central Region Schools Insurance Group	CRSIG MPN	12,500
North Bay Schools Insurance Authority	Tri-County MPN	12,000
Barrett Business Services, Inc.	BBSI/CorVel MPN	12,000
AT&T	Sedgwick CMS Extended Medical Provider Network	11,500
California Contractors Network-Self-Insured Group	WellComp Medical Provider Netowrk	11,260
Dole Food Company, Inc.	First Health CompAmerica Select HCO Network (or "First Health Select")	10,980
Memorial Health Services	TRISTAR CompAmerica Primary HCO	10,827
County of Kern	County of Kern Medical Provider Network	10,800
Saugus Union School District	Prime Advantage Medical Network	10,707
Tulare County Schools Insurance Group Workers Compensation JPA	Prime Advantage Medical Network	10,707
Tenet Healthcare Corporation	First Health CompAmerica Primary HCO Network (or "First Health Primary")	10,642
North Valley Schools Insurance Group	Prime Advantage Medical Network	10,246
Healthcare Industry Self-Insurance Program	Medex	10,000
99¢ Only Stores	Sedgwick CMS Extend MPN	10,000
Monterey County Schools Workers' Compensation Joint Powers Authority	Monterey County Schools MPN	10,000
Foster Farms	CorVel Custom MPN	10,000
LFP, Inc. and Affiliates	CorVel MPN	10,000
Park and Recreation District Employee Compensation	PARDEC MPN	10,000
99¢ Only Stores	WellComp Medical Provider Network	9,976
Circuit City Stores, Inc.	Sedgwick CMS Extended Medical Provider	9,775
San Francisco Unified School District	First Health CompAmerica Primary HCO	9,500
United Airlines	CorVel/UAL/Kaiser MPN	9,500
Foster Poultry Farms	Foster Farms Custom CorVel MPN	9,200
Preferred Auto Dealers Self-Insurance Program	Medex	9,000

Name of Applicant	Name of MPN	Number of Covered employees
Smart & Final, Inc.	Sedgwick CMS Extended Medical Provider Network	9,000
San Mateo County Schools Insurance Group	Prime Advantage Medical Network	8,557
California Contractors Network Self-Insured Group	California Contractors Network (CCN)	8,500
California Livestock Producers, Inc. Self-Insured Group	N/A	8,500
BCI Coca-Cola Bottling Company of Los Angeles (Coca-Cola Enterprises, Inc.)	Sedgwick CMS Medical Provider Network	8,500
Alameda County	First Health CompAmerica Primary Network	8,494
Kaiser Foundation Health Plan, Inc. A California Corporation	Kaiser Permanente MPN	8,448
Shasta-Trinity Schools Insurance Group JPA	Shasta-Trinity Schools Insurance Group JPA MPN	8,000
Save Mart Supermarkets, Inc.	The Status MPN-Save Mart	8,000
Fresno County Self-Insurance Group	TRISTAR - CompAmerica Primary HCO	7,817
North Orange County Self-funded Workers' Compensation Agency	Prime Advantage Medical Network	7,571
The County of Fresno	The County of Fresno MPN	7,500
BLP Schools' Self-Insurance Authority	WellComp Medical Provider Network	7,132
Whittier Area Schools Insurance Authority	WellComp Medical Provider Network	6,850
MERGE Risk Management JPA	WellComp Medical Provider Network	6,778
San Joaquin County Schools WC Ins. Group JPA	PRIME Plus Medical Provider Network	6,768
Valley Insurance Program	WellComp Medical Provider Network	6,763
Santa Ana Unified School District	WellComp Medical Provider Network	6,677
City of Long Beach	TRISTAR CompAmerica Primary HCO	6,674
Special District Risk Management Authority	WellComp Medical Provider Network	6,500
Providence Health System	Intracorp/Providence Medical Provider Network	6,500
Los Angeles County Office of Education	Los Angeles County Office of Education - Comp Care MPN	5,857
City of Glendale	City of Glendale/Concentra	5,641
New United Motor Manufacturers, Inc.	NUMMI MPN	5,536
Northern California Cities Self-Insurance Fund	NCCSIF MPN	5,500
Orange Unified School District	WellComp Medical Provider Network	5,449
The Salvation Army	Red Shield	5,440
Oakland Unified School District	Oakland Unified School District MPN	5,217
San Mateo County	San Mateo County MPN	5,200
San Jose Unified School District	First Health CompAmerica Primary HCO	5,141
County of Monterey	Liberty Mutual Group MPN	5,046

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 $2,500 at the time of initial certification and a fee of $1,000 at the time of each three-year certification. In addition, annually, HCOs are required to pay an annual assessment of $250, $300 or $500 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.

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 were effective January 1, 2010.

Currently, the HCO program has 9 certified HCOs. The names 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

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

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 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 2010, the total enrollment figure had fallen by 73.9 percent from the 2004 number of 481,337 to 125,335. Table 2 shows the number of enrollees as of December 31 of each year 2004 through 2009 and as of June 30, 2010.

Table 2: List of HCOs by Number of Enrollees for 2004 Through June 2010

Name of HCO	Year						
	Dec-04	Dec-05	Dec-06	Dec-07	Dec-08	Dec-09	Jun-10
CompPartners	60,935	61,403	53,279	13,210	1,765	1,729	0
CorVel/ Corvel Select	100,080	20,403	3,719	3,050	3,384	1,983	0
CompAmerica Primary/ Select (First Health)	218,919	2,403	0	0	0	0	0
Intracorp	6,329	3,186	2,976	2,870	0	0	0
Kaiser	30,086	67,147	66,138	69,602	77,567	72,469	72,443
Medex/ Medex 2	62,154	66,304	46,085	69,410	69,783	33,945	35,317
Net Work HCO	1,204	0	0	0	0	0	0
Promesa	na	na	na	na	21,197	16,467	17,575
Prudent Buyer (Blue Cross)	1,390	0	0	0	0	0	0
Sierra	240	0	0	0	0	0	0
TOTAL	**481,337**	**220,846**	**172,197**	**158,142**	**173,696**	**126,593**	**125,335**

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 2009 and 2010, the HCO staff work load includes a review of seven recertification filings.

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 the 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., 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.

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 – Conducted during 2008, Released May, 2010

Labor Code Section 5307.2 of Senate Bill (SB) 228 mandates that the Administrative Director (AD) of the Division of Workers' Compensation (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.

The study "Access, Quality, and Outcomes of Health Care in the California Workers' Compensation System, 2008" was commissioned by the California Department of Industrial Relations, DWC and conducted by researchers at the University of Washington (UW) School of Public Health.

The study was based on three statewide surveys of injured workers and providers in 2008: (1) All-Injury Worker Survey, which assessed access to quality health care among the general population of injured workers; (2) the Back Disability Worker Survey, which examined the effect of access barriers on work disability among workers with back sprains/strains and at least some compensated time loss; and (3) the Provider Survey, which gathered information regarding the practice, experiences, and opinions of providers who participate in California workers' compensation system.

Findings

Findings of the study included the following:

- There have not been any significant changes from 2006 to 2008 in the level of access to quality care.

- Most injured workers were satisfied with their health care and rated their overall quality of health care good or better. Between 84 percent and 89 percent of workers reported that their main provider performed each of four occupational health best practices.

- Over half of providers indicated that their workers' compensation patient volume had decreased in the past two years, and one-third reported that they intended to decrease workers' compensation volume or quit treating workers' compensation altogether. Administrative burden, utilization review-related delays and denials, restrictiveness of treatment guidelines, and issues related to payment and reimbursement, among other factors, were found to be predictive of provider intent to decrease or stop treating workers' compensation patients.

- There were important access barriers that appeared to increase work disability and costs; almost half of injured workers reported experiencing one or more access barriers at some point during their treatment.

On a population level, the excess work disability and costs related to access barriers are substantial, on the order of millions of lost work days and hundreds of millions of dollars in direct economic costs.

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 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.

In calendar year 2009, the DWC I&A Unit:

- Handled 362,581 incoming calls and placed 37,905 outgoing calls.
- Assisted in 18,757 settlements.
- Conducted 23,757 face-to-face informal meetings with members of the public seeking advice on workers' compensation matters.
- Held 256 and attended 1,611 workshops for injured workers.
- Wrote 15,212 correspondences.

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

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.

The UEBTF is administered by the director of the Department of Industrial Relations (DIR). Claims are adjusted for the DIR director by the Special Funds Unit in 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 represented by the Office of the Director of the Legal Unit.

Funding Liabilities and Collections

UEBTF Funding Mechanisms

UEBTF 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 the UEBTF has paid benefits and is able to obtain reimbursement from responsible employers. According to Labor Code Section 62.5(e), the "total amount of the assessment is allocated between the employers in proportion to the payroll paid in the most recent year for which payroll information is available."[24]

The assessment for the insured employers is based on a percentage of the premium, while the percentage for self-insured employers is based on a percentage of indemnity paid during the most recent year. The total assessment collected for fiscal year 2008-09 was $20,572,864.

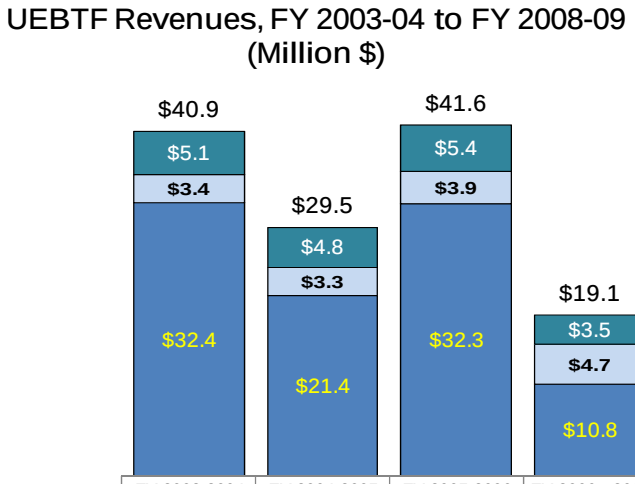
Apart from the assessments on employers required by Labor Code Section 62.5, UEBTF is funded by two other sources:

- Fines and penalties collected by DIR. These include both the Division of Labor Standards and Enforcement (DLSE) penalties as well as Labor Code Section 3701.7 penalties on self-insured employers.

- Recoveries from illegally uninsured employers per Labor Code Section 3717.

[24] Prior to the workers' compensation reforms of 2004, the funding for UEBTF came from the General Fund.

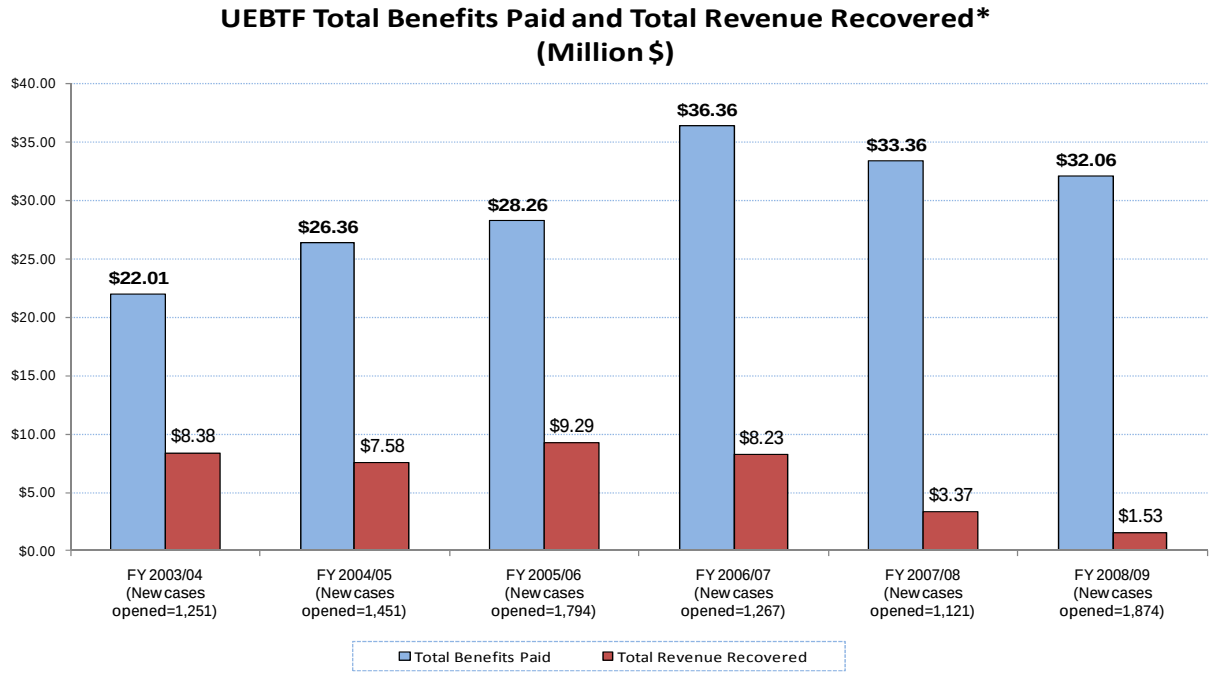
The chart below shows monies collected by the source of the revenue.[25]



	FY 2003-2004	FY 2004-2005	FY 2005-2006	FY 2006 - 2007	FY 2007 - 2008	FY 2008 - 2009
Revenue Collected Pursuant to Labor Code Section 3717	$5.1	$4.8	$5.4	$3.5	$3.4	$1.5
Fines and Penalties Collected	$3.4	$3.3	$3.9	$4.7	$5.3	$9.9
Assessments Collected Pursuant to Labor Code Section 62.5	$32.4	$21.4	$32.3	$10.8	$27.0	$20.6
Total Revenue	$40.9	$29.5	$41.6	$19.1	$35.7	$32.0

Data Source: DWC

The number of new UEBTF cases and dollar amounts associated with new opened claims for the past seven fiscal years are shown below.



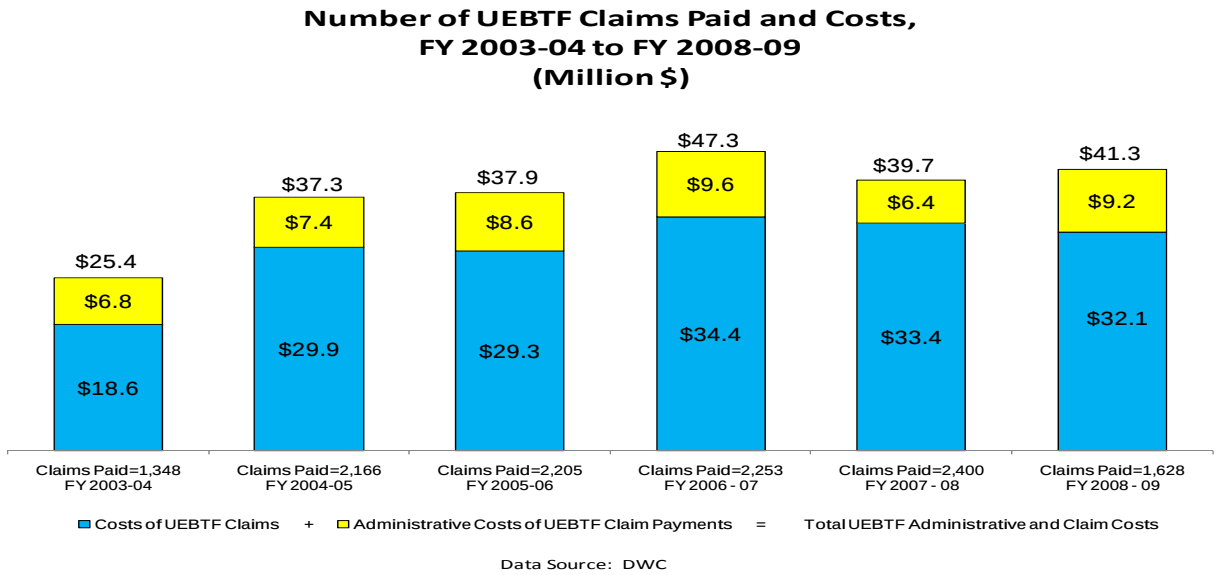
* Includes collections, DLSE penalties, and inmates without dependents

Data Source: DWC

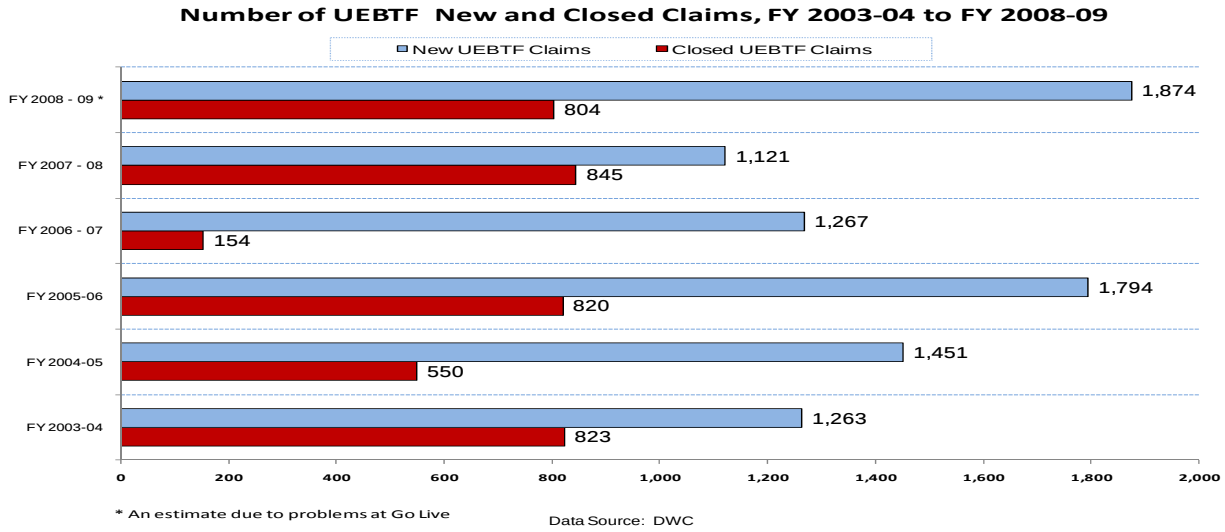
[25] The data in the chart "UEBTF Revenues" can be found at DWC/ Special Funds Unit/UEBTF website http://www.dir.ca.gov/dwc/UEF/UEF_LC3716_1.pdf.

Costs of the Uninsured Employers Benefits Trust Fund

The number of uninsured claims paid increased 78 percent from 1,348 in fiscal year 2003-04 to 2,400 in 2007-08 and decreased by 32 percent from 2007-08 to 2008-09. The cost of claims increased 85 percent from 2003-04 to 2006-07, and decreased 7 percent from 2006-07 to 2008-09. Administrative costs associated with claim payment activities have increased 41 percent from 2003-04 to 2006-07, decreased 33 percent from 2006-07 to 2007-08, and increased almost 44 percent from 2007-08 to 2008-09.

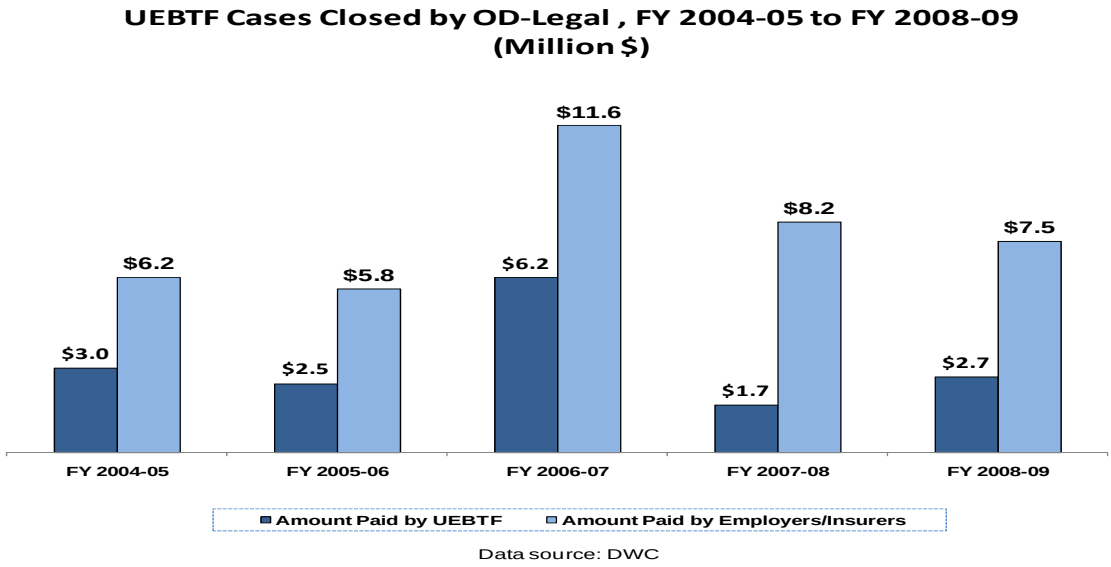


The projected UEBTF annual program cost for the most recent fiscal year 2009-10 is $41.8 million.[26] This cost includes the administrative costs associated with claims-payment activities, as well as the payout on claims filed by injured workers of illegally uninsured employers. As shown in the chart below, the number of new UEBTF claims was increasing each year from fiscal year 2003-04 to fiscal year 2005-06, then decreasing steadily from 2005-06 to 2007-08. The number of new UEBTF claims in fiscal year 2008-09 increased to almost the same level as in fiscal year 2005-06.



[26] Division of Workers' Compensation, "Report of the Uninsured Employers Benefit Trust Fund in Compliance with Labor Code Section 3716.1(c) for Fiscal Year 2008-09at http://www.dir.ca.gov/dwc/UEF/UEF_LC3716_1.pdf.

The chart below provides data on the ratio of money paid out by employers and insurers compared to that paid out by UEBTF in claims where UEBTF was joined in a WCAB case. The chart below demonstrates that in these cases, more money is paid to injured workers from employers and insurers than from UEBTF.[27]



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 data interchange (EDI) since March 2000. As of January 2010, the system had collected more than 7.6 million employers' first report of injury (FROI), subsequent reports of injury (SROI) pertaining to over 3.7 million claims, and detailed medical billing data pertaining to about 2.4 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

[27] Data provided by Office of the Director legal staff (OD-Legal) on cases closed for fiscal years 2004-05 through 2008-09.

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.

WCIS 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). The WCIRB uses WCIS data to analyze claim denials as well as to evaluate the impact of the *Ogilvie* and *Almaraz/Guzman* decisions. Other uses of WCIS data include 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. These reports are updated annually and posted to the Internet. In 2009, DWC began the regulatory process to update California's EDI Implementation Guides for both FROI, SROI reporting and for detailed medical billing data reporting.

In 2009, outside researchers at the University of California, San Diego and Boston University were provided with data extracts from WCIS. Under contract with researchers at the University of Washington, WCIS data were used as the source for the physician and injured worker samples for the Year 2 Medical Access Study, which was conducted pursuant to Labor Code section 5307.2. WCIS data were also used to produce statistics 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 study on adopting a workers' compensation physician fee schedule based on the Resource-Based Relative Value Scale (RBRVS). Under contract with CHSWC, the RAND Center for Health and Safety in the Workplace obtained a WCIS data extract in order to evaluate the effectiveness of California's Injury and Illness Prevention Program and Compliance Officers' Inspections Study.

Electronic Adjudication Management System

EAMS is an electronic records system that replaces traditional paper case files for the Workers' Compensation Appeals Board (WCAB), as well as paper records for the Disability Evaluation Unit, the Subsequent Injuries Benefits Trust Fund, and the Uninsured Employers Benefits Trust Fund.

The system has the potential to greatly improve the quality and efficiency of processes, including:

- Filing Application for Adjudication of Claim and creating new case file.
- Filing documents and entering data, unrestricted by the physical location of a paper file.
- Adding and deleting parties and representatives and updating address information.
- Accessing and routing documents and data, unrestricted by the physical location of a paper file.
- Storing and retrieving documents.
- Calendaring hearings.
- Tracking case status.
- Providing information and assistance to parties.

- Coordinating information available to the court, the rating unit, and the special funds.
- Securing the integrity of court records against alteration, damage, theft or loss.
- Preventing unauthorized access to records.

The system went live at the end of August 2008, and by 2010, all of those benefits are being realized to varying degrees. Nevertheless, significant problems persist, also to varying degrees. For example:

- Electronic filing is still limited. The primary mode of document input requires the parties to prepare paper documents which are then scanned into the electronic filing system. Certain standard form documents are read into the system by optical character recognition (OCR), while other documents are simply stored as images. More clerical input is necessary to identify the imaged documents.
- The forms prescribed for OCR are lengthier than the conventional forms that they replaced.
- The forms prescribed for OCR impose restrictions on conventional practices.
- EAMS is unable to accept some data which are required for normal business practices, even though the prescribed forms request that data (e.g., amended liens versus original liens).
- Some state offices lack the equipment and personnel required to process the volume of paper forms being received for input into EAMS, requiring workload to be shifted to other offices (which is feasible thanks to EAMS) and resulting in accumulations of backlogs.
- The completeness and accuracy of the data input may be compromised by shortcuts taken during document input.
- Accurate document filing requires that documents be properly prepared, and many users find it difficult to prepare documents adequately.

These are just a few of the problems with EAMS that have been reported anecdotally. Resistance to change is to be expected, and a learning period is also to be expected. Two years into EAMS implementation, however, it appears that deeper problems remain to be resolved. For example, the volume of lien filings fell off sharply when EAMS was inaugurated, presumably due to the difficulties of leaning new processes. Even two years later, however, the volume is still recovering. It appears likely that at least part of the problem is that the process is still too demanding for users or for the Department of Industrial Relations (DIR).

CHSWC recommends an independent evaluation of EAMS performance and implementation, followed by a plan to more fully achieve the potential benefits of electronic document management.

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 the 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 return to work (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 …

> *How to Create a Workers' Compensation Carve-out in California: Practical Advice for Unions and Employers*, CHSWC (2006).
> http://www.dir.ca.gov/CHSWC/carve-out1.pdf

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.
  - 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 overall from 1996 to 2009, with significant increases in the number of employees, work hours, and amount of payroll, excluding a 31 percent decrease in the number of participating employers from 2008 to 2009.

Table: Participation in Carve-Out Program

Carve Out Participation	1996	1997	1998	1999	2000*	2001*	2002	2003*	2004*	2005*	2006	2007	2008	2009
Employers	277	550	683	442	260	143	512	316	462	739	981	1,087	1,274	876
Work Hours (in millions)	11.6	10.4	18.5	24.8	16.9	7.9	29.4	22.9	25.4	24.5	49.4	56.1	76.5	99.2
Employees (full-time equivalent)	5,822	5,186	9,250	12,395	8,448	3,949	14,691	11,449	12,700	12,254	24,680	28,028	38,269	49,618
Payroll (in million $)	272	243	415	585	443	202	634	624	1,200	966	1,348	1,777	2,300	3,394

* 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. All data presented in this part on carve-outs are total figures for both construction and non-construction programs.

Person hours and payroll covered by agreements filed

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

For the 2009 calendar year, carve-out programs reported that they covered 99.2 million work hours and $3.4 billion in payroll.

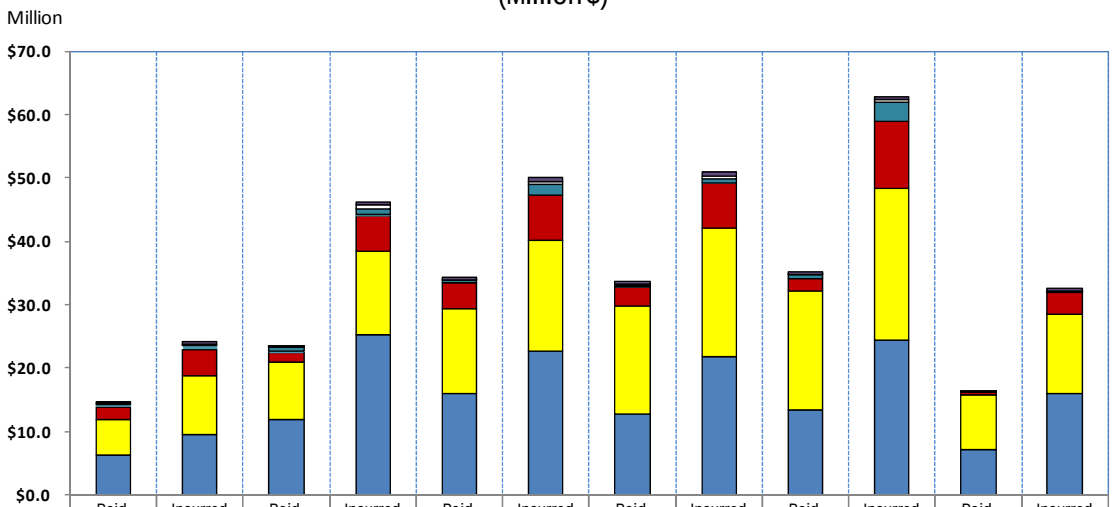
Number of claims filed

During 2009, there were a total of 3,282 claims filed, of which 1,554 (47 percent) claims were medical-only claims, and 1,728 (53 percent) were indemnity claims.

Paid, incurred and average cost per claim

The chart below shows projected paid and incurred costs for all claims combined by types of benefits. The total paid costs for claims filed in 2009 decreased almost 54 percent compared to 2008, while the total incurred costs decreased 48 percent from 2008.

Carve-Out Programs: Paid and Incurred Costs by Type of Benefits, 2004-2009
(Million $)



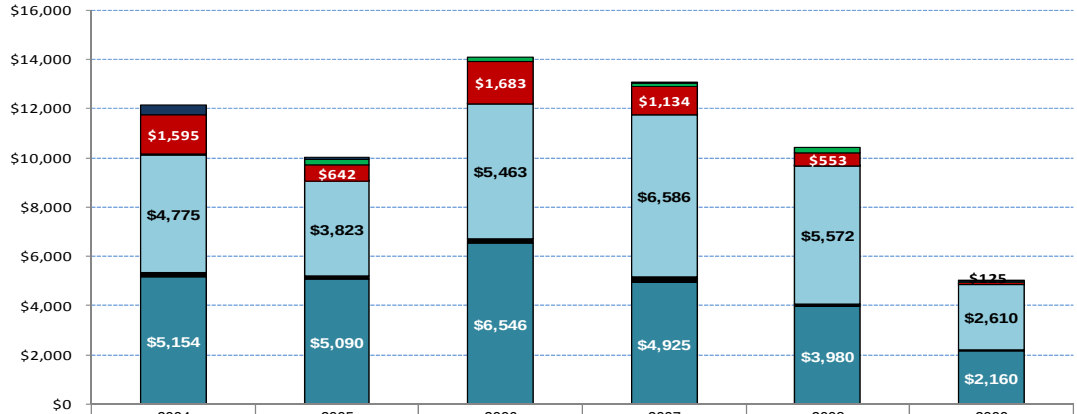
	2004 Paid	2004 Incurred	2005 Paid	2005 Incurred	2006 Paid	2006 Incurred	2007 Paid	2007 Incurred	2008 Paid	2008 Incurred	2009 Paid	2009 Incurred
Medical-Legal Cost	$0.2	$0.3	$0.3	$0.4	$0.4	$0.6	$0.6	$0.8	$0.3	$0.5	$0.2	$0.3
Voc Rehab	$0.0	$0.4	$0.1	$0.6	$0.0	$0.3	$0.0	$0.3	$0.0	$0.3	$0.0	$0.2
Death Benefit	$0.0	$0.0	$0.5	$0.8	$0.5	$1.7	$0.3	$0.6	$0.8	$3.2	$0.0	$0.0
Life Pension	$0.5	$0.5	$0.3	$0.3	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Permanent Disability	$1.9	$4.3	$1.5	$5.5	$4.1	$7.1	$2.9	$7.1	$1.9	$10.4	$0.4	$3.5
Temporary Disability	$5.7	$9.1	$9.0	$13.3	$13.3	$17.5	$17.1	$20.2	$18.7	$23.9	$8.6	$12.5
Medical Cost	$6.2	$9.6	$11.9	$25.2	$16.0	$22.7	$12.8	$21.9	$13.4	$24.5	$7.1	$16.0
All Claims	$14.6	$24.0	$23.6	$46.1	$34.4	$49.9	$33.7	$51.0	$35.1	$62.8	$16.3	$32.5

Data Source: DWC, WCIRB

According to the chart above, the actual costs for claims filed in 2009 totaled $16,339,173, while the incurred costs totaled $32,545,150. The largest share of costs is attributable to payment of medical and temporary disability benefits. These benefits accounted for 43 percent and 52 percent of total actual costs and 49 percent and 38 percent of total incurred costs, respectively.

The following two charts show the average paid and incurred costs per claim by cost components across all claims from 2004 to 2009. The average paid cost for all components per claim decreased overall by 59 percent between 2004 and 2009, while the average incurred cost for all components per claim decreased overall by 50 percent from 2004 to 2009.

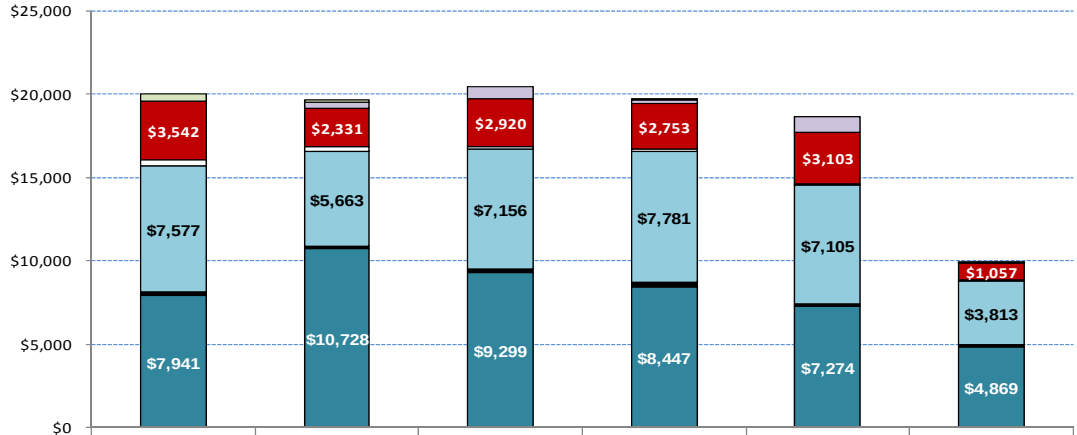
Average Paid Cost per Claim by Cost Components, 2004 - 2009



	2004	2005	2006	2007	2008	2009
Life Pension	$394	$126	$0	$3	$0	$5
Death Benefit	$0	$216	$187	$125	$231	$5
Permanent Disability	$1,595	$642	$1,683	$1,134	$553	$125
Vocational Rehabilitation	$41	$23	$17	$7	$2	$1
Temporary Disability	$4,775	$3,823	$5,463	$6,586	$5,572	$2,610
Medical-legal	$196	$122	$181	$235	$98	$71
Medical	$5,154	$5,090	$6,546	$4,925	$3,980	$2,160
All Claim Components	$12,154	$10,044	$14,077	$13,016	$10,435	$4,978

Data Source: DWC, WCIRB

Average Incurred Cost per Claim by Cost Components, 2004 - 2009



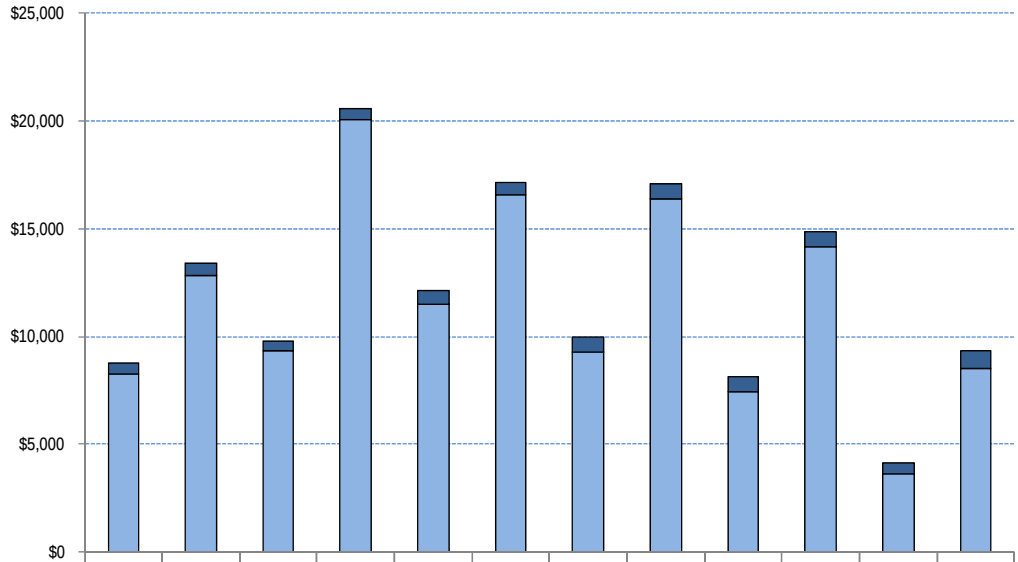
	2004	2005	2006	2007	2008	2009
Life Pension	$394	$126	$0	$4	$0	$5
Death Benefit	$0	$357	$707	$247	$946	$5
Permanent Disability	$3,542	$2,331	$2,920	$2,753	$3,103	$1,057
Vocational Rehabilitation	$325	$273	$114	$133	$102	$65
Temporary Disability	$7,577	$5,663	$7,156	$7,781	$7,105	$3,813
Medical-legal	$211	$167	$246	$310	$146	$101
Medical	$7,941	$10,728	$9,299	$8,447	$7,274	$4,869
All Claim Components *	$19,990	$19,645	$20,441	$19,674	$18,676	$9,916

* 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

In contrast, the following chart shows the cost by the type of claims filed from 2004 to 2009.

Average Paid and Incurred Cost by Claim Type, 2004 - 2009



	Paid	Incurr	Paid	Incurr	Paid	Incurr	Paid	Incurr	Paid	Incurr	Paid	Incurr
	2004		2005		2006		2007		2008		2009	
Total Medical-Only Claims	$500	$593	$439	$519	$597	$613	$637	$703	$655	$709	$544	$811
Total Claims with Indemnity	$8,244	$12,819	$9,336	$20,045	$11,516	$16,555	$9,304	$16,354	$7,466	$14,158	$3,614	$8,519

Cost Per Claim

Data Source: DWC, WCIRB

Number of disputed claims

Three tables below show the numbers and distribution of claims disputed and resolved by stage of dispute resolution process in total claims in carve-outs for years 2004 through 2009. Among the subset of carve-outs with acceptable data reporting, the percentage of claims that were disputed varied from 45 percent in 2004 to almost 90 percent in 2009. As the second table below shows, most disputed claims filed from 2004 to 2009 had been resolved before the first stage of dispute resolution – mediation. Since 2004, these programs reported that 0.1 percent to 0.5 percent of disputed claims have been heard by the Workers' Compensation Appeals Board (WCAB) or the Court of Appeals.

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Table: Total Disputed Carve-Out Claims in Programs Reporting

	2004	2005	2006	2007	2008	2009
Number of Programs Reporting	13	16	20	20	23	23
Total Number of Claims	1,203	2,345	2,443	2,591	3,364	3,282
Total Number of Disputed Claims	542	983	2,064	2,047	2,778	2,943
Percentage of Disputed Claims in Total	45.1%	41.9%	84.5%	79.0%	82.6%	89.7%

Data Source: DWC

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Table: Number of Disputed Claims by Type of Resolution

	2004	2005	2006	2007	2008	2009
Before Mediation	510	941	1,960	1,949	2,640	2,867
At Mediation	20	29	71	71	118	59
At Arbitration	7	6	26	15	19	12
At WCAB	5	5	7	12	1	5
At Court of Appeals	0	2	0	0	0	0
Total Disputed Claims	542	983	2,064	2,047	2,778	2,943

Data Source: DWC

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

	2004	2005	2006	2007	2008	2009
Before Mediation	42.4%	40.1%	80.2%	75.2%	78.5%	87.4%
At Mediation	1.7%	1.2%	2.9%	2.7%	3.5%	1.8%
At Arbitration	0.6%	0.3%	1.1%	0.6%	0.6%	0.4%
At WCAB	0.4%	0.2%	0.3%	0.5%	0.0%	0.2%
At Court of Appeals	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%
Total for Disputed Claims	45.1%	41.9%	84.5%	79.0%	82.6%	89.7%

Data Source: DWC

Number of claims resolved prior to arbitration

In 2009, among the subset of carve-outs with acceptable data reporting, 2,926 claims were resolved[28] prior to arbitration, which was 99 percent of all claims filed. Construction programs resolved 99 percent, and non-construction programs resolved 100 percent of claims prior to arbitration in 2009.

Table: Number of Claims Resolved Prior to Arbitration

	2004	2005	2006	2007	2008	2009
Number of Programs Reporting	13	16	20	20	23	23
Number of Claims resolved prior to Arbitration LC Section (b) (11)	530	970	2,031	2,020	2,758	2,926
Resolved LC Section (b) (11)	542	983	2,064	2,047	2,778	2,943
Percentage Resolved Prior to Arbitration	97.8%	98.7%	98.4%	98.7%	99.3%	99.4%

Data Source: DWC

Safety history

Both the number of injuries reported on OSHA Form 300[29] and the share of such reported incidents in all claims filed were increasing from 2004 to 2009. In 2009, carve-out programs filed 2,694 incidents 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. There was a 70 percent increase in number of injuries reported on OSHA Form Number 300 from 2008 to 2009.

Table: Number of Injuries Filed Using OSHA Form 300

	2004	2005	2006	2007	2008	2009
Number of Injuries Filed on OSHA Form 300	0	3	825	879	1,587	2,694
Total Number of Claims	1,203	2,345	2,443	2,591	3,364	3,282
Percent of OSHA Forms	0%	0.1%	34%	34%	47%	82%

Data Source: DWC

The number of workers participating in vocational rehabilitation programs

The ADR/carve-out system for 2009 reported 10 workers participating in a vocational rehabilitation program. From 2004 to 2009, the number of employees taking part in a vocational rehabilitation program was never more than 10.

Table: Number of Workers in a Vocational Rehabilitation Program

	2004	2005	2006	2007	2008	2009
Number of Programs Reporting[30]	13	16	20	20	23	23
Number of Workers	5	6	10	5	6	10

Data Source: DWC

[28] A resolved claim is defined in section 10203(b)(9) as one in which ultimate liability has been determined, even though payments for the claim may be made beyond the reporting period.
[29] 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.
[30] Excludes programs reporting vocational rehabilitation costs but not vocational rehabilitation program participants.

The number of workers participating in light-duty or modified return-to-work programs

From 2004 to 2009, the number of workers participating in a light-duty program has grown from 2 to 881 participants. In 2009, there was a 281 percent increase from 2008 and 503 percent increase from 2007 in the number of workers participating in light-duty or modified work programs. For 2009, 3.7 claims were filed for every one worker participating in light-duty or modified work, down from ratios of 14.6 to 1 in 2008 and 17.8 to 1 in 2007.

Table: Number of Workers Participating in Light-Duty or Modified Return-to-Work Programs

	2004	2005	2006	2007	2008	2009
Total Claims Filed	1,203	2,345	2,443	2,591	3,364	3,282
Number of Workers	2	61	265	146	231	881
Ratio of Claims Filed to Light-Duty or Modified Work Participants	601.5	38.4	9.2	17.8	14.6	3.7

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.

For 2009, of the four reporting 3201.7 programs, only one submitted results. This carve-out program that reported results for 2009 found that 34 percent of injured workers surveyed were satisfied or very satisfied with 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 December, 2010
Labor Code Section 3201.5

No.	Union	Company	Agreement Type	Exp. Date
Active 3201.5 Construction Carve Out Programs				
1	Operating Engineers Local 12	So. CA Contractors' Association	1 Union, Multiple Employers	4/1/2011
2	Operatives Plasterers & Cement Masons International Association, Local 500 & 600	So. CA Contractors Association, Inc.	1 Union, Multiple Employers	4/1/2011
3	Sheet Metal International Union	Sheet Metal-A/C Contractors National Association	1 Union, Multiple Employers	4/1/2011
4	Building Trades Council of Los Angeles-Orange County	L.A. Comm. College District Construction Program		5/6/2011
5	International Union of Petroleum & Industrial Workers	TIMEC Co., Inc./TIMEC So. CA., Inc.	1 Union, 1 Employer	7/31/2011
6	So. CA District Council of Laborers	Assoc. General Contractors of CA, Building Industry Assoc.; So. CA, So. CA Contractors' Assoc.; Engineering Contractors' Assoc.	1 Union, Multiple Employers	7/31/2011
7	United Union of Roofers, Waterproofers & Allied workers, Local 36 and 220	Union Roofing Contractors Association	1 Union, Multiple Employers	7/31/2011
8	United Union of Roofers, Waterproofers & Allied Workers, Locals 27, 40, 81 & 95	Associated Roofing Contractors of the Bay Area Counties	1 Union, Multiple Employers	7/31/2011
9	Building & Construction Trades Council San Diego	San Diego County Water Authority Emergency Storage Project	Project Labor Agreement	2/20/2012
10	District Council of Iron Workers-State CA & Vicinity	California Ironworker Employers Council	1 Union, Multiple Employers	2/25/2012
11	Sheet Metal Workers International Association #105	Sheet Metal & A/C Labor Management Safety Oversight Committee (LMSOC)	1 Union, Multiple Employers	4/17/2012
12	District Council of Painters	LA Painting & Decorating Contractors' Association	1 Union, Multiple Employers	10/28/2012
13	United Association -Journeyman & Apprentices - Plumbers & Pipefitters, Local #447	No.CA Mechanical Contractors Association & Association Plumbing & Mechanical Contractors of Sacramento. Inc.	1 Union, Multiple Employers	11/7/2012
14	Santa Clara & San Benito Counties Bldg. &Construction Trades	Santa Clara Valley Med'l Cntr-Seismic Safety Project, OCIP	Project Labor Agreement	2/2/2013
15	PIPE Trades District Council.# 36	Mechanical Contractors Council of Central CA	1 Union, Multiple Employers	4/14/2013
16	International Brotherhood of Electrical Workers (IBEW)	National Electrical Contractors Association (NECA)	1 Union, Multiple Employers	8/14/2013

No.	Union	Company	Agreement Type	Exp. Date
17	So. CA District of Carpenters & 19 local unions	6 multi-employer groups - 1000 contractors	1 Union, Multiple Employers	8/14/2013
18	So. CA Pipe Trades Council 16	Multi employer - Plumbing & Piping Industry Council	1 Union, Multiple Employers	8/24/2013
19	(A) No. CA Carpenters Regional Council	Basic Crafts Workers' Compensation Benefits Trust	(A) 1 Union, Multiple Employers	(A) 8/30/2013
	(B) No. CA District Council of Laborers		(B) 1 Union, Multiple Employers	(B) 8/30/2013
	(C) Operating Engineers Local 3		(C) 1 Union, Multiple Employers	(C) 8/30/2013
20	International Unions Public & Industrial Workers	Irwin Industries, Inc.	1 Union, 1 Employer	3/23/2013
21	Industrial, Professional & Technical Workers	Irish Construction	1 Union, 1 Employer	12/20/2013
Completed, Ended or Expired 3201.5 Carve-out Programs*				
1	LA Building & Construction Trades Council AFL-CIO	Cherne Contracting - ARCO	Project Labor Agreement	Completed
2	LA County Building & Construction Trades Council	Cherne Contracting – Equilon Refinery – Wilmington	Project Labor Agreement	Expired 3/1/2007
3	LA/Orange Counties Building & Construction Trade Council	Cherne Contracting – Chevron Refinery – El Segundo	Project Labor Agreement	Expired 7/26/2005
4	Plumbers & Steamfitters	Cherne Contracting – Chevron Refinery – Richmond	Project Labor Agreement	Expired 7/1/2005
5	Plumbers & Steamfitters	Cherne Contracting – Tesoro Refinery – Martinez	Project Labor Agreement	Expired 7/1/2005
6	Plumbing & Pipefitting Local 342	Cherne Contracting - Chevron Base Oil 2000 project	1 Union, 1 Employer	Completed
7	Steamfitters Local 250	Cherne - two projects completed in 1996	1 Union, 1 Employer	Completed 1996
8	Building & Construction Trades Council of Alameda County	Parsons Constructors, Inc. Nat'l Ignition Facility - Lawrence Livermore	Project Labor Agreement	Ended 7/02/2006
9	CA Building & Construction Trades Council	Metropolitan Water District So. CA Inland Feeder Parsons	Project Labor Agreement	Ended 12/31/2002
10	CA Building & Construction Trades Council	Metropolitan Water District So. CA - Diamond Valley Lake	Project Labor Agreement	Expired 11/07/2006
11	Contra Costa Building & Construction Trades Council	Contra Costa Water District - Los Vaqueros	Project Labor Agreement	Completed

*A completed, ended, or expired designation does not exclude a carve-out program from responsibility for any workplace injuries or illnesses that may have occurred during operation.

Data Source: DWC

Non-Construction Industry Carve-Out Participants as of December 1, 2010
(Labor Code Section 3201.7)

No	Union	Company	Permission to Negotiate Start Date	Permission to Negotiate End Date	Application for Recognition of Agreement Date	Agreement Recognition Letter Date
Active 3201.7 Non-Construction Carve Out Programs						
1	(A) No. CA Carpenters Regional Council Non-Construction (B) No. CA District Council of Laborers Non-Construction (C) Operating Engineers Local 3 Non-Construction	Basic Crafts Workers' Compensation Benefits Trust*	12/9/2004	12/9/2005	2/15/2005	2/28/2005
2	United Food & Commercial Workers Union Local 588	Mainstay Business Solutions	8/11/2005	8/11/2006	9/2/2005	9/12/2005
3	Long Beach Peace Officers' Association & Long Beach Fire Fighters' Association Local 372	City of Long Beach	12/11/2006	12/11/2007	11/2/2007	11/13/2007
4	SEIU Local 1877	Various Maintenance Companies	4/13/2007	4/13/2008	2/12/2008	2/28/2008
5	SEIU Local 721	City of Los Angeles	6/18/2007	6/18/2008	4/15/2008	5/8/2008
Open Permission to Negotiate						
1	Kern County Firefighters' Union	County of Kern	6/3/2010	6/3/2011		
2	Kern County Law Enforcement Association	County of Kern	6/3/2010	6/3/2001		
3	United Food & Commercial Workers Local 8	Save Mart Supermarkets dba Yosemite Wholesale	8/11/2010	8/11/2011		
4	Teamsters Local 150	Save Mart Supermarkets dba Roseville Distribution Center	9/13/2010	9/13/2011		
5	Automotive Machinists Lodge 1173	Save Mart Supermarkets dba Vacaville Distrbution Center	11/30/2010	11/30/2011		
Expired Permission to Negotiate						
1	Teamsters CA State Council-Cannery & Food Processing Unions, IBT, AFL-CIO	CA Processors, Inc. Multi-Employer Bargaining Representative	7/6/2004	7/5/2005		
2	UFCW Local 770	Super A Foods - 10 locations- ~283 members	9/1/2004	9/1/2005		

No	Union	Company	Permission to Negotiate Start Date	Permission to Negotiate End Date	Application for Recognition of Agreement Date	Agreement Recognition Letter Date
3	UFCW Local 324	Super A Foods - 2 locations - ~ 76 members	9/1/2004	9/1/2005		
4	UFCW Local 1167	Super A Foods - Meat Department ~8 employees	9/1/2004	9/1/2005		
5	UFCF Local 1036	Super A Foods - All employees, except those engaged in janitorial work or covered under a CBA w/Culinary Workers and demonstrators	9/1/2004	9/1/2005 Withdrawn 7/28/2009		
6	Teamsters Local 952	Orange County Transportation Authority Coach Operators	4/17/2006	4/17/2007 Withdrawn 7/28/2009		
7	Teamsters Local 952	Orange County Transportation Authority Maintenance Workers	7/31/2006	7/31/2007		
8	Teamsters Local 630	SYSCO Food Service	6/22/2007	6/22/2008 Withdawn 7/30/2009		
9	Teamsters Local 848	SYSCO Food Service	6/22/2007	6/22/2008 Withdawn 7/30/2009		
10	UFCW Local 5	Smoked Prime Meats, Inc	7/7/2008	7/7/2009		
11	UFCW Local 5	Milan Salami	7/7/2008	7/7/2009		
12	UFCW Local 5	Berkeley Bowl	7/7/2008	7/7/2009		

*Authorized, but does not currently operate as a non-construction program.

Data Source: DWC

For further information …

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

How to Create a Workers' Compensation Carve-out in California: Practical Advice for Unions and Employers. CHSWC (2006). http://www.dir.ca.gov/CHSWC/carve-out1.pdf.

Carve-outs: A Guidebook for Unions and Employers in Workers' Compensation. CHSWC (2004). http://www.dir.ca.gov/chswc/CARVEOUTSGuidebook2004.pdf

Carve-Outs' in Workers' Compensation: An Analysis of Experience in the California Construction Industry (1999). http://www.dir.ca.gov/CHSWC/CarveOutReport/Carveoutcover.html

DIVISION OF LABOR STANDARDS ENFORCEMENT (DLSE), BUREAU OF FIELD ENFORCEMENT (BOFE)

BOFE is responsible for investigation and enforcement of statutes covering workers' compensation insurance coverage, child labor, cash pay, unlicensed contractors, Industrial Welfare Commission orders, as well as group claims involving minimum wage and overtime claims. BOFE also handles criminal investigations involving these group claims.

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The following chart describes the citations from 2009 enforcement actions.

DLSE 2009 Results by Citation Category

Citation Category	Number of Citations	Penalties Assessed	Penalties Collected
Workers' Compensation	**2,257**	**$11,613,052**	**$3,659,229**
Itemized Statement	977	$10,083,750	$3,307,965
Public Works	263	$4,539,501	$839,123
Non-Registration	427	$2,287,200	$993,108
Unlicensed Construction Contractor	45	$791,400	$67,550
Minimum Wage	113	$393,350	$74,035
Overtime	103	$257,200	$309,688
Child Labor	209	$228,000	$245,675
Garment	71	$111,800	$36,251
Sub-Total	**4,202**	**$25,765,752**	**$8,693,501**
TOTAL	**4,465**	**$30,305,253**	**$9,532,624**

Data Source: DLSE

For further information …

http://www.dir.ca.gov/dlse/DLSEReports.htm

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).

Insurance Commissioner Steve Poizner convened an Advisory Task Force on Insurance Fraud to address major issues relating to insurance fraud. The Executive Officer of CHSWC chaired the Workers' Compensation Expert Working Group of the Task Force. The Task Force completed a comprehensive review of the anti-fraud insurance programs and identified 18 recommendations to consider in reducing insurance fraud in California.

The recommendations are consolidated into the following five categories identified by the Task Force:

- Organization and Efficiency of the CDI Fraud Division Enforcement Branch, California Department of Insurance.

- Industry Role in Fighting Fraud
- Public Role in Fighting Fraud
- Fraud Statutes and Regulations
- Technologies

The Fraud Division is currently implementing the following recommendations:

- Placing personnel in existing fusion centers within the State so law enforcement can share information more efficiently and quickly identify emerging trends and crime patterns.
- Developing and providing better training for the Special Investigation units (SIU) on the recognition, documentation, and reporting of suspected insurance fraud claims.
- Recognizing insurance companies that go beyond compliance for their greater commitment to fighting fraud.
- Increasing the outreach efforts of CDI about the consequences of fraud, how the public can recognize it and report it.

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 California Department of Insurance (CDI) Fraud Division data, the quality of SFCs continues to improve each fiscal year. Several reasons for this trend include:[31]

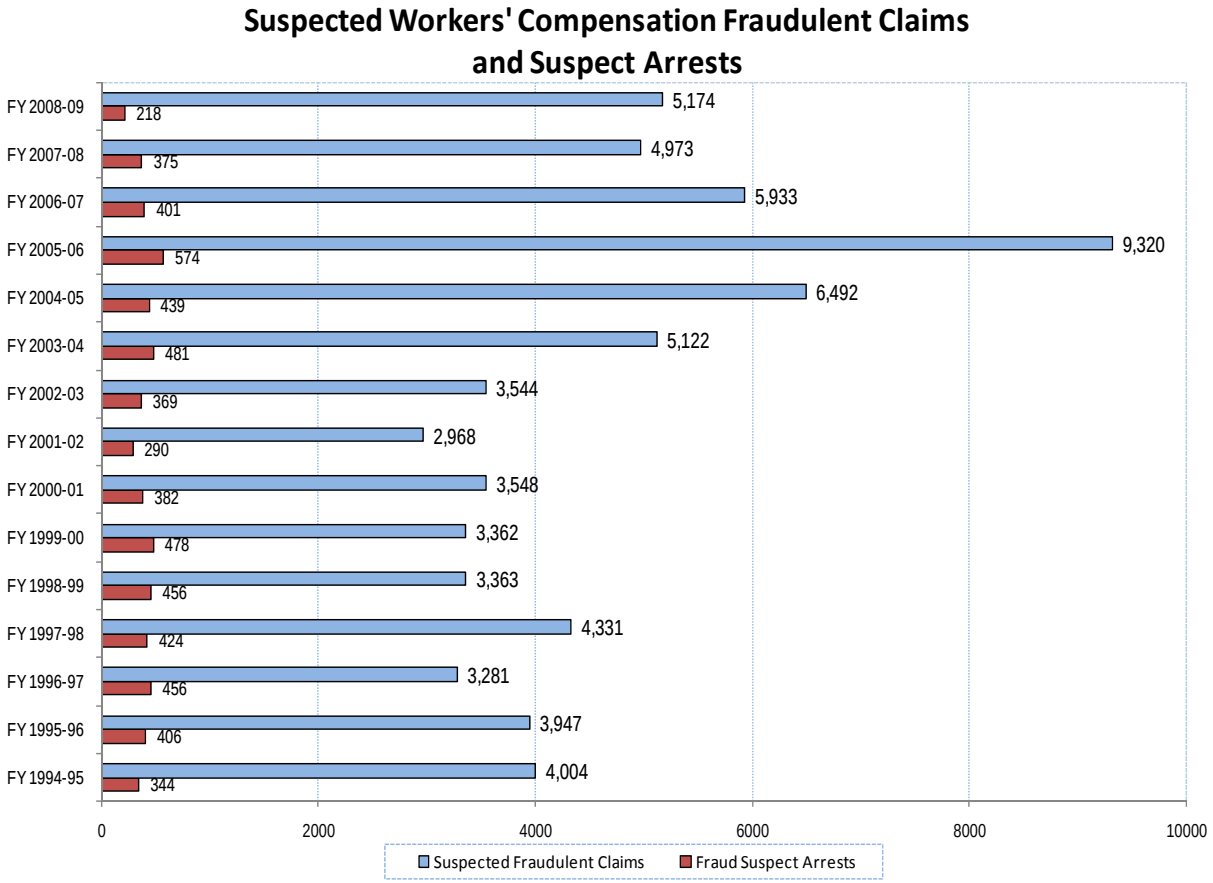
- The extensive efforts to provide training to the insurance claim adjusters and Special Investigation Unit (SIU) personnel by the Fraud Division and District Attorneys.
- Changing submission of SFCs by filling out the FD-1 Form electronically through the Internet.
- The Department promulgated new regulations 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.
- 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 2008-09, the total number of SFCs reported is 5,174.

[31] 2009 Annual Report of the Insurance Commissioner, July 30, 2010

Workers' Compensation Fraud Suspect Arrests

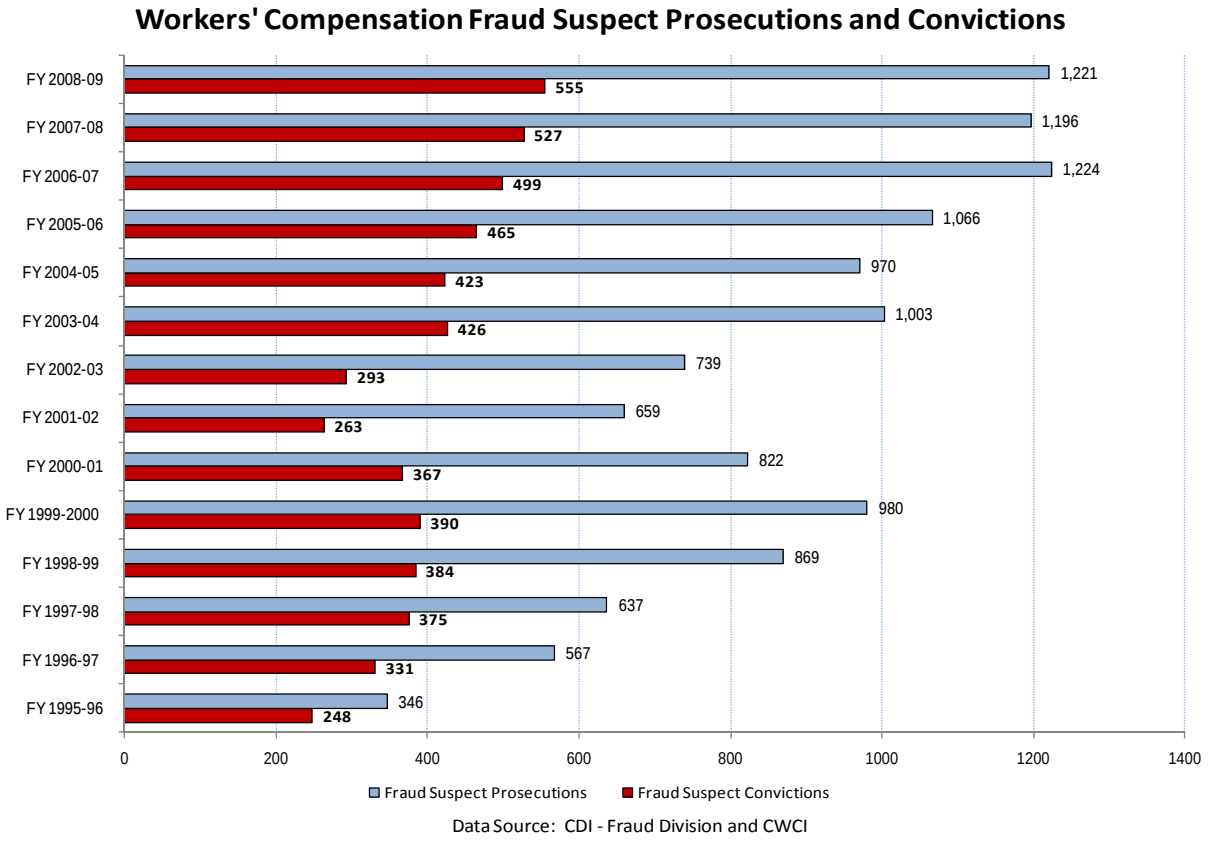
After a fraud referral, an investigation must take place before any warrants are issued or arrests are made. The time for investigation ranges from a few months to a few years depending on the complexity of the caseload. For this reason, the number of arrests does not necessarily correspond to the number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



Data Source: CDI - Fraud Division and CWCI

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 Fraud Investigations

Types of Workers' Compensation Fraud Investigations

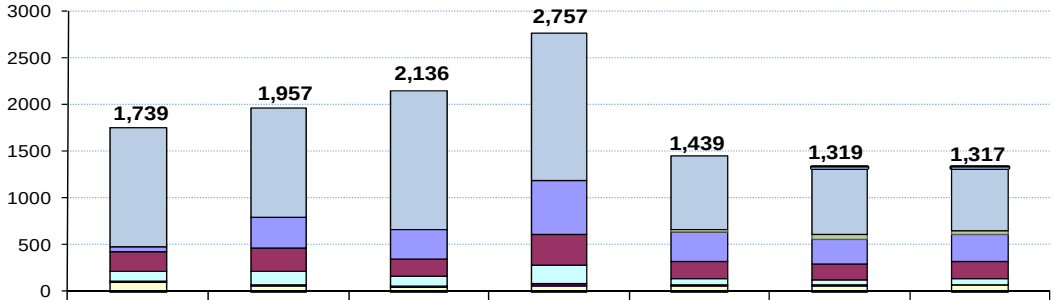
The charts "Caseload by Type of Fraud Investigations" and "Type of Fraud Investigations by Percentage of Total" on the next page indicate the number and types of investigations opened and carried from fiscal years 2002-03 to 2008-09 reported by district attorneys. Applicant fraud appears to be the area 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 58.5 percent increase in workers' compensation fraud investigations from FY 2002-03 to FY 2005-06 followed by 52 percent decrease from FY 2005-06 to FY 2008-09.

Caseload by Type of Fraud Investigations



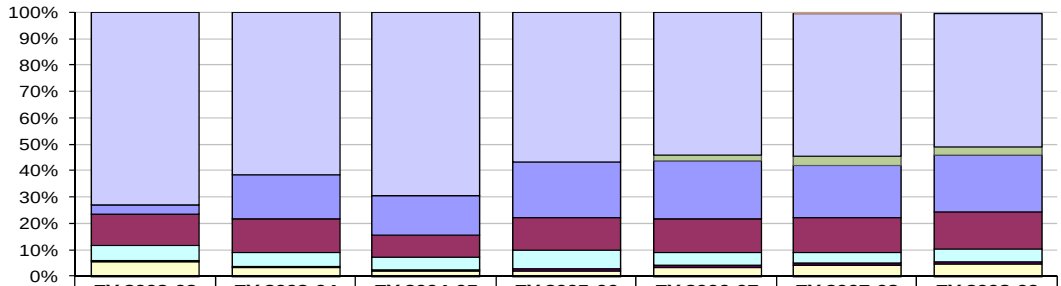
	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09
Legal Provider	N/A	N/A	N/A	N/A	N/A	8	6
Pharmacy	N/A	N/A	N/A	N/A	N/A	1	1
Applicant	1,263	1,177	1,478	1,573	778	714	668
Defrauding Employee	N/A	N/A	N/A	N/A	36	42	37
Uninsured Employer	61	327	325	580	312	265	288
Premium*	207	242	172	331	186	172	185
Medical Provider**	109	141	112	193	69	50	63
Insider	6	14	6	25	12	12	12
Other	93	56	43	55	46	55	57
Total	1,739	1,957	2,136	2,757	1,439	1,319	1,317

* From 2007-2008 on, Includes Misclassification, Underreported Wages, and X-Mod Evasion
** 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 73 percent of the total in 2002-03 to about 51 percent of the total number of investigations in FY 2008-09. 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 4.8 percent between 2005-06 and 2008-09.

Type of Fraud Investigations by Percentage of Total



	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09
Legal Provider	N/A	N/A	N/A	N/A	N/A	0.61%	0.5%
Pharmacy	N/A	N/A	N/A	N/A	N/A	0.08%	0.1%
Applicant	72.6%	60.1%	69.2%	57.1%	54.1%	54.1%	50.7%
Defrauding Employee	0.0%	0.0%	0.0%	0.0%	2.5%	3.2%	2.8%
Uninsured Employer	3.5%	16.7%	15.2%	21.0%	21.7%	20.1%	21.9%
Premium*	11.9%	12.4%	8.0%	12.0%	12.9%	13.0%	14.0%
Medical Provider**	5.6%	5.0%	4.9%	7.0%	4.8%	3.8%	4.8%
Insider	0.3%	0.7%	0.3%	0.9%	0.8%	0.9%	0.9%
Other	5.3%	2.9%	2.0%	2.0%	3.2%	4.2%	4.3%

* From FY 2006-2007 on, Includes Misclassification, Underreported Wages, and X-Mod evasion
** 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

In addition, the *2009 Annual Report of the Insurance Commissioner* notes that the great majority of suspected fraudulent claims in calendar year 2009 came from Los Angeles County (1,704 or 37.4 percent of total cases) followed by Orange County (404 or 9 percent), and then San Bernardino County (301 or 7 percent).

Underground Economy

While most California businesses comply with health, safety and workers' compensation regulations, there are businesses that do not and 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 the Employment Development Department (EDD), the California underground economy is estimated at $60 billion to $140 billion.[32]

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: Assisting Injured Workers and Improvements in Identifying Illegally Uninsured Employers" and the "Projects and Studies" sections of this report.

[32] http://www.bettzedek.org/PDF/voicesfromtheunderground.pdf Page 4.

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 2009 are preliminary as of September 2010.

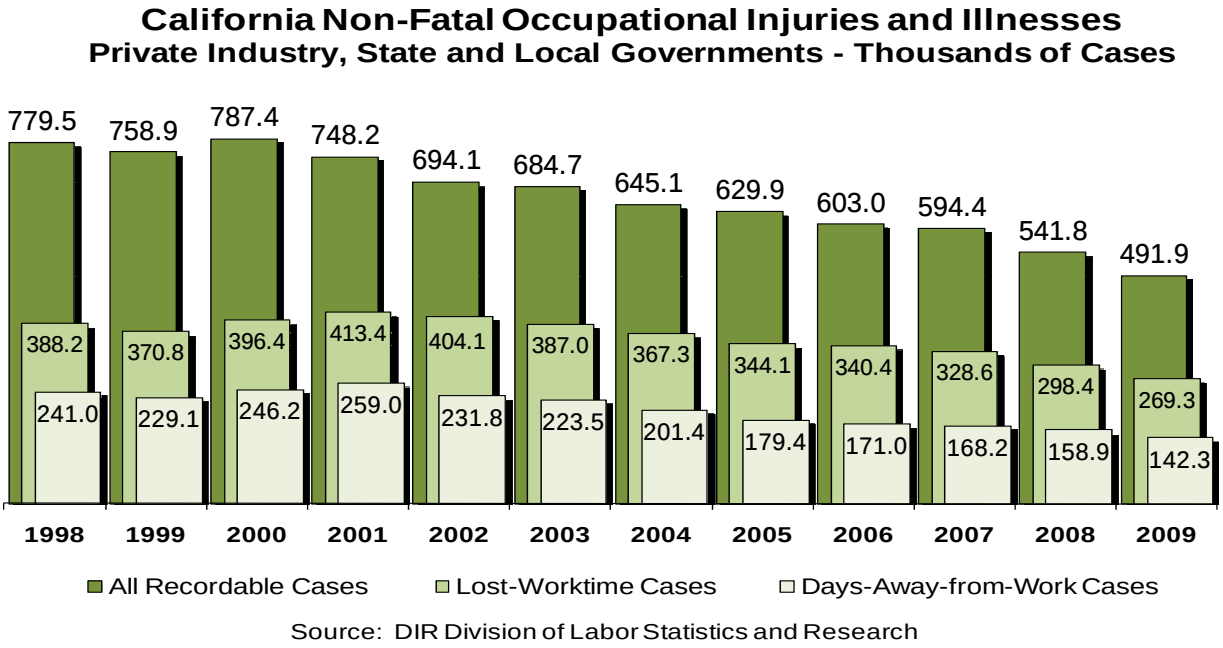
Please note that “lost-work-time” occupational injury and illness cases involve days away from work, job transfer, or days of restricted work activity, and that days-away-from-work cases involve days away from work, whether or not there is also job transfer or restricted work activity.

The National Academy of Social Insurance (NASI) estimated that there were 130,643 million workers covered by workers’ compensation in the U.S. in 2008, including 15,248 million in California.

Public and Private Sectors Compared

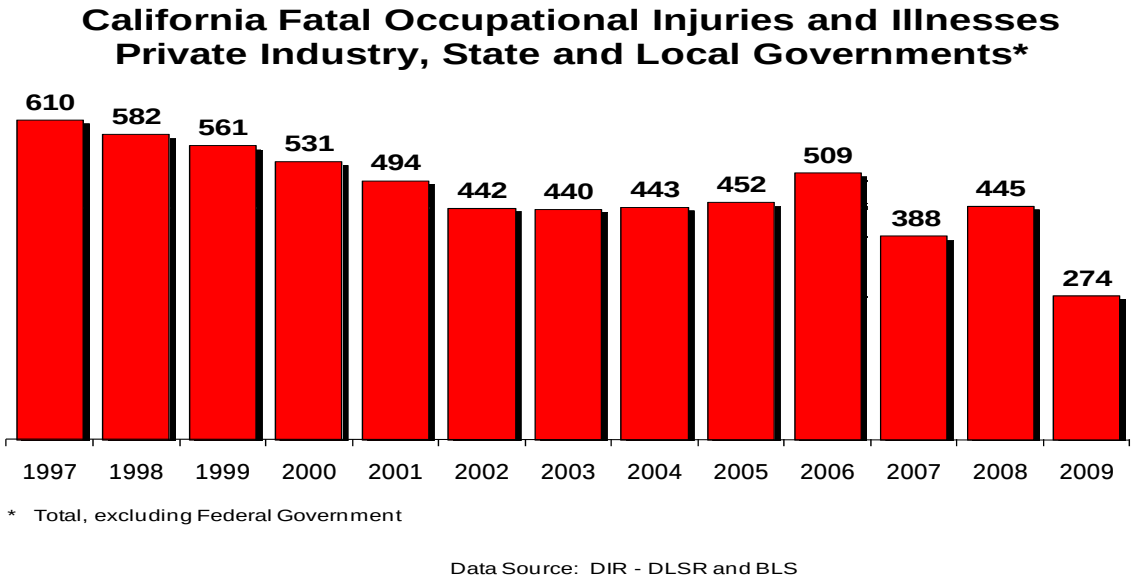
Non-Fatal Occupational Injuries and Illnesses

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 2009.



Fatal Occupational Injuries and Illnesses

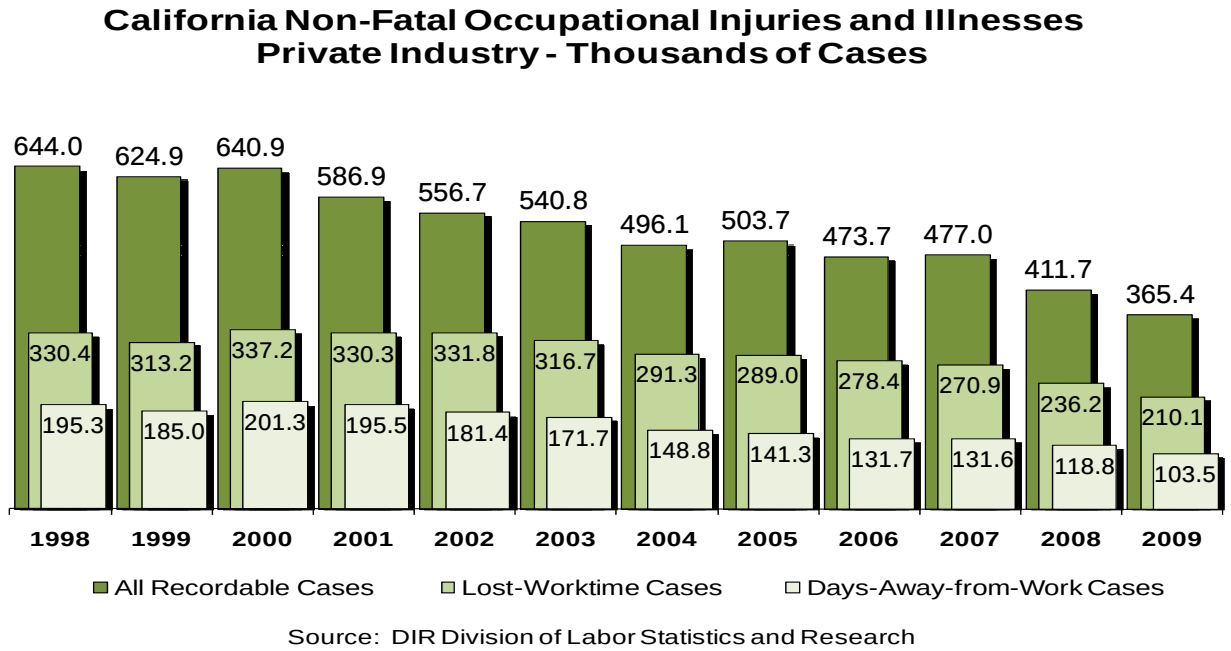
Fatal occupational injuries and illnesses in California have also decreased significantly as depicted in the chart below. Fatal occupational injuries and illnesses in California declined by 27.4 percent from 1997 to 2003 and increased by 15.7 percent from 2003 to 2006. Fatal injuries decreased 23.8 percent from 2006 to 2007, increased 14.7 percent from 2007 to 2008, and then decreased again 38.4 percent from 2008 to 2009, the largest decrease within the past ten years.



Private Sector

Non-Fatal Occupational Injuries and Illnesses

Occupational injuries and illnesses in California's private industry have also decreased noticeably in the past ten years. The total number of recordable injury and illness cases dropped by 43 percent, the number of lost-work-time cases declined by almost 38 percent, and the number of days-away-from-work cases decreased by almost 49 percent, all from 2000 to 2009.



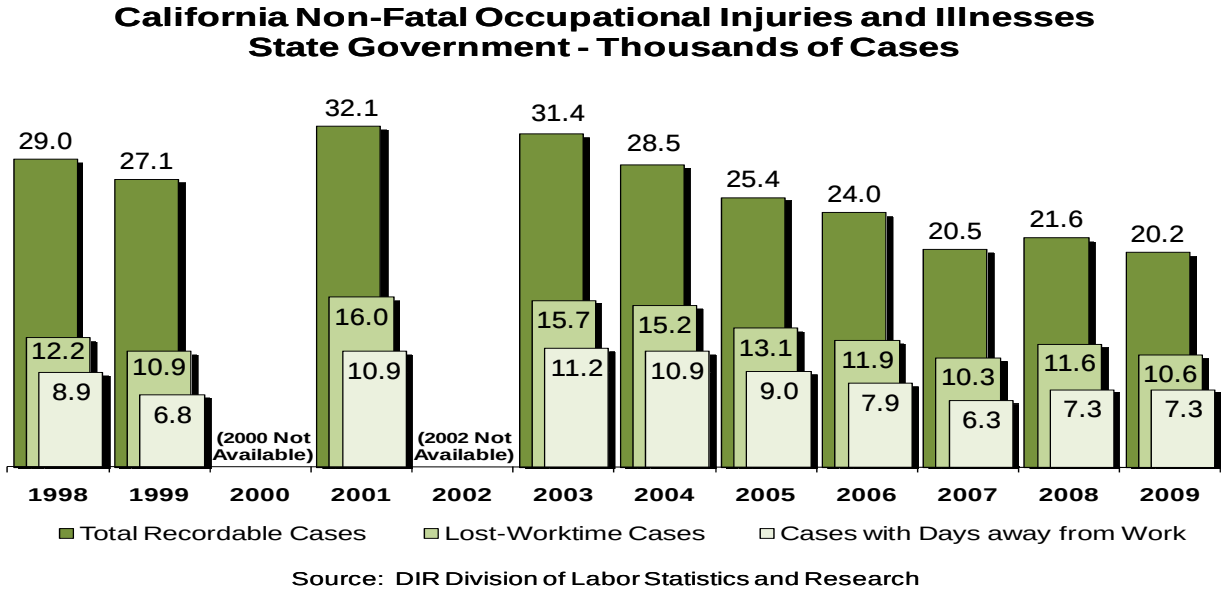
Fatal Occupational Injuries and Illnesses

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 in private industry decreased 24.8 percent from 2006 to 2007, increased 13.6 percent from 2007 to 2008, and decreased 38.8 percent from 2008 to 2009.

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. The total number of cases declined by about 34.7 percent between 2003 and 2007, increased by 5 percent from 2007 to 2008, and then decreased by 6.5 percent from 2008 to 2009.



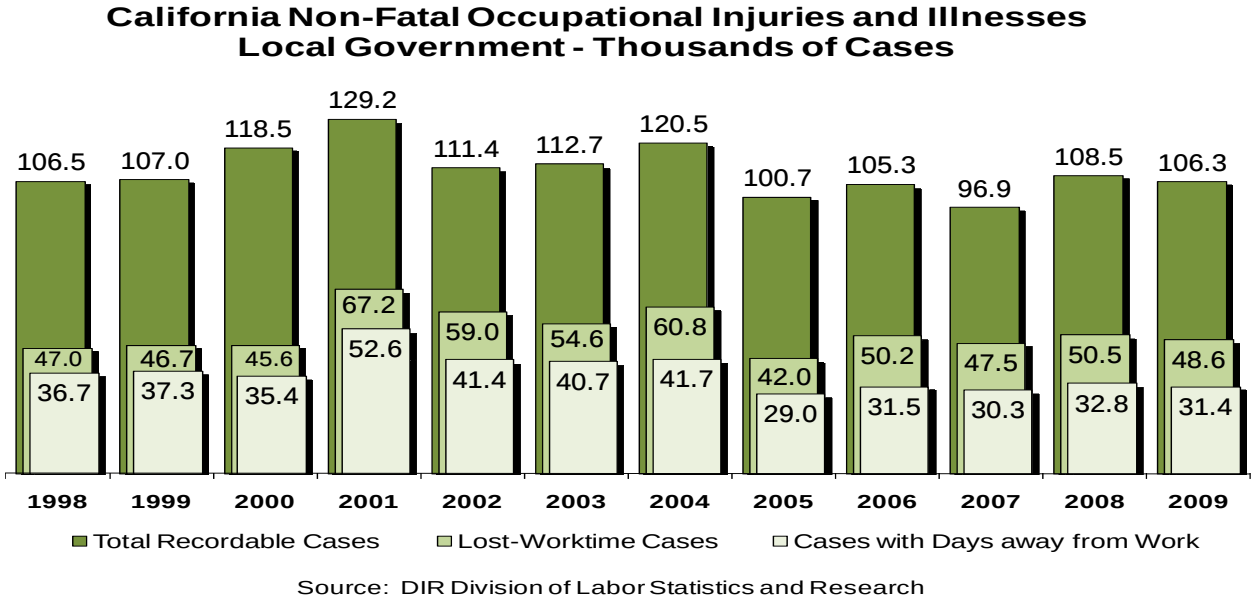
Fatal Occupational Injuries and Illnesses

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 6 from 2006 to 2009.

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 almost 10 percent to 106.3 cases in 2009.



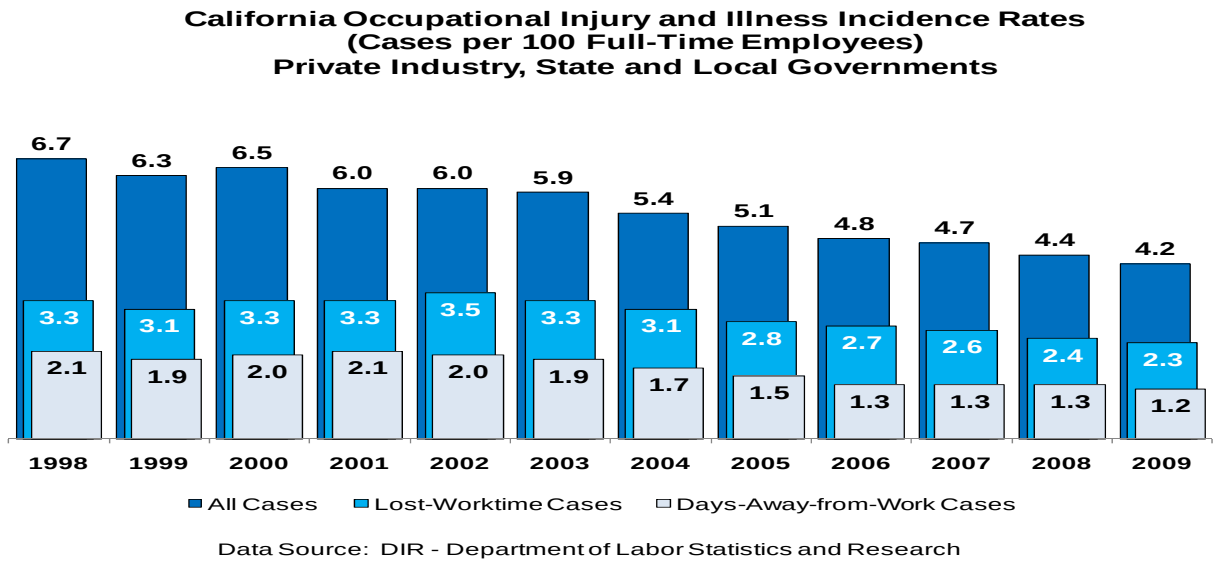
Fatal Occupational Injuries and Illnesses

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 56.5 percent increase in the number of fatal occupational injuries and illnesses in California's local governments from 2007 to 2008, and then a 38.9 percent decrease to its 2005-2007 level from 2008 to 2009.

Occupational Injury and Illness Incidence Rates

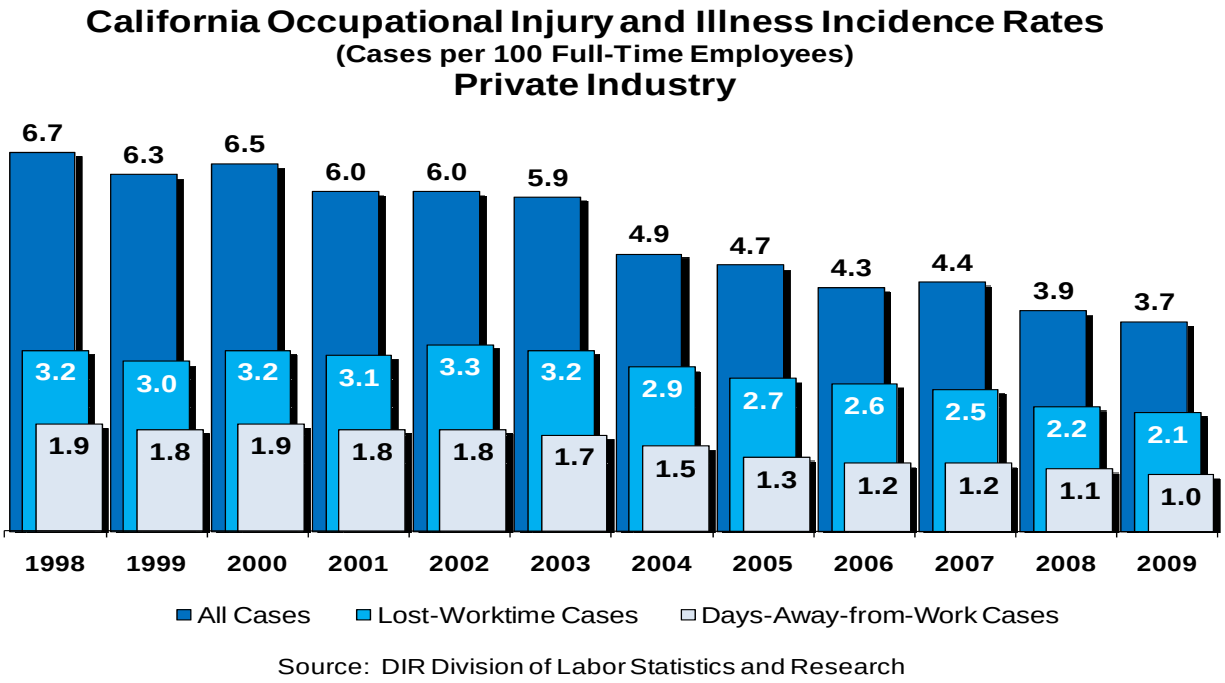
Public and Private Sectors Compared

From 1998 to 2009, 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 then have declined since 2002.



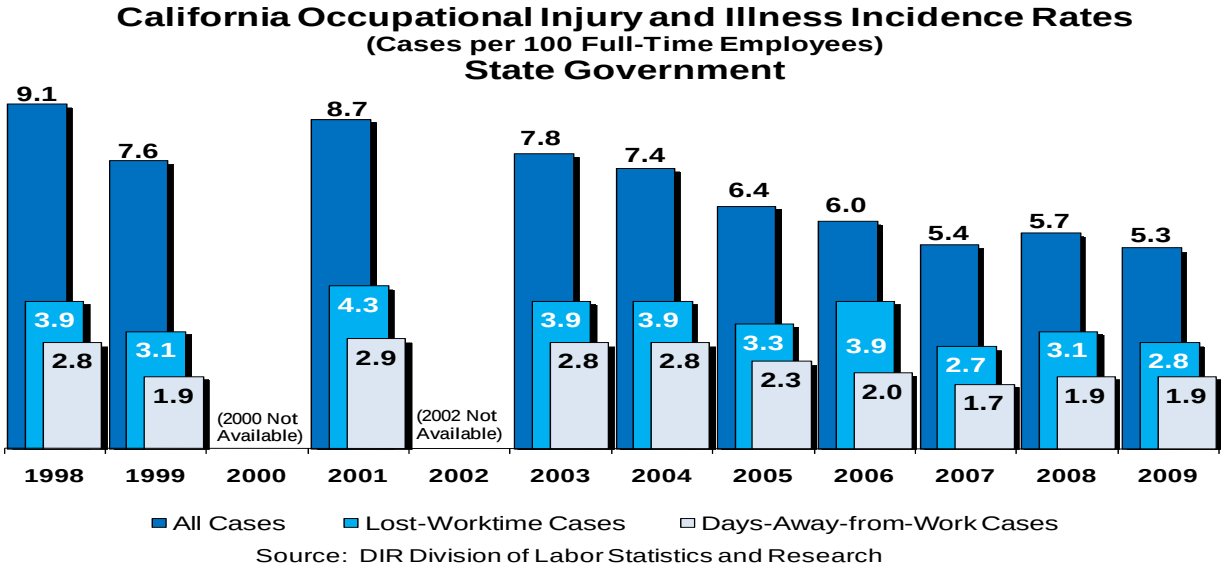
Private Sector

From 1998 to 2009, the occupational injury and illness incidence rate for all cases in California's private industry declined from 6.7 to 3.7, a decrease of almost 45 percent, while the incidence rate for lost-time cases dropped from 3.2 to 2.1, a decrease of 47 percent.



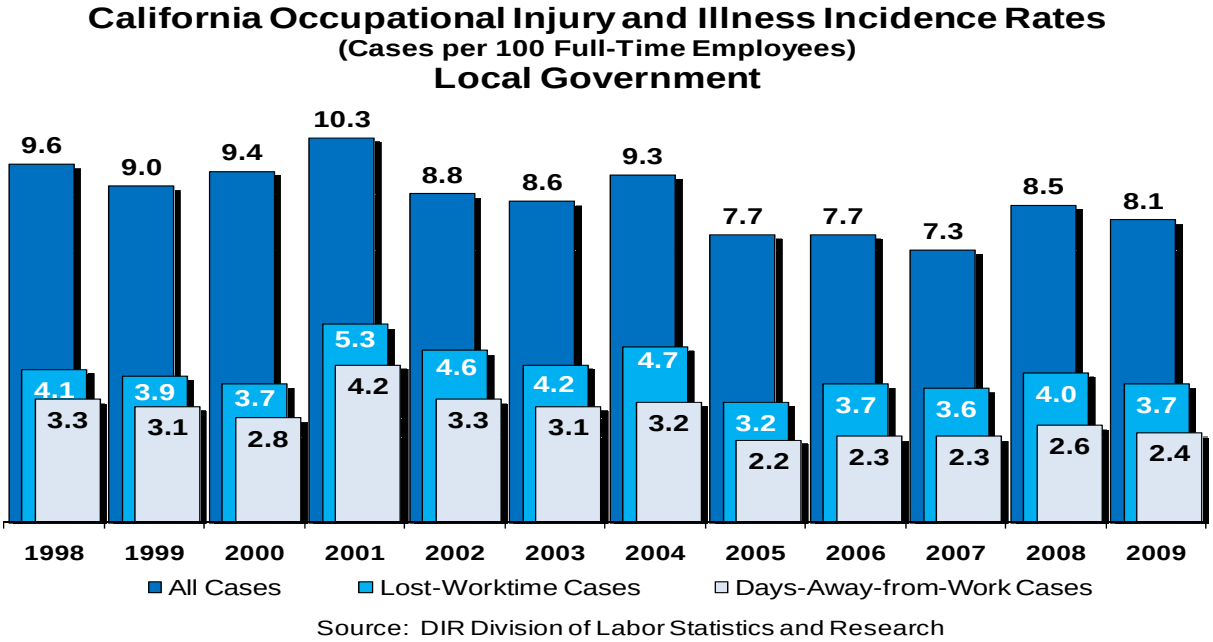
Public Sector - State Government

California state government occupational injury and illness incidence rates declined by 42 percent from 9.1 cases in 1998 to 5.3 cases per 100 full-time employees in 2009.



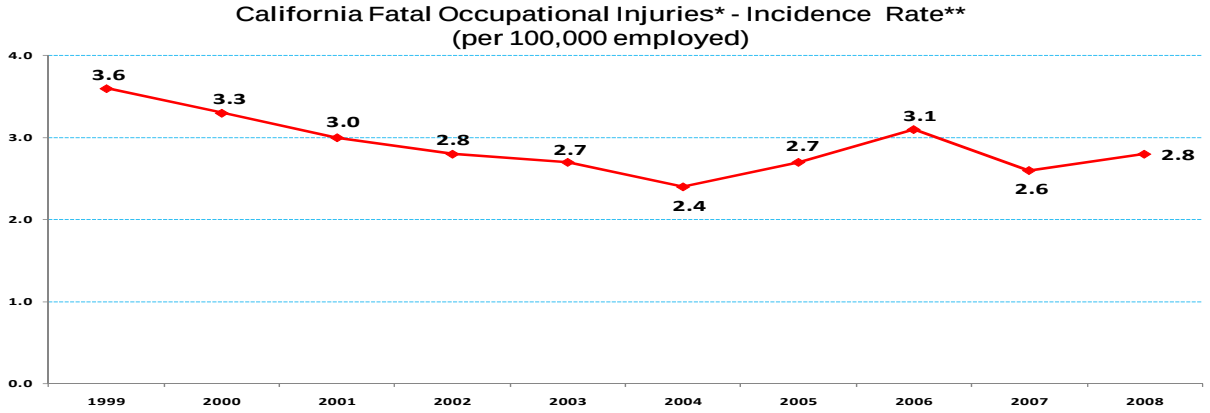
Public Sector – Local Government

Local government occupational injury and illness incidence rates decreased from 1998 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, increased again by 16 percent from 2007 to 2008, and then decreased by 4.7 percent from 2008 to 2009 from 8.5 to 8.1 per 100 full-time employees.



California Fatality Incidence Rates

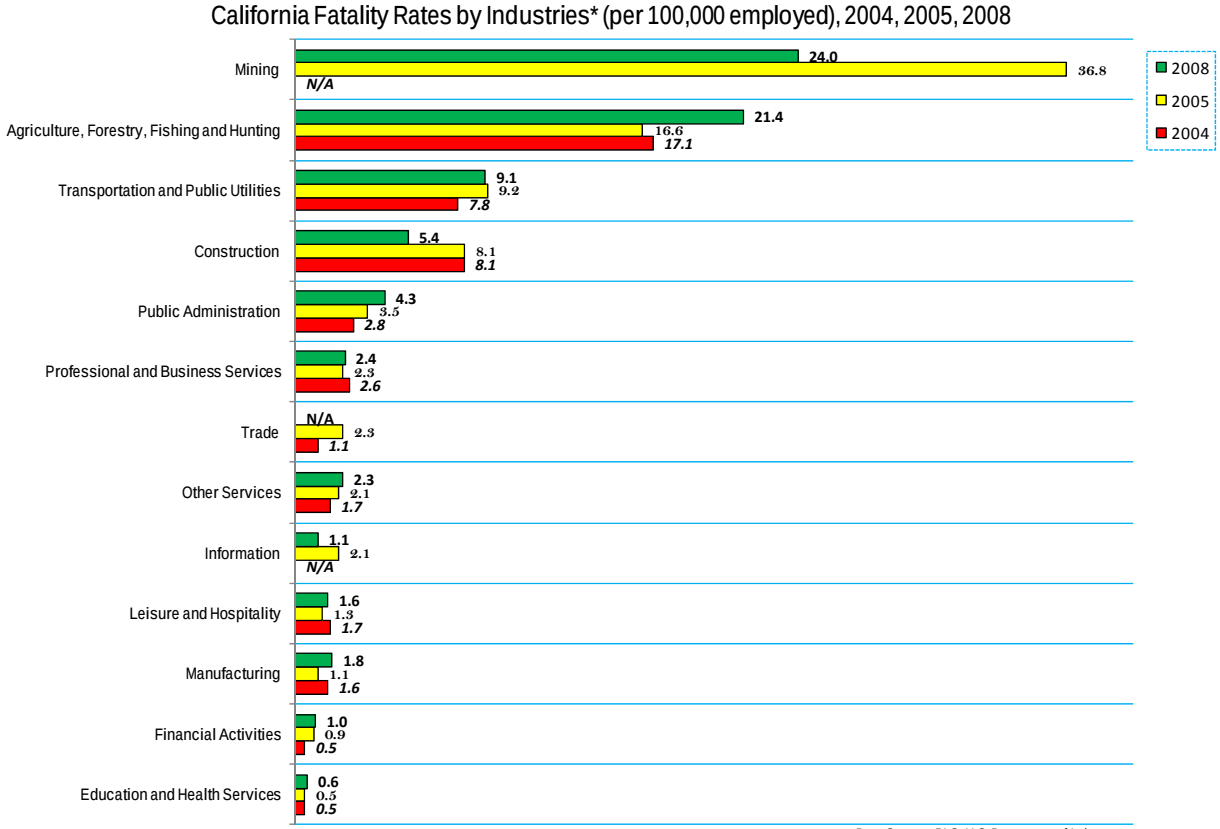
Fatality per employment rates may be used to compare the risk of incurring injury among worker groups with varying employment levels. From 1999 to 2004, there was a decrease of 33.3 percent in fatality rates in California. From 2004 to 2006, the fatality rate increased by 29 percent, decreased by 16 percent from 2006 to 2007, and then increased by 7.7 percent from 2007 to 2008.



* Excludes military personnel and workers under age 16. Includes all self-employed, family business, and wage and salary workers. The Government is not presented separately and may be included in any industry category.
** Computed using estimates of civilian workers (age 16 and older) from the Current Population Survey (CPS) and are expressed as the number of fatalities per 100,000 employed.

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

The chart below shows the fatality incidence rates by major industries in 2004, 2005 and 2008.



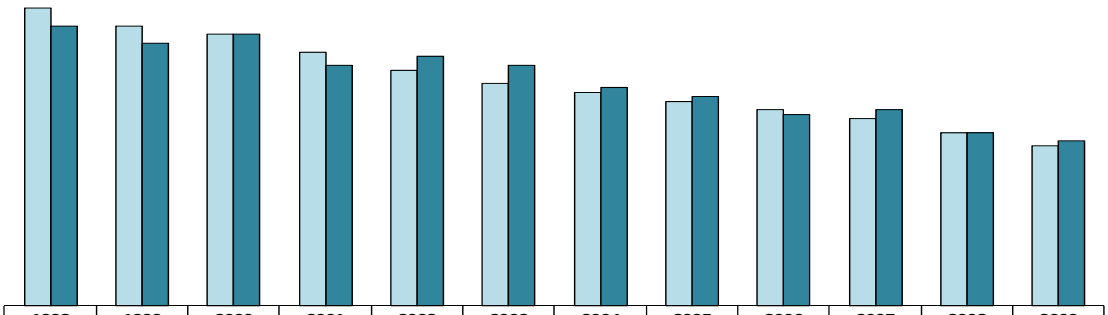
* From 2003, classified by NAICS. Because of substantial differences between NAICS and SIC used for prior years, comparisons between prior years and 2003 and on should not be made. (Data for 2006 and 2007 unavailable)

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

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 1998 through 2009. During that time, the U.S. incidence rate dropped by more than 46 percent, while the California rate declined by 41 percent. Since 2002, the incidence rate in California has been mostly above the national average.

USA and California
Injury and Illness Incidence Rate per 100 Full-Time Workers
Private Industry - Total Recordable Cases

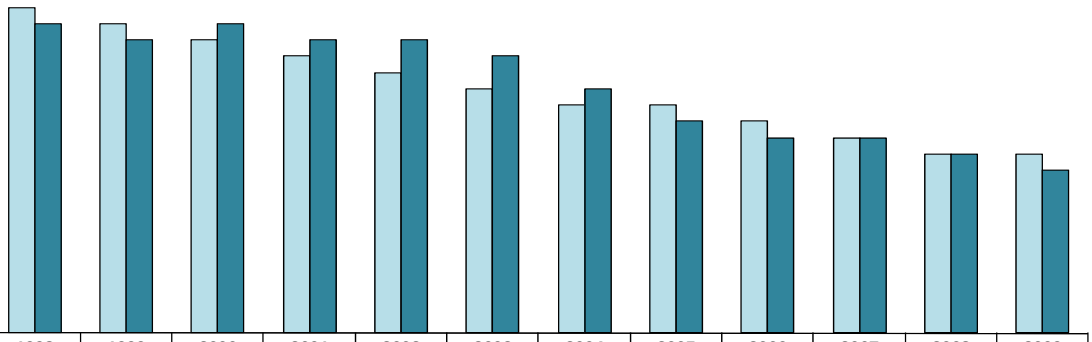


	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
USA	6.7	6.3	6.1	5.7	5.3	5.0	4.8	4.6	4.4	4.2	3.9	3.6
California	6.3	5.9	6.1	5.4	5.6	5.4	4.9	4.7	4.3	4.4	3.9	3.7

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 1998 through 2009. During that time, the U.S. incidence rate for cases with days away from work dropped by more than 45 percent, while the California rate declined by 47 percent.

USA and California
Injury and Illness Incidence Rate per 100 Full-Time Workers
Private Industry - Cases with Days Away from Work

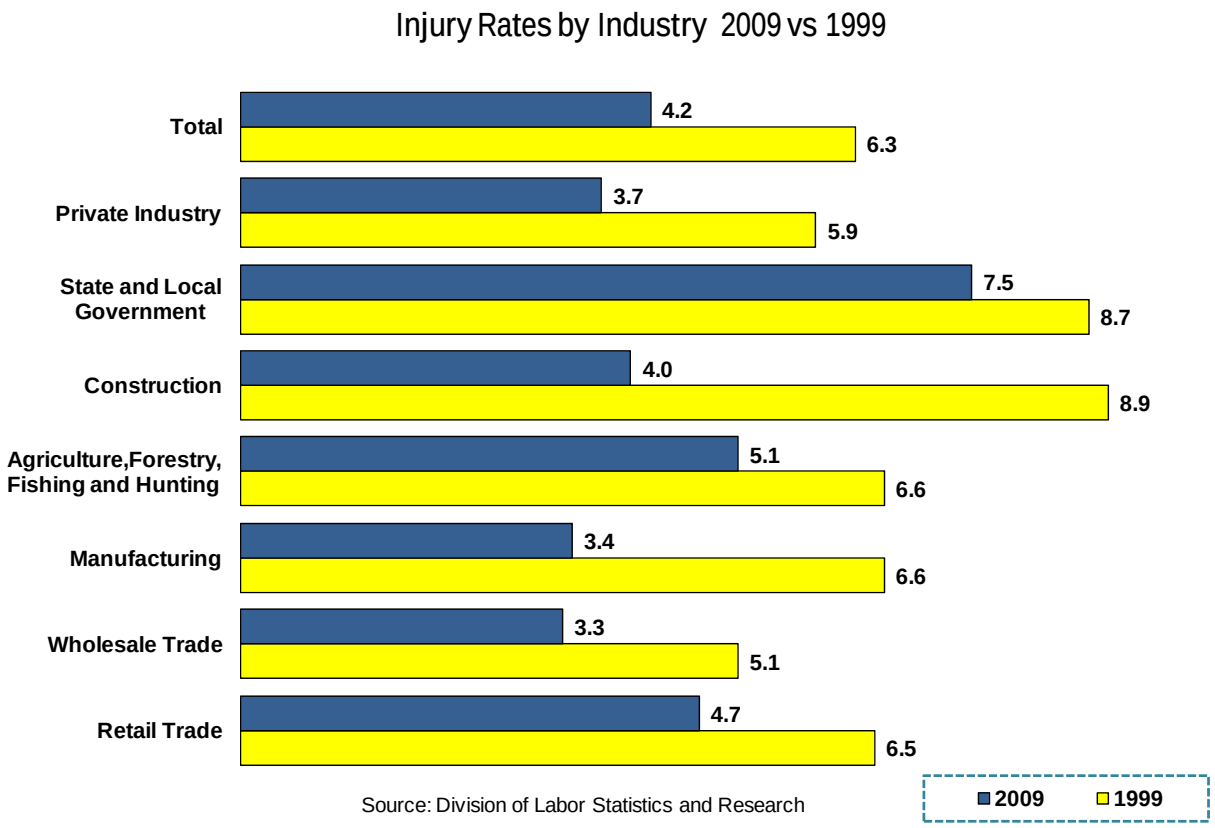


	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
USA	2.0	1.9	1.8	1.7	1.6	1.5	1.4	1.4	1.3	1.2	1.1	1.1
California	1.9	1.8	1.9	1.8	1.8	1.7	1.5	1.3	1.2	1.2	1.1	1.0

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 2009. The overall California occupational injury and illness incidence rates have declined, and the incidence rates in major industries have also declined. The following chart compares incidence rates for total recordable cases in 1999 and 2009 by type of major industry including state and local government.

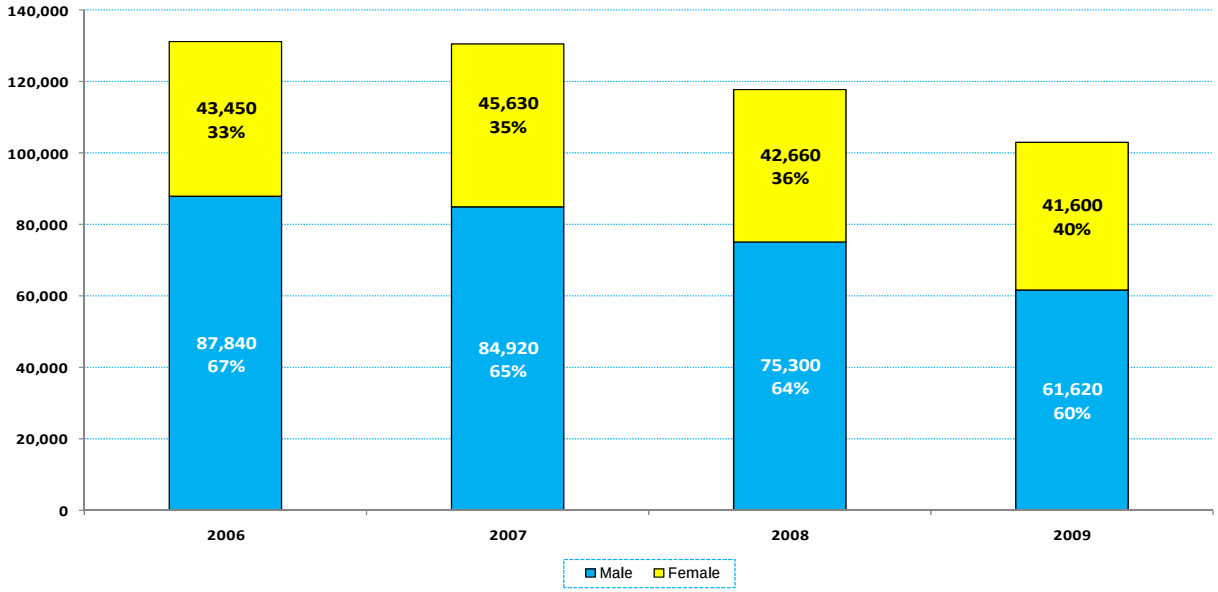


The smallest decline during this period in incidence rates was in the state and local government, and the largest decrease was in construction.

Characteristics of California Non-Fatal Occupational Injuries and Illnesses

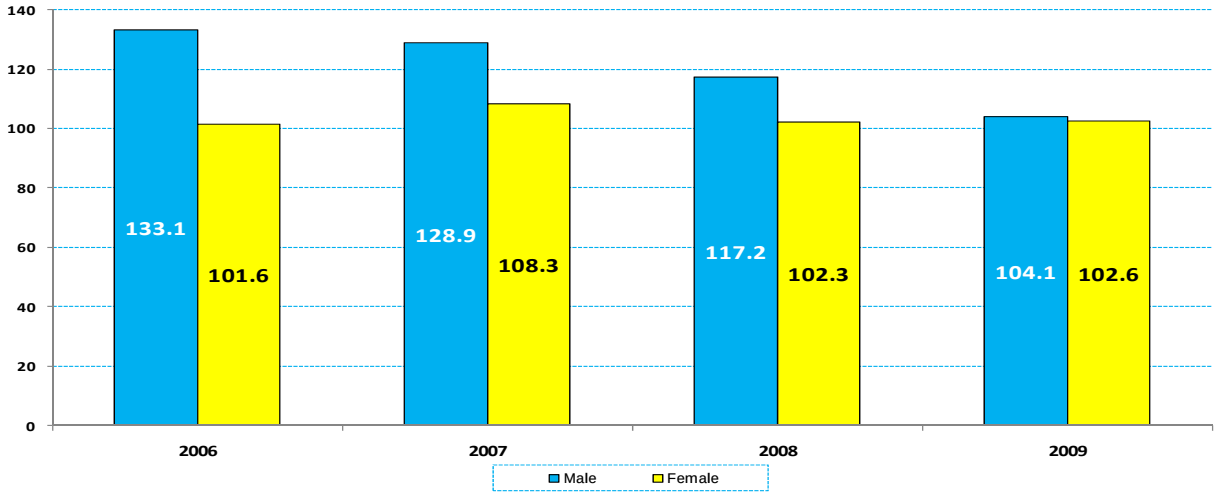
The following charts illustrate various demographic characteristics of non-fatal occupational injuries and illnesses in California's private industry.

Number of Non-Fatal Occupational Inuries and Illnesses in California
by Gender (Private Industry), 2006-2009



Data Source: DLSR

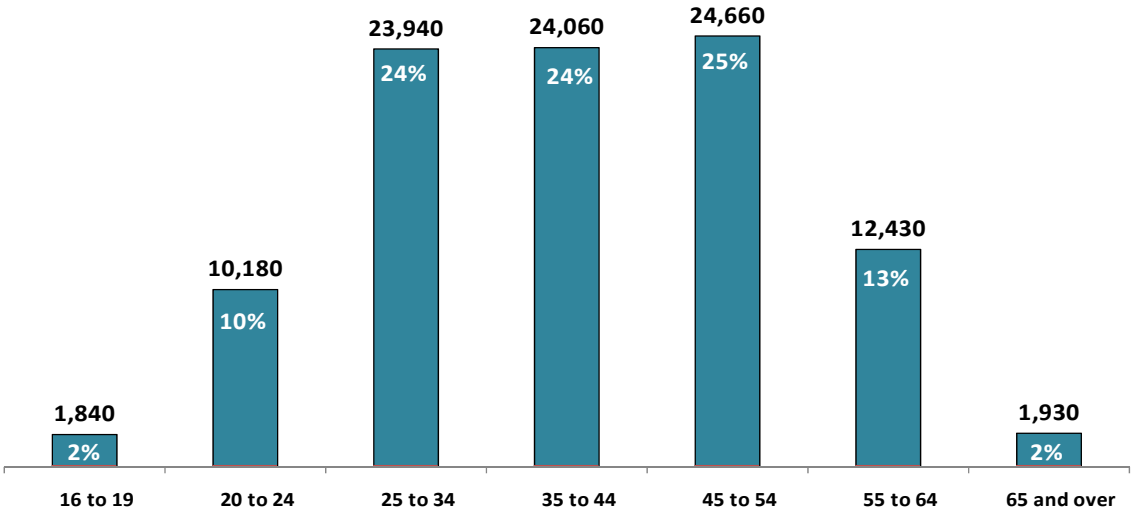
California Occupational Injury and Illness Incidence Rates* by Gender
(Cases per 10,000 full-time employees)
Private Industry, 2006 - 2009



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

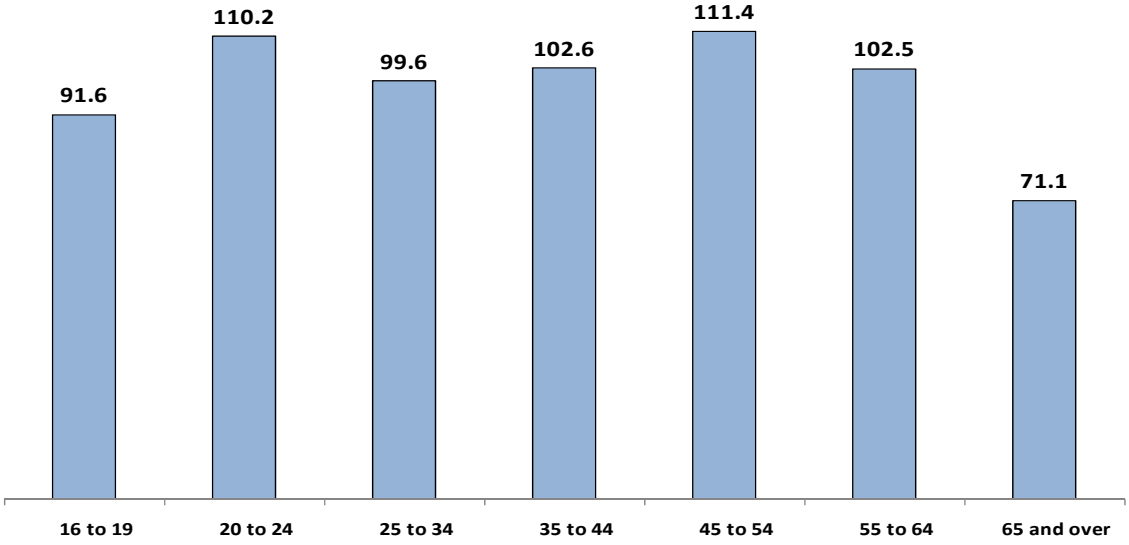
Data Source: BLS, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses in cooperation with participating State agencies.

Number of Non-Fatal Occupational Injuries and Illnesses in California
by Age (Private Industry)- 2009



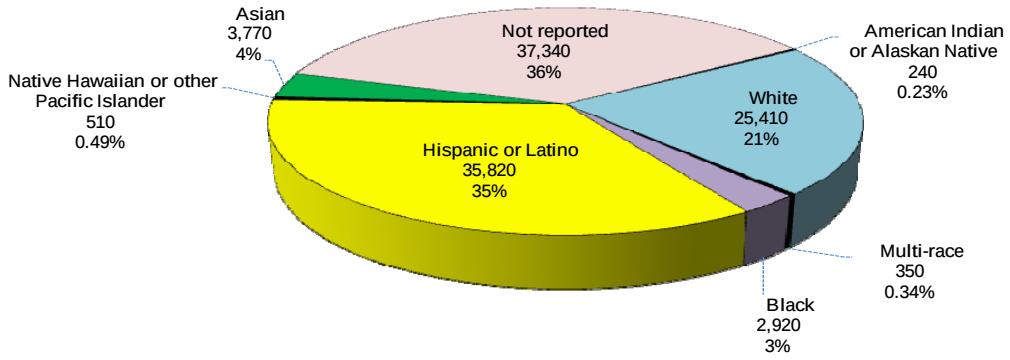
Data Source: DLSR

California Occupational Injury and Illness Incidence Rates by Age
(Cases per 10,000 full-time workers)
Private Industry - 2009



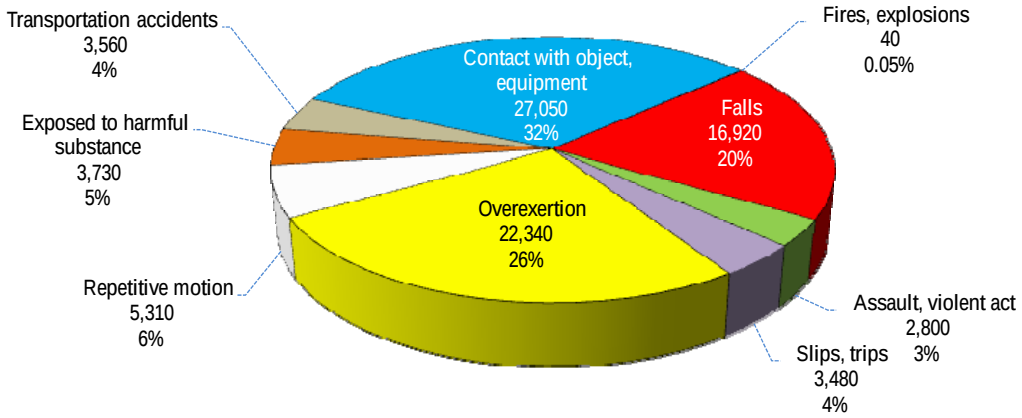
Data Source: BLS, Department of Labor, Survey of Occupational Injuries and Illnesses in cooperation with participating State Agencies

California Non-Fatal Occupational Injuries and Illnesses by Race or Ethnic Origin (Private) - 2009



Data Source: DLSR

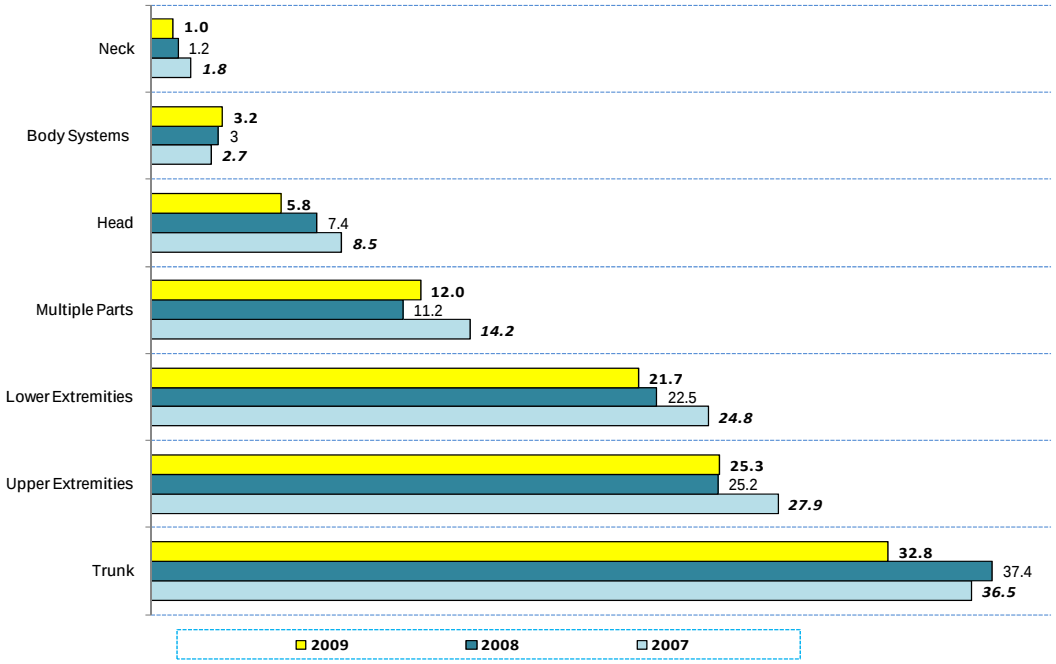
California Non-Fatal Occupational Injuries and Illnesses by Event and Exposure (Private) - 2009



Data Source: DLSR

The following chart shows that the trunk and upper extremities were the major body parts with the greatest incidence rates in 2007, 2008 and 2009.

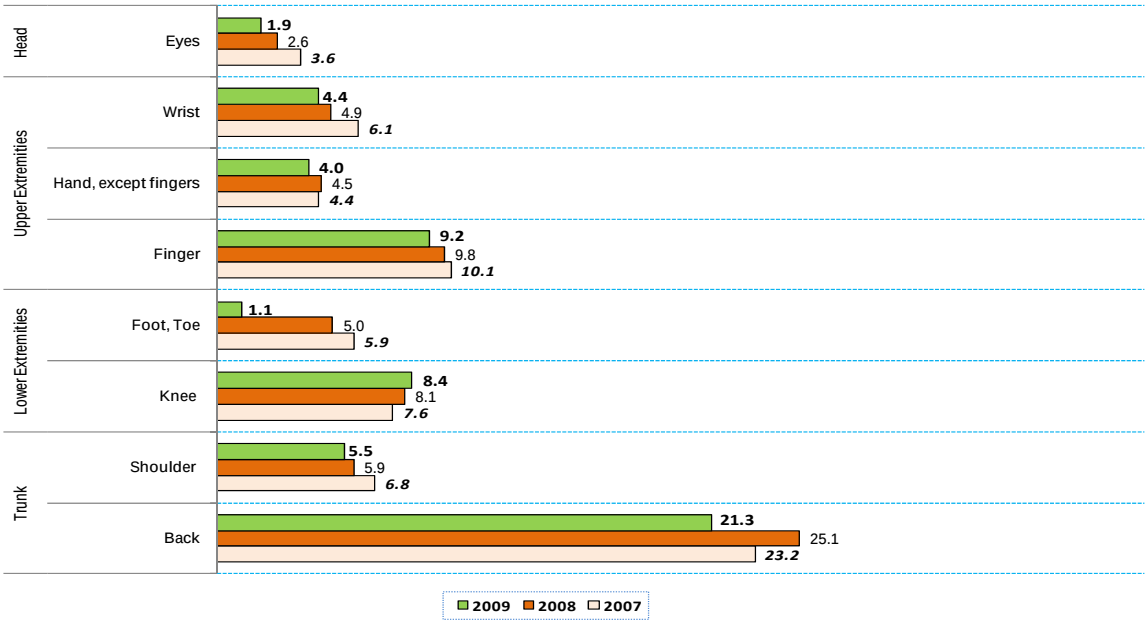
Incidence Rates for Non-Fatal Occupational Injuries and Illnesses by Major Body Parts
(per 10,000 full-time workers) Private Industry, 2007 - 2009



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

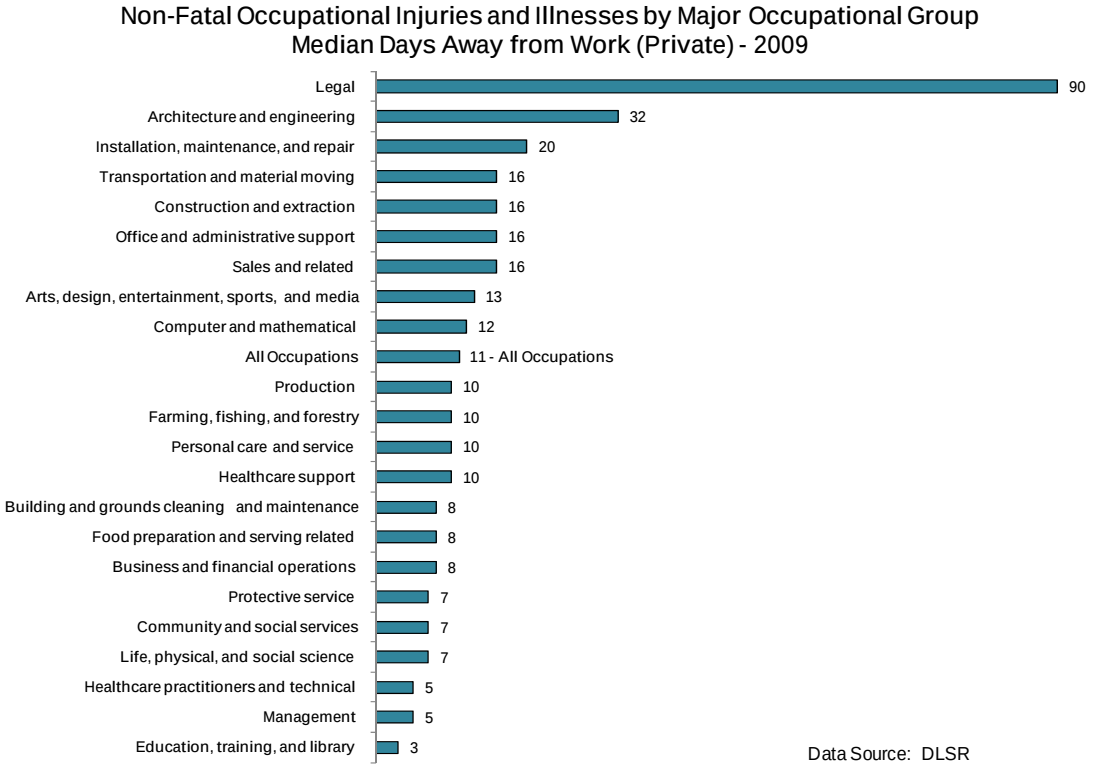
The following chart shows that the back was the body part with the highest incidence rate in 2007, 2008 and 2009.

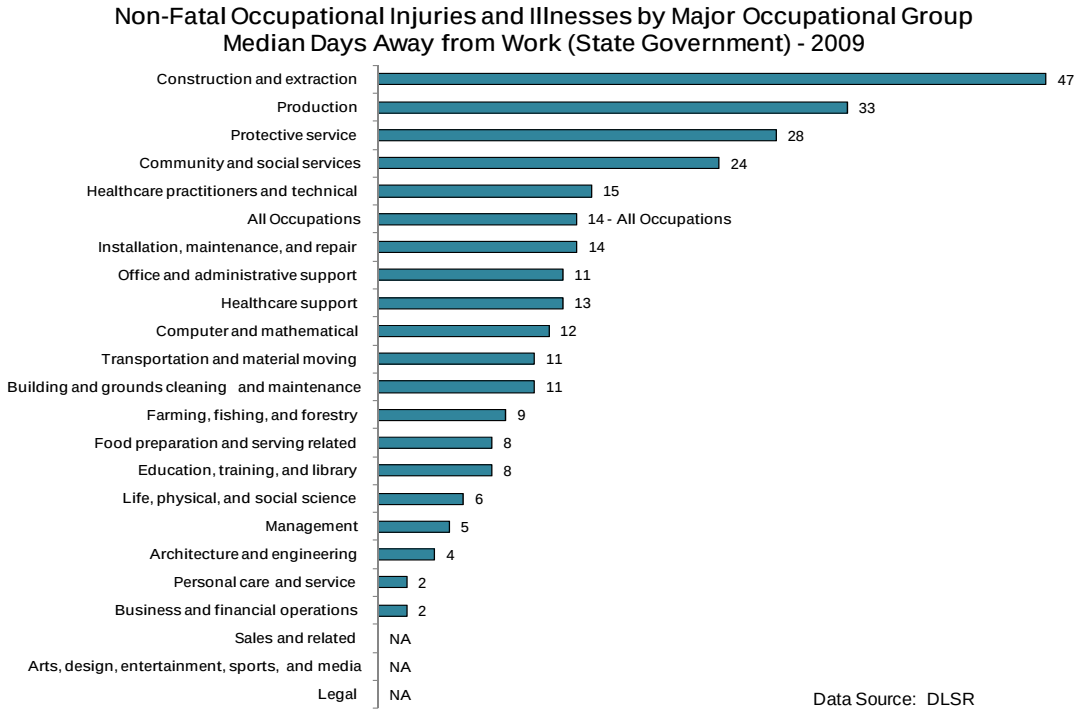
Incidence Rates for Non-Fatal Occupational Injuries and Illnesses by Body Part Units
(per 10,000 full-time workers) Private Industry, 2007 - 2009

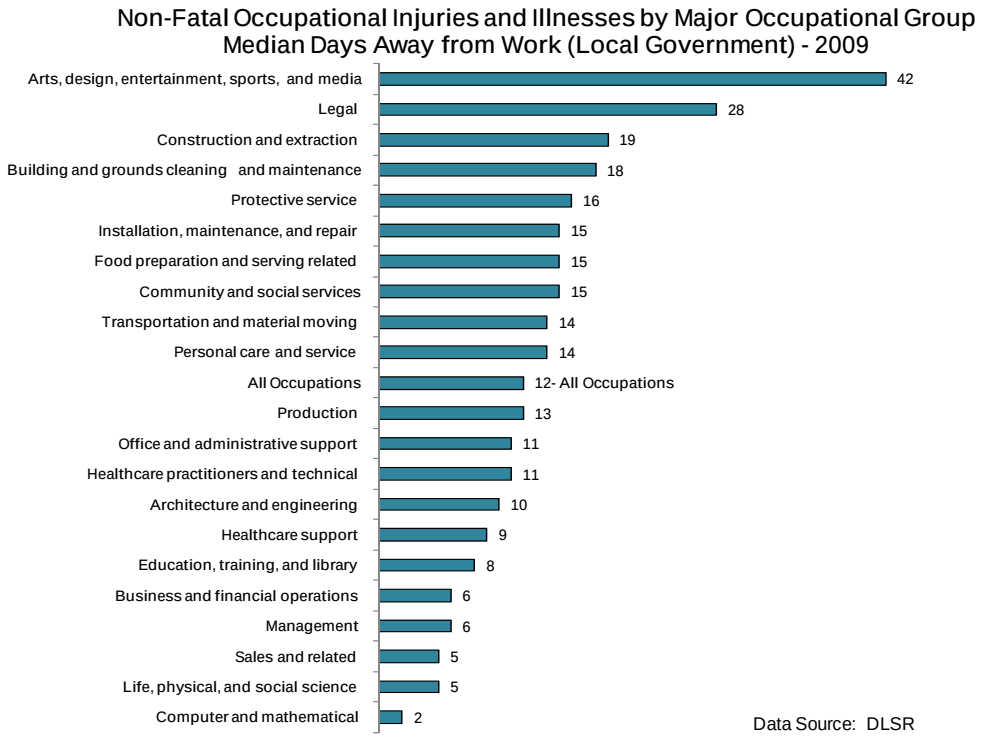


Data Source: BLS, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses (SOII) in cooperation with participating State agencies.

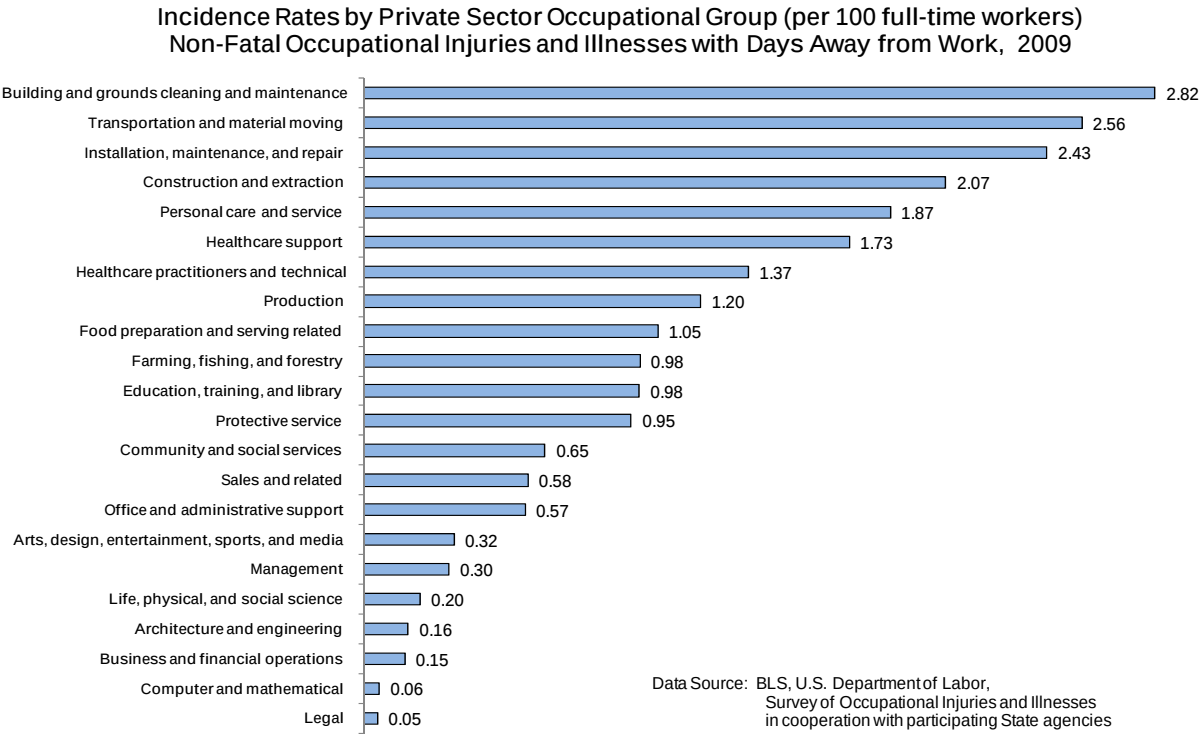
The following three charts compare the median days away from work for private industry occupations, state government occupations, and local government occupations. Legal, construction and extraction, and arts, design, entertainment, sports, and media occupations have the greatest median days away from work in private industry, state government, and local government respectively.

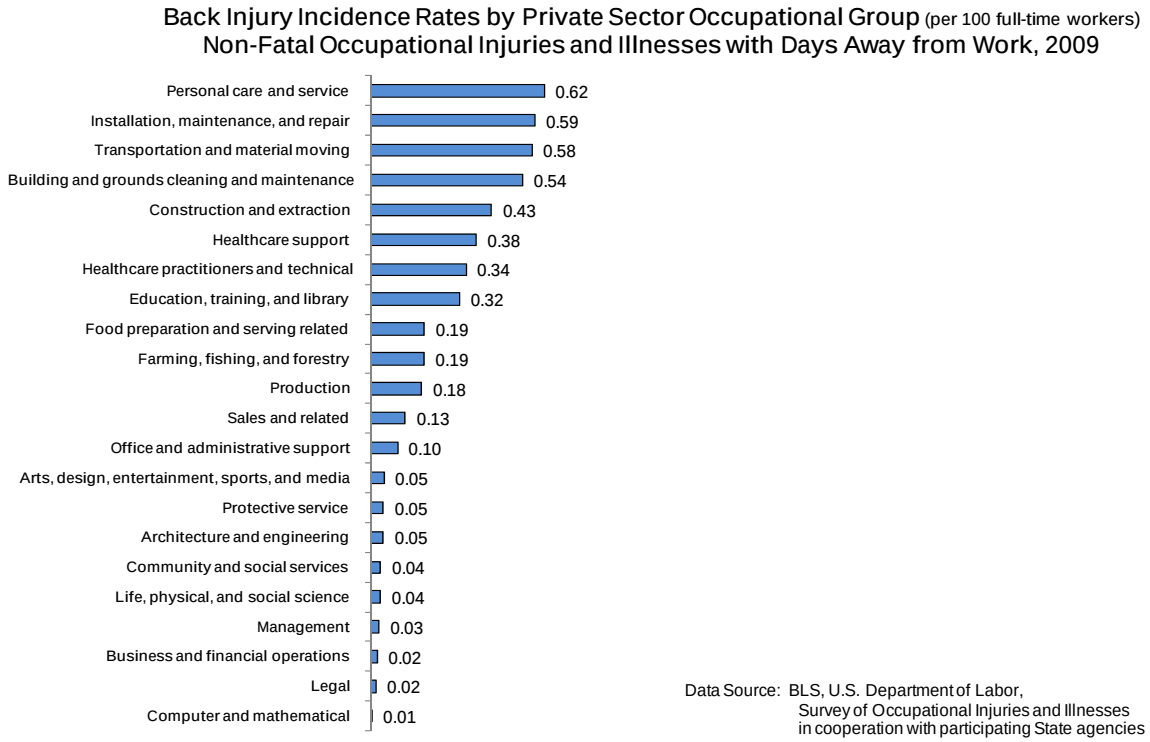




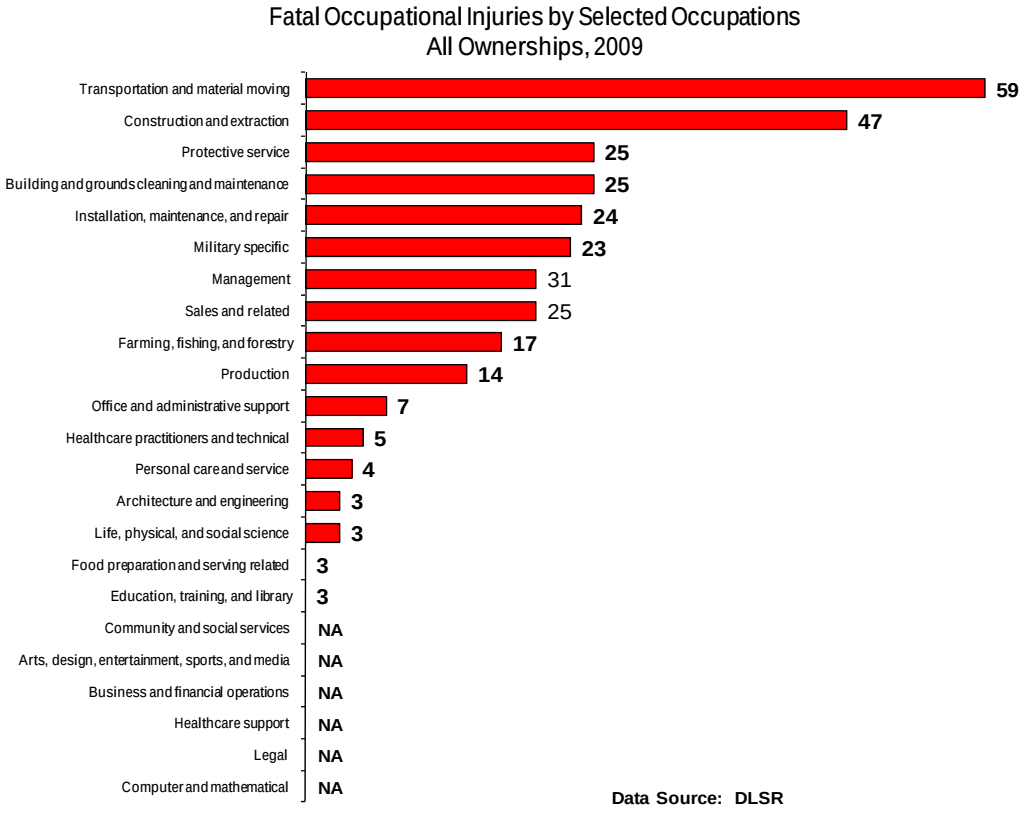


The following two charts compare the injury and illness incidence rates, including back injury, for various occupations. The building and grounds cleaning and maintenance occupations had the highest incidence rate in 2009, followed by the transportation and material moving occupations.





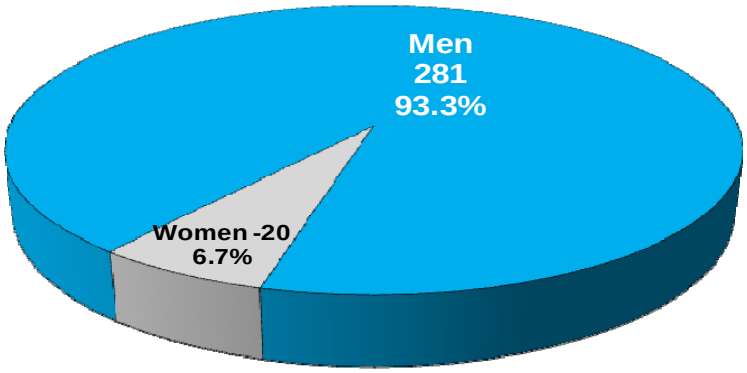
The following chart compares the number of fatalities for various occupations. The transportation and material moving occupation had the greatest number of fatalities in 2009, followed by the construction and extraction occupation.



Characteristics of California Fatal Occupational Injuries and Illnesses

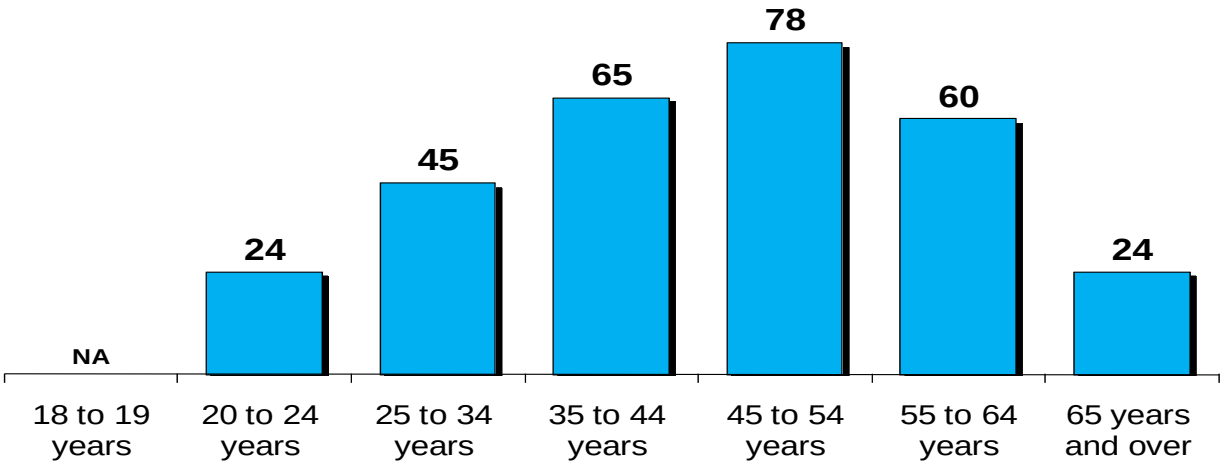
The following charts illustrate various characteristics of fatal occupational injuries and illnesses in California's private industry and federal, state and local governments.

California Fatal Occupational Injuries and Illnesses
by Gender - 2009



Data Source: BLS

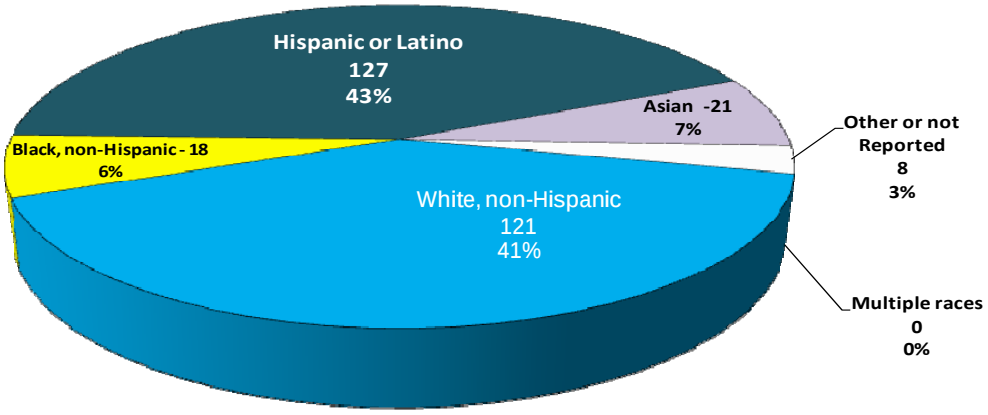
California Fatal Occupational Injuries and Illnesses
by Age of Worker - 2009*



* Preliminary data

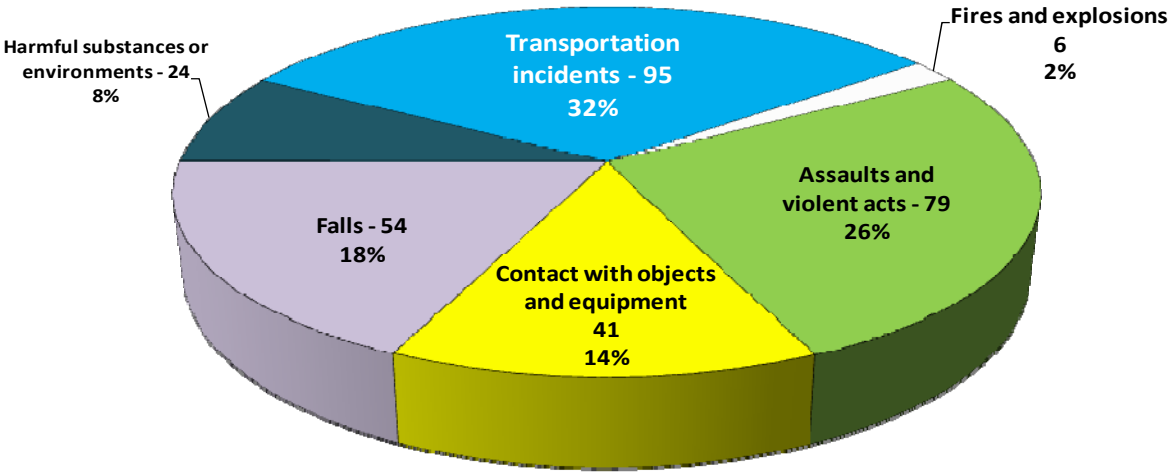
Source: BLS

California Fatal Occupational Injuries and Illnesses by Race and Ethnic Origin - 2009



Data Source: BLS

California Fatal Occupational Injuries and Illnesses by Event and Exposure - 2009



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 2009 indicate a non-fatal injury and illness rate of 3.7 cases per 100 full-time employees in the private sector in 2009. This is a 37.3 percent decline from the 1999 level of 5.9 and an estimated 5 percent decrease from the previous year's figures.
- The trend in California mirrors a national trend. DOL figures for private employers show that from 1999 to 2009, the work injury and illness rate across the U.S. fell from 6.3 to 3.6 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 and the shift from manufacturing toward service jobs.
- In contrast to the private sector rates, California's public sector decline has not been nearly as dramatic and the incidence rates are twice as high as in the private sector. California's state and local government rate for 2009 is 7.5 cases per 100 full-time employees. This is 13.8 percent decline from the 1999 level of 8.7 and almost a 30 percent increase over the state and local government national rate of 5.8. In addition, both the state and local government sectors have seen some increases in incidence rates over the past five years.
- The national fatality rate decreased by 17.8 percent between 1999 and 2008 from 4.5 to 3.7 cases per 100,000 employed while California's fatality rate decreased from 3.7 to 2.8 cases per 100,000 employed during the same period. This is a 24.3 percent decline from the 1999 level and a 7.7 percent increase from the previous year.
- From the Western region states, Alaska, Arizona, California, Hawaii, Nevada, Oregon and Washington, Arizona's and California's 2009 private industry rates of 3.5 and 3.7 respectively for non-fatal occupational injuries and illnesses were the lowest.[33] The state that had the third-lowest incidence rate was Hawaii (4.0).

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 1.0 case per 100 full-time employees from 1999 to 2009 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.
- California's and national overall days-away-from-work rate of 1.2 cases in 2009 was an estimated 8 percent and 5 percent lower than the previous year's figures respectively. Some of this overall decline, according to BLS, may be attributed to economic factors, including a decrease in employment and total hours worked, particularly in construction and manufacturing.

Industry Data

- In 2009, injury and illness incidence rates varied greatly between private industries ranging from 1.5 injuries/illnesses per 100 full-time workers in the finance and insurance industry to 5.4 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 (3.4 and 4.3), agriculture, forestry, fishing and hunting (5.1 and 5.3), construction (4.0 and 4.3), health care and social assistance (5.3 and 5.4), and accommodation and food services (3.6 and 3.7).

[33] The comparisons of industry rates have not been adjusted for industry mix within each state.

- The private industry total case rate for non-fatal injuries decreased between 2008 and 2009 from 3.9 to 3.7, and the rate for the public sector (state and local government) decreased by 2.5 percent from 7.9 in 2008 to 7.5 in 2009.
- According to DLSR, the largest decrease in injury and illness by major industry category was in utilities, from 5.0 to 4.1 per 100 full-time worker injuries in 2008 and 2009 respectively, followed by a decrease in construction from 4.8 to 4.0 per 100 full-time worker injuries in 2008 and 2009, and by administrative and support and waste management and remediation services, from 3.8 to 3.3 per 100 full-time worker injuries in 2008 and 2009.[34]
- According to DLSR, the largest increase in injury and illness by industry sectors was in mining, from 1.7 to 2.5 per 100 full-time worker injuries in 2008 and 2009 respectively, followed by real estate and rental and leasing with an increase from 3.0 to 3.8 per 100 full-time worker injuries in 2008 and 2009, and management of companies and enterprises, from 2.7 to 3.3 in 2008 and 2009.[35]
- Over the past decade (1999-2009), the number of fatal injuries declined 51.2 percent, from 561 to 274.[36] From 2008 to 2009, the number of fatal injuries decreased by 38.4 percent. The highest number of fatal injuries was in trade, transportation and utilities (78), followed by construction (50) and professional and business services (30).
- In private industry, the top ten occupations with the most non-fatal injuries and illnesses in 2009 are: laborers and freight, stock, and material movers, hand; truck drivers, light or delivery services; retail sales persons; janitors and cleaners, except maids and housekeeping cleaners; farm workers and laborers, crop, nursery, and greenhouse; registered nurses; maids and housekeeping cleaners; construction laborers; truck drivers, heavy and tractor-trailer; nursing aides, orderlies, and attendants.
- In California state government, the top ten occupations with the most non-fatal injuries and illnesses in 2009 are: psychiatric technicians; correctional officers and jailers; psychiatric aides; registered nurses; police and sheriff's patrol officers; janitors and cleaners, except maids and housekeeping cleaners; first-line supervisors/managers of correctional officers; nursing aides, orderlies, and attendants; first-line supervisors/managers of food preparation and serving workers; eligibility interviewers, government programs.
- In local government, the top ten occupations with the most non-fatal injuries and illnesses in 2009 are: police and sheriff's patrol officers; janitors and cleaners, except maids and house-keeping cleaners; fire fighters; elementary school teachers, except special education; teacher assistants; bus drivers, transit and intercity; correctional officers and jailers; landscaping and grounds keeping workers; cooks, institution and cafeteria; first-line supervisors/managers of police and detectives; first-line supervisors/managers of fire fighting and prevention workers.
- Transportation and material-moving occupations (59) and construction and extraction (47) accounted for 35.8 percent of the fatal injuries in 2009. Protective services (25), building and grounds cleaning and maintenance (25), installation, maintenance, and repair (24), military specific (23), management (31), sales and related (25), farming, fishing, and forestry (17), production (14) were the other occupations with the most number of fatal injuries in 2009. Transportation and material-moving incidents were the number one cause of fatal injuries accounting for about 20 percent of fatal injuries in 2009.
- 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).

[34] DLSR, Table 1: Incidence rates of non-fatal occupational injuries and illnesses by selected industries and case types, 2008, 2009.
[35] Ibid.
[36] The number of fatalities excludes the number of fatalities for the Federal government.

Establishment Size and Type

- The lowest rate for the total recordable non-fatal cases in 2009 was experienced by the smallest employers. Employers with 1 to 10 employees and 11 to 49 employees had incidence rates of 1.7 and 3.5 cases, respectively, per 100 full-time employees. There was a 15 percent decrease in incidence rates for employers with 1 to 10 employees from 2008 to 2009. Employers with 11 to 49 employees experienced a 6 percent increase in incidence rates compared to 2008.
- Establishments with 250 to 999 and 1,000 and more employees reported the highest rates of 5.1 and 5.2 cases per 100 full-time employees, respectively, in 2009. Establishments with 50 to 249 experienced no change from 5.1 cases per 100 full-time employees from 2008 to 2009.

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 38.4 percent of days-away-from-work cases in the private sector. Cuts, lacerations, bruises, contusions, heat burns, carpal tunnel syndrome, tendonitis, amputations, chemical burns, and multiple injuries have decreased from 1998 to 2009, with the biggest decreases of 74 percent seen in both carpal tunnel syndrome and tendonitis.
- In the private sector, contact with objects and equipment was the leading cause of days-away-from-work injuries, cited in about 26.1 percent of days-away-from-work cases. Overexertion was the second common cause of injury, accounting for about 21.6 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 12.3 percent of days-away-from-work cases, respectively, in 2009.
- In local government, the main causes of injury were overexertion and contact with object, equipment, accounting for 17 and 16.2 percent of days-away-from-work cases, respectively, in 2009.
- The most frequently injured body part is the back, accounting for about 14.6 percent of the cases in state government and about 20 percent cases in local government. In the private sector, back injuries account for 20.6 percent of non-fatal cases.

Demographics

- Over the period from 1999 to 2009 in the California private sector, the number of days-away-from-work cases for women decreased by 30.4 percent. Days-away-from-work cases for men decreased by 49.1 percent.
- Between 1999 and 2009, in private industry, all age groups experienced a decline. The biggest decline (62.2 percent) occurred among 16 to 19 year-old workers. The age group 35 to 44 experienced a 54.8 percent decline, and the age group 25 to 34 experienced a 50.8 percent decrease in the numbers of days away from work.
- In 2009, out of 301 fatalities (including the Federal government), approximately 93 percent were male and 7 percent were female. All age group categories experienced a decrease in fatal injuries between 2008 and 2009. The biggest decrease in the number of fatalities (42 percent) was seen in the 25 to 34 age group (from 77 to 45 cases), followed by a 39 percent decrease in the age group 35 to 44 (from 106 to 65 cases) and a 35 percent decrease in the age group 20 to 24 (from 37 to 24 cases) and the age group 45 to 54 (from 120 to 78) in the period of time from 2008 to 2009.
- The highest number of fatalities in 2009 by race or ethnic origin categories was experienced by “Hispanic or Latino” group followed by “White, non-Hispanic” group, accounting for 43 percent and 41 percent of the fatalities, respectively. From 2008 to 2009, there was a decrease in fatal injuries

for all ethnic groups, except for “Other or Not Reported” with the highest decrease (51 percent) in “Asian” group and 42 percent decrease in “Black or African American” group. There was a 167 percent increase in the number of fatalities (from 3 to 8) in “Other or Not Reported” group from 2008 to 2009.

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.

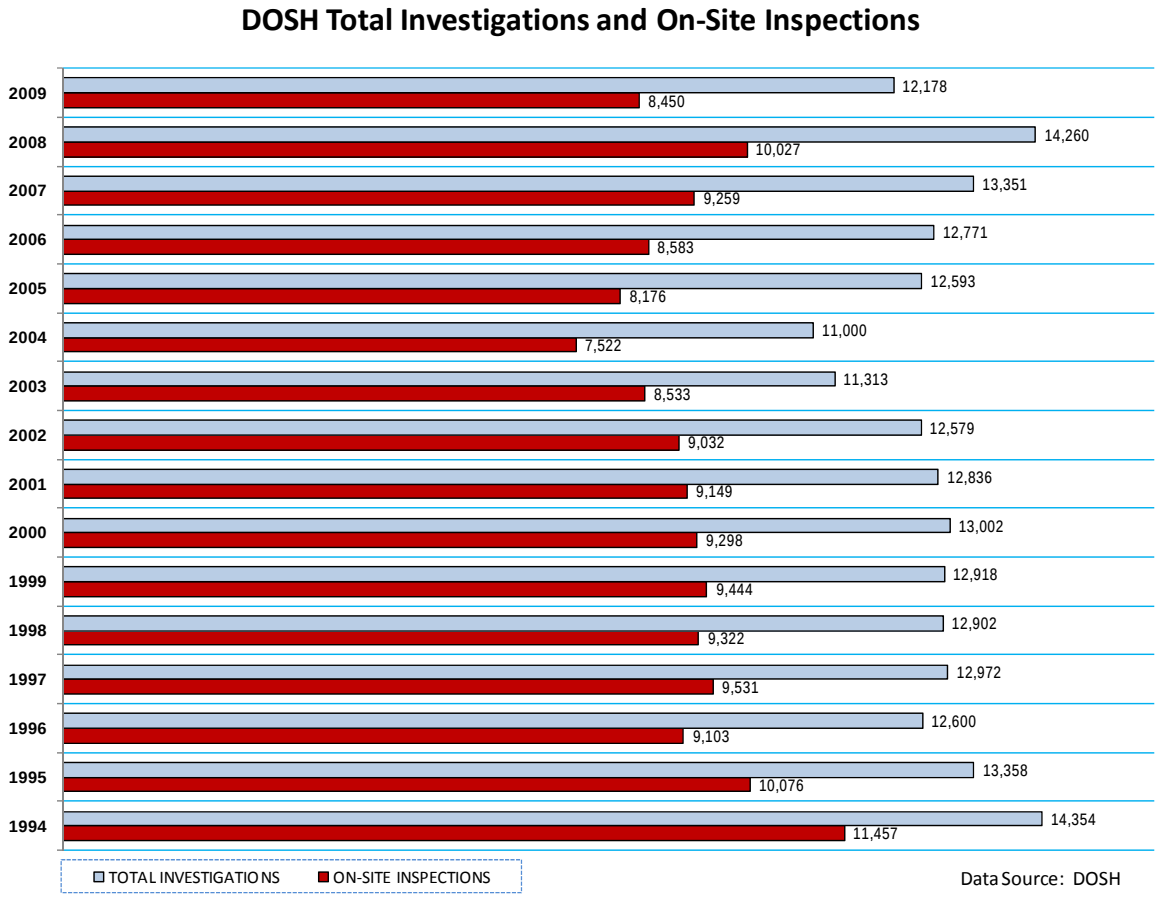
Other specialized units, such as the Crane Certifier Accreditation Unit, the Asbestos Contractors' Registration Unit, the Asbestos Consultant and Site Surveillance Technician Unit and the Asbestos Trainers Approval Unit, are responsible for enforcing regulations pertaining to crane safety and prevention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

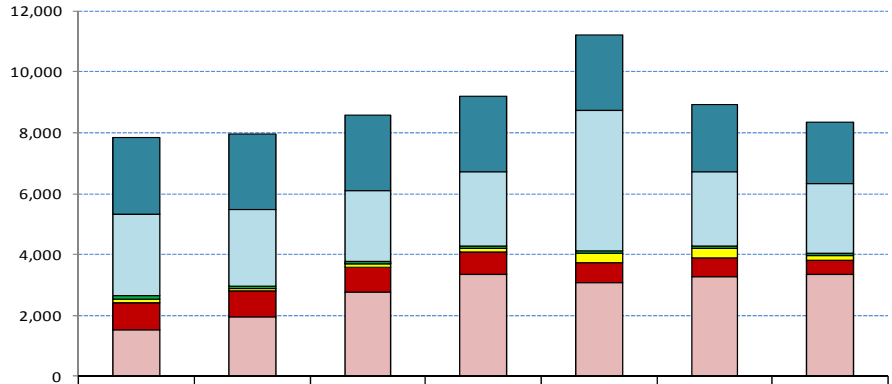
The following chart shows the total numbers of investigations and on-site inspections for the period from calendar year (CY) 1994 through 2009.[37] The total number of investigations decreased 14 percent and the number of on-site inspections decreased 26 percent from CY 1994 to 1996. During the next seven years, from 1996 to 2002, the number of investigations averaged 12,830, and the number of on-site inspections averaged 9,268. From 2002 to 2004, there was decrease in both the number of investigations (14 percent) and number of on-site inspections (20 percent). From 2004 to 2008, there was a 29.6 percent increase in investigations and 33 percent increase in the number of on-site inspections. There was a 17 percent decrease in investigations and almost 19 percent decrease in the number of on-site inspections from 2008 to 2009.



[37] 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 total Inspections had been increasing from 7,831 in FY 2004-05 to 9,198 in FY 2007-08, and then had decreased to 8,347 in FY 2009-2010.

DOSH Inspections by Type FY 2003-04 to FY 2009-10

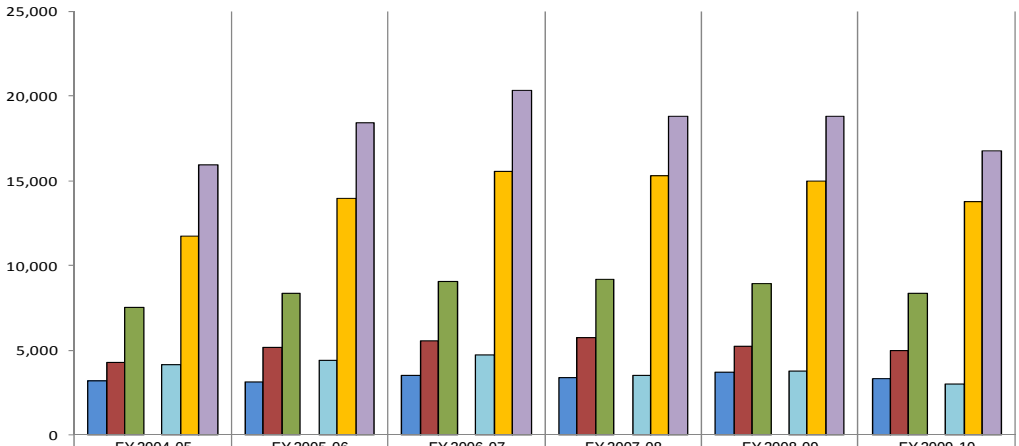


	FY2003-04	FY2004-05	FY2005-06	FY2006-07	FY2007-08	FY2008-09	FY2009-10
Accident (unprogrammed)	2,500	2,479	2,484	2,486	2,483	2,228	2,025
Complaint (unprogrammed)	2,700	2,503	2,305	2,444	4,576	2,421	2,272
Referral (unprogrammed)	109	82	80	74	97	89	82
Monitoring (unprogrammed)	-	-	1	-	-	-	-
Follow-up (unprogrammed)	101	78	114	115	294	295	175
Unprogrammed Related (different employer, same worksite)	909	858	827	730	679	627	461
Programmed	1,512	1,952	2,761	3,344	3,069	3,272	3,332
TOTAL	7,831	7,952	8,572	9,039	9,198	8,932	8,347

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 2009-10, 60 percent of inspections resulted in violations cited. The breakdown by type is shown in the chart below.

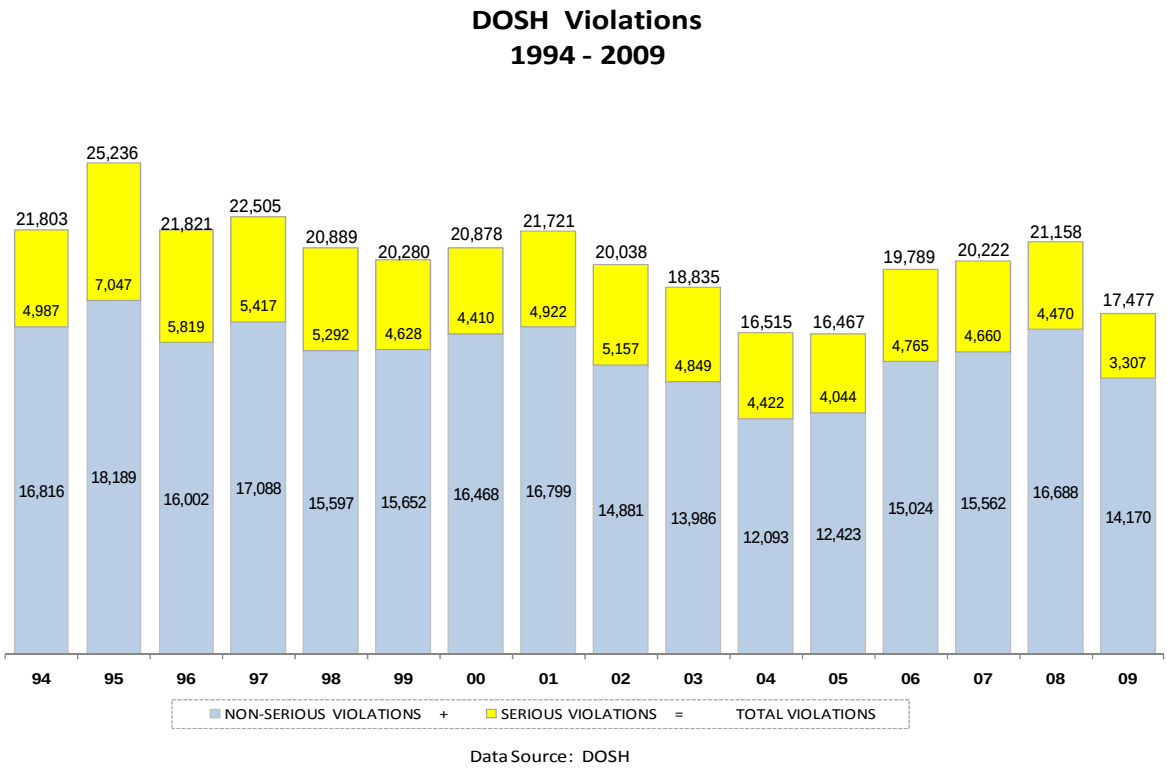
DOSH Inspections and Violations Cited FY 2004-05 to FY 2009-10



	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
Inspect-s without violations cited	3,236	3,162	3,502	3,393	3,692	3,356
Inspections with violations	4,300	5,180	5,537	5,776	5,240	4,991
Total Inspections	7,536	8,342	9,039	9,169	8,932	8,347
Serious Violations	4,176	4,403	4,749	3,513	3,796	2,992
Other than Serious Violations	11,742	13,997	15,585	15,312	15,004	13,799
Total Violations	15,918	18,400	20,334	18,825	18,800	16,791

Data Source: DIR - Division of Occupational Safety and Health

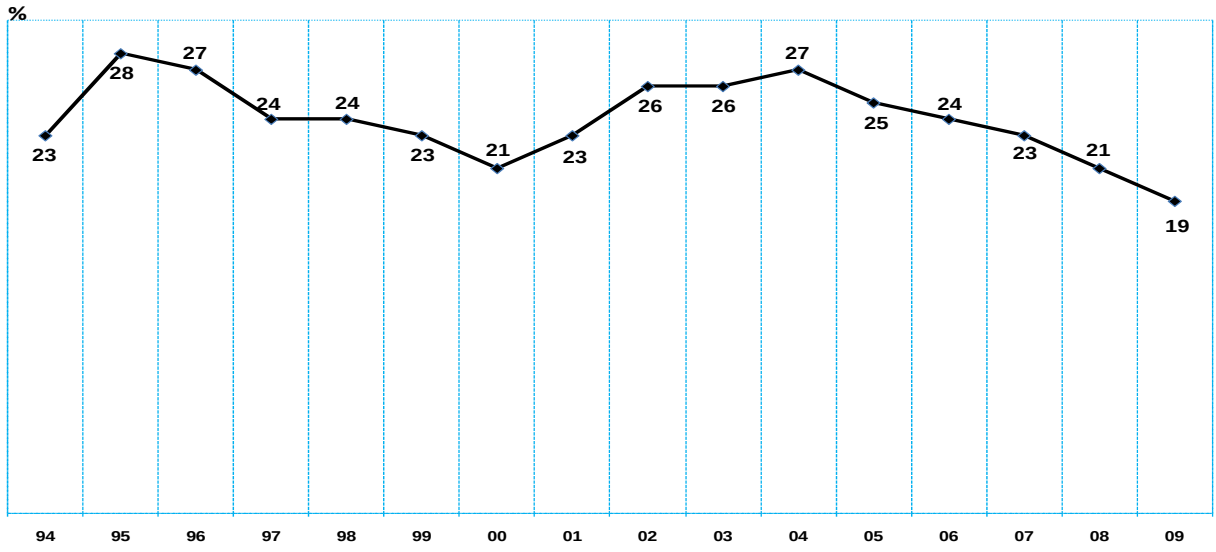
The following chart shows the total numbers of violations, including the number of serious DOSH violations from CY 1994 to CY 2009. The total number of violations increased by 16 percent from 1994 to 1995. After decreasing by 13.5 percent from 1995 to 1996, the total number of DOSH violations averaged 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. From 2008 to 2009, there was a 17 percent decrease in the total number of DOSH violations



As the chart above shows, the number of serious violations increased by 41 percent from 1994 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 almost 31 percent from 2006 to 2009.

The chart below shows the trend in the share of serious DOSH violations in the total number of all violations from 1994 to 2009. The share of serious DOSH violations increased from 23 percent in 1994 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 19 percent from 2004 to 2009.

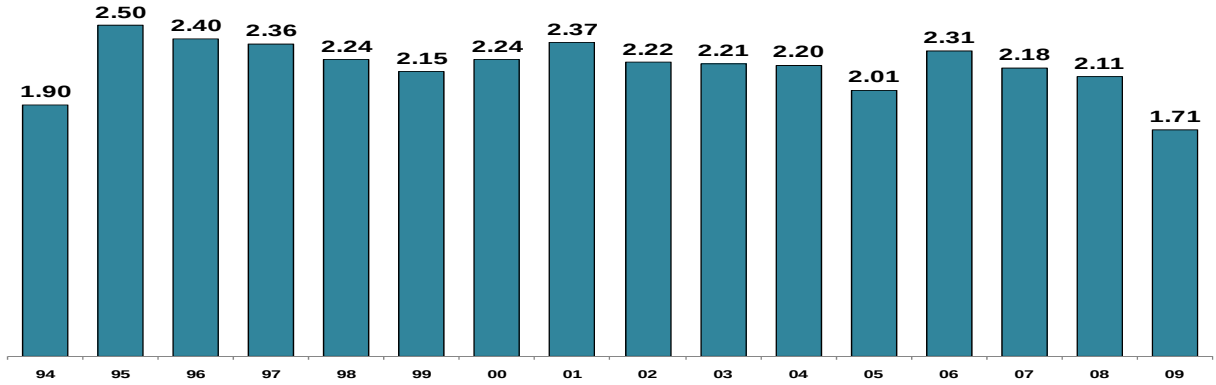
Percent of Serious Violations in Total DOSH Violations
1994 - 2009



Data Source: DOSH

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 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 26 percent from 2006 to 2009.

Average Number of DOSH Violations per Inspection
1994 - 2009



Data Source: DOSH

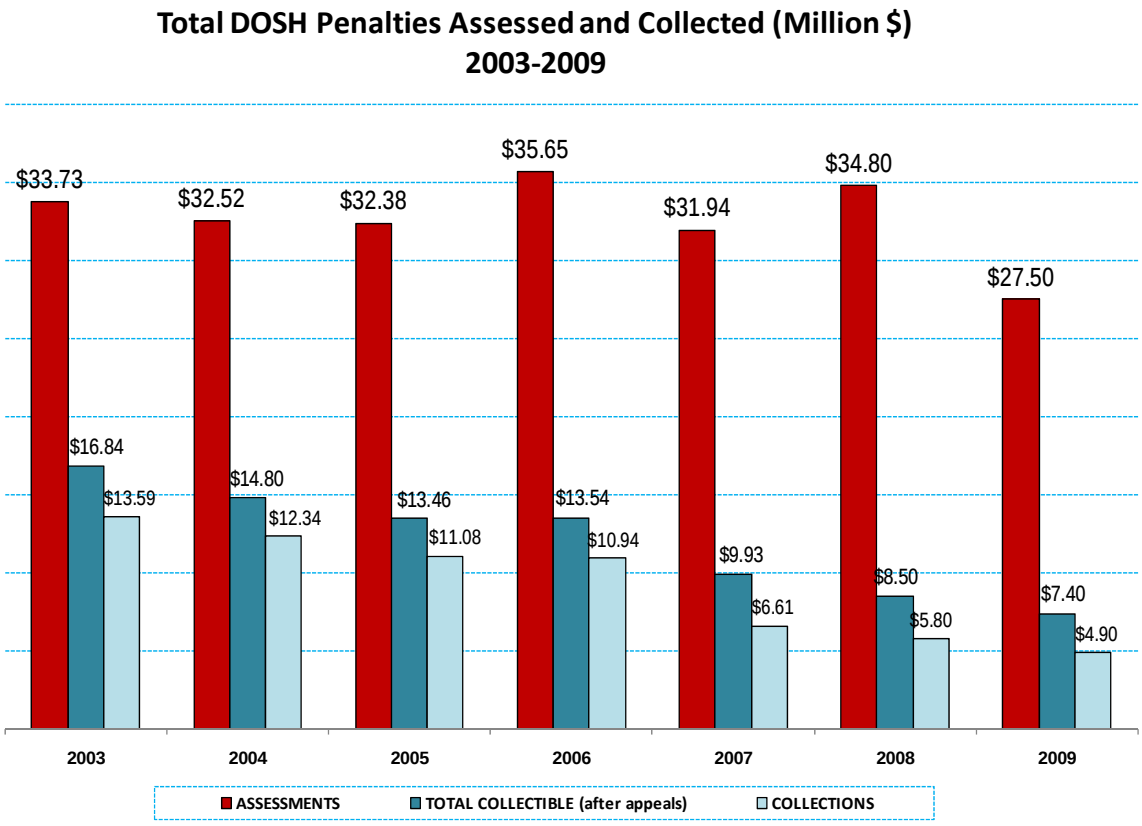
Twenty-Five Most Frequently Cited Title 8 California Code of Regulations (CCR) Standards in 2009

Standard	Description	Total Violations	Serious Violations	Percent Serious
3203	Injury and Illness Prevention Program	1,845	72	3.9
3395	Heat Illness Prevention	1,162	115	9.9
1509	Construction Injury Prevention Program	835	10	1.2
5194	Hazard Communication	660	8	12.2
6151	Portable Fire Extinguishers	523	4	0.8
3314	Clean, Repair, Service and Adjust Prime Movers, Machinery and Equipment	502	147	29.3
342	Reporting Work Fatality or Serious Injury	434	1	0.2
5144	Respiratory Protection Equipment	434	10	2.3
461	Permits to Operate Air Tanks	406	3	0.7
2340.16	Work Space About Electrical Equipment	366	5	1.4
3457	Field Sanitation	296	10	3.4
5162	Emergency Eyewash	294	106	36.0
4650	Compressed Gas and Air Cylinders:	280	40	14.3
1512	Construction: Emergency Medical Services	205	1	0.5
5189	Process Safety Management of Acutely Hazardous Substance	202	48	23.8
3668	Powered Industrial Truck Operator Training	200	9	4.5
2500.08	Flexible Electrical Cords and Cables: Uses Not Permitted	199	2	1.0
3328	Safe Practices, Personal Protection: Machinery and Equipment	177	58	32.8
2340.12	Installation and Maintenance of Electrical Equipment	170	53	31.2
1675	Ladders	161	61	37.9
3577	Use, Care , and Protection of Abrasive Wheels: Protection Devices	161	48	29.8
1644	Metal Scaffolds	156	89	57.0
4070	Belt and Pulley Drive, Guarding	156	123	78.8
2340.17	Guarding of Energized Parts in Electrical Installations	153	53	34.6
2340.22	Equipment Identification in Electrical Installations	152	19	12.5

Data Source: DIR-DOSH

The chart below demonstrates the trends in penalties and collections. Total Penalties Assessed were $27.5 million in 2009. 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 $4.9 million in FY 2009.

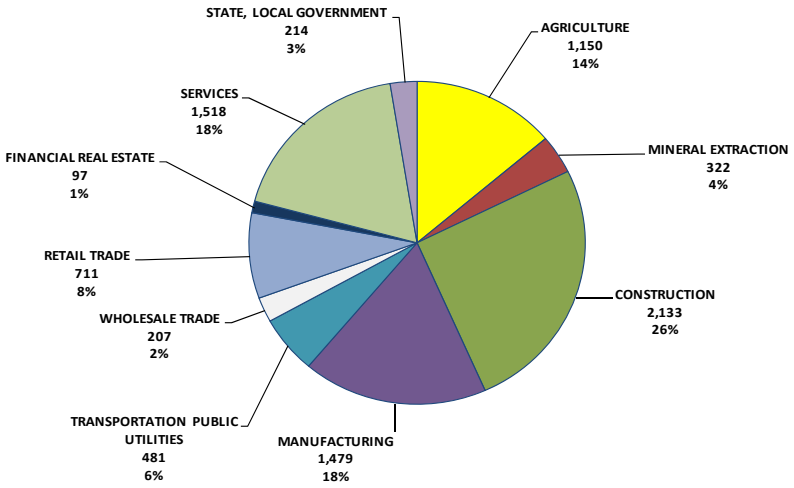
Although the chart below demonstrates the trends in penalties and collections, it cannot be viewed entirely as an indicator of progress in health and safety at places of employment, due to related impacts on the data from DOSH staffing changes and resource changes from year to year, as well as activities 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.



Data Source: DOSH

The chart below illustrates the proportion of inspections in major industrial groups. Of the 8.312 workplace health and safety inspections conducted in FY 2009-10, 2,133 (26 percent) were in construction and 6,179 (74 percent) were in non-construction.

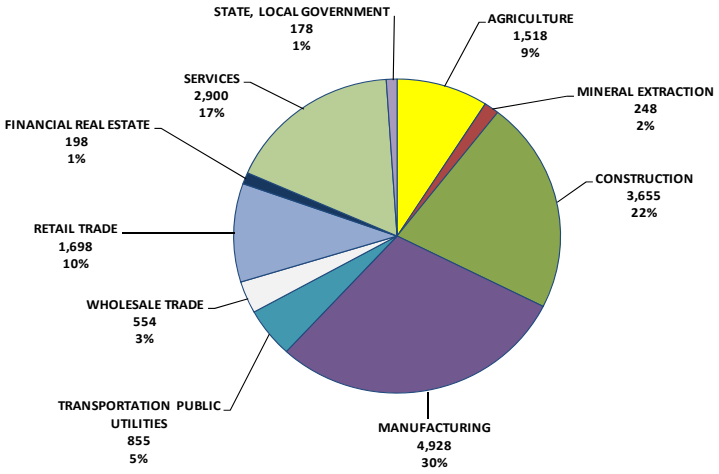
Distribution of Inspections by Major Industry, State FY 2009-10
(Total Inspections=8,312)



Data Source: DOSH

Despite the fact that the greatest percentage of inspections were in construction, the greatest percentage (30 percent) of violations were found to be in manufacturing, as shown in the chart below.

Distribution of Violations by Major Industry, State FY 2009-10
(Total Violations=16,732)



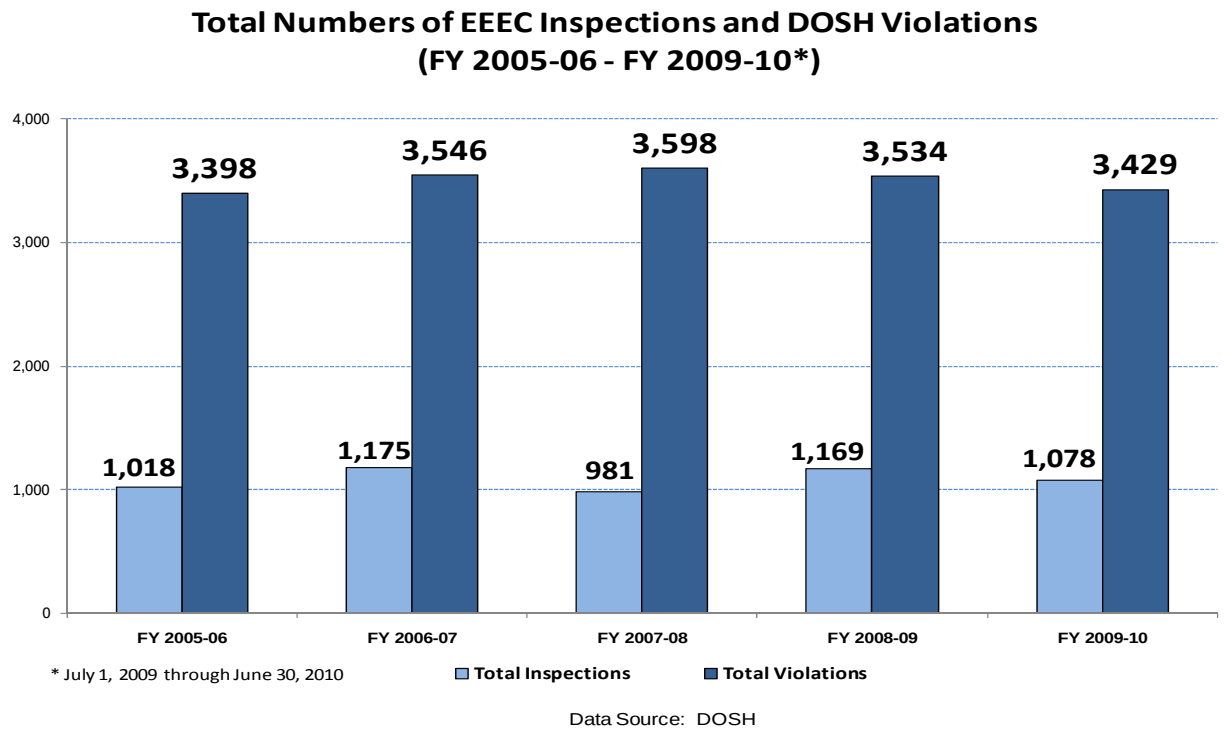
Data Source: DOSH

Economic and Employment Enforcement Coalition[38]

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 its 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.[39]

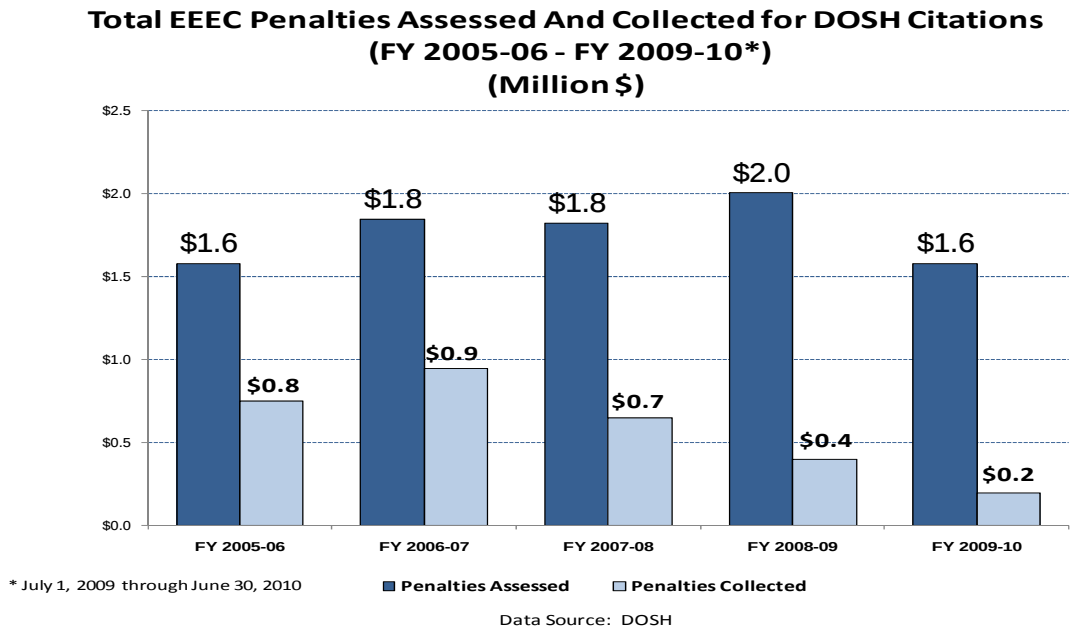
Total EEEC inspections fluctuated during the period from FY 2005-06 to FY 2009-10 with an overall increase of 6 percent during that period, from 1,018 to 1,078, respectively, and violations increased by about 6 percent from FY 2005-06 to FY 2007-2008 and decreased by about 5 percent from FY 2007-08 to FY 2009-10. The penalties assessed were $1.6 million in FY 2009-10 or at the same level as penalties in FY 2005-06; however, only $0.2 million (12.6 percent) were collected in FY 2009-10 as compared to $0.8 million (50 percent) in FY 2005-06. The following two charts illustrate the comparisons.[40]



[38] For further information about the EEEC, visit any of these agency links: http://www.dir.ca.gov/EEEC/EEEC.html, or http://www.edd.ca.gov/eddeeec.htm, or http://www.labor.ca.gov/eeec.htm

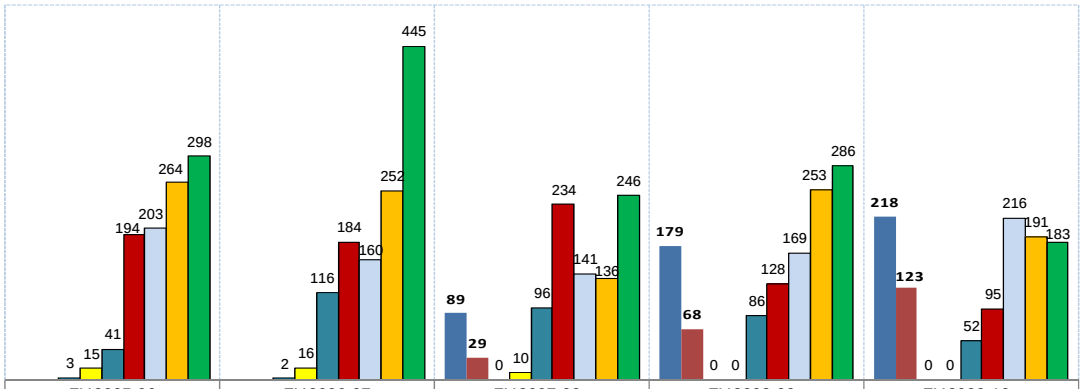
[39] http://www.dir.ca.gov/EEEC/EEEC.html

[40] 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 had led in the number of inspections from FY 2005-06, except for FY 2008-09, when inspections in the restaurant industry reached 216. Agriculture, restaurant, and garment were the other industries with the most number of inspections since FY 2005-06. The auto body, restaurant, pallet, and construction industries had the greatest number of violations in FY 2009-10. However, car was and garment industries' violations decreased by 56 percent and 34 percent respectively from FY 2008-09 to FY 2009-10, while the pallet and restaurant industries' violations increased by 160 percent and 34 percent respectively during the same period. Auto body and pallet industries are leading in penalties assessed for the FY 2009–10.

EEEC Report: Inspections by Industry, FY 2005-06 - FY 2009-10 *



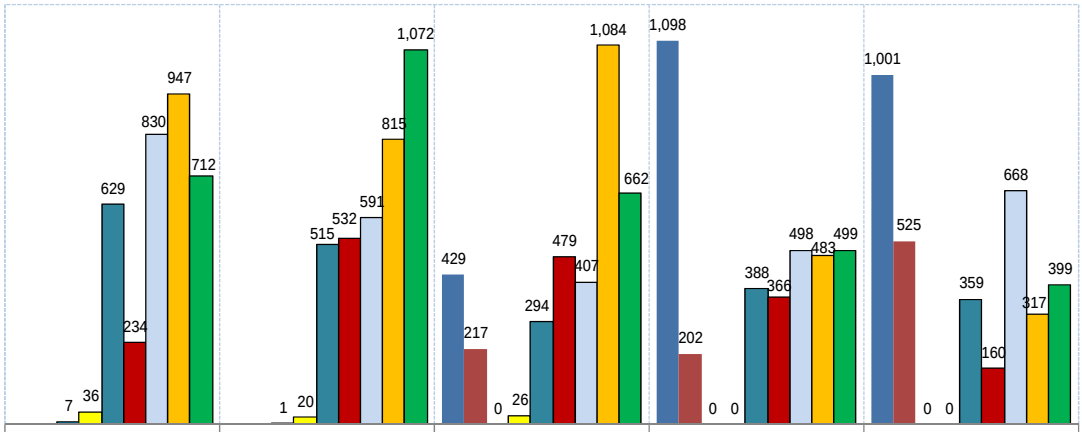
	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
Auto Body	N/A	N/A	89	179	218
Pallet	N/A	N/A	29	68	123
Race Track	3	2	0	0	0
Janitorial	15	16	10	0	0
Car Wash	41	116	96	86	52
Garment	194	184	234	128	95
Restaurant	203	160	141	169	216
Agriculture	264	252	136	253	191
Construction	298	445	246	286	183

* July 1, 2009 through June 30, 2010

Data Source: DIR - DOSH

.

EEEC Report: Violations by Industry, FY 2005-06 - FY 2009-10*



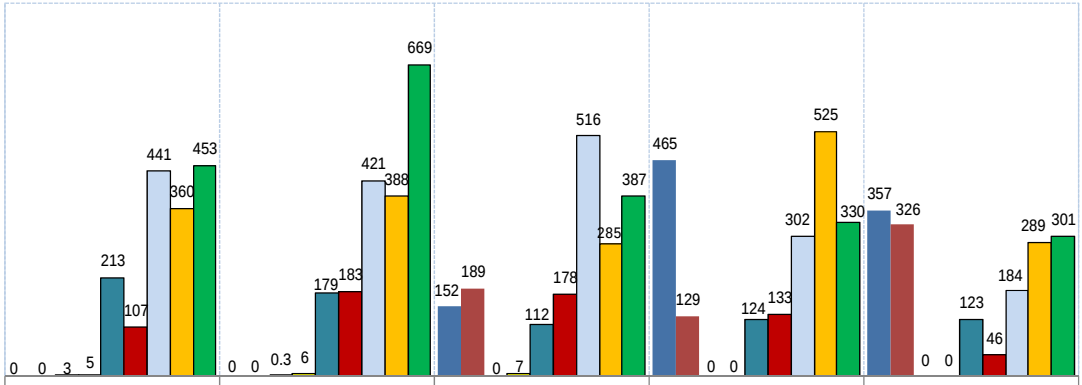
	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
Auto Body	N/A	N/A	429	1,098	1,001
Pallet	N/A	N/A	217	202	525
Race Track	7	1	0	0	0
Janitorial	36	20	26	0	0
Agriculture	629	515	294	388	359
Car Wash	234	532	479	366	160
Restaurant	830	591	407	498	668
Garment	947	815	1,084	483	317
Construction	712	1,072	662	499	399

* July 1, 2009 through June 30, 2010

Data Source: DIR - DOSH

EEEC Report: Penalties Assessed for DOSH Citations FY 2005-06 - FY 2009-10* (Thousand $)

Dollars

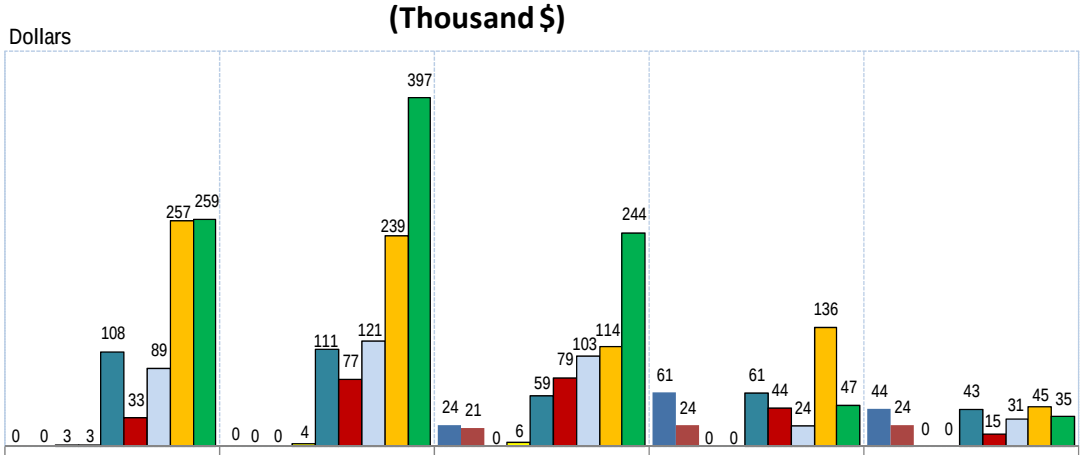


	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
Auto Body	0	0	152	465	357
Pallet	0	0	189	129	326
Race Track	3	0.3	0	0	0
Janitorial	5	6	7	0	0
Restaurant	213	179	112	124	123
Car Wash	107	183	178	133	46
Garment	441	421	516	302	184
Agriculture	360	388	285	525	289
Construction	453	669	387	330	301

* July 1, 2009 through June 30, 2010

Data Source: DIR - DOSH

EEEC Report: Penalties Collected for DOSH Citations
FY 2005-06 - FY 2009-10*
(Thousand $)



	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
Auto Body	0	0	24	61	44
Pallet	0	0	21	24	24
Race Track	3	0	0	0	0
Janitorial	3	4	6	0	0
Restaurant	108	111	59	61	43
Car Wash	33	77	79	44	15
Garment	89	121	103	24	31
Agriculture	257	239	114	136	45
Construction	259	397	244	47	35

* July 1, 2009 through June 30, 2010

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.

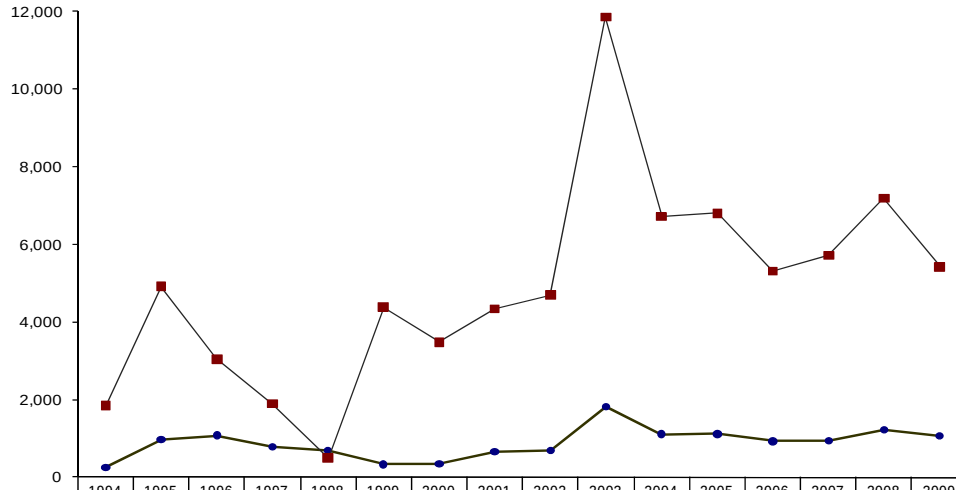
High Hazard Consultation Program

DOSH reports that in 2009, it provided on-site high hazard consultative assistance to 1,072 employers, as compared to 1,231 employers in 2008. During consultation with these employers, 5,422 Title 8 violations were observed and corrected as a result of the provision of consultative assistance.

Since 1994, 14,011 employers have been provided direct on-site consultative assistance, and 78,123 Title 8 violations have been observed and corrected. Of these violations, 36.2 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 1994-2009. 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.

High Hazard Consultation Program Production by Year



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Number of Employers with High Hazard Consultative Assistance	249	978	1,080	773	680	329	348	663	688	1,824	1,112	1,116	926	942	1,231	1,072
Total Number of Title 8 Violations Observed and Corrected	1,848	4,912	3,045	1,898	496	4,385	3,481	4,336	4,691	11,861	6,725	6,808	5,308	5,717	7,190	5,422

Data Source: Division of Occupational Safety and Health

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 2009, 490 employers underwent a targeted high hazard enforcement inspection, up from 427 employers in 2008. During these inspections in 2009, 2,462 violations were observed and cited, whereas in 2008, 2,328 violations were observed and cited.

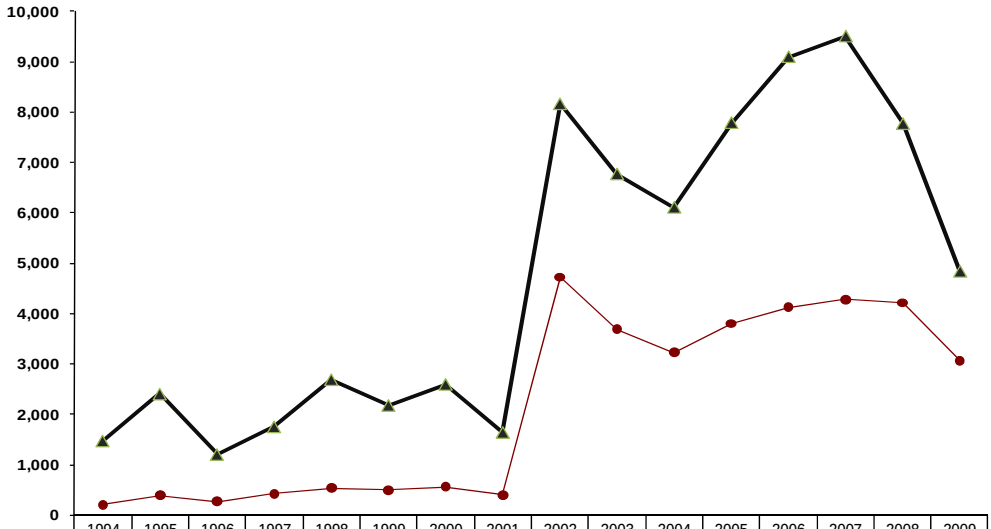
In addition, in 2009, 935 employers underwent an inspection as part of the Agricultural Safety and Health Inspection Project (ASHIP). Of these, 48 inspections were also targeted. During these inspections, 1,189 violations were observed and cited.

In addition, in 2009, 2,135 employers underwent an inspection as part of the Construction Safety and Health Inspection Project (CSHIP). Of these, 17 inspections were also targeted. During these inspections, 3,655 violations were observed and cited.

Since 1994, 34,944 employers have undergone a high hazard enforcement inspection, and 76,705 Title 8 violations have been observed and cited. Of these violations, 32.9 percent were classified as "serious."

The chart below indicates the yearly number of targeted inspections and violations observed and cited during the years 1994-2009. It should be noted that effective 2002, the Safety and Health Inspection Projects (SHIPs) are included in the High Hazard Enforcement Program figures.

High Hazard Enforcement Program Inspections and Violations



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total High Hazard Inspections	207	396	270	423	540	499	560	401	4,724	3,692	3,229	3,804	4,128	4,277	4,214	3,070
Total High Hazard Violations	1,482	2,411	1,211	1,761	2,696	2,186	2,603	1,650	8,164	6,774	6,113	7,791	9,098	9,506	7,771	4,844

Data Souce: Division of Occupational Safety and Health

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
OSHA publishes "Ergonomics: The Study of Work." More than 30 organizations petition Secretary of Labor to issue an Emergency Temporary Standard.

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

Occupational Health and Safety Appeals Board (OSHAB)

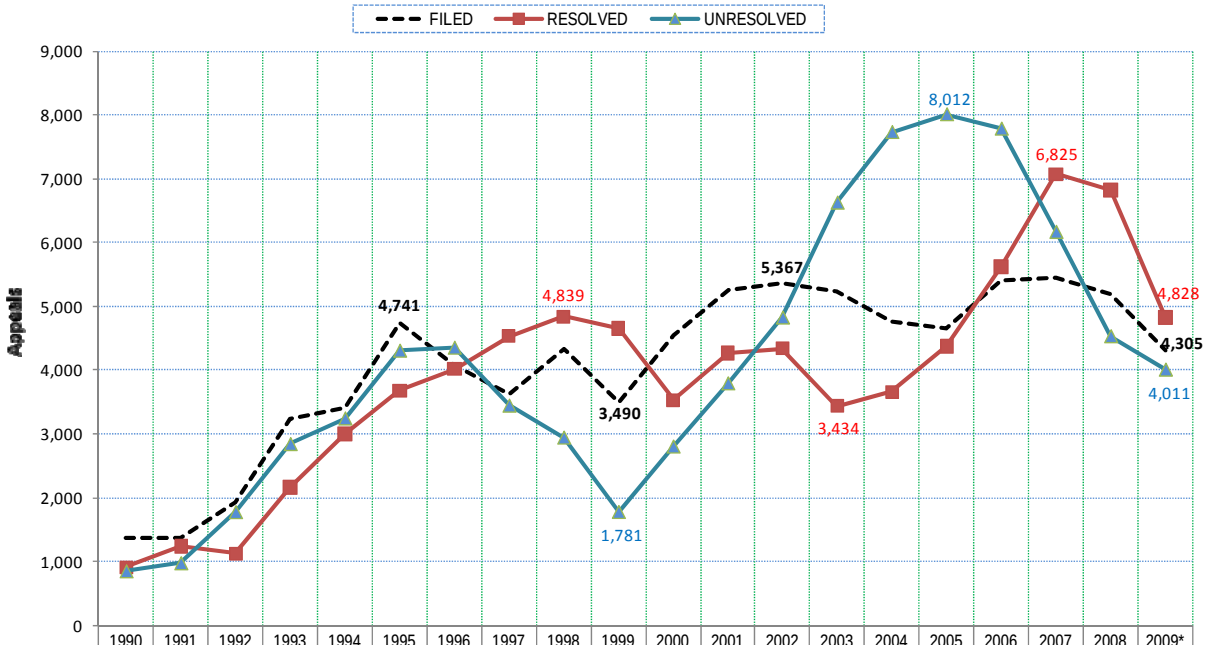
The Occupational Safety and Health Appeals Board (OSHAB) consists of three members appointed by the governor for four-year terms. By statute, the members are selected each from the field of management, labor and the general public. The chairman is selected by the governor.

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 1990, the numbers of appeals filed with OSHAB yearly have been growing steadily until 1995, reaching 4,741 cases in 1995. From 1995 to 2009, the number of appeals filed yearly stabilized at an average number of 4,695 cases, with a maximum of 5,457 appeals filed in 2007.

From 1990 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 8,012 cases in 2005. From 2005 to 2009, the numbers of unresolved cases decreased by 50 percent since an average of 124 percent of yearly filed cases were resolved in 2007, 2008 and 2009.

Occupational Health and Safety Appeals Board (OSHAB) Workload, 1990- 2009

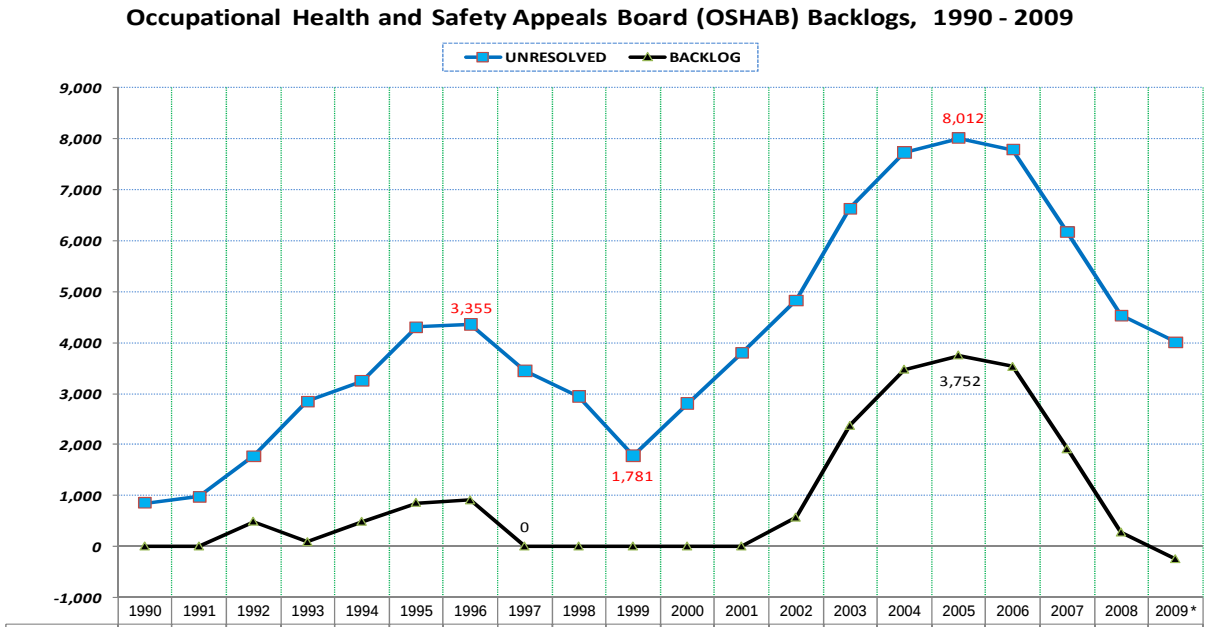


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009*
FILED	1,369	1,367	1,923	3,228	3,400	4,741	4,067	3,623	4,338	3,490	4,555	5,255	5,367	5,235	4,762	4,651	5,396	5,457	5,190	4,305
RESOLVED	911	1,241	1,123	2,161	2,999	3,679	4,020	4,531	4,839	4,655	3,530	4,265	4,336	3,434	3,656	4,373	5,621	7,075	6,825	4,828
UNRESOLVED	852	978	1,778	2,845	3,246	4,308	4,355	3,447	2,946	1,781	2,806	3,796	4,827	6,628	7,734	8,012	7,787	6,169	4,534	4,011

* The information will be updated when complete data is available

Data Source: OSHAB

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.

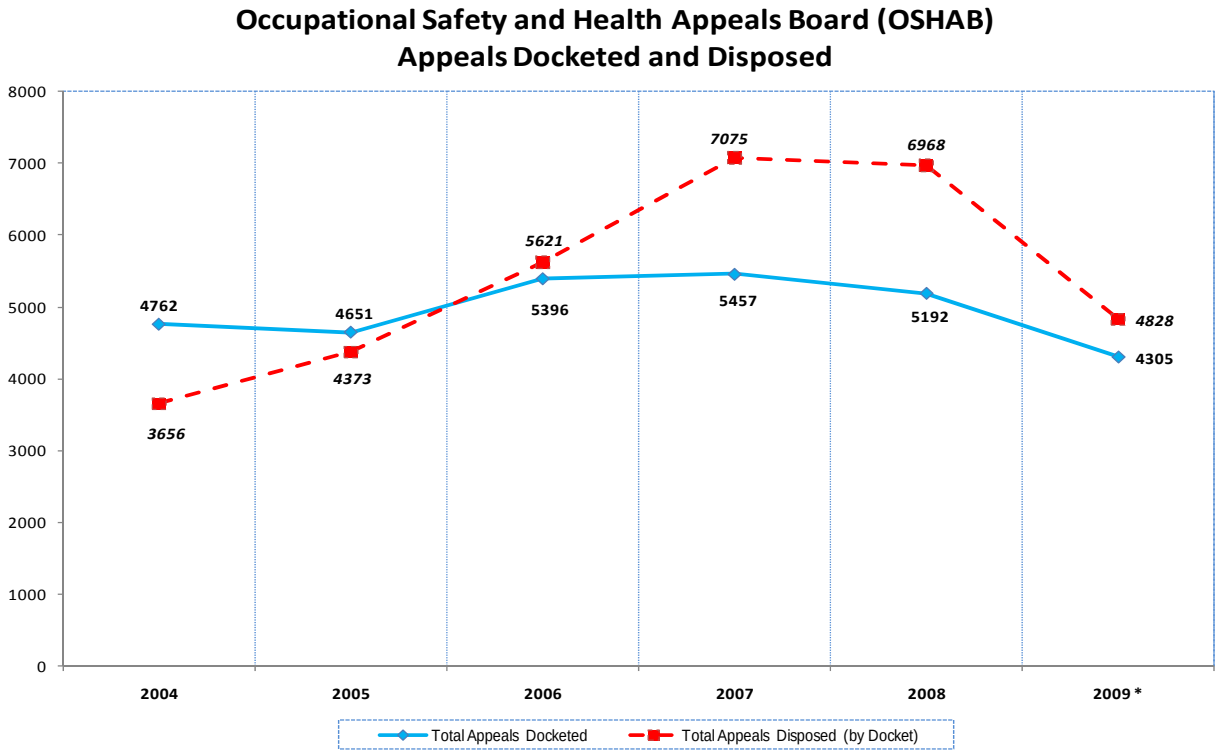


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009*
UNRESOLVED	852	978	1,778	2,845	3,246	4,308	4,355	3,447	2,946	1,781	2,806	3,796	4,827	6,628	7,734	8,012	7,787	6,169	4,534	4,011
BACKLOG	0	0	488	85	486	858	905	0	0	0	0	0	567	2368	3474	3752	3527	1909	274	-249

* The information will be updated when complete data is available

Data Source: OSHAB

The chart below shows the total number of appeals docketed and disposed from 2004 to 2009.



* The information will be updated when complete numbers are available.

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.

School Action for Safety and Health

Per the mandate set forth in the Labor Code, CHSWC is to assist inner-city schools or any school or district in establishing effective occupational injury and illness prevention programs (IIPPs). CHSWC has established a model program, California's School Action for Safety and Health (SASH) program, to help schools statewide improve their injury and illness prevention programs. For further information about SASH 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.

UPDATE: THE CALIFORNIA WORKERS' COMPENSATION INSURANCE INDUSTRY

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

Source: CIGA

Insurance Market Changes

Since 2000, a significant number of workers' compensation insurance companies have experienced problems with payment of workers' compensation claims. Thirty-six (36) insurance companies have gone under liquidation, and 20 companies have withdrawn from offering workers' compensation insurance during that time. However, since 2004, 37 insurance/reinsurance companies have entered the California workers' compensation market, while only 16 companies withdrew from the market.[41]

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 has been completed and includes recommendations to contain the risk of future insolvencies. (See "Special Report: Insurance Insolvency Study: California's Volatile Workers' Compensation Insurance Market: Problems and Recommendations for Change.")

[41] The information on the companies that have withdrawn and entered the market since 2004 is through 07/31/2010.

(continued from previous page)

Insurers Liquidated Since 2000

2006
Vesta Fire Insurance Company
Hawaiian Insurance & Guaranty Company
Municipal Mutual Insurance Company

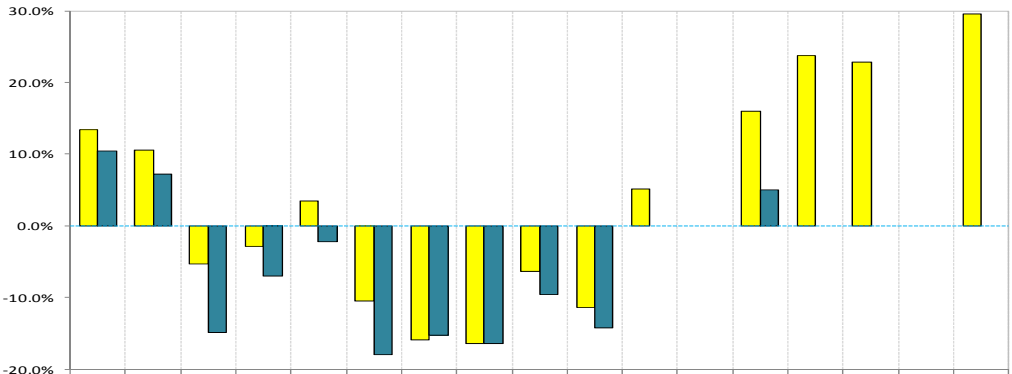
2010
Insurance Corporation of New York (The)

Source: CIGA

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 2004 and January 2010, with the exception of the January 2009 filing. On September 27, 2010, the WCIRB amended its January 1, 2011 filing to propose a change in advisory pure premium rate of +27.7 percent in lieu of the +29.6 percent reflected in its August 18, 2010 filing submitted to the California IC. On November 18, 2010, the IC issued a decision approving no change to the pure premium rates for January 1, 2011. (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



	Jan 1 2003	July 1 2003	Jan 1 2004	July 1 2004	Jan 1 2005	July 1 2005	Jan 1 2006	July 1 2006	Jan 1 2007	July 1 2007	Jan 1 2008	July 1 2008*	Jan 1 2009	July 1 2009	Jan 1 2010	July 1 2010*	Jan 1 2011
WCIRB Recommendation	13.4%	10.6%	-5.3%	-2.9%	3.5%	-10.4%	-15.9%	-16.4%	-6.3%	-11.3%	5.2%		16%	23.7%	22.8%		29.6%
Insurance Commissioner Approved	10.5%	7.2%	-14.9%	-7.0%	-2.2%	-18.0%	-15.3%	-16.4%	-9.5%	-14.2%	0%		5.0%	0.0%	0.0%		0.0%

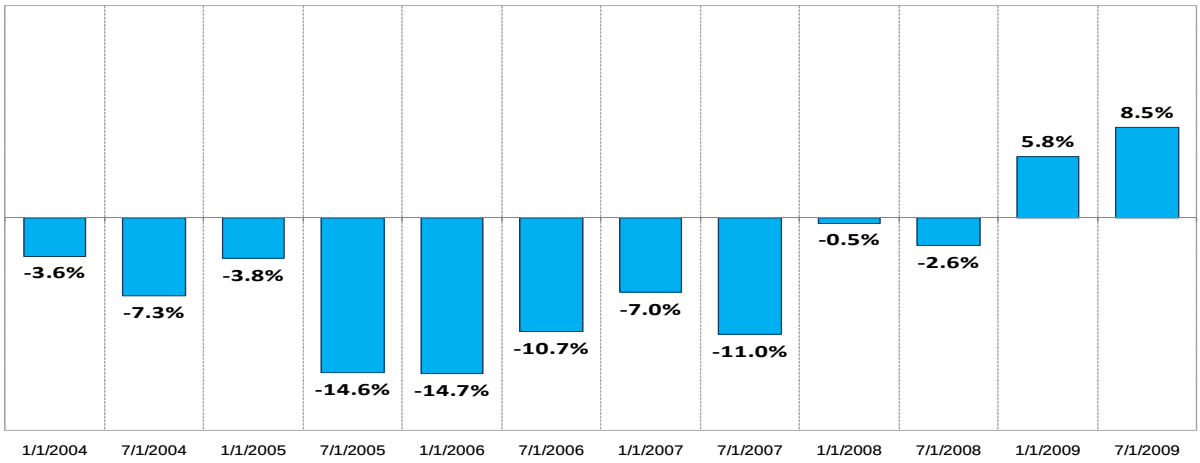
* WCIRB did not issue any recommendations for changes to pure premium rates effective 7/1/2008 and 7/1/2010, and the IC did not issue the interim advisory rates for these periods.

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 between 2004 and 2008, as indicated in the chart below. However, in 2009, average rates filed by insurers increased.

Average Workers' Compensation Rate Reductions Filed by Insurers



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 January 1, 2010, the cumulative premium weighted average rate reduction filed by insurers with the CDI since the reforms is approximately 48.0 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, 3.6 percent on January 1, 2005, 14.9 percent on July 1, 2005, 14.7 percent on January 1, 2006, 10.7 percent on July 1, 2006, 9.4 percent on January 1, 2007, and 10.4 percent on July 1, 2007. Insurer rates were further reduced by 0.8 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, and 3.4 percent on January 1, 2010, also at times when the advisory rates remained unchanged.[42]

WCIRB reports that actual rates charged in the market place as of June 30, 2010, had fallen by approximately 62 percent since the enactment of AB 227, SB 228, and SB 899. The average rate per $100 of payroll fell from $6.44 in the second half of 2003 to $2.44 in 2010.[43]

California Workers' Compensation Top 10 Insurers Rate Filing Changes

COMPANY NAME	GROUP NAME	Market Share 2009	*Cumulative Rate Change 1-04 to 1-10*	1-1-2010 % Filed Rate Change	7-1-2009 % Filed Rate Change	1-1-2009 % Filed Rate Change	7-1-2008 % Filed Rate Change
STATE COMPENSATION INSURANCE FUND		18.65%	*-42.68%*	*5.00%*	*15.00%*	8.90%	*-3.50%*
NATIONAL UNION FIRE INS COMPANY OF PITTS	AIG	3.98%	*-48.84%*	*8.00%*	*7.00%*	*10.00%*	*-15.00%*
ZENITH INSURANCE COMPANY	Zenith National Insurance Gp	3.01%	*-31.61%*	*2.70%*	*4.00%*	*4.00%*	*n/a*
EVEREST NATIONAL INSURANCE COMPANY	Everest Re Group	2.97%	*-57.32%*	*n/a*	*5.00%*	*-3.20%*	*n/a*
ZURICH AMERICAN INSURANCE COMPANY	Zurich Ins Gp	2.70%	*-56.99%*	*1.70%*	*10.00%*	*5.80%*	*n/a*
EMPLOYERS COMPENSATION INSURANCE COMPANY	Employers Group	2.67%	*-53.07%*	*3.00%*	*10.50%*	*10.0%*	*-0.60%*
SOUTHERN INSURANCE COMPANY	Delek Group	2.53%	*29.69%*	*1.50%*	*20.77%*	*5.80%*	*n/a*
TRAVLERS INDEMNITY COMPANY OF CT	Travelers Group	2.51%	*-53.09%*	*n/a*	*13.00%*	*9.50%*	*n/a*
SEABRIGHT INSURANCE COMPANY		1.79%	*-49.26%*	*0.00%*	*10.60%*	*5.00%*	*n/a*
INSURANCE COMPANY OF THE WEST	ICW Group	1.76%	*-53.97%*	*10.00%*	*n/a*	*5.00%*	*n/a*

[42] Source: California Department of Insurance, RFLA3 Rate Filing Bureau.
[43] Source: WCIRB Summary of June 30, 2010 Insurer Experience, released October 15, 2010.

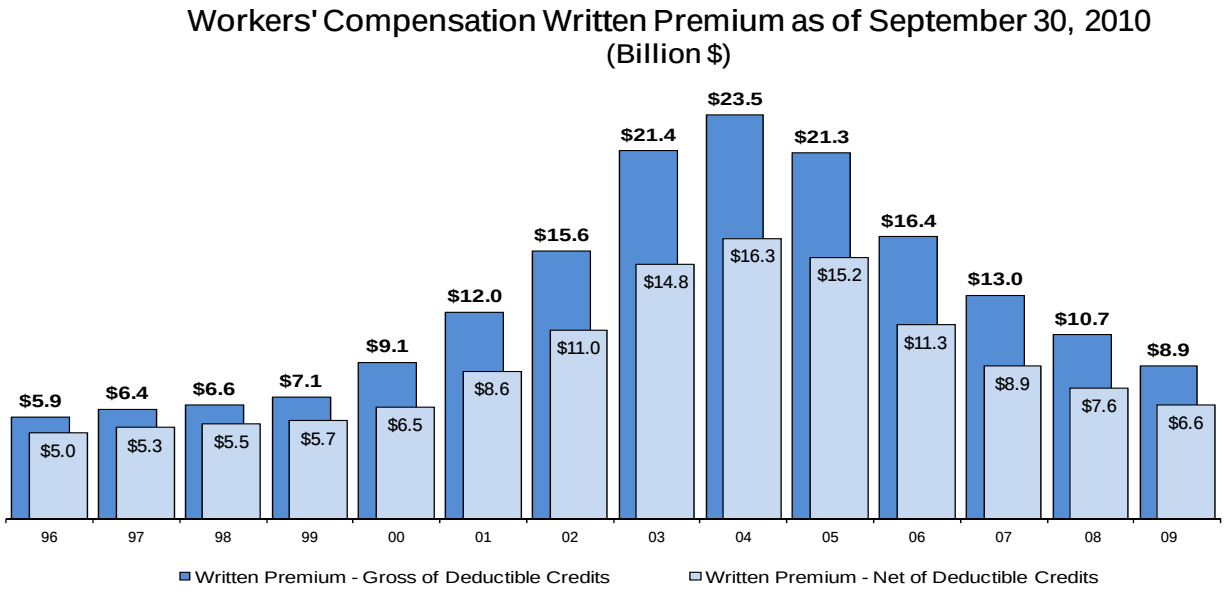
Since the first reform package was chaptered, 41 new insurers have entered the market and existing private insurers have increased their writings. The significant rate reductions totaling 48 percent since the first reforms were enacted, coupled with the reduced market share of State Fund (53.0 percent at its peak in 2003, declining to 18.7 percent in 2009) and an estimated 2008 accident year combined loss and expense ratio of 125 percent,[44] 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 percent to $21.4 billion from 2002 to 2003 and increased by about 10 percent to a peak of $23.5 billion from 2003 to 2004. The written premium declined by 62 percent from $23.5 billion to $8.9 billion between 2004 and 2009 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.



Data Source: WCIRB

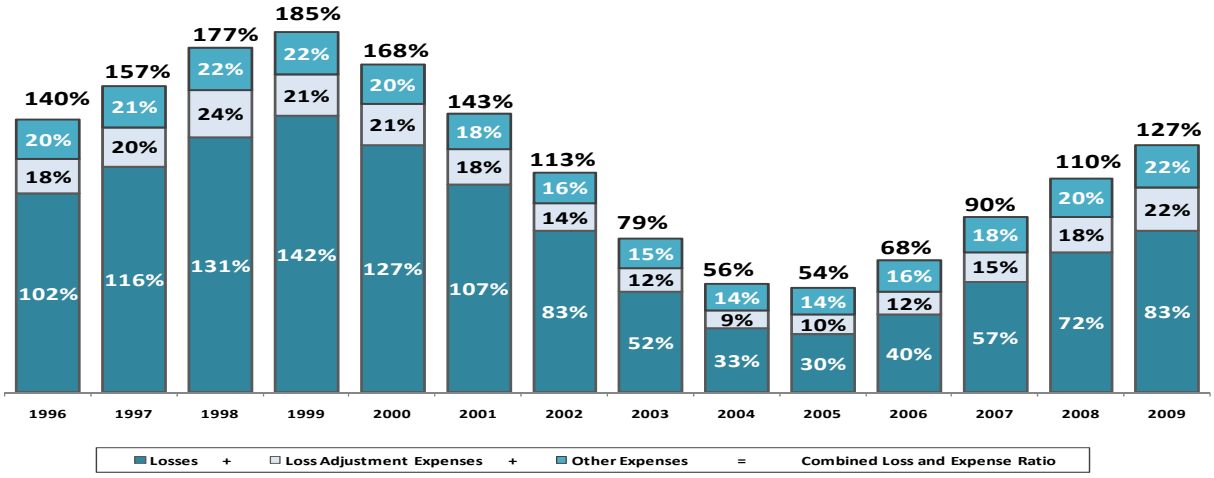
[44] Source: WCIRB Summary of September 30, 2010 Insurer Experience, released December 9, 2010.

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 increased annually from 2005 to 2009.

In accident year 2009, insurers' claim costs and expenses amounted to $1.27 for every dollar of premium collected.

California Workers' Compensation Combined Loss and Expense Ratios
(as of September 30, 2010)



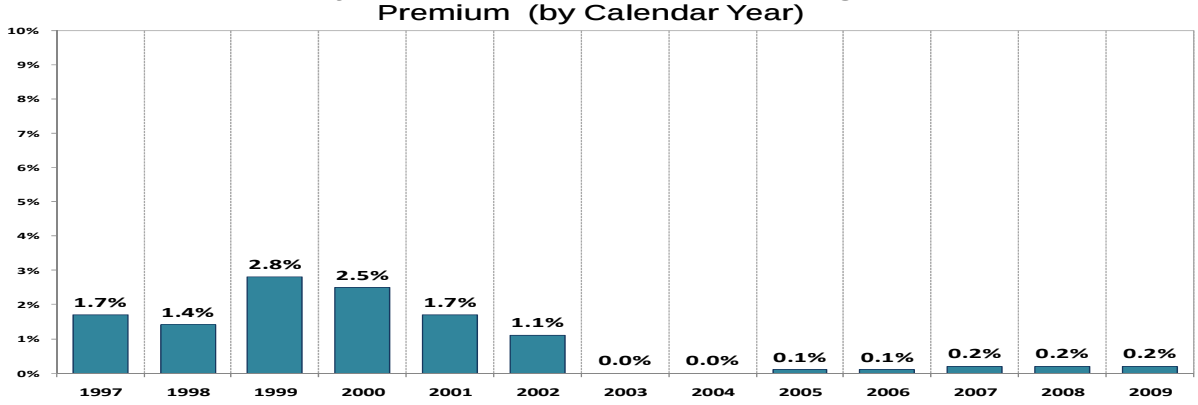
Data Source: WCIRB

WCIRB estimates that the total cost of benefits for injuries occurring prior to January 1, 2010, is $4.5 billion less than insurer-reported loss amounts.

Policy Holder Dividends

Dividends paid to policyholders decreased slightly from 1997 to 1998, 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 2009 at a very low rate.

Insurer Policy Holder Dividends as a Percentage of Earned Premium (by Calendar Year)



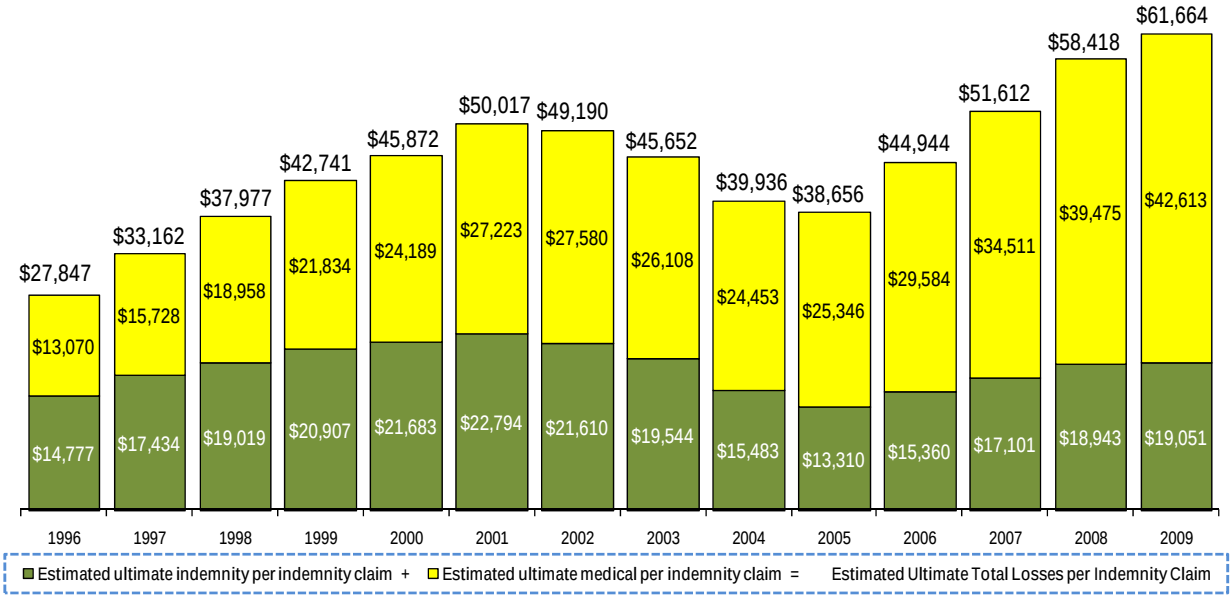
Data Source: WCIRB

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 almost 23 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 about 60 percent between 2005 and 2009. 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
as of September 30, 2010

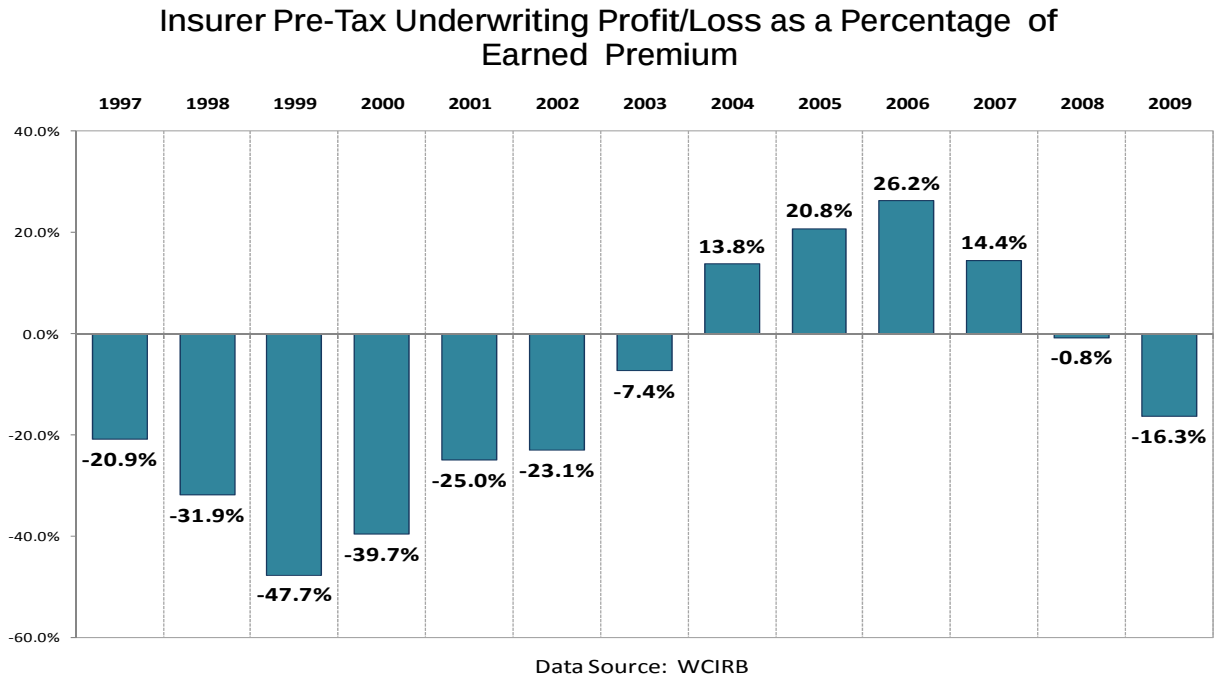


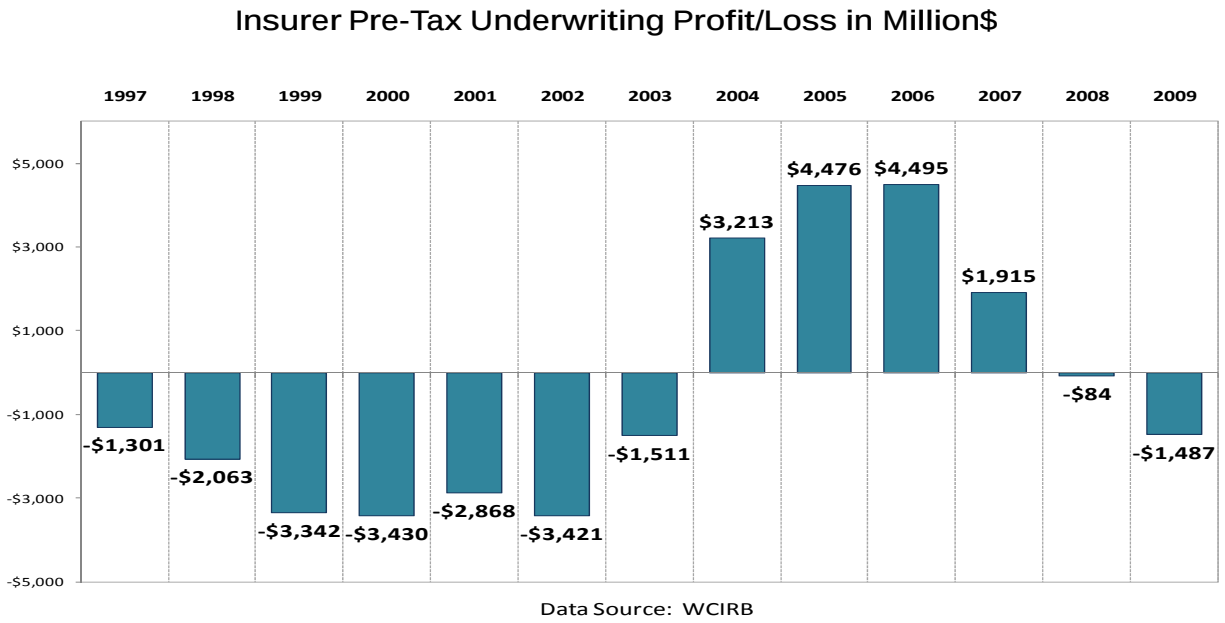
*Excludes medical-only

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, and in 2009, there was a 16 percent drop in insurer pre-tax underwriting profit/loss.





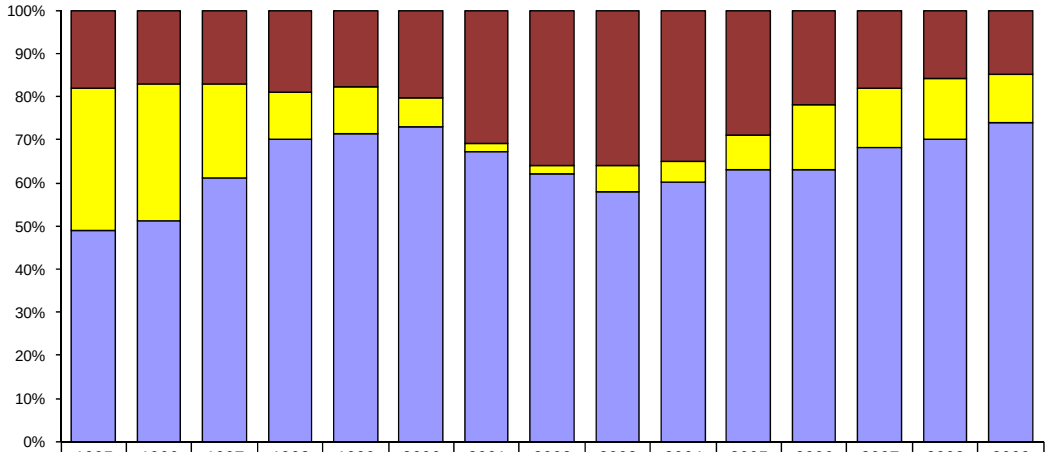
Current State of the Insurance Industry

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. The chart below shows changes in the workers' compensation insurance market share from 1995 to 2009.

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 2009, State Fund's market share decreased to 15 percent. The market share of California companies, excluding State Fund, increased from 5 percent to 14 percent between 2004 and 2008 and decreased to 11 percent from 2008 to 2009.

Workers' Compensation Insurance Market Share in California by Type of Insurer
Based on Written Premium Prior to Deductible Credits



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
State Fund	18%	17%	17%	19%	18%	20%	31%	36%	36%	35%	29%	22%	18%	16%	15%
California Insurers	33%	32%	22%	11%	11%	7%	2%	2%	6%	5%	8%	15%	14%	14%	11%
National Insurers	49%	51%	61%	70%	71%	73%	67%	62%	58%	60%	63%	63%	68%	70%	74%

Source: WCIRB
Please note that totals may not equal 100% due to rounding.

"California Insurers" are difined 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.

Advisory Workers' Compensation Pure Premium Rates
A History since the 1993 Reform Legislation

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:

On January 16, 2002, the WCIRB submitted recommended changes to the California Workers' Compensation Uniform Statistical Reporting Plan – 1995, effective March 1, 2002 and the California Workers' Compensation Experience Rating Plan – 1995, effective April 1, 2002, related to insolvent insurers and losses associated with the September 11, 2001, terrorist actions. No increase in advisory premium rates was proposed.

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

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 advisory 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.

Advisory Workers' Compensation Pure Premium Rates
A History since the 1993 Reform Legislation

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

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 not propose a change in advisory pure premium rates for California to be effective on policies incepting on or after July 1, 2008.

Advisory Workers' Compensation Pure Premium Rates
A History since the 1993 Reform Legislation

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.

Advisory Workers' Compensation Pure Premium Rates

A History since the 1993 Reform Legislation

Page 7 of 7

July 1, 2010

WCIRB recommendations:

On April 7, 2010, WCIRB voted not to submit a pure premium rate filing for July 1, 2010. The WCIRB's analysis of pure premium and loss experience valued as of December 31, 2009, showed that the indicated July 1, 2010 change in pure premium rates was essentially unchanged from the indication reflected in the January 1, 2010 filing.

Insurance Commissioner approval:

The Insurance Commissioner did not issue the interim advisory rate for this period.

January 1, 2011

WCIRB recommendation:

On August 18, 2010, the WCIRB submitted a pure premium rate filing to the California Insurance Commissioner recommending a 29.6 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, 2011. On September 27, 2010, the WCIRB amended its January 1, 2011 filing to propose a change in the claims cost benchmark of +27.7 percent in lieu of the +29.6 percent reflected in its August 18, 2010 filing.

Insurance Commissioner approval:

On November 18, 2010, the Insurance Commissioner approved no change to the pure premium rates effective January 1, 2011, applicable to new and renewal policies as of the first anniversary rating date of a risk on or after January 1, 2011. Other proposed changes to the USRP, ERP and Miscellaneous Regulations were approved as filed with the exception that the experience rating eligibility was increased to $16,700 to reflect the 0 percent approved change in the Claims Cost Benchmark.

https://wcirbonline.org/resources/rate_filings/current_rate_filings.html

Source: WCIRB

SPECIAL REPORT: PERMANENT DISABILITY UPDATE

Introduction

In past years, the Commission on Health and Safety and Workers' Compensation (CHSWC) Annual Report has contained a section entitled "Special Report: Permanent Disability Rating Compensation." Readers may find the report beginning at page 189 of the 2009 Annual Report, available at http://www.dir.ca.gov/chswc/Reports/CHSWC_AnnuualReport2009.pdf. The body of research and the policy issues have changed little, so the 2009 "Special Report: Permanent Disability Rating Compensation" will not be restated here. Instead, this report will highlight recent developments. The major developments have been in judicial interpretation of the statutes governing permanent disability (PD) rating, trends in rating behavior, and research on return to work.

Judicial Interpretations

Labor Code Section 4660 as amended by Senate Bill (SB) 899 in 2004 required certain revisions of the permanent disability rating schedule (PDRS). The PDRS that took effect on 1/1/2005 provides ratings based on impairment evaluations according to the American Medical Association *Guides to the Evaluation of Permanent Impairment,* 5th edition (AMA *Guides*) and an adjustment for diminished future earning capacity (FEC factor) corresponding to each type of injury. The Labor Code also provides that the rating schedule shall be prima facie evidence of the percentage of permanent disability attributed to each injury. Prima facie evidence can support a decision, but it can also be rebutted. When and how the 2005 PDRS could be rebutted remained unanswered for four years after it was adopted.

In 2009, the Workers' Compensation Appeals Board issued decisions setting out the rationale and parameters for individual cases to deviate from a strict interpretation of the AMA *Guides* and for individual cases to rebut the prescribed FEC factor. The cases were *Almaraz v. Environmental Recovery Services and State Compensation Insurance Fund*, *Guzman v. Milpitas Unified School District,* and *Ogilvie v City and County of San Francisco*. The *Almaraz/Guzman* and *Ogilvie* decisions, as they came to be known, were initially issued on February 3, 2009, and subsequently revised after further reconsideration on September 3, 2009. In a joint decision in the *Almaraz* and *Guzman* cases, the Appeals Board allowed an evaluating physician to use "any chapter, table, or method in the AMA *Guides* that most accurately reflects the injured employee's impairment." In *Ogilvie*, the Appeals Board allowed an individual's FEC factor to be calculated with reference to the individual's post-injury earnings loss and impairment rating in lieu of the FEC factor prescribed by the 2005 PDRS.

As of this writing in August of 2010, the *Guzman* decision has been affirmed by the 6th District Court of Appeals, the *Almaraz* decision is pending review in another District Court of Appeals, and the *Ogilvie* decision has been accepted for review by the 1st District Court of Appeals. Most observers expect the appellate process to continue anywhere from a few more months to two more years before these cases are resolved.

Because these decisions allow for departures from a strict application of the AMA *Guides* and the 2005 PDRS, they have the potential to increase awards in individual cases. They also could, in theory, decrease some awards, but that is less practical. The California Workers' Compensation Insurance Rating Bureau (WCIRB) initially estimated the impact of *Almaraz/Guzman* and *Ogilvie* as a 5.8 percent increase in compensation costs, and early experience seems to be consistent with that estimate. It remains to be seen what the impact will be as practitioners become more familiar with the methods of rating permanent disability (PD) allowed by these decisions.

Ratings Trend

A more widespread but less dramatic way in which compensation is being increased on a case-by-case basis is the trend in disability ratings. According to CHSWC research by the RAND Institute for Civil Justice, the average rating under the 2005 PDRS was about 15 percent when the new rating schedule was first adopted, but after about 18 months, it began a consistent upward trend so that the average rating is over 20 percent by the beginning of 2010. This amounts to approximately 33 percent growth in average ratings and an even greater growth in average awards. This may be due in part to a changing case mix as the more severe injuries arrive at PD ratings, but it is probably due to changes in the behavior of evaluating physicians, as well.

Wage Loss and Return to Work

New research also bears on the public policy issues surrounding PD compensation. A CHSWC study by RAND has found that return-to-work rates for injured workers have been improving after reaching a low point for injuries occurring in 2003. This improvement means that the earnings losses associated with lost-time injuries are also improving. Soon after the adoption of the 2005 PDRS, it was hypothesized that improved return to work would offset some of the reduction in PD compensation. (See the 2009 “Special Report: Permanent Disability Rating Compensation” for earlier research and for details on how compensation has been reduced.) Current research by RAND in 2010, demonstrates that improved return to work only partially offsets the reduced compensation, and the overall replacement rate (the percentage of earnings loss that is replaced by compensation benefits) is significantly reduced compared to pre-reform levels.

Status of Permanent Disability Policy Deliberations

The 2005 PDRS was due for revision by January 1, 2010. The Acting Administrative Director (AD) of the Division of Workers’ Compensation (DWC) proposed such a revision and initiated the rulemaking process in May 2008. That process was never completed, and the 2005 PDRS has not been revised. The tension between adequacy of compensation and affordability of coverage remains unresolved. Future efforts to deal with these policy issues may be undertaken in light of the factors discussed in the CHSWC 2009 Annual Report and current research.

SPECIAL REPORT: WORKERS' COMPENSATION REFORM AND RETURN-TO-WORK: THE CALIFORNIA EXPERIENCE

Introduction

Promoting the early and sustained return to work of injured and disabled workers is an important goal of state workers' compensation systems. Return to work benefits workers by reducing the adverse economic consequences of an injury, and it benefits employers by reducing disability benefits and other costs. In California, workers who are permanently disabled as a result of a workplace injury have been found to have poor return-to-work rates on average. The poor return-to-work rates meant that permanently disabled workers in California had worse economic outcomes, even though the workers' compensation costs for California employers were among the highest in the country.

Evidence on the poor adequacy and poor affordability of permanent partial disability (PPD) benefits was a key factor in the multiple reform efforts to workers' compensation in California in early 2000s. The notion that improving return to work could make the system more affordable while also improving the adequacy of benefits motivated many of the reforms to the California workers' compensation system. This report discusses how these reforms affected return to work and the adequacy of benefits for disabled workers in the California workers' compensation system.

Background and Legislative History

In order to understand the role of workers' compensation reforms on the rates of return to work by injured and disabled workers in California and the implications for the adequacy of disability benefits, the Commission on Health and Safety and Workers' Compensation (CHSWC) study by RAND addressed the following broad set of research questions:

- How do public policies, both within and outside the workers' compensation system, influence return to work?
- How have these policies changed in California over the past ten years?
- How have rates of return to work by injured and disabled workers in California changed in the past ten years?
- What has been the impact of reforms in the workers' compensation system on benefit adequacy of benefits for injured and disabled workers? How, if at all, have changes in benefit adequacy been influenced by changes in return to work?

The study classifies return-to-work policy efforts into three broad categories: medical management; incentive-based approaches; and accommodation-based approaches. The medical management approaches attempt to improve return to work by improving the quality and timely receipt of medical care or by improved coordination and communication with medical providers. Some reforms that target this involve the assignment of control of provider choice, or by direct regulation of care through utilization review or treatment guidelines. The incentive-based approaches use financial rewards (or punishments) to influence the behavior of employers or the workers themselves, often by manipulating disability benefits based on return-to-work status. Finally, accommodation-based methods alter the requirements of the job, either the schedule, the tasks required or the physical environment, in order to make it easier for a disabled worker to perform the necessary tasks. Some states adopt subsidies to accommodations in order to improve employment for disabled workers.

From 2001-2004, California adopted reforms that impacted all three of these approaches to improve return to work. In 2003, Senate Bill (SB) 228 made massive changes to medical treatment delivery for workers' compensation cases, including the adoption of utilization review based on treatment guidelines

and caps on certain therapies. In 2004, SB 899 enacted a two-tier permanent disability benefit that requires employers to pay 15 percent higher benefits when they make no offer of return to work and 15 percent lower benefits when an offer is made. The State also made significant changes to the vocational rehabilitation services offered, switching to a voucher program. There were important changes outside of the workers' compensation system as well. In 2001, the State reformed the Fair Employment and Housing Act (FEHA), which protects the disabled from discrimination by their employers, in such a way that potentially penalizes employers who fail to offer "reasonable" accommodations to workers disabled due to a workplace injury. Any or all of these could have affected return to work.

In addition to the two-tiered benefit adopted in 2004, the State also dramatically reformed the evaluation system for permanent disabilities. One effect of this reform is that permanent disability benefits were cut substantially. A cut in disability benefits would reduce the overall level of income replacement (defined as the fraction of lost wages replaced by benefits) for injured workers, unless return to work improved and reduced earnings losses enough to offset the decline in benefits. The study combines administrative data on workers' compensation benefits and earnings of injured and disabled workers in order to estimate how return to work changed after the reforms and to evaluate the net impact on the replacement of lost income.

Findings

The findings of the study include:

- The study conducted a survey of employers that suggests both large and small employers are keenly aware of return-to-work issues and have taken steps to improve return to work. Their answers suggest that workers' compensation costs play a key role in determining their return-to-work decisions.

- The survey also examined how the workers' compensation reforms and the changes to FEHA impacted decisions to accommodate disabled workers in workers' compensation cases. About 40 percent of employers identified both the workers' compensation reforms and changes to FEHA as important factors in return-to-work decisions. These survey findings confirm that policies both within and outside the workers' compensation system are potentially important tools for influencing return to work.

- The empirical findings suggest that return to work improved dramatically in California during the study period. Workers injured in 2003-2006 were significantly more likely to be working one or two years after an injury than workers injured in 2000-2002. Overall employment and employment for the at-injury employer showed improvement. Some of the biggest gains in return to work were observed for the most severely disabled workers.

- The study notes that pinpointing exactly why return to work improved so much is a challenge. According to this study, return to work was improving even before SB 899 reforms were adopted. Workers injured in 2003 and 2004 were not eligible for the tiered benefit, rendering it unlikely to be a driving factor behind the observed trend. At the same time, the study finds modest evidence that the tiered benefit improved return to work for workers employed at medium-sized firms. The findings also cast doubt on the effectiveness of the old vocational rehabilitation system in California in terms of improving employment outcomes for injured workers. The results suggest that the biggest gains in employment for injured workers came from workers who were most likely to participate in the vocational rehabilitation system. This does not necessarily mean that the system had no positive effect on return to work, but it suggests that any such effects were minor. The timing of the return-to-work gains suggests that the changes to FEHA, the medical treatment reforms, or the general activities by employers to improve return to work in response to rising costs might have been important factors.

- Examination of the reforms on the income replacement provided to injured workers indicated that the impact was striking. Indemnity benefits fell dramatically, and most of the decline was experienced by workers with permanent disabilities. Part of the decline experienced by workers

with permanent disabilities was due to the changes to the disability rating schedule, and part was due to the repeal of the vocational rehabilitation system. The reforms also appear to have led to a decline in the fraction of workers that receive permanent disability benefits.

- The decline in indemnity benefits led to a decline in the average replacement rate of lost income. Replacement rates fell about 26 percent on average. The gains in return to work helped offset some of the declines, but not all. Estimates are that if return to work had stayed at its lowest point, replacement rates would have fallen 15 percent more than they ultimately did.

- Declines in replacement rates were experienced most profoundly by the most severely disabled workers. This is despite the fact that the most severely disabled workers experienced the biggest gains in return to work. It is also noteworthy that replacement rates for these workers fell the most, even though SB 899 specifically raised benefits for workers with more severe disabilities and lowered them for workers with less severe disabilities (as measured by the disability rating system). Given the changes to the rating system, however, very few individuals are so severely disabled as to qualify for the higher disability benefits. Additionally, the most severely disabled were more likely to have qualified for vocational rehabilitation benefits.

- Some have argued that there has been an upward trend in physician disability ratings, which tie directly to permanent disability benefits. The study reviewed whether there was a significant increase in disability ratings from 2006-2009. There was some evidence of an increase, with permanent disability ratings rising about 8-10 percent per year from 2007-2009. This offset about a third of the decline in the level of permanent disability awards that workers are eligible for, with a decline of 40 percent from 2004 as opposed to the 60 percent that was observed immediately after adoption of the new schedule.

Recommendations

CHSWC recommendations include:

- Despite the improvements in return to work, the study finds that the level of income replacement provided to disabled workers fell significantly. To maintain previous levels of benefit adequacy, an increase in benefit levels is necessary.

- While California clearly made strides in terms of return-to-work gains, there still are areas where the State could improve. The general lack of use and impact of the workplace modification subsidy program are discouraging; it still seems like more could be done to improve return to work at smaller employers. Most of the return-to-work programs discussed are likely to be geared towards larger employers, who have more flexibility to modify staff and reallocate workers. More research needs to be done to understand what kinds of programs would be most effective for smaller businesses:

    - For example, do self-insurance pools of smaller employers do a better job of promoting return to work than insured small employers do on their own?

    - Would a premium discount for an approved return-to-work program help improve return to work? Would these programs be cost-effective for small employers?

- There are also important issues that should be monitored going forward. The CHSWC study by RAND found evidence of a general trend towards increasing disability ratings over time, and it is particularly prominent in cases with attorney representation. If the medical-legal system is introducing uncertainty or subjectivity into the rating process, this could be another factor that promotes disputes and worsens outcomes for injured workers and their employers.

- Further work is needed to understand the impact of medical treatment guidelines and utilization review on return to work and employment,

- Another implication of this study is the need to further explore the potential gains to the integration of occupational and non-occupational disability compensation. While much work needs to be done to understand the potential implications and challenges of this, both overall and with respect to the impact on return to work, it is an area that merits further consideration.

For further information …

"Workers' Compensation Reform and Return to Work: The California Experience," RAND (2010). http://www.dir.ca.gov/chswc/Reports/2010/WCReformandReturntoWork.pdf

SPECIAL REPORT: HOW EFFECTIVE ARE EMPLOYER RETURN-TO-WORK PROGRAMS?

Introduction

Workplace injuries and illnesses are extremely costly. In addition to the pain and suffering due to the injury itself, workers can experience severe and prolonged earnings losses. Accidents are costly to employers as well. Employers face the cost of reimbursing their injured workers and also face indirect costs such as lost productivity. As part of their ongoing efforts to mitigate these costs, policymakers are continuously motivated to find new ways to reduce the duration of work-related absence and improve early return to work, a key metric for the impact of an injury on both workers and employers. Reducing the recovery time for workers who are injured or disabled by a workplace accident is a key policy goal. This has motivated the promotion of employer return-to-work programs, despite a lack of systematic evidence on the effectiveness of such programs.

The Commission on Health and Safety and Workers' Compensation (CHSWC) study and report by RAND, "How Effective are Employer Return-to-Work Programs?," provide new evidence on the effectiveness of employer return-to-work programs using combined data on the duration of time out of work for workers' compensation claimants with detailed information on employer return-to-work programs. The study focuses on the cost-effectiveness of program use.

Background

Many policy initiatives that are intended to improve return to work for injured or disabled workers operate through employers. For instance, some states offer subsidies to offset the costs to employers of hiring, retaining or accommodating disabled workers. These policies are adopted, however, with relatively little consensus in the scientific literature as to the effectiveness of these employer-based efforts. There have been numerous studies that have demonstrated that these policies have some impact on reducing the duration of work absences; however, there is little evidence as to whether or not the impact is large enough to justify the cost of intervening.

The study used a unique data set that combines information from a firm-level survey of activities and policies designed to improve return to work matched to the post-injury employment outcomes for workers injured at these firms. The survey covered 40 large, self-insured employers in California and obtained detailed information about the formal programs and practices used to lower the duration of work-injury absences, including information such as the frequency of use of various modifications and accommodations. These survey data were matched to more than 17,000 workers injured from 1991-1995, and five years of post-injury employment data were collected. A key feature of the analysis is that some employers adopted a program during the period over which the study observed workplace injuries, which allowed the study to employ firm fixed effects and to eliminate the firm heterogeneity that potentially confounds the analyses of many previous studies, making it more difficult to attribute causality to the programs themselves.

Characterizing the Employer Use of Return-to-Work Programs

Study data included information on the return-to-work practices of a sample of large, private self-insured employers in California coming from a survey conducted by RAND in 2000. The survey asked employers to provide information about methods used to return injured employees to work, how often they are used, and the subjective importance of each method in relation to the overall effectiveness of the program (as of the time of the survey, 2000). The four primary characteristics of return-to-work programs identified in the survey are: modified work tasks; providing a modified workstation or modified equipment; reduced time and work schedule changes; and providing a different job in either the same or a different department. Modified work, which is any temporary change in work tasks or functions, modified workstations and modified equipment, which allow injured workers to perform work functions while recovering from an

injury, reduced time/work schedules, and providing a different job are examples of actions employers may take to facilitate the return of an injured worker to the workplace.

Modifying work tasks was the most common intervention used among employers in the sample, with 82 percent of the firms reporting that they use this method frequently or quite often. Roughly half of the sample reported providing a modified workstation or modified equipment frequently or most of the time. Reduced time and work schedule changes were fairly common with 45 percent of the sample reporting use; 32 percent of the firms reported that they provided a different job in either the same or a different department frequently or quite often.

Return-to-Work Programs are Associated with Lower Duration of Injury-Related Absences

To estimate the impact of program use on return to work, the study combined the survey information with data on the post-injury employment outcomes of workers at the surveyed firms. The study then linked workers' compensation claims information, including whether the claim was temporary or permanent, how much was paid out in benefits, how many weeks of benefits were received, etc., collected directly from the employers to administrative data on wages. Quarterly earnings data of all workers' compensation claimants in the sample for up to 20 quarters after injury were used. As the primary measure of return to work, the study estimated the number of weeks until the worker recorded positive wages for at least two consecutive quarters after temporary disability benefits had been exhausted.

The study identifies the difference in return-to-work rates for employees who are injured with and without a return-to-work program in place. More than half of workers with or without a program return in the first ten weeks. If a program is in place, however, there is a noticeable difference by ten weeks, with workers in a program being more likely to return to work. This gap persists and widens over the entire first year after the date of injury.

The study identified particularly large effects of the programs for injured workers with the most severe injuries. Workers with permanent disability represent 40 percent of the sample, and they have a median duration of injury-related absence of 39.7 weeks (the mean is 69.5 weeks). The impact of the program is to reduce the median duration for those with a permanent disability by 18.8 weeks, or 47 percent. The effect is somewhat smaller if employer-fixed effects are included and the mean difference is looked at, but there is still a drop of 27 percent. This suggests that much of the program effect is driven by the large reduction in injury duration for the most severely injured workers.

Program Use is Cost-Effective for Employers

Study estimates indicate that the employer return-to-work programs reduce the duration of injury-related absences, but does that make their use profitable for firms? The accommodations required can sometimes be quite costly, and ultimately, the key point of interest is whether the benefits from improved return to work outweigh the costs to implement and maintain the programs. The study reports some estimates of the cost-effectiveness of a program for employers in different scenarios. For an estimate of the program benefits to employers, the dollar savings on temporary total disability payments from shorter injury durations are used. Different scenarios reflect different levels of weekly wages for employees, with higher weekly wages reflecting higher weekly benefits (and thus greater benefits of returning workers sooner). The study compares these levels against different levels of average program costs per injured workers, using a range reflected by the survey data.

The study identifies the number of weeks of injury duration a program must reduce in order for a return-to-work program to break even. For example, in a low-benefit, low-cost scenario, the break-even estimate is equal to 1.4 weeks, and any additional reductions in average durations generate a net benefit for the employer. Comparing the study's treatment effect estimates with the break-even numbers, the return-to-work programs generate net benefits for all but the most expensive programs when wages (and thus weekly benefits) are high. With average wages, the return-to-work programs are beneficial when the program cost per injured worker is below $1,500, and with low wages, the programs are beneficial when the program cost per injured worker is below $1,000.

Conclusions

The study finds that return-to-work program adoption is associated with a large reduction in the duration of work-related absences and that the programs are cost-effective for large employers. The study however, does not necessarily indicate that adopting a return-to-work program would be cost-effective for any randomly selected employer. The costs per worker are likely to be higher for smaller firms if there are fixed costs of setting up a return-to-work program (particularly likely for a return-to-work program making a heavy emphasis on physical modifications). The effectiveness of return-to-work programs may also differ for different types of workers; smaller firms or firms with more homogenous job functions might find it more difficult to offer modified work. The study suggests that future research work should consider how return-to-work programs can be implemented effectively at small firms.

For further information …

"How Effective are Employer Return-to-Work Programs?," RAND (2010).
http://www.dir.ca.gov/chswc/Reports/2010/CHSWC_RANDRTW.pdf

SPECIAL REPORT: INTERNATIONAL FORUM ON DISABILITY MANAGEMENT 2010: *COLLABORATING FOR SUCCESS*

Introduction

Disability management, including preventing needless work disability, is an issue of high priority around the world. One of the most effective ways of creating and maintaining jobs, disability management reduces costs to employers, improves productivity, and ensures 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) collaborated 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*, which was held September 20-22, 2010, in Los Angeles, California, brought together over 400 attendees, representing more than 33 countries across the world, from the health, safety, medical, and workers' compensation communities. The diverse audience included 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 was to bring key policymakers into the discussion and to be an agent of change.

Planning Advisory Committee

The IFDM 2010 Planning Advisory Committee met monthly and guided the planning efforts for the forum. The Committee included 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
Lex Frieden
Baylor School of Medicine
Joyce Gravelle
National Institute for Disability Management & Research (NIDMAR)

Henry Harder
Health Sciences Programs, College of Arts, Social and Health Sciences, University of Northern British Columbia
Nikola Lafrenz
Federal Ministry of Labour and Social Affairs, Germany
Bryon MacDonald
California Work Incentives Initiative, World Institute on Disability
Sean McNally
Grimmway Farms
Friedrich Mehrhoff
German Social Accident Insurance
Barbara Murray
International Labour Organization
Robin Nagel
Integrated Disability Management Workplace Safety, Labor Management Partnership, Kaiser Permanente
Patricia Owens
Disability Programs and Issues, U.S. Government Accountability Office, Education, Workforce, and Income Security Team
Susan Parker
Office of Disability Employment Policy, U.S. Department of Labor
Tom Rankin
President Retired, California Labor Federation (AFL-CIO)
Joy Reymond
Rehabilitation Services, Unum
Valerie Royle
Yukon Workers' Compensation Health and Safety Board
Seth Seabury
RAND Corporation
Kristin Tugman
Health and Productivity Development, Unum
Wolfgang Zimmerman
National Institute for Disability Management & Research

Conference Goals

IFDM 2010 Conference Goals included:

- 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.

Key Topics

The conference focused on identifying successful disability management policies and practices that decrease occupational injuries and promote positive outcomes after occupational injuries or illness. Participants in IFDM 2010 shared information and achievements in disability management and identified public policy changes that would facilitate effective disability management programs.

Key topics for the conference include:

- Advancing Awareness and Support for Effective Disability Management Outcomes and Best Practices
- Building Political Consensus to Advance Policy on Disability Management
- Partnerships in Disability Management
- Integration into the Workforce
- Vocational Rehabilitation
- Addressing Specific Problems During Medical Treatment
- The Importance of Coordination Among Stakeholders in the Return-to-Work Process
- An Overview of Government Programs in Disability Management
- Employer Best Practices
- How Medical Providers Can Improve Outcomes in Disability Management
- Measuring Disability Management: Quantitative and Qualitative Analysis
- Employer Success Studies
- Utilizing Research and Analysis to Evaluate Government Programs
- Examining the Competencies of Disability Management Practitioners
- A Comprehensive Societal Disability Management Strategy
- Integrating Young Adults with Disabilities into the Workforce
- Engaging Stakeholders; Government Programs
- Linking Health, Wellness and Productivity
- New Resources for Your Disability Management Toolkit
- Demographics
- Mental Health, Challenges in Return to Work
- Integration of Care
- Prevention: The Most Effective Disability Management Strategy
- New Paradigms in Disability Management
- Fostering Labor and Management Collaboration in Formulating Return-to-Work Policies
- Job Retention and Return to Work in the Context of the UNCRPD

- Next Steps in Moving Disability Management Forward

For further Information …

IFDM 2010 website, www.ifdm2010.com

IAIABC website, www.iaiabc.org

CHSWC website, www.dir.ca.gov/chswc

SPECIAL REPORT: WORKERS' COMPENSATION MEDICAL STUDY OF THE IMPACT OF RECENT REFORMS

Introduction

Senate Bill (SB) 228 and SB 899 made a number of changes that affect how medical-necessity determinations are made for medical care furnished to injured workers in California. These changes included the following: linking the Official Medical Fee Schedule (OMFS) to the 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 a 27.7 percent increase to its pure premium rates due to medical inflation in its January 2011 rate filing.[45]

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 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."

[45] Based on WCIRB Regulatory Report *WCIRB January 1, 2011 Pure Premium Filing Part A*, amended on September 27, 2010.

Inpatient Hospital Services

Background

The AD of the DWC maintains an 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 MPNs 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 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 a 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 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 by 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 has approved the study

For further information …

"Inpatient Hospital Services: An Update on Services Provided Under California's Workers' Compensation Program," RAND (2009).
http://www.dir.ca.gov/chswc/Reports/CHSWC_InpatientHospitalServices.pdf

DWC Labor Code section 5318 on Inpatient Hospital Fee Schedule:
http://www.dir.ca.gov/dwc/dwc newslines/2010/Newsline 32-10.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 study 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.

DWC proposes to revise the ASC fee schedule by modifying the multiplier for ambulatory surgical center facility fees to 100 percent of the Medicare outpatient fee schedule or a 102 percent multiplier that includes an extra 2 percent reimbursement for high-cost outlier cases.

Status

CHSWC has approved the study.

For further information …

"Ambulatory Surgery Facility Services Provided to California's Injured Workers," RAND (March 2009).
http://www.dir.ca.gov/chswc/reports/2009/chswc%5Fdraftfacilityservicesforambulatorysurgery2009.pdf

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 has 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 ED 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 ED 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."[46] 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 communication 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.

[46] California HealthCare Foundation, "Overuse of EDs among Insured Californians," September 2006 available at http://www.chcf.org/topics/hospitals/index.cfm?itemID-126089 as of 3/31/09.

- 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

Key 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 Workers' 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 has been 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 released additional medical treatment guidelines for chronic pain; and DWC is working on a new OMFS for physician devices.

Recommended Next Steps

Several recommended next steps include:

- Convene a working 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.

CHSWC/RAND Study Using WCIS Data

Background

The CHSWC Study by RAND will address the following topic under Workers' Compensation Information System (WCIS) data:

- Develop measures that could be used in an ongoing system of monitoring of the cost and quality of care provided to injured workers.

- 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 and the California Department of Statewide Health Planning and Development.

- Test a set of measures that could be used for ongoing monitoring of the medical care provided to workers with back injuries.

- Generate aggregate payment information by type of service for medical provider network (MPN) and non-MPN care.

Status

In process.

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 of 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 have undergone 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

Three manuscripts have been published in peer-reviewed medical journals.

> Karl J. Sandin, M.D., M.P.H.; Steven M. Asch, M.D., M.P.H.; Charles Jablecki, M.D.; David Kilmer, MD; Teryl K. Nuckols, M.D., M.S.H.S., and the Carpal Tunnel Quality Group. "Clinical Quality Measures for Electrodiagnosis in Suspected Carpal Tunnel Syndrome." *Muscle and Nerve*. 2010 Apr;41(4):444-52.
>
> Melinda Maggard, MD, MPH; Walter Chang, MD; Neil Harness, MD; Janak A. Parikh, MD; Steven M. Asch, MD, MPH; Kevin Chung, MD; Teryl K. Nuckols, MD, MSHS and the Carpal Tunnel Quality Group. "Indications for Performing Carpal Tunnel Surgery: Clinical Quality Measures*." Plastic Reconstructive Surgery.* 2010 Jul;126(1):169-79.
>
> Nuckols T, Harber P, Sandin K, Benner D, Weng H, Shaw R, Griffin A, Asch S; The Carpal Tunnel Quality Group. "Quality Measures for the Diagnosis and Non-Operative Management of Carpal Tunnel Syndrome in Occupational Settings." *Journal of Occupational Rehabilitation.* 2010 Aug 25. [Epub ahead of print]

One additional manuscript is under review at peer-reviewed medical journals. It addresses care for patients who are undergoing carpal tunnel surgery.

The researchers have also developed and pilot tested a comprehensive and detailed tool that enables quality of care to be assessed for people with carpal tunnel syndrome by reviewing their medical records. The tool explains how to identify the patients to which each measure applies and how to determine when care adheres to the measure, as well as other supporting information. A report containing the tool, the RAND/UCLA Quality-of-Care Measures for Carpal Tunnel Syndrome: Data Collection Tools, will be posted online. In addition to the tool, the report provides background information, describes study methods, and includes the algorithm for determining when surgery is necessary, optional, or inappropriate.

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 include the physicians' medical evaluation and management plans, for example.

- 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 reasonably complete record of the care provided for CTS: the claims databases do not provide the necessary information; Doctor's First Report (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 in occupational settings. The U.S. Agency for Healthcare Research & Quality has awarded Dr. Nuckols 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. The U.S. Agency for Healthcare Research & Quality, is also funding this five-year study, which began on September 30, 2010 ("The Value of High Quality Medical Care for Work-Associated Carpal Tunnel Syndrome," grant number R01HS018982-01). At the same time, Kaiser Permanente will use the measures to develop an internal quality assurance program.

Conclusions based on the current 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. 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 or require providers to monitor quality and report results back to the payors than to assess quality directly. However, payors could assure the appropriateness of future surgeries for CTS using the algorithm developed in the study.

SPECIAL REPORT: OCCUPATIONAL AND NON-OCCUPATIONAL INTEGRATED CARE

Introduction

Integration of group health and workers' compensation medical care is an alternative to two separate systems of medical care. Under integrated health care, the same individual physician or health provider group administers treatment for both occupational and non-occupational medical conditions and integrates payment for treatment under a single insurance policy. Integrating workers' compensation medical treatment with group health treatment offers employers the potential for significant savings and could help improve the quality of care and workers' overall access to health insurance.

Group health care and workers' compensation medical care are typically delivered through separate provider systems, often resulting in unnecessary, duplicative and potentially contra-indicated treatment. A lack of integration of group health care and workers' compensation medical systems creates major financial challenges for employers, especially those in industries with already high workers' compensation costs.

Background

The Commission on Health and Safety and Workers' Compensation (CHSWC) issued a working paper titled "Comparing the Costs of Delivering Medical Benefits under Group Health and Workers' Compensation — Could Integration Pay for Covering the Working Uninsured?" At its October 22, 2009 meeting, CHSWC voted to create an advisory group to discuss the findings of the issue paper on integrating workers' compensation medical and group health care. Subsequently, on February 25, 2010, CHSWC held a roundtable to discuss the issue paper in detail, get feedback from the advisory group, and examine the feasibility of adopting integrated care in California. The roundtable was composed of over 40 participants representing employers, labor, government agencies, medical providers, insurance companies, and attorneys.

Integration of Care Study

The integration of care study involves a partnership between CHSWC, the California HealthCare Foundation (CHCF) and the University of California (UC), Berkeley.[47,48]

One of the prerequisites for integrating occupational and non-occupational care is near universal health insurance coverage. The study argues that if occupational care and non-occupational care are integrated, the savings would be sufficient to finance a substantial fraction of the incremental cost of universal health coverage. Furthermore, the savings from integration can be obtained without reducing payments to medical providers, i.e., hospitals, doctors and pharmacies, and without raising costs to employers. This process can occur without restricting health care provided to patients and injured workers.

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[47] Frank Neuhauser, MPP, Institute for the Study of Social Insurance, University of California, Berkeley; Jasjeet Sekhon, Ph.D., Professor of Political Science, University of California, Berkeley; Mark Priven, FCAS, MAAA, Actuary, Principal, Bickmore Risk Services; Rena David, MBA, MPH, Healthcare Consultant; Nicola Wells, BS, University of California, Berkeley; Christine Baker, MA, Executive Officer, California Commission on Health and Safety and Workers' Compensation; Jon Stiles, Ph.D., UC DATA, University of California, Berkeley.

[48] The study involved assistance from the following organizations:
Workers' Compensation Insurance Rating Bureau (WCIRB)
Council on Compensation Insurance, Inc. (NCCI)
National Academy of Social Insurance (NASI)
California Department of Insurance (CDI)
National Association of Insurance Commissioners (NAIC)

The recent national healthcare reforms laid the groundwork on which states can begin to build integrated care systems.

Key Issues

Differences between workers' compensation and group health care

- Workers' compensation covers everyone from the first day they are on the job; there is no waiting period, and there are no eligibility requirements. In contrast, under group health care, approximately 80 percent of employees at employers that offer group health insurance are eligible for the program, and 20 percent are not eligible; the ineligible employees are often part-time, and even fewer employees are eligible for benefits from the first day they start their job.

- Employment-based group health care almost always involves shared premiums, co-pays, and deductibles. Workers' compensation is entirely paid by employers.

- Workers' compensation is "event-based"; it pays for all medical treatment for a condition, the onset of which occurred during the policy period, even if that care is delivered years in the future. In this respect, worker's compensation is similar to other types of property casualty insurance that have a medical liability component, like automobile and malpractice. Health insurance is "service-date-based" paying for all services delivered in the policy period regardless of the date of a condition's onset. Health insurance does not pay for any treatment after the policy period, even if a condition's onset occurred during the policy period.

- Workers' compensation is regulated at the state level, and there is almost no federal regulation. Within states, benefits are identical across employers and workers in the workers' compensation system.

- Group health care is regulated at the federal and state level. One can buy several different types of policies for group health care with different benefit levels and coverage restrictions.

- Because workers' compensation is regulated at the state level, reforms have to occur on a state-by-state basis even if some of the prerequisites are put in place at the national level by the federal government.

Prerequisites for Integration

- Universal coverage or near universal coverage for the working population: having universal coverage is a prerequisite because labor will require continuous medical coverage for workers injured on the job *even* if they are employed or moving to a different employer.

- De-coupling the liability of the employer for the medical portion of the workers' compensation coverage: medical treatment and the liability for the medical treatment should be treated exactly like a non-occupational medical condition. The liability for medical treatment related to a workers' compensation injury would not be linked to an employer as in the current system. The liability for treatment would rest with the health insurer covering the worker when treatment is delivered.

- The treatment and payment processes have to be integrated. Past pilot efforts at integration have kept the insurance products separate and have integrated only the treatment process. There should be only one medical insurance product with the integration of care, avoiding the situation where the health care provider is responsible for occupational and non-occupational care but gets paid from two different sources.

Savings from integration

- The study made two separate estimates: one that relied on data from California insurance rate filings by hundreds of individual insurers; and a second that relied on more aggregated national data from the National Academy of Social Insurance (NASI) and the National Council on Compensation Insurance (NCCI). The California data are detailed and drawn only from insurers' individual financial reports and rate filings. Administrative costs are reported by individual insurers. Loss costs are reported by individual insurers and aggregated by the California Workers' Compensation Insurance Rating Bureau (WCIRB).

- The administrative costs derived from NASI are derived from aggregate reporting by state workers' compensation agencies and insurance reporting services. NASI administrative cost estimates tend to be conservative because of the underlying assumptions used in the analyses. These estimates can be thought of as a check on California insurers' estimates that are more detailed but cover only a single state.

- For California insurers and NASI estimates, the cost under integration is very low in the initial year because employers have insured all the liabilities that occurred before the first year of integration. Insurers and employers only pay about 10 percent of the liabilities on injuries occurring under a policy during the first year of the policy. As the period covered by integration becomes longer, treatment for more injuries are included under the integrated benefit. On a national level, there is $52 billion savings in the first year. The savings would gradually decline to $43.4 billion dollars in the fifth year. Then, as medical inflation becomes the dominant driver, annual savings begin to increase, reaching $60 billion in the tenth year.

- Total national savings estimates over the first ten years would be between $497 billion (based on NASI data) and $560 billion (based on California insurer data). Savings for California alone would be about $10 billion in the first year and $100 billion for the ten years 2011 to 2020 inclusive.

- Key reasons for the savings are that it is expensive to deliver medical care separately for a single condition. This is very expensive initially and even more expensive over a life-time of separate treatment. Additionally, life-time medical costs are very difficult to predict, and insurers have to charge a "risk premium" for taking on a highly speculative liability. Health insurers are only estimating medical treatment costs over the next 12 months, a much less risky proposition. Workers' compensation cases can be impacted by court decisions, medical technology changes, medical inflation, and other factors even number 20 or more years after the inception of the policy.

Labor-Management Comments from Roundtable Participants

- A single payor system could make it easier for integration of care to work.

- There is a need to look at other systems that are more efficient in order to compete with the rest of the world.

- It is inaccurate to state that workers' compensation is entirely paid for by employers. When workers' compensation costs go up, it puts pressure on workers' wages. Therefore, it is not only the employers, but also the workers who are paying for workers' compensation.

- There are significant costs on loss adjustment expenses in workers' compensation. Part of the goal of the 2004 reforms was to lower the frictional costs in the workers' compensation system. This has not been addressed, and there are still considerable frictional costs. Even if the broader issues cannot be addressed, there is still a need to examine the potentially unnecessary administrative costs in the system.

- Cost savings identified by the study are substantial, and it is in the best interests of business and labor to examine and address the concept of integrated care. Some participants commented that state organizations such as the State Compensation Insurance Fund or CalPERS could run pilot programs since they are providing health care and workers' compensation.

Employer Comments from Roundtable Participants

- There is waste in the current workers' compensation system and issues are how to reduce duplication and costs in the workers' compensation and group health care.

- Employers are hesitant about the single payor or universal health care system. Additionally, it is difficult for them to understand how integrated care would mean that there would be no cost increases for small businesses, since some small businesses currently do not provide health care.

- Nothing is stopping an employer from working with its labor force to put together 24-hour care coverage. However, it is a complicated process. In the past, the 24-hour care model did not work for every employer of every size.

- Another issue was who would act as the gatekeeper on medical care so that occupational disease was getting the correct amount of care according to the treatment guidelines and fee schedules. A lot more gate-keeping had to take place in the 24-hour care model than people expected.

Summary of Roundtable Recommendations

- Focus on reducing administrative costs in the current system in the short-term.

- Continue to get data to see what the frictional costs are so that even when the two systems are not integrated, they are operating at maximum efficiency.

- Look at the group health system to see what can be done differently in workers' compensation. Certain reporting requirements, including duplicate reporting, especially for medical-only claims, may not be necessary and could be eliminated. The reporting requirements are a big portion of the costs and create an administrative burden on the system. In particular, the Doctors' First Report of Injury is very cumbersome and may be irrelevant in medical-only cases.

- Identify what will occur at the national level prior to implementing integration of care at the state level.

- Focus in the short-term on identifying and reducing unnecessary administrative costs in the workers' compensation system.

- Examine what works in health insurance and apply that to workers' compensation rather than implement a systemwide change of integration of care.

- Consider piloting the integration of care model in the public employment sector.

- Look at the example of New Zealand in delivering medical and indemnity.

- Ask the Massachusetts Rating Bureau if it has noticed any changes in claims activity.

- Examine how utilization review costs are defined in the Health and Safety Code and look at the Statement of Statutory Accounting Principles of health plans.

For further information …

"Comparing the costs of delivering medical benefits under group health and workers' compensation – Could Integration pay for covering the working uninsured?" (October 2009).
www.dir.ca.gov/chswc/PublicCommentsandFeedback.html

SPECIAL REPORT: SELF INSURANCE GROUPS (SIGs)

Introduction

In October 2008, Assembly Member Joe Coto, Chair of the Assembly Insurance Committee, requested 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. The "Report on Self Insurance Groups" found that California already has substantial protections in place, but further improvements can strengthen the program. Statutory and regulatory changes are recommended. The complete report can be found on the CHSWC website at http://www.dir.ca.gov/chswc/Reports/2009/CHSWC_SIGReport.pdf

History of Private Group Self Insurance in California

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. For decades, public entities have also been permitted to self insure, either individually or in groups called joint powers authorities (JPAs). 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.[49] 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.

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 (SIP, commonly called 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, the Chair of the California Assembly Insurance Committee requested an analysis by CHSWC.

Methodology

The report is based on CHSWC staff interviews and discussions with stakeholders and experts, reviews of statutes and regulations and public documents and literature, and reviews of confidential records by CHSWC staff and by an independent consultant. Additional input was received at an April 16, 2009 meeting of SIG administrators as well as representatives of the Self Insurers' Security Fund (SISF) and CHSWC staff. Public comments were received at CHSWC meetings and following the April 30, 2009 release of a draft version of this report.

[49] Sources: Office of Self Insurance Plans website and e-mail correspondence 1/8/2009.

Lessons Learned from Others

New York State has a long history of group self insurance leading up to some well-publicized failures. The Director of Self Insurance for the State of New York Workers' Compensation Board generously shared informal impressions or suggestions with CHSWC staff when work on this CHSWC report began in October 2008, and they are listed in bullet form in the full report. They include: requiring actuarial opinions; requiring year-specific accounting; restricting what is acceptable as an asset to cover the liabilities; requiring trustee training and annual meetings with the regulators to emphasize fiduciary responsibility; and limiting the return of surplus contributions, among others.

Evidently, many New York groups were headed for trouble long before most California groups were created. It can take years for the consequences of inadequate oversight to unfold, and the damage can progress inexorably despite the insights of the current regulator. However, there is little comfort in the arguments of some California SIGs that there has never been a SIG failure in this state.

On the other hand, there is comfort in the fact that California regulations from their beginning have reflected many of the lessons learned in states with years of experience. California prohibits a group administrator from acting as the group's claims administrator, requires year-specific accounting, requires actuarial reports and audited financial reports, restricts the investment of funds, requires a security deposit of 135 percent of expected future liabilities, and requires each group to carry funding at a high confidence level. The most serious mistakes of other states have been already been avoided, and at this early stage in California's history of group self insurance, it is not too late to correct the smaller vulnerabilities that remain. The first lesson learned by comparison to other states is that California has gotten group self insurance off to a good start.

Understanding the Nature of Group Self Insurance

Group self insurance has certain characteristics of insurance and other characteristics of stand-alone self insurance, as well as characteristics unique to group self insurance. Like insured employers, members of a SIG pay in advance to cover their projected liabilities for workers' compensation benefits. Like self-insured employers, members remain at risk. Unlike employers in either of the other models, members of a SIG are jointly and severally liable for the amounts required to pay the liabilities of all the members of the group, and they may be assessed to cover any shortfall in the group even if their own experience is loss-free. None of the three models are purely one type, since each model also involves some combination of deductibles, experience ratings, dividends, deposits, and reinsurance. Each model is ultimately backed by a guaranty fund, either the California Insurance Guaranty Association (CIGA) for insurers or the Self Insurers' Security Fund (SISF) for self-insured employers and SIGs. The group self insurance model, however, is unique, and it creates its own challenges for legislative and regulatory oversight. Across the country, the methods for overseeing group self insurance are still being developed.

The reason the State takes on the challenge of overseeing a program for group self insurance is that this model has the potential to save money and reduce the adverse impacts of industrial injuries for both employers and injured workers. Furthermore, group self insurance may be able to serve public policy goals by providing appropriate incentives to participating employers.

Although group self insurance is not regarded as "insurance" for purposes of the Insurance Code and is not under the jurisdiction of the Department of Insurance, it is, in essence, insurance. Group self insurance is fundamentally different from stand-alone self insurance. Group self insurance has the defining characteristic of insurance, which is the transfer of risk of an occurrence from one entity to another in exchange for a payment in advance of the occurrence.

Despite the name "self insurance," individual or stand-alone self insurance is not insurance; it is self-funding. When there is no transfer of risk in exchange for payment of consideration, there is no insurance. A "self-insured" employer is one that is permitted to retain its own risk upon showing that it has the financial capacity to make good on its potential liabilities. The workers' compensation liabilities of a self-insured employer are paid by the employer out of its ongoing revenue or other available funds.

Group self insurance is different from individual self insurance because group members are not required to demonstrate their financial capacity individually or to pay their individual liabilities. The group as a whole must have the financial capacity to make good on the members' liabilities. It is the solvency of the group, like the solvency of an insurance carrier, which secures the payment of compensation on behalf of the employers covered by the group.

The workers' compensation liabilities of a member of a SIG are ordinarily paid by the SIG out of funds collected in advance from the members. In a SIG, there is a transfer of primary liability from the member to the SIG in exchange for the member's payment of a fee. Whether that fee is called "premium," as in conventional insurance, or "contribution," as in group self insurance, it is nevertheless consideration paid by the member in exchange for the SIG's acceptance of the member's risk of workers' compensation liabilities. Unlike conventional insurance, an employer in a SIG may be assessed for additional funds if the assets of the SIG are insufficient to fund the payment of all of the liabilities assumed by the SIG. Any member can be required to cover the unpaid assessments of the others. Surplus funds may be returned to the members. Despite the overlay of these other provisions – joint and several liability, the potential for assessments for deficits, the potential for return of excess funds, and the ultimate recourse to joint and several liability for other members' liabilities – the fundamental characteristic of group self insurance is an insurance transaction.

The Role of the Regulator

Because group self insurance has the essential characteristic of insurance, the State's oversight of group self insurance must address the same problems as the State's oversight of conventional insurance. The states that permit group self insurance have chosen varied approaches to regulating the arrangement. In 16 states, group self insurance is under the jurisdiction of the insurance agency. In 5 of those states, stand-alone self insurance is also under insurance agency jurisdiction, while in 11 of the states, stand-alone self insurance is separately regulated by the workers' compensation agency. California is among the 13 states that have both group self insurance and stand-alone self insurance regulated by the workers' compensation agency.[50] There is no reason that either agency, given the necessary resources, could not appropriately regulate group self insurance. Group self insurance in California is regulated by the Director of the Department of Industrial Relations (DIR) through the Office of Self Insurance Plans (SIP, commonly called OSIP). CHSWC does not find a compelling reason to shift group self insurance to the jurisdiction of the Department of Insurance (CDI).

For the Department of Industrial Relations (DIR) to successfully oversee group self insurance, however, the regulator of the program must approach it with the same concerns as an insurance regulator. For example, the solvency experiences from New York State show the consequence of allowing a SIG to continue sinking into deficit rather than face the need to levy assessments on members. California regulators should be prepared to shut down any SIG that is unable to come into compliance with the higher standards set in new regulations which require both funding for future unallocated loss adjustment expense (ULAE) and funding for every program year at the 80 percent confidence level, rather than just for the current program year. These regulations are necessary to assure with a high degree of confidence that funding is adequate for all incurred claims and that, in addition to money to pay the claims, there will be money to pay the adjusters to handle those claims. Some groups are already in runoff, paying accrued claims but not currently self-insuring, and their financial status is being examined by OSIP. Thanks in part to the high confidence level already required, most groups can probably adapt and meet the new standards.[51]

[50] Self-Insurance Regulators' Handbook, 2005, IAIABC, Madison, WI, Table 1-2, citing Self-Insurance Institute of America, August 2003 data. .

[51] Generalizations in this report about the condition of SIGs are based on reviews of financial and actuarial reports for 2007. CHSWC has not requested or received any additional financial or actuarial information about any group. No particular groups have been identified as threatened by the regulatory changes. It would be a mistake for the reader to infer that this discussion refers to any particular group. Specifically, CHSWC has no reason to believe that any group that has announced closure or change of administrators is unable to pay fully all of its obligations or to continue as a going concern.

Summary of Regulatory Provisions

A SIG must be organized as a nonprofit corporation (Rule 15470[52]) governed by a board of trustees (Rule 15475). The SIG must obtain Certificate of Consent to Self Insure, and each member receives an Affiliate Certificate of Consent to Self Insure. Each member must agree to joint and several liability for the workers' compensation obligations of all the other members.

CONFIDENCE LEVELS

The confidence level is an expression of the probability that an estimate of losses will be at least equal to the actual losses. Absolute certainty is not feasible. California SIGs are required to use higher confidence levels than are used in the insurance industry.

Actuaries attempt to project the ultimate losses by a variety of methods. Because of the various uncertainties in these processes, the actuarial projection of the ultimate loss is stated as a range. A 50 percent confidence level would be the number which is equally likely to be too high or too low.

The insurance industry uses the "expected" loss, which is somewhat greater than a 50 percent confidence level. This estimate is more likely to be adequate than inadequate. There is a substantial chance of any given year's losses being underestimated, and there is only a limited margin for error to balance out from year to year. Insurers are required to have certain levels of capital and surplus to help cushion against unexpectedly high losses.

California requires that SIGs must be funded at the 80 percent confidence level, meaning that the actuarially projected losses will exceed actual losses eight out of ten years and fall short only two out of ten years, on the average.

Payment of the workers' compensation obligations of the members is made by the SIG from the SIG's assets. The assets derive from the payment by the members for their coverage. The rates for these payments are not directly regulated, but the amount collected must be adequate to fund the SIG's liabilities estimated at an 80 percent confidence level. Accounting is required by program year, with funding to the requisite confidence level separately for each program year. As of March 2, 2009, the funding must include unallocated loss adjustment expense (ULAE), so the sufficiency of the funding to administer all incurred claims should no longer rely on a SIG remaining a going concern in future years. A SIG must correct any deficit in the required funding level by some means. Transfer of surplus funds from other program years is permitted. Assessments of members may be compelled by the Director if necessary to correct a deficit. (Rule 15477)

A SIG is required to keep a deposit with the Director of DIR in the amount of at least 135 percent of estimated future liabilities. (Labor Code Section 3701) If a SIG defaults on payment of compensation liabilities, the Director may turn the deposit over to SISF and require SISF to pay the compensation benefits. (Labor Code Section 3701.3) SISF would be obligated to make all payments of compensation even if the deposit is exhausted. The ultimate recourse is still against the members of the SIG, but SISF may have to pay benefits on behalf of a failed SIG and pursue collections actions against the members.

In summary, the priority of security for payment of workers' compensation is the assets of the SIG, assessments of the members, the security deposit, and SISF. Depending on the practicalities of collection from members, it may be necessary to draw on the deposit and SISF while collection actions against the members and former members are prosecuted.

[52] All references to Rule numbers are to sections of Title 8 of the Code of Regulations, as amended through March 2, 2009. Self insurance regulations are in Subchapter 2, Articles 1 (beginning with Section 15470) through 13.

Summary of Findings and Recommendations

Self insurance groups have the potential to serve the interests of California employers and employees by promptly providing workers' compensation benefits to injured workers at reasonable cost while enabling and encouraging employers to improve safety and provide the earliest appropriate return to work for injured employees.

Self insurance groups also have the potential to drive up costs and disrupt the delivery of benefits when poorly managed. At the least, the members or former members of an underfunded group may be exposed to unexpected costs to make up for the shortage. At worst, responsibility for payment of a failed group's obligations may be shifted to employers who were not connected with the failed group, and benefits to injured workers may be interrupted and delayed during the collapse of the group.

The purpose of this report is to review what legislation or oversight might be needed to preserve group self insurance as an option for eligible employers and to assure that the risks are held to a reasonable minimum. California already has regulations designed to protect against the most obvious risks of financial failure and default by self insurance groups. This report recommends additional steps for improved solvency, security and oversight.

Findings

- Since the time private group self insurance was first authorized in California, this state had protections against fiscal mismanagement superior to most states:
    - Program administrators have never been permitted to act as claims administrators.
    - Funding for loss reserves has always been required at a higher confidence level than required elsewhere.

- California has, as of March 2, 2009, adopted regulations which will enhance regulatory oversight and protection against the problems that have occurred in other states:
    - The new regulations prohibit certain additional conflicts of interest among service providers and require disclosure of certain other conflicts.
    - Requirements for funding loss reserves are applicable separately to each and every program year.
    - Requirements for funding loss reserves include unallocated loss adjustment expense.

- The regulatory system is not as strong as it could be to manage the risk of defaults:
    - The regulatory office does not have sufficient expert resources to examine the actuarial and fiscal integrity of SIGs.
    - SISF does not have access to information needed to identify and mitigate the fund's exposure to risks of default by SIGs.
    - There are no minimum qualifications required for group administrators.
    - Disclosure of SIG financial condition to prospective members is not currently required.

- If the regulator and SISF have access to adequate information, if SISF has the ability to trigger enforcement or corrective action by the Director, and if prospective members are provided with appropriate information, then public disclosure of SIG financial information is not likely to further enhance the security of SIGs for participating employers, for the injured employees of participating employers, or for the security fund.

- Provisions of the Corporations Code prohibiting distributions by nonprofit corporations are arguably in conflict with the practice of SIGs that return surplus contributions to members in the form of dividends or refunds.

Legislative Recommendations

- Authorize SISF, upon approval by the Director of DIR, to create separate accounts within the fund for SIGs and for individually self-insured employers and to allocate expenses and liabilities between the two accounts.

- Authorize SISF as well as the Director to conduct or obtain independent audits and examinations of any aspect of the books and operations of SIGs.

- Authorize the Director and SISF to share confidential information with each other.

- Provide that if SISF recommends corrective action or enforcement action, the burden of proof shall be on a SIG to demonstrate to the Director that its estimates of future liability are adequate and that it is in compliance with statutory and regulatory requirements.

- Confirm that member financial records are confidential and shall not be disclosed by the Director either publicly or to SISF.

- Provide that financial and actuarial information obtained by the Director or SISF is exempt from public disclosure, except that aggregate or statistical information that is not individually identifiable may be publicly disclosed and the compliance status of any SIG may be publicly disclosed:
    - "Compliance status" is intended to include the rosters of active SIGs and member employers already published by OSIP, as well as the identity of each SIG which has and has not filed reports on time or complied with requirements such as funding loss reserve and filing reports on time or paying security deposits.

- Either amend the Corporations Code to permit SIGs to return surplus funds to members or expressly provide that surplus funds from any program year may only be used to reduce contributions required for a different program year.

- Establish a judicial procedure to consolidate all state court litigation arising from the insolvency of a SIG into one liquidation proceeding.

Regulatory Recommendations

- Require that every member or prospective member and the agent or broker for every member or prospective member shall be provided a copy of the group's most current financial report and other prescribed reports, provided that a SIG may first require that the member, prospective member, agent, or broker executes a nondisclosure agreement in a form approved by the Director.

- Adopt regulations as necessary to carry out the statutory provisions, including:
    - Criteria for the publication of status information on SIGs that are out of compliance with statutory or regulatory requirements.
    - Guidelines for statistical information that can be released without revealing confidential information about identifiable SIGs.
    - Amendment of Regulation 15405, Confidentiality, to permit sharing confidential information with authorized representatives of SISF.

- Make group administrators accountable for performance:
    - The Director should establish qualifications and licensing for program administrators, as it has for third-party adjusting agents (TPAs). In addition, consider increased prohibitions against conflict of interest; the new regulations prohibit certain conflicts such as the roles of program administrator and the certified public accountant (CPA). Weigh the arguments that may be made for or against prohibitions of other potential conflicts, such as actuary and program administrator.

- Audit additional aspects of performance beyond claims adjusting:
  - A complete independent audit should not be limited to the accuracy of the financial statement. It should include key points of regulatory compliance such as the identity and terms of all reinsurance, the identity and essential terms of all service provider contracts, and regular records of key actions by the Board of Trustees as well as the composition and structure of the Board.

- Evaluate potential changes to the audit process:
  - Consider randomly selecting claims for audit to reflect a cross-section of the case inventory and then extrapolating the results of the audit to the entire case inventory for purposes of requiring increased deposits and revised actuarial projections.
  - Evaluate which aspects of SIG operations can best be reviewed by claims auditors and which by the independent CPAs who prepare the certified, independently audited financial statement.
  - Adopt requirements for the format of independent audits to include the selected items, which may include but need not be limited to reinsurance, contracts with service providers, freedom from prohibited conflicts of interest, reliable processes to assure required disclosures of group financial information to members and prospective members, management of funds in accordance with regulations, and collection of contributions due from members.

- The Director should disapprove reinsurance coverage that results in an unreasonable concentration of risk in a small number of reinsurers that would endanger the entire SIG program in the event of collapse of one reinsurer.

- Require each SIG to file its rate plan and adhere to its rate plan. Clarify whether experience modification or any other reduction from a uniform rate for each classification in a SIG is permitted.

- Enhance the independence and fiduciary responsibility of trustees:
  - Require that trustees receive approved training or otherwise demonstrate understanding of the fiduciary duties of trustees and the operations of group self insurance.
  - Review Board minutes for adherence to procedures.
  - Ensure that Board members are involved in communications between the Director or the OSIP Manager and the group administrators.

- Unhesitatingly enforce regulations, even if enforcement requires shutting down a group:
  - New York waited too long to act in some cases, until the requisite remediation was too onerous for some groups to remain viable.
  - A small number of California SIGs have reported deficits. These should be corrected forthwith. Corrective action should take into consideration any pattern which may occur, such as chronic deficits in a single group or multiple groups administered by a particular administrator.
  - Existing regulations do not clearly specify the time in which a group must correct any deficiencies before the group may be ordered to take specific actions.

- Prohibit false or misleading statements in marketing materials. Require specified disclosures in marketing materials. Adopt a procedure to enforce regulations of content of marketing materials.

- Establish contractual arrangements with persons or organizations that can be swiftly appointed by the Director to act as group administrators, TPAs, auditors, accountants, and actuaries if the need arises.

- Continue long-term discussions of whether requirements of capital and surplus should supplement or replace the requirement of reserving to the 80 percent confidence level as a means of cushioning against adverse loss development.

Further Study

Too little is known about the actual performance of SIGs. Their supposed benefits are known only though anecdote. While self-promotional and self-congratulatory statements must always be taken with skepticism, CHSWC believes there is truth in the claims that group self insurance can reduce employer costs and improve worker safety and return to work. The same potential may not be realized in all groups. To better evaluate and quantify whether group self insurance is living up to its potential, the performance of SIGs should be objectively studied and compared to the performance of conventional insurance. The Workers' Compensation Information System (WCIS) operated by the Division of Workers' Compensation (DWC) will provide a useful database for research once participants fully comply with its data reporting requirements, and OSIP should insist on compliance by all of the entities under its jurisdiction. Based on the information currently available, CHSWC believes group self insurance to be a valuable option among the choices available to California employers. The recommendations in this report are intended to enhance the long-term value of group self insurance for California employers and employees.

SPECIAL REPORT: ASSISTING INJURED WORKERS AND 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 and/or until the employer is identified and made to reimburse those expenses made by the fund. The State administers the fund, and all costs and expenses of the fund are paid by assessments to legally insured employers in California.

The workers' compensation community has expressed concern with several aspects of the program, ranging from the complex nature of bringing a claim to the fund, the complex directions provided to the public, and difficulty in identifying uninsured employers.

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.

The following is an update on the progress in addressing these issues.

Pilot I&A Enhanced Customer Service Initiative to Assist Injured Workers

Background to the I&A Enhanced Customer Service Initiative

The Division of Workers' Compensation (DWC) Information & 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 unit plays a major role in reducing litigation before the Workers' Compensation Appeals Board (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.

As discussed above, one helpful resource is the UEBTF which may provide for the payment of workers' compensation benefits to injured employees of illegally uninsured employers. 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 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.

DWC has reported that 3,100 cases per year come through I&A offices, of which 1,700 become UEBTF claims. Virtually no UEBTF claims are pursued 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: A Joint Partnership

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 legally 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 the Division of Labor Standards Enforcement (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. The additional assistance provided by I&A Officers requires additional training, including additional investigative expertise that is already available within DIR.

Data Collection and Evaluation

In order to evaluate the pilot, data were collected by the I&A Officer. A report will be prepared based on data collected and observed results. Recommendations for improvement will be included.

Duration of Initiative

This initiative began in the I&A Office in Salinas, California, on June 1, 2009, and ended June 1, 2010.

Results (Preliminary)

Preliminary results indicate that many injured workers either believe that their employer is not insured or that the employer tells them that they are not eligible or covered (to avoid reporting requirements and potentially other liabilities) when in fact they are.

With additional training, the I&A Officer can assist the injured worker in important ways. More often than not, the I&A Officer is successful in verifying that the employer is insured and can then point the injured worker towards the straight-forward claims process. This is an important service to direct only legitimate claims to the UEBTF.

In cases where the employer is found to be likely illegally uninsured, the I&A Officer can be helpful in suggesting that the employer be joined during a hearing, thereby avoiding the complicated service of process requirement.

In cases where the employer is found to be likely illegally uninsured, the unrepresented injured worker actually has more success in obtaining representation by a lawyer, since the process of trying to track down the employer and its coverage information has already been completed.

The additional customer service can take up to 3.5 additional hours, but as there are relatively few truly uninsured injured workers, that time may be well spent.

CHSWC UEBTF Booklet

Injured workers, legal services organizations, and agencies that investigate workers' compensation fraud have expressed a need for these workers to receive additional help and support in following the UEBTF claims steps described in the above 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 DWC materials with easy-to-understand terminology and examples.

Funding was 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 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 with 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).

CHSWC is pleased that earlier results of pilot studies informed the process to create the statute related to this matching program to identify illegally uninsured employers. CHSWC is now interested in seeing that the data matching program and the reporting of results become routine and effective at bringing illegally uninsured employers into compliance and/or fined when necessary.

First DIR report on Labor Code 90.3 Uninsured Employer Identification Program

In 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.

Second DIR report on Labor Code 90.3 Uninsured Employer Identification Program

In 2010, the second 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-2009.pdf

The reported results of the program yielded 62 citations issued per Labor Code Section 3722(a) for not being insured and 22 citations issued per Labor Code Section 3722(b) for being found to not be insured in the past. Of the $227,090 in workers' compensation penalties assessed, $57,583 in workers' compensation penalties were collected, and $43,000 in citations were administratively dismissed.

The report states that while the number of investigations was only 5 percent less than last year, the number of citations under Labor Code section 3722(a) were approximately 50 percent less, suggesting that the program is improving compliance. While it is not clearly evident from the information presented in the report that the reported statistics can be interpreted, especially to "suggest" that the lower numbers of citations in 2009 can be related to improving compliance, CHSWC does not have access to the data with which to review any steps or changes in the steps in the data matching, investigation and enforcement processes. The report concludes with the same statement from last year that DLSE will continue to refine the efficiency and effectiveness of this program for the benefit of both employees and employers.

SPECIAL REPORT: SCHOOL ACTION FOR SAFETY AND HEALTH

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.

A significant number of school employees are injured on the job each year. In 2008, the incidence rate of occupational injuries and illnesses for California school employees was higher than for all other industries in California: 7.6 cases per 100 full-time employees as compared to 4.4 cases per 100 full-time employees. Common causes of injuries and illness for school employees include overexertion, repetitive motions, slips and falls, vehicle collisions, and assaults. These injuries are often serious and involve lost work time, including days away from work or days of restricted activity or both. Work-related injuries and illnesses impact the school community, not only the injured employee, but also his or her family, co-workers, the districts, and the students.

School districts are frequently cited by Division of Occupational Safety and Health (Cal/OSHA) for occupational health and safety violations. The most common citation issued by the Cal/OSHA against schools was for not having a written Injury and Illness Prevention Plan (IIPP). Other common citations are for lack of chemical safety training under the Hazard Communication Standard, violation of the Asbestos Standards, and violation of sanitation standards. Between 2004 and 2008, California assessed school districts $273,000 in penalties for violations of Cal/OSHA standards.

School Action for Safety and Health (SASH) Program

CHSWC has established a schools safety and health 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 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 target audience is composed of 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).

The SASH program was developed to help:

- Ensure that employees do not have to deal with the consequences of a work-related injury or illness.
- Prevent disruptions in the class routine so that students can continue to learn and be successful in school.
- Boost employee morale and productivity when they see problems addressed and injuries prevented.
- Reduce the expenses that often go along with an injury, including the costs or workers' compensation claims, hiring substitutes, and Cal/OSHA fines.

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 schools districts with the priority training going to schools or school districts with high incidence rates and a pilot with schools from around the State.

Subsequent Advisory Group meetings were held on June 30, 2009, and March 29, 2010, to provide feedback on the project.

The SASH program includes: a needs assessment conducted to determine the types of training and resources needed; development of materials and resources; implementation with a pilot group; and evaluation of the program. 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.

Program Components

The SASH Program is a statewide initiative to help school districts reduce the high rate of work-related injuries and illnesses among school employees offering:

- A free training program to help build the capacity of district-level health and safety coordinators to be resources to other employees and develop an IIPP to identify, prevent and eliminate hazards.
- Written materials that support injury and illness prevention activities.
- Problem-solving assistance provided in an ongoing manner by a statewide SASH resource center.

The free one-day training program has been designed for school district staff responsible for employee safety and health. These employees are typically from human resources/administration and/or the maintenance and operations departments. Training is provided by University of California trainers and held in convenient locations so participants do not have to travel far to attend.

Participants learn valuable skills in how to:

- Identify and solve safety problems.
- Prepare written IIPPs.
- Involve other employees in carrying out prevention activities.

Once participants complete the training, they become “SASH Coordinators” for their district and receive a certificate from the Commission on Health and Safety and Workers’ Compensation and the University of California.

SASH materials are free and designed to help school employees identify and address health and safety issues in the school environment. Materials include:

- An online template for writing an IIPP, with an accompanying Guidebook.
- Factsheets on hazards commonly found in schools, including:
    - Overview of the SASH Program
    - Underlying Causes of Injury and Illness

  - Job Hazards in Schools; Investigating Job Hazards
  - Controlling Hazards
  - Prioritizing Health and Safety Problems
  - Addressing Ergonomic Hazards
  - Preparing for Emergencies at School
  - Basics of Cal/OSHA
  - Key Cal/OSHA Standards that Apply to Schools
  - Elements of an Effective Workers' Compensation Program
  - Health and Safety Committees

- Checklists and other tools to help identify problems, investigate and learn from accidents, and keep track of safety activities. Tools include:

  - Inspection Checklist
  - Incident/Accident/Near Miss Investigation Report
  - Hazard Correction Record
  - Employee Training Record

- Tip sheets for employees on hazards and solutions for their particular occupation, including:

  - Teachers and teaching aides
  - Maintenance staff
  - Groundskeepers
  - Food service employees
  - Custodians
  - Administrative and office staff
  - Bus drivers

- A poster for school employees promoting their involvement in safety activities.

- An online Resource Guide that provides additional school-related materials on particular hazards/issues and a list of agencies and organizations.

The SASH Resource Center is located in the University of California (UC), Berkeley Labor Occupational Health Program (LOHP). In collaboration with UCLA's Labor Occupational Safety and Health (LOSH) Program, the Resource Center is available to help school districts find additional information and obtain assistance after the trainings.

Partnerships

The following organizations were involved in shaping the SASH Program activities and materials:

- California Association of School Business Officials (CASBO)
- California Department of Education
- California Federation of Teachers (CFT)
- California School Employees Association (CSEA)
- California Teachers Association (CTA)
- Contra Costa County Schools Insurance Group
- Kennan & Associates
- North Bay Schools Insurance Authority
- San Diego County Schools Risk Management JPA
- Schools Insurance Authority

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

School Action for Safety and Health (SASH) Program Information and Resource Center
http://www.dir.ca.gov/chswc/SASH/index.htm

SASH Brochure
http://www.dir.ca.gov/chswc/SASH/Publications/SASH_brochure.pdf

SASH Flyer
http://www.dir.ca.gov/chswc/SASH/Publications/SASH_Flier.pdf

Injury and Illness Prevention Program Template
http://www.dir.ca.gov/chswc/SASH/index.htm

SASH Factsheets, Tools, Tip Sheets, Resource List, Worksheets, and IIPP Guide and Template.
http://www.dir.ca.gov/chswc/SASH/index.htm

SASH Online Resource Guide
http://www.lohp.org/docs/projects/sash/sashonlineresourceguideweb.pdf

SASH Poster
http://www.dir.ca.gov/chswc/SASH/Publications/SASH_Poster.pdf

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.

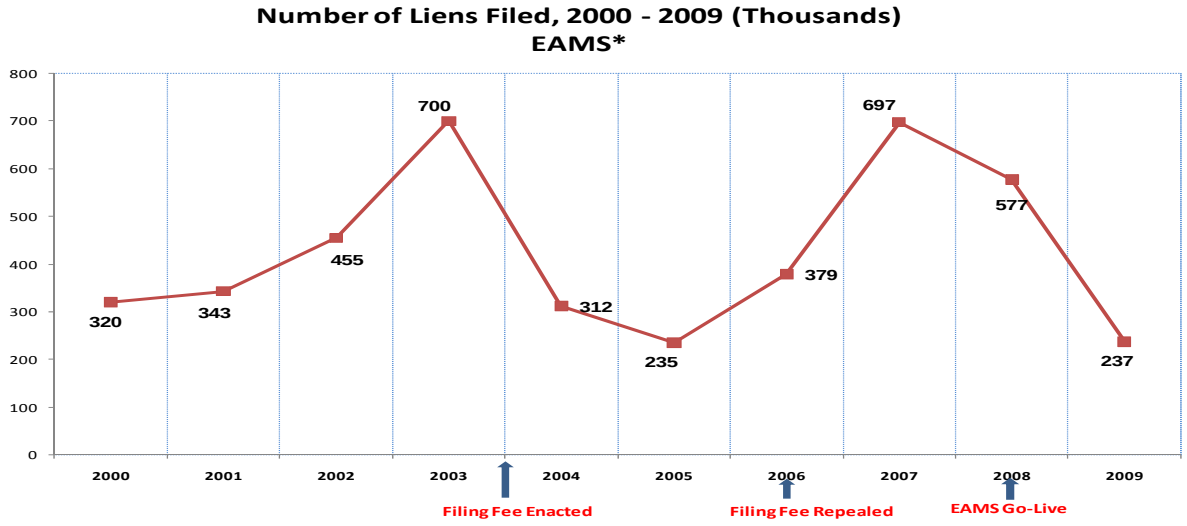
In 1997, the Commission on Health and Safety and Workers' Compensation (CHSWC) convened several roundtable meetings on the WCAB lien backlog that was delaying the processing of cases filed by injured workers in many WCAB district offices. Commission staff also visited DWC district offices and found that 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.



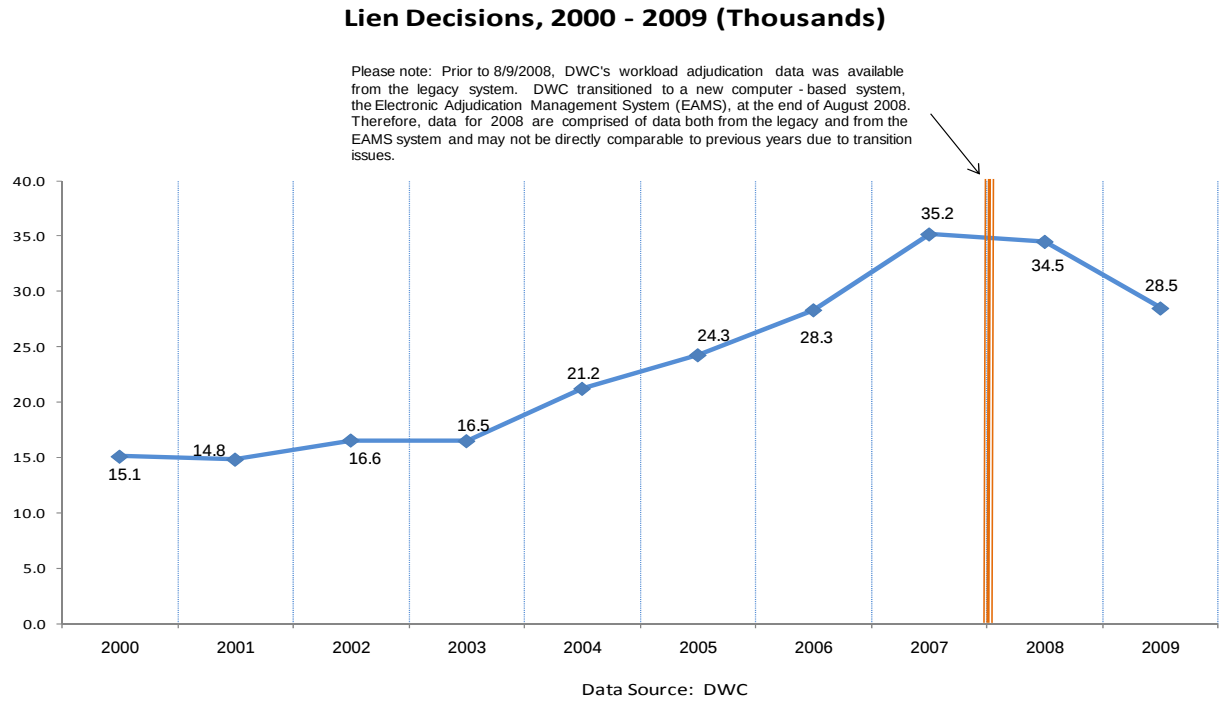
* Please Note that data from Electronic Adjudication Management System (EAMS) does not include Informational liens
Data Source: DWC

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.[53] 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.



[53] Data provided by DWC. Edex Filings.

SPECIAL REPORT: INSURANCE INSOLVENCY STUDY: CALIFORNIA'S VOLATILE WORKERS' COMPENSATION INSURANCE MARKET: PROBLEMS AND RECOMMENDATIONS FOR CHANGE

Introduction

Pursuant to Senate Bill (SB) 316, which was signed into law in 2007, the Commission on Health and Safety and Workers' Compensation (CHSWC) contracted with RAND to conduct an insurance insolvency study: "California's Volatile Workers' Compensation Insurance Market, Problems and Recommendations for Change."[54] The insurance insolvency study identified the main factors that contributed to increased market volatility and examined the reasons for the large number of insolvencies following price deregulation. This study also examined 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 of this study, 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.

Executive Summary

Since workers' compensation rates were deregulated in 1995, the California workers' compensation insurance market has been very volatile. 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. Insurer pre-tax underwriting profit in the California market dropped dramatically in the second half of the 1990s, and 31 of the roughly 250 insurers who wrote workers' compensation coverage in California, including some of the largest market participants, failed. The market share of the state-chartered State Compensation Insurance Fund (State Fund) rose to 53 percent in 2003, and the private market appeared near collapse. In response to legislative reforms between 2002 and 2004, the private market then sharply rebounded. Underwriting profits reached historic highs in 2006, and State Fund's market share retreated to a more typical 20 percent from a high of 53 percent in 2003. Recently, however, low pricing and rising claim costs have led some to fear a return to the dire conditions of the first part of the decade.

Volatility in the workers' compensation market has also affected the prices paid by the state's employers for workers' compensation insurance. Average premium per $100 of payroll net of policyholder dividends has varied by nearly a factor of three since the mid-1990s. Such variability makes it difficult for businesses to plan and makes California a less attractive place to do business. In addition, insurer insolvencies have been costly to the State's employers and injured workers and more generally to California residents. Employers are expected ultimately to be assessed $6.9 billion to pay for the unresolved claims of insolvent insurers. Insolvencies can delay benefits to injured workers, and residents are affected because employer assessments reduce business taxable income.

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. The findings and recommendations of this study are based on information obtained through interviews with a wide range of interested parties, detailed examination of eight insurers groups that became insolvent and eight insurance groups that survived, a review of previous studies, as well as an analysis of data from the Workers' Compensation Insurance Rating Bureau (WCIRB), California Department of Insurance (CDI), State Fund, California Insurance Guarantee Association (CIGA), and the Conservation and Liquidation Office (CLO).

[54] The study was conducted jointly by RAND and Navigant Consulting.

Findings

Six key factors that contributed to the insolvencies and volatility over the past 15 years are:

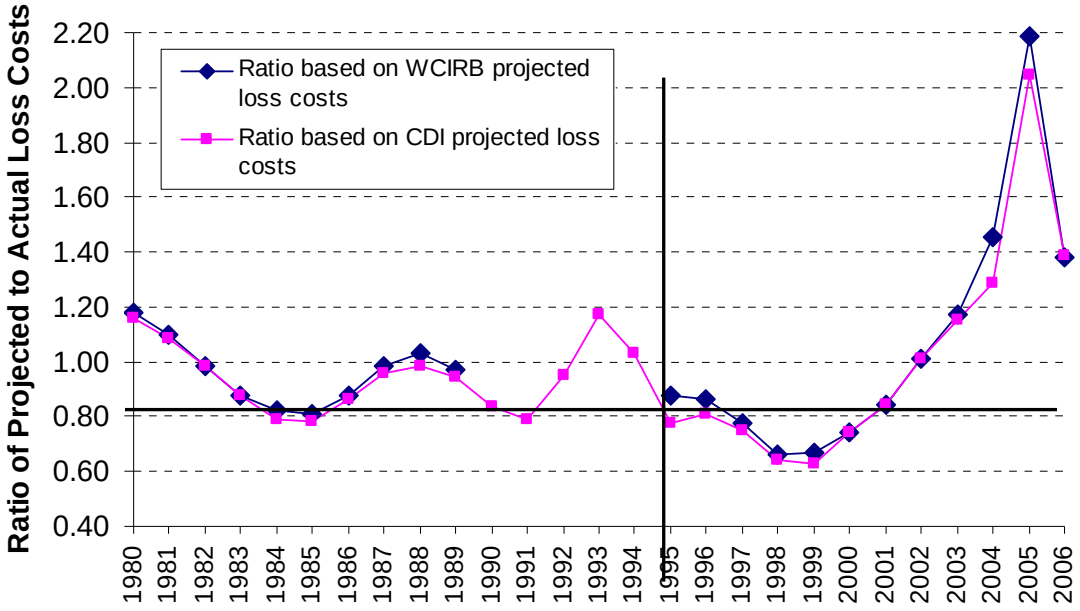
- Inaccurate projections of claim costs.
- Pricing below projected costs.
- Reinsurance contracts that gave insurers and reinsurers insufficient stake in the profitability of the policies they wrote.
- Managing general agents who had little financial interest in the ultimately profitability of policies.
- Under-reserving for claim costs by insurers.
- Insurer surplus and capital that were inadequate to provide a cushion against adverse events.

Inaccurate Projections of Claim Costs

Delayed recognition of the rapid increase in claim costs following open rating was an important factor behind the insolvencies. Without accurate estimates of expected future claim costs, insurers tended to price policies too low and thus collect insufficient revenue to cover future claims payments.

Figure 1 compares the projected loss costs to the actual loss costs from 1980 through 2006. Both the ratio of WCIRB-projected loss costs to actual loss costs and the ratio of the CDI-projected loss costs to actual loss costs are reported.[55] As shown in Figure 1, projected loss ratios were within 20 percent of the actual loss ratios in the years prior to open rating. However, in the years following open rating, projections swung from being 40 percent too low to over 100 percent too high. With few exceptions, there is not a great deal of difference in the accuracy of the WCIRB projections and the CDI projections.

Figure 1: Ratio of Projected to Actual Loss Costs



[55] WCIRB files a set of proposed pure premium rates with the CDI every 6 or 12 months. Based on these rates, public hearings, and staff review, CDI then adopts a set of advisory rates.

Repeated major change in the workers' compensation system was a primary driver of the under-prediction and over-prediction of workers' compensation loss costs. A substantial increase in costs followed the *Minniear* decision in 1996, and a substantial decline in costs followed a series of bills enacted by the California Legislature between 2002 and 2004. It was very difficult to predict the effects of these changes on claim costs. Compounding the problem were a slowdown in claim payment patterns in the second half of the 1990s, incomplete data on certain types of claims, and the fact that WCIRB does not have direct access to transaction-level data on claim payments.

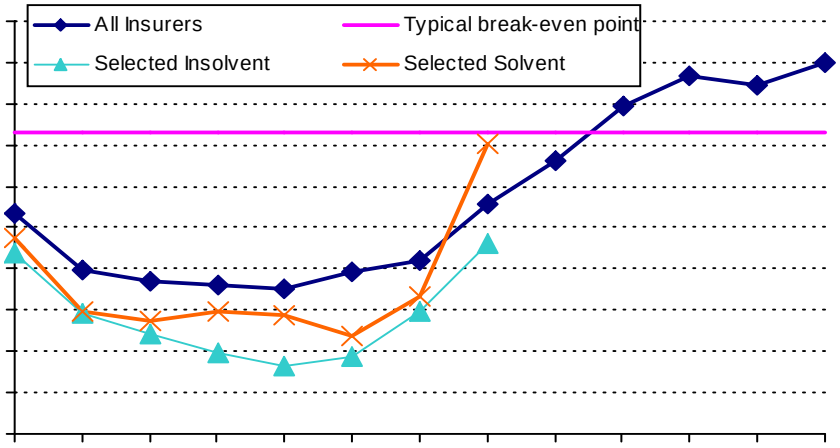
Pricing Below Projected Costs

The pricing practices of workers' compensation insurers during the second half of the 1990s contributed to the surge in insolvencies that began in 2000. Insurers charged prices that were below the already low projections of loss costs, resulting in revenue that was not adequate to cover the ultimate cost of the claims.

Figure 2 shows the ratio of the premium charged by insurers to the "pure premium" rate (expected medical, indemnity, and loss adjustment costs) approved by CDI for that year. A ratio below 1.33 (which includes other expenses) typically suggests that an insurer is not charging enough to cover the costs of providing the coverage.

As shown in Figure 2, the premium charged by California insurers as a whole was near or below the expected loss and loss adjustment costs (ratio less than 1.0) between 1996 and 2000.[56] Also shown are the pricing ratios for the insurance groups selected for detailed analysis in this study. As might be expected, the figure suggests that the groups that ultimately became insolvent priced more aggressively than those that did not. (The sample sizes are relatively small, however, and the differences may not be statistically significant.)

Figure 2: Ratio of Insurer Rate to Approved Rate



[56] Note that the ratio is calculated using the CDI-approved premium rate. If rates recommended by WCIRB were used, the ratios would be noticeably lower for some years.

The study found that the low pricing was driven by a number of different factors including:

- Concern by companies that specialized in the California workers' compensation market that national, multi-line insurance companies would reduce rates to gain market share.
- Lack of experience among the smaller mono-line companies in an open-rating setting.
- Unrealistically inexpensive reinsurance (discussed below).
- Entry of group health insurers that mistakenly believed that their health care experience would give them an advantage in controlling medical costs in the very complex California workers' compensation system.
- Reduced concern by employers about the financial health of insurers given that CIGA pays the claims of insurers in the event they become insolvent.
- Aggressive competition from State Fund.

Analysis suggests that State Fund was competing aggressively for large accounts in the late 1990s and the beginning of this decade. The ratio of charged premium to pure premium did not decline much in the period following open rating for state Fund's smaller accounts; however, it dropped sharply for larger accounts resulting in charged premium that was well below expected loss and loss adjustment expense cost. Due to the aggressive pricing and other factors such as increased broker commissions, the number of large policies written by State Fund jumped dramatically between 1999 and 2003, and State Fund's market share jumped from 22 percent in 1999 to 53 percent in 2003.

CDI became aware that the insurance rates were inadequate at several companies in 1999 but did not act aggressively to force insurers to raise rates because of both limited ability and limited willingness to act. Through 2002, when new legislation was enacted, CDI was required to show that an insurer was operating in a way that would impair or threaten its insolvency before it could require rate increases. This requirement limited CDI's ability to act quickly because the consequences of low rates typically become manifest in a long-tailed line like workers' compensation only slowly over time and because multi-line insurers can offset losses in workers' compensation with returns in other lines. A strong philosophical commitment to rate deregulation at the department during the second half of the 1990s and concern that higher rates would dampen economic activity reduced the department's willingness to act.

Reinsurance Contracts that Gave Insurers and Reinsurers Insufficient Stake in Profitability of the Policies they Wrote

The workers' compensation reinsurance market changed significantly in the mid-1990s with the entry of several large life insurers who wrote reinsurance treaties that provided reimbursement for the health and life losses resulting from workers' compensation accidents. The life underwriters had little experience in the workers' compensation market and offered workers' compensation insurers very low retentions, in many cases equaling a small fraction of what they previously retained. The pricing offered for this protection was also far below normal.

While reinsurance is a critical part of a well-functioning competitive workers' compensation market, the particular reinsurance arrangements that arose during this period contributed to at least some of the insolvencies. The negative repercussions of reinsurance in this setting were a consequence of some insurers not having enough of a stake in the ultimate profitability of the policies they wrote. The very low reinsurance retentions created incentives to reduce prices, relax underwriting standards, and passively process claims. Insurers were starting to see the need to increase prices around 1998, but availability of low-cost reinsurance with low retentions delayed pricing increases.

The reinsurance rates that many thought were too good to be true indeed turned out to be so. Once the discrepancy between revenue and cost became clear to the reinsurers, reinsurers began to delay payments and seek arbitration to suspend or modify terms of the contracts. Some insurers had written policies on the presumption that attractive reinsurance would be available and established reserves for loss costs based on the existence of this reinsurance. Once the reinsurance contracts were rescinded or modified, the insurers bore a greater share of the costs of the policies and had to increase the reserves set aside for the policies. Had the insurers' retained a greater financial interest in the business they wrote, they might have taken more care in pricing, underwriting decisions, and claims handling practices.

Managing General Agents who had Little Financial Interest in the Ultimately Profitability of Workers' Compensation Policies

Managing general agents (MGAs) play an important role in the workers' compensation insurance marketplace. There are two basic reasons that insurance companies engage MGAs: they provide the underwriting and loss control or claims management abilities that would be costly otherwise; and they provide a marketing network that offers the insurer a better opportunity to write business than is otherwise available through its normal production sources. MGAs were active in both the primary California workers' compensation insurance market following the switch to open rating and in the reinsurance markets to which the primary carriers turned. While many of those interviewed for this study stated that there are responsible MGAs who have performed well over time, the actions of some MGAs exacerbated the volatile market conditions following open rating and contributed to some insolvency. The problem stems from the fact that MGAs are often given authority to negotiate and bind insurance policies but are not required to invest in the insurer's balance sheet primarily because they do not bear risk. Because losses in workers' compensation take many years to develop, the profitability of the policies they write is not clear for at least three or four years, and conflicts are created between the growth goals of MGAs and the profitability concerns of insurers or reinsurers. Without close supervision or contractual arrangements that closely align the incentives of the MGAs with the insurer, adverse outcomes can result for the insurer, particularly in a difficult market. Additionally, as risk was transferred to parties ever more distant from the initial transaction, there was increasingly less oversight of the underwriting behavior.

Under-Reserving

Analyses by WCIRB suggest that there was substantial under-reserving by California worker's compensation insurers following open rating given the projections of ultimate claim costs at that time. Beginning in 1999, WCIRB calculated the difference between the losses reported by insurers (which include reserves for future claim costs) and its estimate of the ultimate cost of the claims. In 1999, reported losses were $4.3 billion below WCIRB estimates of ultimate claim costs, and the gap rose to reach $12.4 billion in 2001, larger than the $10.9 billion in workers' compensation premium written that year.

Insurance regulators have put in place requirements meant to deter and detect under-reserving. CDI conducts regular financial exams to assess reserve levels, and since the early 1990s, insurers have been required to submit an opinion from a qualified actuary with their annual statement attesting that their reserves are adequate. The large amount of under-reserving occurred despite the fact that an actuary confirmed that the reserves of each insurer were reasonable. In addition, it was only after CDI examinations that large reserve deficiencies were uncovered at several of the insolvent insurers selected for detailed study. Reserves were found deficient despite the fact that the companies had received clean actuarial opinions, suggesting that the system for ensuring adequate reserves had broken down.

There are a number of reasons why actuaries may declare reserves reasonable when they are, in fact, not. Important among them is the fact that insurers hire and pay actuaries and can change actuaries if they do not like the findings. Pressure to rubber-stamp an insurer's reserve levels presumably increases if the actuary's firm has multiple business relationships with the insurer. Also important is the fact that most actuarial firms do not have seasoned claim personnel on staff and thus are not able to independently give

an opinion about whether the reserves posted for individual claims are reasonable. Rather, actuaries frequently rely on data provided by the insurer on claims frequency, payments to date, claim reserves, and reserve development factors (changes in reserves over time). The actuary may not be aware of the changes in claim-reserving practice, and failure to catch such changes may cause distortions in estimates of ultimate claim costs. Thus, if an insurer is systematically under-reserving individual claims, the actuary will propagate these distortions in his or her estimates of ultimate claim costs.

Inadequate Surplus Cushion

The capital (policyholder surplus) held by the insurers that ultimately become insolvent did not provide an adequate cushion for the adverse events that led up to their insolvencies. As evidenced by the $6.9 billion in expected employer assessments, the assets of these insurers turned out to be billions of dollars short of their liabilities. The Risk-Based Capital (RBC) system developed by the National Association of Insurance Commissioners (NAIC) specifies how much capital a property-casualty insurer should hold and spells out what regulatory actions are appropriate should capital fall below the target. The RBC system is very complex and was not fully in place during the period leading up to the insolvencies, and the study examines what type of regulatory action would have been required if the current RBC system had been in place.

For four of the eight insolvent insurers selected for detailed analysis, the "company action level" would have been triggered two or three years prior to the date the insurer was conserved.[57] This may have given regulators enough warning so that they could intervene in time to avert insolvency. For the other insurers, however, the company action level was either not triggered or triggered only for the year prior to the year in which the insurer was conserved. Large reserve deficiencies were discovered at three of the five insurers for which there would have been little or no warning, and it is important to note that the RBC system does not attempt to capture under-reserving. If the losses at these companies had been properly reserved, their RBC ratios would have been substantially lower two years prior to the date they ultimately were conserved and may have triggered the company action level.

Recommendations

There are four broad themes that run through the 29 recommendations: improve predictability; enhance transparency of the system; better align incentives of major players; and improve CDI oversight. The first theme notes that the lack of predictability was repeatedly emphasized during study interviews as a key driver of the volatility in the market following open rating. The second theme is the benefit of enhancing the transparency of the system. Providing more information to investors and other market participants allows them to better monitor the actions of workers' compensation insurers and can help curtail some of the excesses that can occur in an open-rating regime. The third theme is the need to better align the incentives of some of the major types of parties involved in the workers' compensation market, and the fourth theme is the need to fine-tune CDI oversight.

The 29 recommendations that are attached to these four broad themes are discussed in detail below.

[57] The first level of response in the RBC system is the company-action level. When the company-action level is triggered, the insurer must identify the conditions that contributed to the event and prepare a report to the commissioner outlining the corrective actions the company intends to take in order to come back into compliance with the RBC requirements.

Improve the Reliability of Cost Projections

The six recommendations aimed at improving the reliability of projection costs are noted below. The first three recommendations aim to make the system more predictable, and the next three help WCIRB, CDI and insurers do a better job of predicting costs:

- Increase clarity of legislative intent.
- Expeditiously release guidance and regulation on issues when there are important disagreements among stakeholders.
- Review the Workers' Compensation Appeals Board system.
- Explore the most appropriate way for WCIRB to take advantage of transaction-level data.
- Increase the comprehensiveness of data provided to WCIRB.
- Fast track analyses of the impact of important legislation and judicial opinions.

The Legislature can make the impact of legislative reforms more predictable by being as clear as possible about the intent and scope of the legislation. In addition, CDI and the Department of Industrial Relations (DIR) could reduce uncertainty over the interpretation and impact of legislative reform by more expeditiously issuing regulations and guidance. Also, evaluation should focus on the consistency of decisions across judges as well as how closely judges follow the law.

Cost prediction can be enhanced if WCIRB is given various alternatives to receiving transactional-level data. Limited access to a number of different types of data hampers the ability of WCIRB and CDI to project costs. The most appropriate way for WCIRB to take advantage of transaction-level data should be explored, and the comprehensiveness of data provided to WCIRB on large-deductible workers' compensation policies should be evaluated. The cost and practicality of providing or improving the data available to WCIRB should be examined for three types of claim payments: first, payments by CIGA on the claims of insolvent insurers; second, payments on claims by self-insured mechanisms should also be explored to provide WCIRB with data on payments made by CIGA to cover the claims of insolvent insurers; and finally, analyses of important legislative and judicial changes by organizations such as CHSWC should be expedited, since that could help WCIRB and CDI better anticipate the effects of important changes in the system.

Increase Pricing Discipline in an Open-Rating Setting

A number of changes in CDI's rate making authority and rate making procedures occurred since the rash of insolvencies has occurred. In 2002, legislation was passed that allowed CDI to require that workers' compensation rates be adequate to cover an insurer's losses and expenses. CDI's financial examiners now interview the company underwriting officer and review the company's underwriting policies. Although these changes are steps in the right direction, there appears to have been little fundamental change in CDI's approach to rate regulation since the insurer insolvencies following the switch to open rating. There are several changes that CDI, State Fund, CIGA and other participants in the system can make that will increase pricing discipline in an open rating setting.

Of the following nine recommendations to improve the reliability of projection costs, the first six are directed at CDI, the seventh provides incentives for the demand side of the market, and the last two increase discipline in State Fund's pricing practice:

- Make WCIRB pricing reports public.
- Post insurers' annual and quarterly financial statements on the CDI website.
- Consider publicly releasing the results of CDI field rating and underwriting exams.
- Impose penalties for violations in field underwriting examinations.
- Improve training and professional standards for workers' compensation underwriters.
- Create a whistle-blower program to report excessively low rates.
- Explore ways to give insurance brokers and other intermediaries a greater stake in the financial soundness of the insurers with which they place policies.
- Publicly release State Fund's ratio of charged premium to modified pure premium by size of account.
- Increase State Fund staffing flexibility.

Every quarter, WCIRB provides CDI with a confidential report comparing the premium charged to the modified pure premium for each insurer. Making these reports public would increase scrutiny of insurer pricing practices. Also, insurers are required to submit annual and quarterly financial statements to CDI. Posting them on CDI's website would facilitate broader access to this information. Releasing the results of CDI field rating and underwriting reports would provide valuable information on whether the insurer has provided documentation and support for schedule credits and whether it is adhering to the rate plan and underwriting guidelines filed with CDI. There are no penalties in the insurance code specifically for violations uncovered in the field rating and underwriting examinations. Consideration should be given to imposing penalties sufficient to deter violations.

Currently, there are no licensing or minimum certification requirements for insurer personnel who negotiate rates and terms with potential policyholders. CDI could work with insurers and professional organizations to develop an appropriate training program that would increase professionalism and underwriting discipline. CDI would also benefit from intelligence on low pricing from the people in the field, but currently there are no formal procedures for making such complaints. In addition, CDI might set up a whistle-blower program and then pay particularly close attention to the surplus or RBC ratios of insurers consistently identified by whistle-blowers.

Other ways to improve the California's volatile workers' compensation insurance market might be to begin to levy surcharges on insurance brokers and other intermediaries who place policies with insurers that subsequently became insolvent.

It is important to increase discipline in State Fund's pricing practices because it is important to remove incentives for State Fund to price more aggressively in a soft market, and such incentives may be created by the desire to maintain enough premium volume to support a fairly inflexible staffing level. State Fund might consider setting a permanent staffing level required for a relatively low market share, such as 10 percent, and then address additional demands using temporary staff and contractors.

Better Align Incentives Created by Reinsurance and MGA Contracts

The California Legislature and CDI have moved to better align the incentives created by reinsurance contracts and by MGA contracts but have not gone far enough in this action. The first two recommendations may help to mitigate the downside of reinsurance while maintaining some of the benefits. The next three

recommendations aim to increase the stake of MGAs in the profitability of the insurer or reinsurer and to increase the care with which insurers monitor their MGAs:

- Evaluate adequacy of the current risk-retention requirement and enforcement mechanism.
- Require licensed insurers to obtain approval before entering the reinsurance business.
- Broaden the definition of MGA to include firms that take on substantial roles in underwriting or paying insurance claims.
- Augment the requirements in MGA contracts to give MGAs more "skin in the game."
- Enforce requirements that insurers regularly audit their MGAs.

Regarding reinsurance, policymakers and regulators should assess whether the current requirement that insurers retain at least 10 percent of the risk in a reinsurance transaction is adequate. Similarly, they should consider whether to set minimum attachment points for reinsurance treaties based on the amount of premium written or the size of the insurer's policyholder surplus. Restrictions on reinsurance contract terms for insurers who are pricing below pure premium should also be considered.

The recommendations to increase the stake of MGAs in the profitability of insurers and reinsurers start with policymakers and regulators who should assess whether the current language in the Insurance Code that requires profit sharing between insurers and MGAs be delayed under certain circumstances until claims maturity is sufficiently broad to apply to most circumstances where insurers delegate important underwriting or claims payment authority to outside firms. They should also consider how to broaden the definition of an MGA to include firms that take on substantial roles in underwriting or paying insurance claims.

The California Insurance Code requires profit sharing between insurers and MGAs to be delayed under certain circumstances until claims mature. Policymakers and regulators should assess whether the current language is sufficiently broad to apply to most circumstances in which insurers delegate important underwriting or claim-payment authority to outside firms. Current code requires semiannual on-site review of the underwriting and claim-paying operations of an MGA. CDI should monitor whether insurers are complying with this requirement and whether the audits meet minimum standards. Current code requires on-site review twice a year of the underwriting and claims paying operations of an MGA. CDI should monitor whether insurers are complying with this requirement and whether the audits meet minimum standards.

Improve Reliability of Actuarial Opinions

There was a sense among those interviewed for the study that the independence and objectivity of actuaries have improved in recent years. However, it is difficult to determine how often actuaries will give an opinion that reserves are reasonable when they clearly are not. Situations could still arise in which actuaries have incentives to give less-than-objective assessments.

The following five recommendations aim to reduce the chances that situations will arise that will compromise actuarial opinion:

- Require that actuarial opinions provide additional information.
- Require that actuarial opinions review reserves for a sample of claims.
- Consider requiring CDI to appoint and pay actuaries.

- Review CDI's prioritization scheme for financial examinations, and consider a mandatory trigger for examinations.

- Impose penalties for inadequate reserving.

Policymakers and regulators should consider imposing additional requirements on actuarial opinions as well as enhancing the monitoring of reserve adequacy. A certification program for actuaries should be considered. Requiring actuaries to be certified by CDI would allow CDI to ensure that actuaries are familiar with the particular features of California's workers' compensation system and follow a set of best practices in developing their opinions. Best practices might include (or be considered separately if a certification program is not established) a requirement that the actuarial opinion include a claim audit under certain circumstances. They might also require opinions to be developed by an outside firm and prohibit the actuarial firm from providing other goods or services to the insurer. A more far-reaching reform would be to direct CDI to appoint and pay the actuaries, with costs covered by a premium tax.

There are often long gaps between CDI financial exams. It seems reasonable for CDI to audit reserves every three years or so, particularly for companies about which it has some concern. Penalties are currently not assessed if a CDI financial exam reveals substantial under-reserving. Policymakers and regulators should consider imposing fines that are sufficient to deter such behavior from occurring or re-occurring.

Improve Formula and Reporting Requirements for Risk-Based Capital to Maintain an Adequate Surplus Cushion

Findings also suggest that if under-reserving were eliminated, the RBC system would have done a reasonable job of alerting regulators to financial weakness and requiring regulatory intervention during the period following open rating. The analysis is based on a fairly small number of insurers, however, and would be strengthened by including data for more insurers. While the study findings do not make a strong case for substantial tightening of RBC requirements, review of the RBC formula does suggest a number of changes in the formula and reporting requirements that should be considered. The following recommendations in this area are best implemented by (National Association of Insurance Commissioners (NAIC) as opposed to CDI; however, as the largest member of the NAIC, California is well-positioned to make the case for such changes:

- Consider strengthening the trigger for the company action level.

- Consider modifying the RBC formula to better reflect the risks faced by workers' compensation insurers.

- Consider requiring insurers to submit RBC calculations more frequently.

- Introduce systemic risk and enterprise-level "stress testing" into evaluations of capital adequacy.

To eliminate under-reserving, the advantages and disadvantages of more stringent thresholds for the RBC ratio and the combined ratio should be explored. This study suggests that relatively modest changes in the current trigger would not make a major difference absent elimination of substantial under-reserving. Further analysis is needed to determine the appropriate trigger, and progress in efforts to improve reserve adequacy should be an important factor in any such analysis.

Currently, the RBC formula considers the worst average reserve-development percentage or the worst average loss ratio over a ten-year period, and the ten-year period is changed only infrequently. Lengthening the period would enable the RBC system to provide protection against a more diverse set of adverse events. The RBC formula also only partially reflects the risk of an insurer whose business is

concentrated in states with a difficult workers' compensation market. Modifications to the RBC formula should be considered to reflect more fully the insurer's situation.

A shortcoming of the RBC approach is the implicit assumption that the past is reasonably predictive of the future. The study suggests that when evaluating policyholder-surplus adequacy, state regulators consider plausible scenarios that could stress workers' compensation insurers and their reinsurers, such as major court decisions, earthquakes, and economic downturns. Regarding reporting requirements, NAIC should consider requiring insurers to submit RBC calculations more frequently. Much can happen in the insurance industry in one year, and it seems appropriate to consider whether the RBC calculations should be updated either quarterly or biannually.

Conclusions

Many factors came together to cause the volatility and insolvencies that followed price deregulation. The factors included inaccurate cost projections, pricing below projected costs, reinsurance and MGA arrangements, under-reserving, and inadequate levels of surplus to protect against adverse events. While it is true that the volatility and insolvencies were due to a number of factors other than price deregulation, it should be acknowledged that price deregulation created an atmosphere that exacerbated the adverse effects of several factors. The accuracy of claim cost projections became more important following deregulation. Under the minimum rate law, insurers competed on price by paying dividends to policyholders after the policy period had ended. Doing so allowed insurers to refine estimates of claim costs after the policy was in place. Once prices were de-regulated, however, insurers increasingly competed on the price at policy inception, with limited ability to adjust the price if costs changed. Preexisting incentive problems with reinsurance contracts and MGAs were also magnified by price deregulation. Insurers that passed risk to reinsurers could quickly lower prices, as could MGAs that retained little or any stake in the ultimate profitability of the policies they wrote. Positive feedback loops with pricing also magnified the impacts of some factors. Because prices are often based on premium (particularly for new or growing insurers), lower prices can lead to lower reserves and then to lower prices.

As evidenced by the recent *Ogilvie* and *Almaraz/Guzman* decisions, claim costs are subject to rapid and unanticipated change. Large insurers are able to fuel price wars by subsidizing their California workers' compensation premiums with business in other states or other lines. MGAs and reinsurance deals contributed to problems and could so again, and new risks could emerge. As a result, substantial volatility in the insurance market could occur again.

SPECIAL REPORT: EVALUATING THE QME PROCESS

Background

The delivery of workers' compensation benefits ordinarily depends on medical findings, and medical findings are often disputed. The California Legislature has placed the Qualified Medical Evaluator, or QME, at the core of California's occupational and injury dispute resolution system. Physicians are certified as QMEs after passing a test and meeting requirements spelled out in regulations. These requirements are intended to assure that a QME has the expertise to address the issues that will be presented to the QME. The current process is the result of a series of reforms over the past 15 years, reforms that were meant to deliver medical-legal evaluations expeditiously and equitably for both parties. A study by the Commission on Health and Safety and Workers' Compensation (CHSWC), "Evaluating the QME Process: Is it Equitable and Efficient?," examines how well the QME process is operating in fulfillment of those important goals.

Study Methodology

Frank Neuhauser, of the University of California (UC), Berkeley, has studied the QME system by using extensive electronic administrative data made available by the Division of Workers' Compensation (DWC) Medical Unit and Disability Evaluation Unit (DEU) supplemented with samples of paper records. The study covers the period from January 2005 through June 2010. This period includes the 2003-2004 reforms which introduced utilization and treatment guidelines, a new permanent disability rating schedule based on the American Medical Association (AMA) *Guides*, and changes to the manner parties in represented cases can select QMEs.

The study and report describe the criteria for measuring success of the system, and the basic analytic approach to obtaining the outcome measures is discussed. Descriptive data on the dispute process and overall trends are presented, and data on the assignments of QMEs are discussed. The time frame for the different dispute resolution steps requiring QME evaluations and the consistency and fairness of the QME process as it pertains to disability ratings are described. The final section discusses the implications of the findings.

Research Results

Key results of the study include:

- The number of providers registered as QMEs declined by about 45 percent between 2005 and 2010, but this decline was nearly the same as the decline in disabling injuries. The decline in registered QMEs likely did not lead to scheduling problems and delays.

- There was a dramatic spike in the number of panel-QME requests starting in late 2007 and ending in early 2009. This spike likely is the cause of most complaints about difficulty and delay in obtaining QME appointments.

- The spike was not caused by an increase in requests for medical-legal evaluations related to permanent disability (PD), which remained constant over this period. Most likely, the spike was a result of disputes over medical treatment and the use of QMEs to resolve these disputes. The *Sandhagen* decision[58] clarified the path for medical treatment disputes and substantially reduced the use of QMEs in these cases.

[58] The *Sandhagen* decision requires insurers and employers to use utilization review, not the QME process, to reject requests for medical treatment. The high court's decision clarified a long-standing ambiguity after passage of SB 228 in 2003, which required workers' compensation carriers to institute utilization review programs.

- The perception of delays in the QME process is likely partially the result of this temporary spike in panel requests that has since resolved.

- Remaining problems in scheduling QMEs are the result of mismatches in the demand and supply of specific specialties. Orthopedic specialists account for only 25 percent of registered QMEs, but an orthopedic specialty is requested 45-65 percent of the time. While this ratio has remained stable, it does suggest that efforts should be made to expand the pool of orthopedists willing to participate as QMEs.

- Other specialties with potential for delays are pain specialists and hand specialists (usually orthopedists) who are underrepresented, like orthopedists, relative to the number of requests. Pain specialists are also in an area where requests have been increasing dramatically over the past several years.

- Chiropractors and acupuncturists are heavily over-represented in QME registrations relative to the fraction of requests for these providers.

- Psychologists and psychiatrists are somewhat over-represented in registrations, but there may be an increasing problem with scheduling these specialists. Their evaluations typically require more face-to-face time, and the number of requests for psychological specialists has increased dramatically since 2005, currently representing over 12.5 percent of all panel-QME requests.

By assigning panel QMEs randomly, the reforms hoped to reduce the incentive of QMEs to favor the party that was selecting them for the evaluation. Reputation was thought to lead parties to select QMEs that perceived medical-legal issues in a way that favored the party's case. Any feedback loop, it was feared, could lead to increasingly disparate reports for similar cases.

The system for assigning QMEs to panels has resulted in a distribution of assignments and ratings that stakeholders may find inequitable across parties and inconsistent with the objectives of the reforms. Panels are assigned by identifying QMEs with registered addresses near an injured worker's residence and selecting randomly from those within a prescribed radius. QMEs can increase their probability of assignment by registering at more locations and, to a lesser extent, registering under more specialties. A small number of QMEs have registered at a very large number of addresses, dominating assignments. Most of these QMEs are assisted in scheduling and possibly developing locations by a small number of facilitating services:

- 63 percent of QMEs are registered at only one location. These QMEs are assigned to 23 percent of panels.

- 3.9 percent of QMEs are registered at 11 or more addresses. This small number of QMEs conducts nearly 40 percent of all evaluations, mainly because the large number of locations makes them much more likely to be assigned.

This distribution of assignments is not necessarily problematic. A select group of high-volume QMEs may be very skilled and may execute the assignments quickly and assign ratings in a consistent and equitable manner. However, the evidence in this report supports a different conclusion. The study examined the ratings of 31 very high-volume QMEs who accounted for 10 percent of the reports rated by DEU. There were no advantages in terms of the time from assignment to DEU rating.

Additional study findings include that:

- The ratings assigned to reports by these very high-volume QMEs were, on average, substantially and significantly lower than the ratings assigned to the reports of all other QMEs.

- The ratings were 7 percent to 19 percent lower on high-volume QME reports.

- This tendency towards conservative evaluation was not limited to QME evaluations; reports by high-volume QMEs were rated 10 percent to 21 percent lower than similar reports rated by DEU when the high-volume QMES were acting as Agreed Medical Evaluators (AMEs) or writing reports as primary treating physicians (PTPs).

- The conservative tendency also predates the current AMA *Guides*-based schedule. On average, high-volume QMEs write reports that result in ratings substantially lower than other QMEs on both the 1997 and 2005 schedules.

- The conservative tendency of very high-volume QMEs is consistent across the group; only 2 of the 31 QMEs wrote reports that resulted in higher-than-average ratings. Virtually all of the others were conservative and nearly always statistically significantly for all types of reports (QME, AME, and PTP) for which they wrote a large enough number of reports to evaluate.

Comments and Recommendations

The results of this study suggest some potential changes to the system to improve both timeliness and equity. First, overall, the number of QMEs has tracked the number of disabling injuries. Any general problems with delays that the system experienced were likely resolved by the Sandhagen decision and other changes to the application of utilization and treatment guidelines. Ongoing problems are likely generated more narrowly by a mismatch in the supply of and demand for specific specialties:

- DWC could conduct outreach efforts to specific specialties (orthopedic, pain, and psych, for example) to increase the registration of these providers.

- DWC could also modify the Official Medical-Legal Fee Schedule to increase reimbursement for underrepresented specialties relative to overrepresented specialties.

- The opportunity cost for orthopedists and similar specialties is almost surely higher than for less specialized providers like chiropractors and acupuncturists or even family practice physicians. Reimbursing at different rates would reflect the same public policy decisions as moving to a Resource-Based Relative Value Scale (RBRVS) for treatment reimbursement.

- If stakeholders perceive the increasing concentration of QME assignments among a small number of very high-volume providers as inconsistent with legislative intent and/or public policy, DWC could place restrictions on the number of locations at which any QME can register.

- Limiting the concentration of reports among a small number of high-volume QMEs could also increase the willingness of more providers to participate as QMEs. The concentration of assignments among a few QMEs means fewer assignments for the large number of remaining providers. This may explain why CHSWC has heard a number of concerns about QMEs dropping out due to too few assignments, despite the reasonably stable relationship between the number of panel requests and the number of QMEs.

For further information …

"Evaluating the QME Process: Is it Equitable and Efficient?"
http://www.dir.ca.gov/chswc/Reports/2010/QMEstudy.pdf

A Review of Disability Evaluation Delays and Supplemental QME Reports, June 2010

Background

Delays in summary ratings of Qualified Medical Examiner (QME) reports are a concern to many stakeholders. The Commission on Health and Safety and Workers' Compensation (CHSWC) staff were requested to examine this issue. The delay is a problem because it prevents the parties from closing the claim and it fosters dissatisfaction on all sides. The problems are compounded when there is a deficiency in the report which requires clarification or correction by the QME, but the claims administrator is not allowed to request a supplemental report until the Disability Evaluation Unit (DEU) has issued the rating.

Research Approach

Frank Neuhauser, of the University of California (UC), Berkeley, analyzed a database of all summary ratings and consultative ratings issued in a 16-month period from September 2008 through December 2009. Summary ratings are issued on QME reports in unrepresented cases. Consultative ratings are issued in represented cases. The analysis excluded formal ratings, which are issued in response to rating instructions from a workers' compensation judge in connection with a case that has gone to trial. DEU data contain the date the report was received by DEU and the date the rating was issued by DEU. The CHSWC report "A Review of Disability Evaluation Delays and Supplemental QME Reports" summarizes the time parties waited for a DEU rating.

Research Results

Across the 16 months of ratings examined, the ratings were prepared an average of 104 days after DEU received the medical-legal reports. The analysis demonstrated the difference in waiting time for attorney-represented cases (consultative ratings) and unrepresented cases (summary ratings). Across the 16-month period, the average was 129 days for cases without attorneys and 84 days for cases with attorneys.

Month-by-month figures were also calculated for the mean and the median, for both consultative ratings and summary ratings. The patterns refute complaints that the delays have been growing longer. After growing longer in the first six months of 2009, the delays generally grew shorter in the second six months. By December 2009, every parameter except the mean time to rating for unrepresented cases had improved over December 2008. The mean time to rating for unrepresented cases stood at 119 days in December 2009.

One explanation for the shorter times for rating in represented cases is walk-in ratings, which are offered almost exclusively to attorney-represented cases. DEU also gives priority to ratings in cases that are set for a type of settlement conference called a Rating MSC. These almost exclusively apply to attorney-involved cases. These two factors are believed to account for most of the difference in turnaround times for represented cases compared to unrepresented cases.

Embargo on Supplemental Report Requests

The regulation that prevents obtaining a supplemental report to correct or clarify the initial QME report is found in 8 California Code of Regulations, Section 36(e) and it is reprinted in the study report. This regulation, effective February 17, 2009, reflects an effort to equalize the power of the claims administrator and the unrepresented injured worker. An underlying concern is that claims administrators sometimes improperly influence a QME's conclusions without the worker having the knowledge or resources to resist those tactics.

Comments and Recommendations

Labor Code Section 4061(e) requires that the summary rating be issued within 20 days of receipt of the QME report. CHSWC does not anticipate that the Division of Workers' Compensation (DWC) will consistently meet the statutory timeline in the foreseeable future. The balance of interests reflected in Rule

36(e) might be appropriate if ratings were issued within three weeks, but may not be appropriate when ratings take an average of four months.

CHSWC suggests that continuing examination of the rule and its consequences might lead to a solution that accomplishes the stated purposes of Rule 36(e) without significantly adding to the excessive time already required for resolving unrepresented workers' claims.

For further information …

> "A Review of Disability Evaluation Delays and Supplemental QME Reports" (2010).
> http://www.dir.ca.gov/chswc/Reports/2010/CHSWC_DEUDelaysandSupplementalQMEReports.pdf

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, Temporary Disability, Benefits and Other
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

SYNOPSES OF CURRENT CHSWC PROJECTS AND STUDIES

PERMANENT DISABILITY, TEMPORARY DISABILITY, BENEFITS AND OTHER

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 ongoing CHSWC evaluation incorporates public discussions with studies by RAND and other independent research organizations. The CHSWC evaluation studies deal with major policy issues regarding the way that California workers are compensated for PD incurred on the job.

The determination 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

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 …

"Compensating Permanent Workplace Injuries: A Study of the California System," RAND (1998)

"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.

Goals Established by the CHSWC Permanent Disability Policy Advisory Committee

- Decrease in an efficient way the uncompensated wage loss for disabled workers in California.
- Increase the number of injured workers promptly returning to sustained work.
- Reduce transaction and friction costs, including costs to injured workers.

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 …

CHSWC Report: "Permanent Disability at Private Self-Insured Firms," RAND (2001).
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 *Guides 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.

For further information …

"Evaluation of California's Permanent Disability Rating Schedule: Interim Report," RAND (2003)
http://www.dir.ca.gov/CHSWC/Reports/PermanentDisabilityRatingSchedule-InterimReport.pdf

"An Evaluation of California's Permanent Disability Rating System," RAND (2005)
http://www.dir.ca.gov/CHSWC/Reports/Eval_Of_CA_PD_System.pdf

Legislative Changes and Administrative Implementation

With the enactment of SB 899 in 2004, the Governor and the Legislature intended to enact a PD rating system that would promote "consistency, uniformity, and objectivity."[59] 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 …

"Data for Adjusting Disability Ratings to Reflect Diminished Future Earnings and Capacity in Compliance with SB 899," RAND (2004)
http://www.rand.org/pubs/working_papers/2004/RAND_WR214.pdf

Schedule for Rating Permanent Disabilities, State of California (2005).
http://www.dir.ca.gov/dwc/PDR.pdf

[59] 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).
> http://www.dir.ca.gov/chswc and http://www.dir.ca.gov/CHSWC/Reports/CHSWC-PD-Report-Feb23- 2006.pdf

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 in the compensation structure that may be considered. A recent study by RAND (2010) indicates the California RTW improved but not enough to cover reductions in benefits. (See http://www.dir.ca.gov/chswc/Reports/2010/WCReformandReturntoWork.pdf.) The next analyses that will begin in 2011 will evaluate the adequacy and affordability of the PD system in conjunction with the medical system.

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

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.

BENEFITS

Disability Evaluation and Medical Treatment in the California Workers' Compensation System Study

Background

On April 19, 2004, California Governor Arnold Schwarzenegger signed into law Senate Bill (SB) 899, a sweeping bill which dramatically overhauled the state's workers' compensation system. These reforms were made on top of some already stringent reforms to medical treatment in the system. While the reforms did lead to a decline in the overall cost of workers' compensation in the state, with a more than 40 percent reduction in premiums between 2004 and 2006, many controversies remain. In particular, there are complaints that the systems for evaluating disability and providing medical treatment are inefficient, inconsistent and fraught with error. The Commission on Health and Safety and Workers' Compensation (CHSWC) issued a Request for Proposal (RFP) to conduct this disability evaluation study, and the contract was awarded to RAND. The study commenced in December 2010.

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Purpose

The purpose of the study is to conduct research on disability ratings and worker outcomes in order to assess the accuracy and consistency of disability ratings in California. Additionally, this study will identify potential practices and policies that would improve both the quality and efficiency of the medical care provided under the California's workers' compensation system and increase the efficiency of medical benefit administration.

Of particular importance in this research will be the response to the following:

- How accurately does the new rating system predict the economic consequences of disability for injured workers?
- Is the rating system both consistent and fair? In other words, do workers with similar ratings experience similar economic outcomes? Is the relationship between economic outcomes comparable across injuries to different parts of the body?
- Do the future earnings capacity (FEC) adjustments currently in place accurately predict the relationship between losses across different parts of the body and ratings in the new schedule?
- Does the medical-legal process introduce inconsistencies in the application of the disability rating schedule? Does this affect the relationship between ratings and economic outcomes?
- Does medical treatment in California's workers' compensation system conform to external best practices for providing high-quality, affordable care?
- How effective are medical provider networks in the California workers' compensation program?

Status: In process.

BENEFITS

Qualified Medical Evaluator

Background

The delivery of workers' compensation benefits ordinarily depends on medical findings, and medical findings are often disputed. The California Legislature has placed the Qualified Medical Evaluator, or QME, at the core of California's occupational and injury dispute resolution system. Medical providers are certified as QMEs after passing a test and meeting requirements spelled out in regulations. These requirements are intended to assure that a QME has the expertise to address the issues that will be presented to the QME. The current process is the result of a series of reforms over the past 15 years, reforms that were meant to deliver medical-legal evaluations expeditiously and equitably for both parties. The study and report "Evaluating the QME Process: Is it Equitable and Efficient?" by the Commission on Health and Safety and Workers' Compensation (CHSWC) examine how well the process is operating in fulfillment of those important goals.

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Description

Frank Neuhauser of the University of California (UC), Berkeley, assisted with the Commission's study of the QME system. The study uses extensive electronic administrative data made available by the Division of Workers' Compensation (DWC) Medical Unit and Disability Evaluation Unit (DEU) supplemented with samples of paper records. The study covers the period from January 2005 through June 2010. The period includes the 2003-2004 reforms which introduced utilization and treatment guidelines, a new permanent disability rating schedule based on the American Medical Association (AMA) *Guides*, and changes to the way parties in represented cases selected QMEs.

The study describes the criteria for measuring success of the system, and the basic analytic approach to obtaining the outcome measures is discussed. Descriptive data on the dispute process and overall trends are presented as well as data on the assignments of QMEs. The time frame for the different dispute resolution steps requiring QME evaluations and the consistency and fairness of the QME process as it pertains to disability ratings are described. The final section of the study discusses the findings.

Objectives

The objectives of this project are to:

- Examine the fairness of the QME process and whether QME evaluations, over all, are consistent in their measurement.
- Assess the QME process to determine if there is a balance between the supply of QMEs and the demand for QME evaluations.
- Analyze the reasons for the spike in QME requests.
- Discuss the timeliness of the QME process.

Findings

The study findings include:

- The number of providers registered as QMEs declined by about 45 percent between 2005 and 2010, but this decline was nearly the same as the decline in disabling injuries. The decline in registered QMEs likely did not lead to scheduling problems and delays.

- There was a dramatic spike in the number of panel-QME requests starting in late 2007 and ending in early 2009. This spike is likely the cause of most complaints about difficulty and delay in obtaining QME appointments. The spike was not caused by an increase in requests for medical-legal evaluations related to permanent disability (PD), which remained constant over this period. Most likely, the spike was a result of disputes over medical treatment and the use of QMEs to resolve these disputes. The *Sandhagen* decision clarified the path for medical treatment disputes and substantially reduced the use of QMEs in these cases.

- The perception of delays in the QME process is probably partially the result of this temporary spike in panel requests that has since resolved.

- Remaining problems in scheduling QMEs are the result of mismatches in the demand and supply of specific specialties. Orthopedic specialists account for only 25 percent of registered QMEs, but an orthopedic specialty is requested 45-65 percent of the time. While this ratio has remained stable, it does suggest that efforts should be made to expand the pool of orthopedists willing to participate as QMEs.

- Other specialties with potential for delays are pain specialists and hand specialists who are underrepresented, like orthopedists, relative to the number of requests. Pain specialists are also in an area where requests have been increasing dramatically over the past several years.

- Chiropractors and acupuncturists are heavily overrepresented in QME registrations relative to the fraction of requests for these providers.

- Psychologists and psychiatrists are somewhat overrepresented in registrations, but there may be an increasing problem with scheduling these specialists. Their evaluations typically require more face-to-face time, and the number of requests for psychiatric specialists has increased dramatically since 2005, currently representing over 12.5 percent of all panel-QME requests.

- According to this QME study, a small number of QMEs have registered at a very large number of addresses, dominating assignments. Most of these QMEs are assisted in scheduling and possibly developing locations by a small number of facilitating services. The study indicates that:

    - 63 percent of QMEs are registered at only one location. These QMEs are assigned to 23 percent of the panels.

    - 3.9 percent of QMEs are registered at 11 or more addresses. The small number of QMEs conducts nearly 40 percent of all evaluations, mainly because the large number of locations makes them much more likely to be assigned.

- A select group of high-volume QMEs may be very skilled and may execute the assignments quickly and assign ratings in a consistent and equitable manner. However, the evidence in this report supports a different conclusion. The study examined the ratings of 31 very high-volume QMEs who accounted for 10 percent of the reports rated by DEU. There were no advantages in terms of the time from assignment to DEU rating. However:

    - The ratings assigned to reports by these very high-volume QMEs were, on average, substantially and significantly lower than the ratings assigned to the reports of all other QMEs.

    - The ratings were 7 percent to 19 percent lower on high-volume QME reports.

- This tendency towards conservative evaluation was not limited to QME evaluations; reports by high volume QME were rated 10 percent to 21 percent lower than similar reports rated by DEU when the high volume QMEs were acting as Agreed Medical Evaluators (AMEs) or writing reports as primary treating physicians (PTPs).

- The conservative tendency also predates the current AMA Guides based schedule. On average, high volume QMEs write reports that result in ratings substantially lower than other QMEs on both the 1997 and 2005 schedules.

- The conservative tendency of very high volume QMEs is consistent across the group; only 2 of the 31 QMEs wrote reports that resulted in higher than average ratings. Virtually all of the others were conservative and nearly always statistically significant for all types of reports (QME, AME and PTP) for which they wrote a large enough number of reports to evaluate.

Status: Completed.

For further information …

"Evaluating the QME Process: Is it Equitable and Efficient?" (September, 2010)
http://www.dir.ca.gov/chswc/Reports/2010/QMEstudy.pdf

BENEFITS

Piloting Electronic Linkage Between Social Security and Disability Insurance and Workers' Compensation Disability Benefits

Background

At a recent National Academy of Social Insurance (NASI)/Social Security Administration (SSA) conference in Washington, D.C., participants identified coordinating workers' compensation and Social Security Disability Insurance (SSDI) payments as a major issue. The lack of coordination often mistakenly reduces workers' benefits and sometimes causes SSA to over-pay compensation. What limited coordination does exist is labor-intensive and expensive to administer. SSA, insurers, self-insured employers and state agencies coordinate the hundreds of thousands of claims, benefits and numerous benefit changes by telephone and letter communications.

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The paper-driven coordination is the product of decades-old systems with very dispersed benefit information and no standard electronic formats for claims data. With the introduction of electronic systems, and particularly standard Electronic Data Interchange (EDI)-formatted reporting to state agencies on all claims, the groundwork is in place to transition this process to a simple, inexpensive, and accurate benefit-coordination system.

The main challenge is to overcome the inertia inherent in decades-old systems and the concerns of all participants with transitioning to an entirely new approach. California is ideally situated to pilot this transition, work out the issues, and act as a model for other states to follow in interacting with SSA. California has a centralized data system, the Workers' Compensation Information System (WCIS), which is large enough to motivate SSA to join as a partner, and most if not all major national insurers are represented among California-registered insurance entities. In addition, California is one of only five states that also needs to coordinate non-occupational disability benefits, State Disability Insurance (SDI), with SSDI benefits.

Electronic data interchange would improve benefit delivery to workers while substantially reducing costs to employers, the California Division of Workers' Compensation (DWC), the Employment Development Department (EDD), and SSA. It is likely that SSA would be willing to put resources into the project to defray any initial costs of setting up the pilot project in California.

Description

The initial step of the pilot would be a workshop jointly sponsored by the Commission on Health and Safety and Workers' Compensation (CHSWC), SSA, DWC, and SDI covering:

- Current California experience with electronic data coordination with SSA.
- SSA's minimum data requirements.
- California's minimum data requirements.
- Translation of the minimum requirements into International Association of Industrial Accident Boards and Commission (IAIABC)-EDI data elements.
- Mechanics of standard electronic data coordination.
- Confidentiality and other legal issues.

- Advantages to California and SSA.

Prior to the workshop, the University of California (UC), Berkeley, would interview the key participants about anticipated issues and, in conjunction with CHSWC, prepare background on each discussion point. The background will be distributed ahead of the workshop.

The next step will be to create a roadmap for piloting electronic interchange using California as the test state. This roadmap will include:

- Draft data requirements.
- Suggested working group on technical aspects of the electronic interchange.
- Suggested working group on legal issues and interagency agreements.
- Suggested working group on any necessary budget change proposals.
- Draft timeline for each step.
- Estimated cost and offsetting funding sources.
- Draft estimate of cost savings and impacts on benefit delivery accuracy.

CHSWC and UC Berkeley will work with each agency to develop each document and issue above.

The third step will be that the workshop members will reconvene along with technical, legal and agency decision-makers to finalize technical and legal issues and timelines.

If the working group is successful in planning and committing to piloting integration in California, CHSWC and UC Berkeley will create:

- Detailed timelines.
- Detailed work plans.
- Necessary documentation.
- Tracking of progress and reporting regularly to all involved agencies.

Status: *O*ngoing.

BENEFITS

Review of Disability Evaluation Delays and Supplemental QME Reports, July 2010

Background

Delays in summary ratings of Qualified Medical Examiner (QME) reports are a concern to many stakeholders, and Commission on Health and Safety and Workers' Compensation (CHSWC) staff was asked to examine this issue. Delays are a problem because they prevent the parties from closing the claim, and they foster dissatisfaction on all sides. The problems are compounded when there is a deficiency in the report which requires clarification or correction by the QME but the claims administrator is not allowed to request a supplemental report until the Disability Evaluation Unit (DEU) has issued the rating.

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Description

The CHSWC analysis used a database of all summary ratings and consultative ratings issued in a 16-month period from September 2008 through December 2009. The CHSWC report summarized the length of time parties waited for a DEU rating.

Findings

Across the 16 months of ratings examined, the ratings were prepared an average of 104 days after DEU received the medical-legal reports. The analysis demonstrated the difference in waiting time for attorney-represented cases (consultative ratings) and unrepresented cases (summary ratings). Across the 16-month period, the average was 129 days for cases without attorneys and 84 days for cases with attorneys. Month-by-month figures were also calculated for the mean and the median for both consultative and summary ratings. The patterns refute complaints that the delays have been growing longer. After growing longer in the first six months of 2009, the delays generally grew shorter in the second six months. By December 2009, every parameter except the mean time to rating for unrepresented cases had improved over December 2008. The mean time to rating for unrepresented cases stood at 119 days in December 2009.

Comments and Recommendations

Required timelines in Labor Code Section 4061(e) and 8 California Code of Regulations, Section 36(e) are discussed in the CHSWC report "A Review of Disability Evaluation Delays and Supplemental QME Reports," along with a description of the concern that claims administrators sometimes improperly influence a QME's conclusions without the worker having the knowledge or resources to resist those tactics.

CHSWC recommends continuing examination of this issue.

Status: Completed.

For further Information …

"A Review of Disability Evaluation Delays and Supplemental QME Reports"
http://www.dir.ca.gov/chswc/Reports/2010/CHSWC_DEUDelaysandSupplementalQMEReports.pdf

BENEFITS

Class Action Suits in Worker's Compensation

Background

Recently, a group of applicants' attorneys filed a class action in civil court to enforce awards of attorneys' fees issued by the Workers' Compensation Appeals Board (WCAB) (*Koszdin v. SCIF*). The dispute centered on whether the awards implicitly included interest or whether the awards excluded interest because interest was not expressly included. This problem might be resolved with the outcome of the litigation or through changes in the Workers' Compensation Appeals Board (WCAB) Policy and Procedure Manual.

The issue presented to the Commission on Health and Safety and Workers' Compensation (CHSWC), however, is whether parties should have to resort to civil courts, instead of seeking their class-action-like remedies from WCAB.

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Julian Sum

Labor Code Section 5806 confers jurisdiction on civil courts to enforce WCAB awards. The purpose of Labor Code Section 5806 is to allow a party to convert an award into a judgment upon which the party may then collect. With a judgment, a party may obtain a writ of execution to cause property to be sold to satisfy a judgment, for example.

The question in *Koszdin* is how far the civil court should go in interpreting WCAB awards as part of its function of enforcing awards. The more general question exemplified by these proceedings is whether WCAB can or should provide a class-action forum for disputes which are not efficiently handled through individual case litigation.

Description

To fully understand the legal issues involved, more time doing legal research (statutes and case law) and analysis is required. The area of class actions is complex. The California Codes provide for four separate types of class actions. As a result, there are two separate treatises devoted solely to this topic. Furthermore, implementing changes may require legislation and possibly increased demands on workers' compensation judges and WCAB, but at the same time, may reduce costs of civil litigation.

At the August 19, 2010 Commission meeting, the Commission voted to proceed to develop an issue paper and analysis of alternatives.

Status: In process.

OTHER

Medicare Set-Aside Study

Introduction

CHSWC is conducting an analysis of ways to improve the administration of the Medicare set-aside. State and federal legislation have been proposed to make such improvements. The Centers for Medicaid and Medicare Services (CMS) have reserved the right to go back to insurers and self-insurers to recover medical treatment costs. Further, CMS has recently issued instructions on how its contractor will handle the estimation of future prescription drug costs.

As currently required, the injured worker, or his/her attorney, and the insurance company must accurately estimate future costs of care for an injury, and the injured worker must plan to pay for such future costs after a settlement is reached.

Description

This project will also develop possible alternatives to this current future payment responsibility. Estimates will be developed to identify future medical costs of Medicare-age injured workers and estimates of medical care for certain conditions. Current administrative costs to handle this program are deemed excessive for both employers and Medicare.

Status: In process.

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RETURN-TO-WORK

Workers' Compensation Reform and Return to Work: The California Experience

Introduction

The effectiveness of a workers' compensation system can be assessed by two important measures: adequacy and affordability. Adequacy reflects the extent to which indemnity benefits compensate an appropriate amount of workers' earnings losses from workplace injury. Affordability reflects the extent to which workers' compensation benefits, including the delivery costs, affect the cost to employers. In California and in many other states, compensation for injured workers with permanent partial disabilities has been the most expensive portion of the indemnity benefits and the most controversial part of the system. The poor adequacy and poor affordability of the California permanent partial disability (PPD) system were both key factors in the multiple reform efforts to workers' compensation in California in the early 1900s. According to the Commission on Health and Safety and Workers' Compensation (CHSWC) study by RAND, "Workers Compensation Reform and Return to Work: the California Experience," the system could achieve improvements in both adequacy and affordability by improving return to work of permanently disabled workers.

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Description

The study reviews the role of public policy in promoting return to work and discusses how public policy can be used to improve outcomes for injured workers and employers. Policy efforts are classified into three broad approaches: medical management; incentive-based; and accommodation-based. Medical management approaches attempt to improve return to work by improving the quality and timely receipt of medical care or by improved coordination and communication with medical providers. Some reforms that target this approach involve the assignment of control of provider choice or direct regulation of care through utilization review or treatment guidelines. Incentive-based approaches use financial rewards or punishments to influence the behavior of employers of the workers themselves, often by manipulating disability benefits based on return-to-work status. Finally, accommodation-based methods alter the requirements of the job, either the schedule, the tasks required or the physical environment, in order to make it easier for a disabled worker to perform the necessary tasks. Some states adopt subsidies for accommodations in order to improve employment for disabled workers. Over the past ten years, California has adopted reforms that affect all of these.

To evaluate the return-to-work rates of injured and disabled workers after the reforms, the study analyzed data on workers' compensation claims for workers who were injured from 2000-2007 reported to the Workers' Compensation Insurance Rating Bureau (WCIRB) and Disability Evaluation Unit (DEU. These data were linked to quarterly earnings data from the Employment Development Department (EDD). The study matched injured workers to uninjured "control" workers to estimate the change in post-injury outcomes that are attributable to the injury.

Objectives

The objectives of this study are to:

- Examine public policies within and outside the workers' compensation system and their influence on return to work as well as the changes in these policies in the past ten years in California.

- Analyze the change in the rates of return to work of injured and disabled workers in California in the past ten years.

- Examine the impact of reforms to the workers' compensation system on the adequacy of benefits for injured and disabled workers and whether the changes in benefit adequacy have been influenced by changes in return to work.

Findings

The study findings include:

- Return-to-work outcomes improved considerably for injuries that occurred from 2002-2005. Moreover, the biggest gains were experienced by workers with the most severe injuries. The study noted gains in overall employment and in employment for at-injury employers. Overall, the improvements in return to work represent a significant gain for disabled workers.

- Results do not pinpoint why return to work improved so much. The study's findings indicate that return to work was improving even before Senate Bill (SB) 899 reforms were adopted. Workers injured in 2003 and 2004 were not eligible for the tiered benefit, so that is unlikely to be a driving factor behind the observed trend. The timing of the trend suggests that changes to the Fair Employment and Housing Act (FEHA) or the adoption of medical treatment guidelines could have an effect.

- Adequacy of benefits has fallen since the reforms. Indemnity benefits fell dramatically and most of the decline was experienced by workers with permanent disabilities. The reforms also appear to have led to a decline in the fraction of workers that receive permanent disability benefits. The gain in return to work offset some of the decline but not all. This suggests that an increase in benefits is necessary to return replacement rates to their previous levels, or improve them.

- There is some evidence of increasing disability ratings over time, which could offset some of the decline.

- More work is needed to understand the following: trends in return to work; explorations or other methods to improve return to work; role of the medical treatment reforms; greater exploration of the potential gains from further integration of the occupational and non-occupational systems that affect return to work of disabled workers; and the overlap between California FEHA and the Americans with Disabilities Act (ADA).

Status: Completed.

For further Information …

"Workers' Compensation Reform and Return to Work: The California Experience" (November 2010)
http://www.dir.ca.gov/chswc/Reports/2010/WCReformandReturntoWork.pdf

RETURN TO WORK

How Effective are Employer Return to Work Programs?

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.

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Description

The study examines the effectiveness of employer-based RTW programs adopted by a sample of large, private, self-insured employers in California. The study combines data on duration of time out of work for workers' compensation claimants with information on employer RTW programs from a survey of 40 large, private self-insured California employers to estimate the impact of the programs on time out of work. The data include detailed information about the formal programs and practices used to lower the duration of work-injury absences, including information such as the frequency of use of various modifications and accommodations.

Objectives

The objectives of this project are to:

- Examine the effectiveness of employer-based RTW programs.
- 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

The study findings include:

- Employer-based RTW programs led to a significant reduction in the duration of injury absences:
    - Workers in an RTW program return approximately 1.4 times sooner compared to workers injured at a firm without a program. This corresponds to a 3-4 week reduction in the median injury duration of injury-related absences.
- Much of the impact of RTW programs appears to be driven by a large improvement in RTW for 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.

Employer-based RTW programs are cost-effective when adopted by large, self-insured firms, but it is

unclear if RTW initiatives would provide a cost-effective means of improving employment outcomes for disabled workers at small or medium-sized firms.

Status: Completed.

For further Information …

"How Effective are Employer Return to Work Programs?" March 2010
. http://www.dir.ca.gov/chswc/Reports/2010/CHSWC_RANDRTW.pdf

RETURN TO WORK AND DISABIILTY MANAGEMENT

International Forum on Disability Management 2010: *Collaborating for Success*

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) collaborated with the International Association of Industrial Accident Boards and Commissions (IAIABC) to host the International Forum on Disability Management (IFDM) 2010: *Collaborating for Success*, in Los Angeles on September 20th through 22nd. The Forum was devoted to multinational 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. A major goal of IFDM is to bring key policymakers into the discussion and be an agent of change.

Description

IFDM 2010 brought together over 400 attendees, representing over 33 countries across the world, from the health, safety, and workers' compensation communities.

The purpose of IFDM 2010 was 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 participated in presentations, discussions and workshops.

The goals of the conference included:

- 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 public policy and institutional changes that countries and policymakers 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.

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Nikola Lafrenz
Federal Ministry of Labour and Social Affairs, Germany

- 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.

Key topics included:

- Advancing Awareness and Support for Effective Disability Management Outcomes and Best Practices
- Building Political Consensus to Advance Policy on Disability Management
- Partnerships in Disability Management
- Integration into the Workforce
- Vocational Rehabilitation
- Addressing Specific Problems During Medical Treatment
- The Importance of Coordination Among Stakeholders in the Return-to-Work Process
- An Overview of Government Programs in Disability Management
- Employer Best Practices
- How Medical Providers Can Improve Outcomes in Disability Management
- Measuring Disability Management: Quantitative and Qualitative Analysis
- Employer Success Studies
- Utilizing Research and Analysis to Evaluate Government Programs
- Examining the Competencies of Disability Management Practitioners
- A Comprehensive Societal Disability Management Strategy
- Integrating Young Adults with Disabilities into the Workforce
- Engaging Stakeholders; Government Programs
- Linking Health, Wellness and Productivity
- New Resources for Your Disability Management Toolkit
- Demographics
- Mental Health, Challenges in Return to Work
- Integration of Care
- Prevention: The Most Effective Disability Management Strategy
- New Paradigms in Disability Management
- Fostering Labor and Management Collaboration in Formulating Return-to-Work Policies
- Job Retention and Return to Work in the Context of the UNCRPD
- Next Steps in Moving Disability Management Forward

Status: Completed.

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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 Industrial Accident Boards and Commissions
www.iaiabc.org

RETURN TO WORK AND DISABIILTY 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 "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.)

From 2008 through 2010, CHSWC has participated 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 Consortium to promote SAW/RTW.

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 Consortium to promote SAW/RTW:

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."

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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

Coordination Between Healthcare Reform and Workers' Compensation

Background

There will be policy implications for workers' compensation as a result of the requirements of the new healthcare laws in the U.S. The Commission on Health and Safety and Workers' Compensation (CHSWC) study will look at areas where workers' compensation and healthcare overlap and/or should or should not overlap.

Project Team

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The CHSWC study will focus on: (1) where there are important interactions between the two systems; (2) where an effort led by the CHSWC could have a substantial impact on California and national implementation efforts; and (3) where ideas might be attractive to funding partners.

Key areas thought to be important to the coordination of workers' compensation and the changes relating to implementation of the healthcare reform legislation include:

- *Cost effectiveness of medical treatment regimes*

  The healthcare reform legislation explicitly sets aside funding for studies about cost-effectiveness of medical treatment. A challenge is that outcome measures in health care are often limited. Either the types of measures are limited or nonexistent or the data have to be collected on a case-by-case basis, and the resulting number of observations is too limited to study many issues. Workers' compensation has outcome measures, particularly length of disability, earnings loss, return to work, and residual permanent impairment, which are not available in any other system and answer broader questions about the secondary economic effects of treatment regimes. This makes workers' compensation ideal for large-scale studies of treatment strategies. A RAND project with Kaiser plans to employ some of these measures to evaluate the effectiveness of quality measures. This is one of many opportunities that can lead to important advances in medical treatment and be attractive to funders.

- *Third-party liability for treatment costs*

  Healthcare reform envisions substantial efforts to develop portable electronic medical records that coordinate all of a person's medical care and medical history. At least one implication is the potential for disputes and/or recoveries by one payor from another. Most specifically, property-casualty insurers, e.g. workers' compensation insurers, because they have responsibility for treatment for the life of the claim, will be subject to increased recovery efforts. These recovery efforts can be retroactive, potentially happening years after an injury. Anticipating and studying these issues could reduce friction and potentially develop efficient solutions that reduce cost for all parties.

- *Changing employer responsibility for employment-based health insurance*

  The interaction of employment-based health insurance and the shifting of claims between occupational and non-occupational reporting are poorly understood. The expansion of health insurance availability and the unknown impact of reform on employment-based health insurance make understanding the direction of cross-subsidy between these systems important for workers' compensation insurers, health insurers, workers, and employers.

- *Impact of occupational conditions on state and federal budgets*

  Healthcare reform involves a substantial increase in the role of government programs in delivering or subsidizing the delivery of healthcare treatment, particularly for the key group with expanded coverage, the working poor. Consequently, understanding the cost shifting between occupational and non-occupational medical systems will become much more important to federal, state, and local government budgets. This is an area of research that could have important fiscal consequences and could also suggest solutions that would streamline delivery and improve efficiency.

- *Piloting an integrated occupational and non-occupational medical treatment database*

  One complicated but potentially valuable project would be to pilot an effort to link at least some occupational and non-occupational treatment histories for a set of workers. This would involve linking Workers' Compensation Information System (WCIS) medical treatment data to one or more health insurers and possibly Medicare/MediCal databases. There could be many issues with implementing an integrated research database, and these issues would need to be resolved to achieve other efforts. Attempting this initially with several employers with broad-based health benefits, reasonably stable insurer-employer relationships and stable workforces, for example state agencies or University of California or California State University systems, would be the best initial step.

Status: In process.

For further information …

"Summary of Occupational and Non-Occupational Integrated Care Roundtables" (2008).
http://www.dir.ca.gov/chswc/Reports/SummaryOandNO_ICR2008.pdf

"Integrating Group Health and Workers' Compensation Medical Care Factsheet" (2008).
http://www.dir.ca.gov/chswc/Reports/CHSWC_IntegrationofCareFactsheet.pdf

"Comparing the Costs of Delivering Medical Benefits Under Group Health and Workers' Compensation: Could Integration Pay for Covering the Working Uninsured?" (October 2009).
http://www.dir.ca.gov/chswc/Reports/2009/Medical_Overhead_Cost_Comparision_2009.pdf

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 Bill (SB) 228 and SB 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

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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 DWC to examine the following issues using 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.

- 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 …

See "Special Report: Workers' Compensation Medical Study of Recent Reforms" in this Annual Report.

"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

"Ambulatory Surgery Facility Services Provided to California's Injured Workers," RAND (March 2009).
http://www.dir.ca.gov/chswc/Reports/2009/FacilityServicesforAmbulatorySurgery.pdf

"Hospital Emergency Department Services Furnished Under California's Workers' Compensation Program," RAND (April 2009).
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/

"Pay-for-Performance in California's Workers' Compensation Medical Treatment System," RAND (August 2007).
http://www.dir.ca.gov/chswc/Reports/Pay_for_Performance_Report_2007.pdf

"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

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 would 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," attempts to suggest a mechanism for monitoring and improving the quality of care provided to injured workers.

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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; a report is forthcoming in 2011, and published medical papers are listed below:

For further information …

Published

Karl J. Sandin, M.D., M.P.H.; Steven M. Asch, M.D., M.P.H.; Charles Jablecki, M.D.; David Kilmer, MD; Teryl K. Nuckols, M.D., M.S.H.S., and the Carpal Tunnel Quality Group. Clinical Quality Measures for Electrodiagnosis in Suspected Carpal Tunnel Syndrome. *Muscle and Nerve.* 2010 Apr;41(4):444-52.

Melinda Maggard, MD, MPH; Walter Chang, MD; Neil Harness, MD; Janak A. Parikh, MD; Steven M. Asch, MD, MPH; Kevin Chung, MD; Teryl K. Nuckols, MD, MSHS and the Carpal Tunnel Quality Group. Indications for Performing Carpal Tunnel Surgery: Clinical Quality Measures. *Plast Reconstr Surg.* 2010 Jul;126(1):169-79.

In Press

Teryl Nuckols, Karl Sandin, Haoling Weng, Rebecca Shaw, Anne Griffin, Lisa Hiatt, Philip Harber, Douglas Benner, Steven Asch, and The Carpal Tunnel Quality Group. Quality Measures for the Diagnosis and Non-Operative Management of Carpal Tunnel Syndrome in Workers' Compensation Settings. *Journal of Occupational Rehabilitation.*

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. Under integrated health care, the same individual physician or health provider group administers treatment for both occupational and non-occupational medical conditions and integrates payment for treatment under a single insurance policy. Integrating workers' compensation medical treatment with group health treatment offers employers the potential for significant savings and could help improve the quality of care and workers' overall access to health insurance.

Integration of Care Pilot Program

The Commission on Health and Safety and Workers' Compensation (CHSWC) has partnered with the California HealthCare Foundation (CHCF) and the University of California (UC), Berkeley, to examine the feasibility of integrated care in California. To conduct a pilot project, partnerships between CHSWC, CHCF and UC Berkeley, DMS Facility Services, and the Service Employees International Union (SEIU) Local 1877 were established. 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. 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.

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Evaluating the Potential for Savings Under Integration: Study of Cost Savings

CHSWC has issued a working paper titled "Comparing the Costs of Delivering Medical Benefits Under Group Health and Workers' Compensation — Could Integration Pay for Covering the Working Uninsured?" At its October 22, 2009 meeting, CHSWC voted to create an advisory group to discuss the findings of the issue paper on integrating workers' compensation medical and group health care. Subsequently, on February 25, 2010, CHSWC held a roundtable to discuss the issue paper in detail, get feedback from the advisory group, and examine the feasibility of adopting integrated care in California. The roundtable was composed of over 40 participants representing employers, labor, government agencies, medical providers, insurance companies, and attorneys.

Study Findings

Study findings indicate that total national savings estimates over the first ten years would be between $490 billion, based on National Academy of Social Insurance (NASI) data, and $560 billion, based on California insurer data. Savings for California alone would be about $10 billion in the first year and $100 billion for the ten years 2011 to 2020 inclusive.

Key reasons for the savings are that it is expensive to deliver medical care separately for a single condition. This is very expensive initially and even more expensive over a life-time of separate treatment. Additionally, life-time medical costs are very difficult to predict, and insurers have to charge a "risk premium" for taking on a highly speculative liability. Health insurers are only estimating medical treatment costs over the next 12 months, a much less risky proposition.

Status: Ongoing.

For further information …

"Comparing the Costs of Delivering Medical Benefits Under Group Health and Workers' Compensation – Could Integration Pay for Covering the Working Uninsured?" (October 2009). www.dir.ca.gov/chswc/PublicCommentsandFeedback.html

"Summary of Occupational and Non-Occupational Integrated Care Roundtables," December 2008.
http://www.dir.ca.gov/chswc/Reports/SummaryOandNO_ICR2008.pdf

"Integrating Group Health and Workers' Compensation Medical Care," Factsheet 2008.
http://www.dir.ca.gov/chswc/Reports/CHSWC_IntegrationofCareFactsheet.pdf

Roundtable Participants

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Roundtable Participants

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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 University of California (UC), Berkeley to carry out this study.

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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.

FRAUD

Anti-Fraud Studies and Activities and Related Projects to Assist Injured Workers

This section describes the findings from Commission on Health and Safety and Workers' Compensation (CHSWC) studies on fraud and fraud measurements.

Background

Over the past several years, the Commission has focused on anti-fraud studies to quantify and identify areas of system cost losses and system cost shifting. Partnerships with the Department of Insurance (CDI) and others have created an ongoing agenda to combat fraud through measurement and identification of types of fraud in the system.

The objectives of the fraud studies were to:

- 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 Fraud Assessment Commission (FAC) and CHSWC. (See "List of Projects and Studies" in this report.)

- 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.")

Some of the studies created findings which became initiatives or projects to improve the delivery of services and assist injured workers who may be potential unsuspecting victims of fraud or simply vulnerable to the intricacies of the benefit delivery system when procedures are not properly followed by employers or the injured workers themselves.

Studies described below include project summaries of these offshoot initiatives. While some reports are completed, the focus on anti-fraud efforts is ongoing:

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.

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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.

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 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; 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.

Recommendation

- Improve WCIS reporting.

Status: Completed.

For further information, including additional recommendations …

> "Reporting Workers' Compensation Injuries in California: How Many are Missed?" (August 2008). http://www.dir.ca.gov/chswc/Reports/ReportingWorkersCompensationInjuriesinCalifornia2008August.pdf

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.

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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.

Findings

From 1997 to 2005, the most recent data available at publication, there was 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 to 12 percent in 2003-2004, when rates were several times higher than in 1997. This amounts to about $15 billion of underreported payroll in 1997 and up to $68 billion in payroll in 2003 (and $61 billion in 2004).

Between $15 and $68 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 ten 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.

Status: Completed.

For further information, including suggested next steps …

"Fraud in Workers' Compensation Payroll Reporting: How Much Employer Fraud Exists? What is the Impact on Honest Employers?" (August 2007 and January 2009).
http://www.dir.ca.gov/chswc/Reports/Fraud_in_WC_payroll_Report_Aug_14_2007.pdf
(August 2007)
http://www.dir.ca.gov/chswc/Reports/2011/Final_Report_FAC_Premium_Avoidance.pdf
(January 2009)

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).[60]

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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.

[60] UEBTF is also still commonly called the Uninsured Employers Fund (UEF).

- Tax payments.
- 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.

Fraud Studies - Related Initiatives: Uninsured Employers Benefits Trust Fund Project – Information and Assistance (I&A) Officer Customer Service Project, UEBTF Handbook, and Labor Code 90.3 Data Matching

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. Fraudulent misreporting or illegally uninsured employers shift costs to other payors inside and outside of the workers' compensation system.

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.

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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 4 or 5 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 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

As a result of these past findings, CHSWC has worked with DIR and stakeholders to address emerging issues:

- 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 ended in June 2010 with positive results.

- CHSWC has funded the development of a UEBTF booklet in simple language for use by uninsured workers, which is being translated into Spanish.

- Progress is being made in following the requirements of Labor Code Section 90.3, as evidenced by the release of the annual reports required by Labor Code Section 90.3 in 2009 and 2010 by the Division of Labor Standards Enforcement (DLSE).

Status: In process.

For further information …

"CHSWC Background Paper: Uninsured Employer Benefits Trust Fund" (April 2007).
http://www.dir.ca.gov/CHSWC/Reports/UEBTF-Final.pdf

"2009 Annual Report of the Unlawfully Uninsured Employer Enforcement Program, Labor Code Section 90.3(d)."
http://www.dir.ca.gov/dlse/UUEEP-2009.pdf

"2008 Annual Report of the Unlawfully Uninsured Employer Enforcement Program, Labor Code Section 90.3(d)."
http://www.dir.ca.gov/dlse/UUEEP-2008.pdf

Division of Labor Standards Enforcement Reports.
http://www.dir.ca.gov/dlse/DLSEReports.htm.

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, "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.

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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 insurers 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.

There are four broad themes that run through the 29 policy recommendations: improve predictability; enhance transparency of the system; better align incentives of major players; and improve California Department of Insurance (CDI) oversight.

Status: Completed.

For further information …

> "California's Volatile Workers' Compensation Insurance Market: Problems and Recommendations for Change," RAND, December 2009.
> http://www.dir.ca.gov/chswc/Reports/2009/InsolvencyReport.pdf

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 for decades, either individually or in groups called joint powers authorities (JPAs). 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.

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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.[61] 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.

Findings

The CHSWC study found that self insurance groups have the potential to serve the interests of California employers and employees by promptly providing workers' compensation benefits to injured workers at reasonable cost while enabling and encouraging employers to improve safety and provide the earliest appropriate return to work for injured employees.

Self insurance groups also have the potential to drive up costs and disrupt the delivery of benefits when poorly managed. At the least, the members or former members of an underfunded group may be exposed to unexpected costs to make up for the shortage. At the worst, responsibility for payment of a failed

[61] Sources: Office of Self Insurance Plans website and e-mail correspondence 1/8/2009.

group's obligations may be shifted to employers who were not connected with the failed group, and benefits to injured workers may be interrupted and delayed during the collapse of the group.

The purpose of the CHSWC "Report on Self Insurance Groups" was to review what legislation or oversight might be needed to preserve group self insurance as an option for eligible employers and to assure that the risks are held to a reasonable minimum. California already has regulations designed to protect against the most obvious risks of financial failure and default by self insurance groups. This report recommends additional steps for improved solvency, security and oversight.

Status: Completed. See the "Special Report: Self Insurance Groups" section in this Annual Report for more details and specific recommendations.

For further information …

"Report on Self Insurance Groups" (December 2009).
http://www.dir.ca.gov/chswc/Reports/2009/CHSWC_SIGReport.pdf

INFORMATION FOR WORKERS AND EMPLOYERS

Return-to-Work/FEHA/ADA Handbook and Factsheet

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 2010 for the Department of Industrial Relations (DIR) Division of Workers' Compensation (DWC) and the Commission on Health and Safety and Workers' Compensation (CHSWC) ,as well as 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

Several stakeholders have requested information to help workers and employers meet their responsibilities under FEHA and ADA. The director of DIR requested that 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 and convened the Return-to-Work/FEHA/ADA Advisory Group on December 9, 2008. This was a multi-agency effort 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 RTW 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.

Recommendations for a 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.

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- Emphasize the economic necessity of keeping Californians working safely and productively; and 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; and 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.

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Handbook and Factsheet

Handbook: Helping Injured Employees Return to Work: Practical Guidance Under Workers' Compensation and Disability Rights Laws in California

CHSWC worked with DFEH and partnered with 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,* prepared by CHSWC and the University of California (UC), Berkeley, in collaboration with DFEH and DWC.

The handbook, which was available beginning in February 2010, 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 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 RTW in construction and agriculture. In addition, it discusses: how to establish an effective program to carry out 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.

Factsheet: "Best Practice in Returning and Injured Employee to Work: Factsheet for Employers"

A Factsheet based on the Handbook, **"**Best Practices in Returning an Injured Employee to Work: Factsheet for Employers," was also prepared and made available in February 2010. The Factsheet presents key points from the RTW/FEHA/ADA Handbook: *Helping Injured Employees Return to Work: Practical Guidance Under Workers' Compensation and Disability Rights Laws in California, February 2010.*

Status: Completed.

For further information …

"Summary of December 9, 2008 Return-to-Work/FEHA/ADA Advisory Group Meeting" (April 2009).
http://www.dir.ca.gov/chswc/Reports/2009/CHSWC_SummaryRTWFEHAADAGuidebookRoundtable2009.pdf

Helping Injured Employees Return to Work: Practical Guidance Under Workers' Compensation and Disability Rights Laws in California
http://www.dir.ca.gov/chswc/Reports/2010/HandbookRTW_2010.pdf

"Best Practices in Returning an Injured Employee to Work: Factsheet for Employers," February 2010.
http://www.dir.ca.gov/chswc/CHSWC_FactsheetRTW_2010.pdf

INFORMATION FOR WORKERS AND EMPLOYERS

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.

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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 CHSWC'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 (I&A) 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 …

"CHSWC Background Paper: Uninsured Employers Benefits Trust Fund" (April 2007).
http://www.dir.ca.gov/CHSWC/Reports/UEBTF-Final.pdf

INFORMATION FOR WORKERS AND EMPLOYERS

Benefit Notices: Recommendations

Background

Labor Code Section 77(b) authorizes the Commission on Health and Safety and Workers' Compensation (CHSWC) to issue periodic reports and recommendations to improve and simplify benefit notices. In March and April 2010, Commission staff held separate meetings with members of a small task force of knowledgeable advisors from organizations including the Schools Insurance Authority, California Workers' Compensation Institute, Tristar Risk Management, California Applicants' Attorneys Association, and Southern California Edison Company to review specific problems with the current system of benefit notices and discuss possible alternatives.

Objectives

California does not have a streamlined benefit notices program that allows claims administrators to communicate effectively with injured workers. Benefit notices should:

- Help injured workers understand the entire claims process.
- At particular stages, inform injured workers of their rights and obligations and instruct them on steps to take.
- Be easy to administer.
- Help avoid unnecessary litigation.

Scope of Study

Advisors consulted identified problems with benefit notices:

- Too voluminous (e.g., overly wordy, redundant, containing factsheets and forms that are not needed by all workers).
- Complex, overwhelming, frightening, vague, confusing (e.g., "you may lose important rights if you do not take certain actions within 10 days"; "you may be asked to return to the physician for a new evaluation").
- Difficult to understand (e.g., indirect wording, unfamiliar terminology).
- Not coordinated as a single system, not standardized.
- Misleading (e.g., workers think they are required to submit the Qualified Medical Evaluator (QME) panel request form; notice that no permanent disability exists sounds like denial of the entire claim).
- Not conveying the main points to workers.
- Difficult to keep updated (i.e., the required factsheets).

Suggestions to improve benefit notices included:

- Identify what injured workers need to know at each stage. Relay necessary information at the right time, eliminate unnecessary information, and use plain language. Clearly inform injured workers about applicable deadlines.

- Explore providing background and explanatory information to all injured workers about the entire claims process and workers' rights and obligations. Provide the information early in their claims, and make it continually available to allow workers to access

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relevant portions later in their claims. The information could be posted on the Internet, for example. Transferring this information from factsheets included with the current benefit notices to an online source would greatly reduce the volume of paper in the system and would allow claims administrators to convey the main points about a particular claim in the individual notices.

- Provide clear information to workers about where and how they can access information on the Internet about workers' compensation and the forms that are needed by some workers. Create mechanisms to allow access for workers who do not have easy access to the Internet, such as providing paper copies upon request.

- Simplify and standardize the language of benefit notices. Consider, for example, using a form similar to Form DIA 500, which was a one-page benefit status notice used in the 1980s by the Division of Industrial Accidents, the predecessor to the Division of Workers' Compensation (DWC). Using a similar form may help claims administrators concisely relay necessary messages to the workers about their claims.

To assess the feasibility of providing background and explanatory information through online sources, Commission staff sought data to estimate the extent that injured workers have access to the Internet. Over the course of four working days in April 2010, Commission and DWC staff administered a brief questionnaire to injured workers calling and visiting the Information & Assistance (I&A) offices in Salinas, San Bernardino, San Diego, Oakland, and Stockton. These five offices have high volumes of traffic, serve urban and rural locations in Northern and Southern California, and employ one or more I&A officers. In addition, these offices probably serve populations facing some of the greatest barriers to accessing the Internet.

The workers were asked whether they access the Internet and whether they or anyone in their household accesses the Internet at least once a month. Of the 162 workers who responded, 16 percent indicated they did not have access to the Internet.

Recommendations

Currently, there is no requirement to provide all injured workers with comprehensive information that workers can use and reference to understand the individual benefit notices they receive in their claims. It is recommended that CHSWC collaborate with the Division of Workers' Compensation (DWC) to explore and implement methods to provide clear information to all injured workers soon after injury describing the entire workers' compensation claims process and the parties' respective rights and obligations, to make this information continually available for workers to access later in their claims, and to improve California's system of benefit notices.

The bulk of the information currently provided with benefit notices, including the DWC form to request a QME panel and the content of the DWC fact sheets on temporary disability benefits, permanent disability benefits, and the QME/agreed medical evaluator (AME) process, would be made available on the Internet for most workers and made available upon request to workers who do not have easy access to the Internet. The notices themselves would become much shorter in length and greatly reduced in total volume. This would allow claims administrators to effectively communicate the main messages. It would also enable injured workers to understand their rights and obligations and not be overwhelmed by the claims process.

Estimated Costs

Sixteen (16) percent of the workers in the survey described above indicated they did not have access to the Internet. Because a greater percentage of all injured workers in California probably have access to the Internet compared to the workers who participated in the survey, we believe the 16 percent figure is on the high side. Furthermore, Internet access will probably increase over time for everyone. On the other hand, some workers would request a paper copy even if they are able to access the Internet. Therefore, it

is estimated that 10 to 20 percent of newly injured workers would request a paper copy of a written booklet describing the entire claims process if informed of its availability.

There were 625,765 claims in 2008 (CHSWC Annual Report, 2009, page 44). Assuming 10 to 20 percent of newly injured workers would request a paper copy, it is estimated that 60,000 to 130,000 copies will need to be provided. The cost of printing and delivering one booklet similar to the CHSWC *Guidebook for Injured* Workers is $5.00. This cost multiplied by 60,000 to 130,000 yields a total cost to print and deliver paper booklets of $300,000 to $650,000, or less than $1 million per year.

Estimated Savings

Improving communications between claims administrators and injured workers will reduce confusion, misunderstandings, disputes and litigation. Insured employers incur legal defense expenses of $607 million per year (Workers' Compensation Insurance Rating Bureau, 2008 California Workers Compensation Losses and Expenses report, June 25, 2009, page 4) and represent 70 percent of all California workers' compensation claims (DWC Workers' Compensation Information System data). Dividing the $607 figure by 70 percent yields an estimated cost of $867 million for all employers. We assume, conservatively, that providing comprehensive information early in the claims process and substantially clarifying the information in benefit notices will reduce legal defense expenses by 5 percent, or $43 million per year.

In addition, shortening the length of benefit notices and eliminating enclosures will significantly reduce printing and mailing costs.

Estimated Net Savings

As discussed above, the costs of providing paper copies of an informational booklet to injured workers upon request are estimated be less than $1 million per year, and the savings in legal defense costs and printing and mailing costs are estimated to be $43 million or more per year. The overall net savings are estimated to be more than $42 million per year.

Recommendation

The Commission's Report on Benefit Notices and Recommendations, July 2010, recommends legislation requiring a system of benefit notices to be written in plain language and a guidebook for injured workers also to be written in plain language, which the benefit notices can refer to. At its August 19, 2010 meeting, the Commission voted to initiate background work on simplification of notices and to revise the 2006 *Guidebook for Injured Workers*.

The revised Guidebook will also include changes since 2006, such as the extension of time to receive temporary disability benefits, the new Medical Treatment Utilization Schedule, and changes in the right to pre-designate.

Status: Report **c**ompleted. Revision to benefit notices and the 2006 *Guidebook for Injured Workers* is in process.

For further information …

> "Report on Benefit Notices and Recommendations," July 2010.
> http://www.dir.ca.gov/chswc/Reports/2010/BenefitNoticesRecommendationspdf.pdf

INFORMATION FOR WORKERS AND EMPLOYERS

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.

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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 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*, was 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: Completed.

For further information **…**

The Whole Worker: Integrating Wellness and Occupational Health and Safety Programs
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/WOSHTEP_TheWholeWorker.pdf

"Summary of the July 16, 2008 Workplace Wellness Roundtable" (December 2008).
http://www.dir.ca.gov/chswc/Reports/CHSWC_SummaryWorkplaceWellnessRoundtable.pdf

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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."

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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, whether employers would 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 to reduce injury and illness rates, as well as to identify the effects and policy implications of IIPP in California. 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 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 reductions in injury and illness rates vary depending on the 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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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?

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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:

- 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.

Findings

RAND conducted in-depth discussions with members of eight California agencies covering fire/emergency-management services, law enforcement, and corrections. Key findings from these discussions included:

- Better surveillance of injury data, particularly for injuries to law enforcement and emergency medical personnel, is needed.
- 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 for Public Safety Employees: Assessing the Evidence and the Implications for Public Policy," RAND (2008).
http://www.dir.ca.gov/CHSWC/Reports/CHSWC_PublicSafetyEmployeesReport2008.pdf

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.

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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. While musculoskeletal conditions represent the most common injury type in virtually all occupations, 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 frequent musculoskeletal injuries are to firefighters in California, how severe these injuries are when they occur, and what the economic consequences are for injured firefighters. Such information is essential in order to design effective policies to protect firefighters against such injuries and safeguard them when they do sustain these types of occupational injuries.

The importance of understanding the frequency and severity of firefighter musculoskeletal disorders (MSDs) has also become heightened due to recent changes to the California workers' compensation system since 2004. These changes include the reduction of permanent disability ratings that occurred due to the adoption of a new disability rating system, new rules for apportioning disability, the adoption of treatment guidelines to provide utilization review, and the imposition of caps on the number of chiropractic and physical therapy visits. Many of these changes could have a disproportionate impact on workers with musculoskeletal injuries, potentially making firefighters more vulnerable to any adverse impacts.

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 CHSWC musculoskeletal injury study gathered data and analyzed the types, frequencies and treatments applied to major musculoskeletal injuries incurred by firefighters while performing their job-related duties. The objectives of this project included:

- Describe the average frequency and severity of work-related MSDs experienced by firefighters in California.

- Study the impact of work-related MSDs on the earnings and employment of firefighters several years after injury.

- Evaluate the impact of reforms to the disability rating system on the ratings of firefighters with permanently disabling MSDs.

- Assess whether reforms to the medical delivery system impacted the employment outcomes of firefighters with MSDs.

Findings

- Firefighters face considerably more risk of nonfatal injuries than workers in the private sector, but the risk is even more pronounced for MSDs. In addition, firefighters 55 years of age and older are more than 10 times more likely to suffer an MSD relative to private sector workers of the same age, and when injured, they take more than four times longer to return to work.

- Both the frequency and severity of injuries, particularly MSDs, are worse for older firefighters than for younger firefighters.

- Although the frequency and severity of MSDs are greater for firefighters than workers in other occupations, particularly in the private sector, that does not necessarily translate into worse long-term economic consequences for workers.

- Firefighters experienced significant declines in average permanent disability ratings as a result of the reforms to the disability rating system.

    - The declines experienced by firefighters are comparable to those experienced by other workers.

    - The biggest impact on firefighters appears to have come from a disproportionately large fraction of cases that now receive a zero disability rating.

    - Apportionment has led to a small reduction in the average rating for firefighters as it has for other workers. However, while the effects are small on average, there is often a large reduction in ratings whenever apportionment is applied.

- Since chiropractor and physical therapy treatments do not appear to be correlated with significantly better health or return to work relative to treatment by a general practitioner, it does not appear that outcomes for firefighters who are unable to obtain treatment beyond the 24-hour cap will dramatically worsen.

- The study's analysis does not suggest that employment outcomes of firefighters were worse after the adoption of medical reforms designed to limit the utilization of chiropractic and physical therapy treatments.

Status: Completed.

For further information **…**

"The Frequency, Severity, and Economic Consequences of Musculoskeletal Injuries to Firefighters in California," RAND, 2010.
http://www.dir.ca.gov/chswc/Reports/2010/FirefightersMusculoskeletal.pdf

OCCUPATIONAL SAFETY AND HEALTH

Study on Older Workers, Injury Risk and Future Cost Trends

Background

The Commission on Health and Safety and Workers' Compensation (CHSWC), with the assistance of the University of California (UC), Berkeley, is preparing a study on older workers and their post-injury outcomes. One of the recommendations of the Commission's annual report for several years has been to examine disability duration by age. The study will help determine if older workers experience longer average time off work when disabled in California, or if older workers simply experience the kinds of injuries that are associated with longer disability durations. This determination will be ultimately important for both safety and prevention.

Project Team

CHSWC Staff

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Aging Workforce

Key questions about the aging workforce include: do older workers get injured more or less often than younger workers? and how does the duration of disability compare by age? These are important questions for employers, workers, government budgets and benefit programs. The importance is magnified because the workforce is aging, and many older workers are choosing to stay in the labor force for economic reasons.

At best, the research in this area is limited or, at worst, anecdotal. One perspective is that older workers get injured less often because they are safer and more experienced. However, when older workers are injured, it takes longer to recover, costs more in disability payments and medical treatment, is more likely to result in permanent disability, and results in greater economic loss to the worker. The study will seek to assess how true these claims are and if true, whether the cause is age-related or driven by other causes, as well as what the answers to these questions mean for future trends.

Even if the study reveals that older workers are less likely to experience injury, as many claim, key questions still needing to be answered include whether older workers are actually safer due to experience, or whether lower injury rates are simply the consequence of more experience, or whether older workers sorting into safer jobs (supervisor, etc.).

The study will also examine whether older workers experience longer average time off work when disabled and whether age is the reason, or whether older workers simply experience the kinds of injuries that are associated with longer disability duration, perhaps because of the types of occupations in which they work. For instance, older workers may be more likely to suffer back injuries which take longer to heal than lacerations and contusions. Alternatively, older workers may experience more cumulative injuries, also associated with longer disability, because of greater lifetime exposure to the underlying cause.

If age drives injuries and disability duration, then an aging workforce will lead to increasing occupational medical and disability costs and costs for government programs. On the other hand, to the extent that any differences in older workers' frequency and duration of occupational conditions are due to the types of work into which they migrate over their careers and not a due to their age, a higher proportion of older workers will not lead to changes in medical treatment, insurance, and government benefit costs. In either case, understanding how an older workforce interacts with occupational safety is important for focusing future investments in prevention and research.

Status: In process.

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.

Project Team

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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

- ***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. (See http://www.dir.ca.gov/chswc/woshtep.html)

- ***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.

- ***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).

- ***Adapted and disseminated statewide WOSH Specialist curriculum materials for the State Building and Construction Trades Council (SBCTC)*** including construction industry-specific health and safety case studies, including green case studies, which can be incorporated into apprenticeship and pre-apprenticeship training on health and safety and on green jobs.

- ***Developed materials for the implementation of heat illness training to protect California's farm workers from outdoor heat illness and workers in other industries from indoor heat illness.*** Developed *Heat Hazards in Agriculture* tailgate guide and implemented distribution statewide, collaborating with existing *promotora* networks to reach farm workers.

- ***Developed materials in collaboration with the State Building & Construction Trades Council (SBCTC) to incorporate WOSHTEP curricula into apprenticeship and pre-apprenticeship training programs in California.*** Disseminated materials statewide to provide construction industry-specific case studies, including green case studies, which can be incorporated into apprenticeship and pre-apprenticeship training on health and safety and on green jobs.

- ***Adapted the WOSH Specialist curriculum and materials for NISH-affiliated Community Rehabilitation Programs in California that serve and employ individuals with disabilities***. LOHP provided WOSH Specialist trainings to the managers and supervisors from several community rehabilitation programs (CRPs) on how to teach basic health and safety skills to their workers with disabilities and how to design and implement a successful injury and illness prevention program (IIPP) in their workplaces. This program was promoted by: NISH – Creating Employment Opportunities for People with Severe Disabilities; The ARC in Southern California; and Pride Industries in Northern California.

- ***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 owners and managers of small businesses across industries, and industry-specific materials have been developed for the restaurant industry, the janitorial industry, and the dairy industry.

- ***Created health and safety programs for young workers, including a Young Worker Leadership Academy***. Two Academies have been offered annually, one in Northern California and one in Southern California.

- ***Completed and disseminated a booklet, "The Whole Worker: Integrating Wellness & Occupational Health and Safety Programs."*** The booklet outlines what constitutes an integrated approach to health promotion and occupational health and safety programs and provides examples of specific wellness/health promotion programs and their effectiveness.

- ***Established Resource Centers that house and distribute training materials and additional health and safety resources***. These Resource Centers are located at LOHP, 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.)

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, the Central Valley partner, is conducting WOSHTEP activities under the direction of LOHP WOSHTEP staff. Expansion in Southern California includes San Diego and the Inland Empire.

- ***Ongoing development and dissemination of injury and illness prevention materials on*** health and safety topics such as indoor and outdoor heat illness, motor vehicle safety, emergency preparedness, and integration of wellness and occupational safety and health.

- ***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 health and safety 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.

Status: Ongoing.

WOSHTEP Advisory Board Members

Lisa Barbato
Service Employees International Union (SEIU) – United Healthcare West and Joint Employer Education Fund

Laura Boatman
State Building & Construction Trades Council

Marti Fisher
California Chamber of Commerce

Judith Freyman
ORC, Inc.

Simmi Gandhi
Garment Workers Center

Deborah Gold
California Division of Occupational Safety and Health

Scott Hauge
Small Business California

Jon Hughes
United Food and Commercial Workers Union (UFCW) Local 5

Cynthia Leon
California Manufacturers & Technology Association

Tom Rankin
State Fund, California, and formerly President, California Labor Federation (AFL-CIO)

Christina Vasquez
Union of Needletrades, Industrial and Textile Employees (UNITE HERE!)

Len Welsh
State of California
Division of Occupational Safety and Health

Chad Wright
Laborers-Employers Cooperation and Education Trust

Gail Bateson
Worksafe

Advisory Board Ex-officio Members

Charles Boettger
Municipal Pooling Authority

Mary Deems
California Department of Public Health

Cindy Delgado
San Jose State University

Ken Helfrich
Employers Direct Insurance

Scott Henderson
Henderson Insurance Agency

Dori Rose Inda
Watsonville Law Center

Mark Jansen
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State Compensation Insurance Fund

Dave Mack
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Michael Marsh
California Rural Legal Assistance

John McDowell
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Thomas Neale
Chubb & Son

Bob Snyder
Liberty Mutual Insurance Group

John Stassi
Food Service Insurance Managers

Dave Strickland
Zurich Insurance

Ed Walters
QBE the Americas

Jim Zanotti
Chartis Insurance

For further information …

WOSHTEP List of Publications
http://www.dir.ca.gov/chswc/WOSHTEP.html

OCCUPATIONAL SAFETY AND HEALTH

California Partnership for Young Worker Health and Safety

Background

Over the past five years, an average of 37 teens have died each year in the United States (U.S.) as a result of approximately 146,000 work-related injuries, and an estimated 49,000 are injured severely enough to require treatment in hospital emergency rooms. Most of these injuries are preventable.

Project Team

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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 twelfth 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 six communities (San Diego, Los Angeles, Ventura, Bakersfield, Napa, and San Francisco) for a month; and distribution of the current Safe Jobs for Youth Month Resource Kit to over 300 educators and community groups (by 270 downloads from the website and 30 hard copies requested to date), plus over 1500 downloads of resource kit materials from past years.

  For the first time, Partnership members came together to conduct a press conference to promote Safe Jobs for Youth Month on May 24th, 2010. Agency heads from CHSWC, DIR, and the state Superintendent of Public Instruction joined with a teen representative from the Young Worker Leadership Academy (YWLA) to honor the poster and PSA contest winners at a press

conference held at a Sacramento Job Corps Career Fair. Coverage was aired on several Spanish-language TV channels.

In addition, 12 youth teams that participated in the YWLAs (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, including a short video, for distribution at career centers and other work-readiness programs; school wide job fairs and lunchtime information-sharing events; and presentations to a school board, mayor, and city council in support of Safe Jobs for Youth Month.

- ***Support and conduct two Young Worker Leadership Academies.*** Young Worker Leadership Academies (YWLAs) in 2010 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 12 different organizations around the State attended the Academies in 2010. 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.

- ***Support and conduct at least one reunion for YWLA participants.*** A day-long reunion was held for participants of the Northern California YWLA on July 8, 2010. Fourteen youth participated, representing four of the six community teams. They shared their project successes and learned more about policy development and advocacy.

- ***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 and Washington (sponsored by the University of Oregon and the University of Washington).

- ***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.

California Partnership for Young Worker Health and Safety

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California Association of Work Experience Educators

Mario Feletto
DIR, Cal/OSHA

Susan Gard
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Fred Glass
California Federation of Teachers

Kelly Howard
DIR, Cal/OSHA

Jonathan Hughes
UFCW Local 5

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California Teachers Association

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U.S. Department of Labor, Wage & Hour

Charlene Mouille
New Ways to Work

Jim Muldavin
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Lee Pliscou
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Eric Rood
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Cory Sanfilippo
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Carol Smith
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Nance Steffen
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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).
http://socrates.bekeley.edu/-safejobs/downloads/pdf/2004Recommendations904.pdf.

OCCUPATIONAL SAFETY AND HEALTH

School Action for Safety and Health Program

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.

Project Team

CHSWC

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Linda Delp, Ph.D.

Description

CHSWC has established a schools health and safety 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 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 target audience consists of 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 schools 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. An additional Advisory Group meeting held March 29, 2010, focused on feedback from the two pilot trainings and suggestions for implementation.

The SASH program includes: a needs assessment conducted to determine the types of training and resources; development of materials and resources, including an online resource guide and establishment of a SASH Resource Center at the University of California (UC), Berkeley Labor Occupational Health Program (LOHP); 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.

Advisory Group

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Commissioner, CHSWC

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Cal/OSHA Consultation Service

Lee Taylor Austin
San Diego County Schools Risk Management JPA

Denise Banker
Governor's Office of Homeland Security

Martin Brady
Schools Insurance Authority

Margie Brown
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Julianne Broyles
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Robert Chacanaca
California Federation of Teachers

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Emily Kephart
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Schools Insurance Authority

Advisory Group (continued)

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Cal/OSHA Enforcement

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Governor's Office of Homeland Security

Julie Smith
Schools Insurance Authority

David Struthers
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School Facilities Planning Division

Kathleen Webb
Interagency Support Division Department of General Services

Mark Weber
Governor's Office of Homeland Security

Charles Williams
CSAC Excess Insurance Authority

Status: Materials have been finalized and posted to the Commission's website. Materials include: the SASH brochure, Factsheets, Tools, Tip Sheets, a Resource List, Worksheets for the training course, and IIPP Guide and template. Trainings are being offered statewide.

For further information …

SASH Website
http://www.dir.ca.gov/chswc/SASH/index.htm

LIST OF PROJECTS AND STUDIES

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).
http://www.dir.ca.gov/CHSWC/Reports/MemoOnRatingsThruJan2007.pdf
"Permanent Disability Rating Schedule Analysis" (2006).
http://www.dir.ca.gov/CHSWC/Reports/CHSWC-PD-Report-Feb23-2006.pdf

Impact of Changes to the Temporary Disability Benefits
Status: Completed
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:
"Compensating Permanent Workplace Injuries: A Study of the California System," RAND (1998).
http://www.rand.org/pubs/monograph_reports/MR920
"Findings and Recommendations on California's Permanent Partial Disability System - Executive Summary," RAND (1997).
http://www.dir.ca.gov/CHSWC/Reports/PPDFindingsAndRecommendations.pdf

Enhancement of Wage Loss Analysis – Private Self-Insured Employers
Status: Completed
CHSWC Report:
"Permanent Disability at Private Self-Insured Firms: A Study of Earnings Loss, Replacement, and Return to Work for Workers' Compensation Claimants," RAND (2003).
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:
"Trends in Earnings Loss from Disabling Workplace Injuries in California – The Role of Economic Conditions," RAND (2001).
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:

"An Evaluation of California's Permanent Disability Rating System," Summary, RAND (2005).
http://www.dir.ca.gov/CHSWC/Reports/Eval_Of_CA_PD_System_Summary.pdf
"An Evaluation of California's Permanent Disability Rating System," Full Report, RAND (2005).
http://www.dir.ca.gov/CHSWC/Reports/Eval_Of_CA_PD_System.pdf
"Evaluation of California's Permanent Disability Rating Schedule," Interim Report, RAND (2003).
http://www.dir.ca.gov/CHSWC/Reports/PermanentDisabilityRatingSchedule-InterimReport.pdf

Apportionment

Status: Completed

*CHSWC Report*s:

"Understanding the Effect of SB 899 (Stats 2004, Chap 34) on the Law of Apportionment" (April 2007).
http://www.dir.ca.gov/chswc/CHSWC_ApportionmentPaper.pdf
"Understanding the Effect of SB 899 (Stats 2004, Chap 34) on the Law of Apportionment" (October 2005).
http://www.dir.ca.gov/CHSWC/FinalApportionmentPaper.pdf
"Background Paper on Workers' Compensation Causation and Apportionment" (May 2004).
http://www.dir.ca.gov/CHSWC/Causation_and_Apportionment_Final_May_2004.pdf

Disability Evaluation and Medical Treatment

Status: Completed

*CHSWC Report*s:

For further information…

See the project synopsis in the "Projects and Studies" section.

II. RETURN TO WORK

Return to Work Programs

Status: Completed

CHSWC Reports:

"How Effective are Employer Return to Work Programs?" RAND, February 2010.
http://www.dir.ca.gov/chswc/Reports/2010/CHSWC_RANDRTW.pdf
"Report on the Return-To-Work Program Established in Labor Code Section 139.48."
http://www.dir.ca.gov/chswc/Reports/2010/CHSWC_RTWReport.pdf
http://www.dir.ca.gov/chswc/Reports/2009/ReimbursementProgramRecommendations2009.pdf
"Best Practices in Returning an Injured Employee to Work: Factsheet for Employers," February 2010.
http://www.dir.ca.gov/chswc/CHSWC_FactsheetRTW_2010.pdf
Helping Injured Employees Return to Work: Practical Guidance Under Workers' Compensation and Disability Rights Laws in California, February 2010.
http://www.dir.ca.gov/chswc/Reports/2010/HandbookRTW_2010.pdf

International Forum on Disability Management (IFDM) 2010

Status: Completed

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 and the "Special Report: International Forum on Disability Management 2010: *Collaborating for Success*."

RETURN TO WORK (continued)

Return-to-Work Program Established in Labor Code Section 139.48

Status: Completed

CHSWC Reports:

"Recommendations for the Return-to-Work Program Established in Labor Code Section 139.48" (April 2009).
http://www.dir.ca.gov/chswc/Reports/2009/ReimbursementProgramRecommendations2009.pdf

"Report on the California Return-to-Work Program Established in Labor Code 139.48" (April 2009).
http://www.dir.ca.gov/chswc/Reports/2009/CHSWC_ReportontheCaliforniaReturntoWorkProgramEstablishedinLaborCode139_48_2009.pdf

For further information …

See the project synopsis in the "Projects and Studies" section.

RTW/FEHA/ADA – Coordination and Interaction

Status: Completed

CHSWC Booklet, Factsheet and Report:

Helping Injured Employees Return to Work: Practical Guidance Under Workers' Compensation and Disability Rights Laws in California, February 2010.
http://www.dir.ca.gov/chswc/Reports/2010/HandbookRTW_2010.pdf

"Best Practices in Returning an Injured Employee to Work: Factsheet for Employers," February 2010.
http://www.dir.ca.gov/chswc/CHSWC_FactsheetRTW_2010.pdf

"Summary of December 9, 2008 Return-to-Work/FEHA/ADA Advisory Group Meeting" (April 2009).
http://www.dir.ca.gov/chswc/Reports/2009/CHSWC_SummaryRTWFEHAADAGuidebookRoundtable2009.pdf

For further information …

See the project synopsis in the "Projects and Studies" section.

Evaluation of Return-to-Work Reforms

Status: Completed

"Workers' Compensation Reform and Return to Work: The California Experience" (November 2010).
http://www.dir.ca.gov/chswc/Reports/2010/WCReformandReturntoWork.pdf

For further information…

See the project synopsis in the "Projects and Studies" section.

Return-to-Work Roundtable

Status: Completed

CHSWC Report:

"Summary of November 17, 2006 CHSWC Return-to-Work Roundtable" (April 2007).
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).
http://www.dir.ca.gov/CHSWC/Reports/RTW-AB1987.pdf

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

RETURN TO WORK (continued)

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:
"Physical Workplace Factors and Return to Work After Compensated Low-Back Injury: A Disability Phase-Specific Analysis," JOEM (March 2000).
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:
"Determinants of Duration of Disability and Return to Work After Work-Related Injury and Illness: Challenges for Future Research" (April 2001).
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).
http://www.dir.ca.gov/CHSWC/Reports/Reforms_of_2003-AB227.pdf
"Reforms of 2003, SB 228" (October 2003).
http://www.dir.ca.gov/CHSWC/Reports/Reforms_of_2003-SB228.pdf

WORKERS' COMPENSATION REFORMS (continued)

Senate Bill 899 Analysis
Status: Completed
CHSWC Summaries:
"Summary of Workers' Compensation Reform Legislation" (2004).
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:
"CHSWC Report on the Division of Workers' Compensation Audit Function" (1998).
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.

Vocational Rehabilitation Study
Status: Completed
CHSWC Reports:
"Vocational Rehabilitation Reform Evaluation" (March 2000).
http://www.dir.ca.gov/CHSWC/Vocrehabreform2000.pdf
"Vocational Rehabilitation Benefit: An Analysis of Costs, Characteristics, and the Impact of the 1993 Reforms" (August 1997).
http://www.dir.ca.gov/CHSWC/rehab/rehabcover.html

Evaluation of Treating Physician Reports and Presumption
Status: Completed
CHSWC Report:
"Report on the Quality of the Treating Physician Reports and the Cost-Benefit of Presumption in Favor of the Treating Physician" (August 1999).
http://www.dir.ca.gov/CHSWC/Report99/TPhysician.html

Update of Treating Physician Reports and Presumption Study
Status: Completed
CHSWC Report:
"Doctors and Courts: Do Legal Decisions Affect Medical Treatment Practice"? (November 2002).
http://www.dir.ca.gov/CHSWC/CHSWCLegalDecAffectMedTreatPractice/ptpfinalrpt.html

WORKERS' COMPENSATION REFORMS (continued)

Evaluation of Labor Code Section 5814 Penalty Provisions
Status: Completed
CHSWC Reports:
"Issue Paper on Labor Code Section 5814" (April 2000).
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:
"Preliminary Evidence on the Implementation of 'Baseball Arbitration' in Workers' Compensation" (November 1999).
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
"Summary Estimating the Workers' Compensation Reform Impact on Employer Costs and Employee Benefits" (August 1999).
http:///www.dir.ca.gov/chswc/Summary.htm

Cost Trends 1985-2005
Status: Completed
NASI Brief:
"Workers' Compensation in California and in the Nation: Benefit and Employer Cost Trends, 1989-2005" (April 2008).
http://www.dir.ca.gov/chswc/Reports/CAWorkers'CompensationBrief2008.pdf

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.

OCCUPATIONAL SAFETY AND HEALTH (continued)

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
Status: Report completed; individual studies ongoing.
CHSWC Report:
"Research Agenda for Improving Workplace Health and Safety in California" (February 2008).
http://www.dir.ca.gov/CHSWC/reports/CHSWCReportHealthandSafetyResearchAgendaFeb2008.pdf

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:
"Quality Management and Job Quality: How the ISO 9001 Standard for Quality Management Systems Affects Employees and Employers" (August 2008).
http://www.dir.ca.gov/chswc/Reports/ISO_9001_2008_August.pdf

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:
"Occupational Safety and Health for Public Safety Employees: Assessing the Evidence and the Implications for Public Policy" (2008).
http://www.dir.ca.gov/CHSWC/Reports/CHSWC_PublicSafetyEmployeesReport2008.pdf
For further information …
See the project synopsis in the "Projects and Studies" section.

Musculoskeletal Injuries to Firefighters in California
Status: Completed
CHSWC Report:
"The Frequency, Severity, and Economic Consequences of Musculoskeletal Injuries to Firefighters in California," RAND 2010.
http://www.dir.ca.gov/chswc/Reports/2010/FirefightersMusculoskeletal.pdf
For further information …
See the project synopsis in the "Projects and Studies" section.

OCCUPATIONAL SAFETY AND HEALTH (continued)

School Action for Safety and Health Program

Status: In process

CHSWC Report and Materials:

SASH Brochure
http://www.dir.ca.gov/chswc/SASH/Publications/SASH_brochure.pdf
SASH Flyer
http://www.dir.ca.gov/chswc/SASH/Publications/SASH_Flier.pdf
Injury and Illness Prevention Program Template
http://www.dir.ca.gov/chswc/SASH/index.htm
SASH Factsheets, Tools, Tip Sheets, Resource List, Worksheets, and IIPP Guide and Template.
http://www.dir.ca.gov/chswc/SASH/index.htm
SASH Online Resource Guide
http://www.lohp.org/docs/projects/sash/sashonlineresourceguideweb.pdf
SASH Poster
http://www.dir.ca.gov/chswc/SASH/Publications/SASH_Poster.pdf
"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.

Project: Worker Occupational Safety and Health Training and Education Program (WOSHTEP)

Status: Ongoing

CHSWC Reports and Materials:

WOSHTEP Brochure
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/WOSHTEP%20Brochures.English.2009.06.09.pdf
"2010 WOSHTEP Advisory Board Annual Report"
"2009 WOSHTEP Advisory Board Annual Report"
http://www.dir.ca.gov/Chswc/Reports/WOSHTEP-2009AdvBrdAnnualReport.pdf
"2008 WOSHTEP Advisory Board Annual Report"
http://www.dir.ca.gov/Chswc/Reports/WOSHTEP-2008AdvBrdAnnualReport.pdf
"2007 WOSHTEP Advisory Board Annual Report"
http://www.dir.ca.gov/Chswc/Reports/WOSHTEP_AnnualReport2007.pdf
"2006 WOSHTEP Advisory Board Annual Report"
http://www.dir.ca.gov/CHSWC/Reports/WOSHTEP-2006AdvBrdAnnualReport.pdf
"2005 WOSHTEP Advisory Board Annual Report"
http://www.dir.ca.gov/CHSWC/Reports/WOSHTEP-2005AdvBrdAnnualReport.pdf
"2004 WOSHTEP Advisory Board Annual Report"
http://www.dir.ca.gov/CHSWC/WOSHTEPReportNov2004.pdf
"State, National and International Safety and Health Training Program Resources" (2003)
http://www.dir.ca.gov/CHSWC/TrainingProgramsResources/Surveycover.html
"Workplace Health and Safety Worker Training Materials: An Electronic Multilingual Resource List" (July 2009).
http://www.dir.ca.gov/CHSWC/MultilingualGuide/MultilingualGuideMain.html
Heat Hazards in Agriculture: A Guide for Employers to Carry out Tailgate Training for Workers (2008).
http://www.dir.ca.gov/chswc/Reports/CHSWC_HeatAgriculturEnglish.pdf
http://www.dir.ca.gov/chswc/Reports/CHSWC_HeatAgricultureSpanish.pdf
The Whole Worker: Integrating Wellness & Occupational Health and Safety Programs
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/WOSHTEP_TheWholeWorker.pdf

OCCUPATIONAL SAFETY AND HEALTH (continued)

"WOSHTEP NEEDS ASSESSMENT REPORT: Opportunities to Integrate Worker Health and Safety Education into Building Trades Apprenticeship Programs, March 2010"
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/ApprenticeshipNeedsAssessment.pdf
NISH Occupational Health and Safety Course Flier
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/NISHGenericFlier.pdf
Awareness Session: Preventing Workplace Injuries and Illnesses
Guide – English and Spanish
http://www.dir.ca.gov/chswc/WOSHTEP/Awareness/AwarenessModuleEnglish.pdf
http://www.dir.ca.gov/chswc/WOSHTEP/Awareness/AwarenessModuleSpanish.pdf
Training Cards – English and Spanish
http://www.dir.ca.gov/chswc/WOSHTEP/Awareness/CardsEnglish.pdf
http://www.dir.ca.gov/chswc/WOSHTEP/Awareness/CardsSpanish.pdf
Small Business Health and Safety Training Materials (General) (July 2009).
http://www.dir.ca.gov/chswc/SBMRhealthandsafety.htm
Small Business Restaurant Supervisor Safety Training Materials (Industry-specific) (July 2009).
http://www.dir.ca.gov/chswc/SBMRMaterials.htm (English and Spanish)
Protecting the Safety and Health of Restaurant Workers: A Workbook for Employees – English and Spanish and Korean
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/RestaurantWorkbook.pdf
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/RestaurantTrainingGuide_Spanish.pdf
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/RestaurantWorkbook_Korean.pdf
Small Business Janitorial Health and Safety Training Materials (Industry-specific) (July 2009).
http://www.dir.ca.gov/chswc/WOSHTEP/SBMR_Janitorial.htm (English and Spanish)
Small Business Health and Safety Materials for the Dairy Industry – English and Spanish (in development)
Training Guide
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/DairyTrainingGuide.pdf
Fotonovela (Picture Book)
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/DairySafetyFotonovela.pdf
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
Teens Speak Out for Safety on the Job: Lessons from the Young Worker Leadership Academy (2008).
http://www.youngworkers.org/downloads/pdf/TeensSpeakOut.pdf

For further information …
See the project synopsis in the "Projects and Studies" section.

Workplace Wellness
Status: Completed
CHSWC Booklet and Report:
The Whole Worker: Integrating Wellness & Occupational Health and Safety Programs.
http://www.dir.ca.gov/chswc/WOSHTEP/Publications/WOSHTEP_TheWholeWorker.pdf
"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

OCCUPATIONAL SAFETY AND HEALTH (continued)

California Partnership for Young Worker Health and Safety

Status: Ongoing
CHSWC Report:
"Protecting and Educating Young Workers: Report of the California Study Group on Young Worker Health and Safety" (March 1998).
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

Review of Disability Evaluation Delays and Supplemental QME Reports

Status: Completed
CHSWC Report:
"Review of Disability Evaluation Delays and Supplemental QME Reports," June 2010.
http://www.dir.ca.gov/chswc/Reports/2010/CHSWC_DEUDelaysandSupplementalQMEReports.pdf

Report on Benefit Notices and Recommendations, July 2010

Status: Completed
CHSWC Report:
Report on Benefit Notices and Recommendations, July 2010
http://www.dir.ca.gov/chswc/Reports/2010/BenefitNoticesRecommendationspdf.pdf

Selected Indicators in Workers' Compensation

Status: Completed
*CHSWC Report*s:
"Selected Indicators in Workers' Compensation: A Report Card for California" (December 2009).
http://www.dir.ca.gov/chswc/Reports/2009/CHSWC_ReportCard2009.pdf
"Selected Indicators in Workers' Compensation: A Report Card for California" (December 2008).
http://www.dir.ca.gov/CHSWC/Reports/WC_ReportCard_Dec2008.pdf
"Selected Indicators in Workers' Compensation: A Report Card for Californians" (December 2007).
http://www.dir.ca.gov/CHSWC/Reports/WC_ReportCard_Dec2007.pdf
"Selected Indicators in Workers' Compensation: A Report Card for Californians" (December 2006).
http://www.dir.ca.gov/CHSWC/Reports/WC_ReportCard_Dec2006.pdf
"Selected Indicators in Workers' Compensation: A Report Card for Californians" (December 2005).
http://www.dir.ca.gov/CHSWC/Reports/WC_ReportCard_Dec2005.pdf

The System of Access to Benefits for Injured Employees When Employer May Not Be Insured

Status: Completed
CHSWC Report:
"Background Paper on Uninsured Employers Benefits Trust Fund" (April 2007).
http://www.dir.ca.gov/CHSWC/Reports/UEBTF-Final.pdf

WORKERS' COMPENSATION ADMINISTRATION (continued)

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_accesstofunds.pdf/

Workers' Compensation Court Management and Judicial Function Study
Status: Completed
CHSWC Reports:
"Improving Dispute Resolution for California's Injured Workers," Summary, RAND (2003).
http://www.dir.ca.gov/CHSWC/Reports/ImprovingDisputeResolution-Summary.pdf
"Improving Dispute Resolution for California's Injured Workers," Full Report, RAND (2003).
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).
"Feasibility Study Report," Gartner (2003).

Final Offer Arbitration in Determining a Permanent Disability Rating Under Labor Code 4065
Status: Completed
CHSWC Reports:
"Preliminary Evidence on the Implementation of Baseball Arbitration" (November 1999).
http://www.dir.ca.gov/chswc/BasebalArbFfinal.htm

Local Forms and Procedures – Labor Code Section 5500.3
Status: Completed
For further information …
CHSWC 1998-99 Annual Report: "Projects and Studies" section.

Profile of Division of Workers' Compensation (DWC) District Office Operations
Status: Completed
For further information …
CHSWC 1997-98 Annual Report: "Program Oversight" section.

CHSWC Roundtable on Division of Workers' Compensation (DWC) Lien Workload
Status: Completed
For further information …
CHSWC 1998-99 Annual Report: "Projects and Studies" section.

Evaluation of the DWC Audit Function
(*Special Study at the Request of the Legislature*)
Status: Completed
CHSWC Reports:
"CHSWC Report on the Workers' Compensation Audit Function" (December 1998).
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/AuditSummary Cover.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: Completed

Helping Injured Employees Return to Work: Practical Guidance Under Workers' Compensation and Disability Rights Laws in California, February 2010.
http://www.dir.ca.gov/chswc/Reports/2010/HandbookRTW_2010.pdf
"Best Practices in Returning an Injured Employee to Work: Factsheet for Employers," February 2010.
http://www.dir.ca.gov/chswc/CHSWC_FactsheetRTW_2010.pdf
"Summary of December 9, 2008 Return-to-Work/FEHA/ADA Advisory Group Meeting" (April 2009).
http://www.dir.ca.gov/chswc/Reports/2009/CHSWC_SummaryRTWFEHAADAGuidebookRoundtable2009.pdf

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
"Navigating the California Workers' Compensation System: The Injured Workers' Experience" (July 1996).
http://www.dir.ca.gov/CHSWC/navigate/navigate.html

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:

Workers' Compensation in California: A Guidebook for Injured Workers Third Edition (November 2006).
http://www.dir.ca.gov/CHSWC/Reports/WorkersCompGuidebook-3rdEd.pdf (English)
http://www.dir.ca.gov/CHSWC/Reports/GuidebookSpanishforInjuredWorkers2006.pdf (Spanish)

INFORMATION FOR WORKERS AND EMPLOYERS (continued)

"Workers Compensation Update: Predesignating a Medical Group" (March 2007).
http://www.dir.ca.gov/chswc/Reports/WorkersCompUpdateMarch2007d.pdf
"Workers Compensation Update: New Law Extends Period for Temporary Disability Payments to Injured Workers" (April 2008).
http://www.dir.ca.gov/chswc/Reports/WorkersCompUpdate-2008.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:
How to Create a Workers' Compensation Carve-Out in California: Practical Advice for Unions and Employers (2006).
http://www.dir.ca.gov/CHSWC/carve-out1.pdf

Workers' Compensation Carve-Out Guidebook
Status: Completed
CHSWC Report:
Carve-Outs: A Guidebook for Unions and Employers in Workers' Compensation (May 2004).
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: Completed
CHSWC Report:
"Working Paper: Pay-for-Performance in California's Workers' Compensation Medical Treatment System," RAND (August 2007).
http://www.dir.ca.gov/chswc/Reports/Pay_for_Performance_Report_2007.pdf

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.

MEDICAL CARE (continued)

CHSWC Study on Spinal Surgery Second-Opinion Process
Status: Completed
CHSWC Report:
"Report and Recommendations on the Spinal Surgery Second-Opinion Process" (April 2007).
http://www.dir.ca.gov/chswc/Reports/SSSOP-Final.pdf

State Disability Insurance Integration Project
Status: In process
CHSWC Draft Report:
"The Impact of Occupational Injury and Illness on Pricing an Integrated Disability Benefit" (October 2008).
http://www.dir.ca.gov/chswc/Reports/SDI_paper_final_draft_2008_Oct_29.pdf

Medical Treatment Studies
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).
http://www.dir.ca.gov/chswc/Reports/2009/FacilityServicesforAmbulatorySurgery.pdf
"Hospital Emergency Department Services Furnished Under California's Workers' Compensation Program," RAND (April 2009).
http://www.dir.ca.gov/chswc/Reports/2009/EmergencyDepartmentServices.pdf
"Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California's Workers' Compensation Program," RAND (July 2009).
http://www.dir.ca.gov/chswc/Reports/2009/RANDpaper.pdf
For further information …
See the project synopsis in the "Projects and Studies" section.

CHSWC Study on Medical Treatment Protocols
Status: Completed
CHSWC Reports:
"Evaluating Medical Treatment Guideline Sets for Injured Workers in California," RAND (April 2006).
http://www.dir.ca.gov/CHSWC/Reports/Evaluating_med_tx_guideline.pdf Full Report
"Evaluating Medical Treatment Guideline Sets for Injured Workers in California," Summary, RAND (April 2006).
http://www.dir.ca.gov/CHSWC/Reports/Eval_med_tx_guideline_summary.pdf
"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/CHSWC_Med%20Treat_Nov2004.pdf
"Estimating the Range of Savings from Introduction of Guidelines Including ACOEM" (October 2003).
http://www.dir.ca.gov/CHSWC/ACOEMGuideline.pdf

MEDICAL CARE (continued)

Health Care Organizations
Status: Completed
CHSWC Staff Report:
"A Report on Health Care Organizations (HCOs) in Workers' Compensation" (April 2006).
http://www.dir.ca.gov/CHSWC/Reports/HCO-WC-Apr2006.pdf

Repackaged Drugs Study
Status: Completed
CHSWC Issue Paper:
"Paying for Repackaged Drugs Under the California Workers' Compensation Official Medical Fee Schedule" (May 2005).
http://www.dir.ca.gov/CHSWC/WR260-1050525_Repack.pdf

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-Dispensend-Pharmaceuticals.pdf

Workers' Compensation Pharmaceutical Costs Study
Status: Completed
*CHSWC Report*s:
"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

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).
http://www.dir.ca.gov/CHSWC/WR-263.Burn050525.pdf

California Research Colloquium on Workers' Compensation Medical Benefit Delivery and Return to Work
Status: Completed
CHSWC Report:
"California Research Colloquium on Workers' Compensation Medical Benefit Delivery and Return to Work," RAND (2006).
http://www.dir.ca.gov/chswc/Reports/2009/MedBenefit_and_RTW_2006.pdf

Integrating Occupational and Non-Occupational Medical Treatment
Status: In process
For further information …
See the project synopsis in the "Projects and Studies" section.

MEDICAL CARE (continued)

Occupational and Non-Occupational Integrated Care (ONIC) Roundtables

Status: Completed
CHSWC Report:
"Summary of Occupational and Non-Occupational Integrated Care Roundtables" (December 2008).
http://www.dir.ca.gov/chswc/Reports/SummaryOandNO_ICR2008.pdf

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
"Assessment of 24-Hour Care Options for California" (2004).
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
For further information …
See the project synopsis in the "Projects and Studies" section.

Workers' Compensation Medical Billing Process

Status: Completed
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).

Workers' Compensation Medical Payment Systems

Status: Completed
CHSWC Staff Reports:
"Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, Prepared for the Honorable Richard Alarcón, Chair, California Senate Committee on Labor and Industrial Relations" (2003).
http://www.dir.ca.gov/CHSWC/CHSWC_WCMedicalPaymentSystem/CHSWC_WCMedicalPaymentSystem.pdf
"Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program," RAND (2003).
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).
http://www.dir.ca.gov/chswc/Reports/Analysis_of_proposed_WCIRB_2009_pure_premium_rates-20080923.pdf

COMMUNITY CONCERNS (continued)

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
"CHSWC Issue Paper on Public Access to Workers' Compensation Insurance Coverage Information" (April 2005).
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:
"CHSWC Issue Paper on the United States Longshore and Harbor Workers' Compensation Market in California" (April 2005).
http://www.dir.ca.gov/CHSWC/USLonghsoreAndHarborPaper.pdf

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

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
"Summary Estimating the Workers' Compensation Reform Impact on Employer Costs and Employee Benefits" (August 1999).
http://www.dir.ca.gov/CHSWC/Summary.htm
CHSWC 1998-99 Annual Report incorporates this report.

Workers' Compensation Anti-fraud Activities
Status: Completed
CHSWC/Fraud Assessment Commission (FAC) Study:
"Workers' Compensation Medical Payment Accuracy Study" (June 2008).
http://www.dir.ca.gov/chswc/Reports/2009/Navigant_Medical_Payment_Report.pdf

COMMUNITY CONCERNS (continued)

CHSWC Reports:

"Reporting Workers' Compensation Injuries in California: How Many are Missed?" (August, 2008)
http://www.dir.ca.gov/chswc/Reports/ReportingWorkersCompensationInjuriesinCalifornia2008August.pdf

"Fraud in Workers' Compensation Payroll Reporting: How Much Employer Fraud Exists? What is the Impact on Honest Employers?" (August 2007).
http://www.dir.ca.gov/chswc/Reports/Fraud_in_WC_payroll_Report_Aug_14_2007.pdf

"Split Class Codes: Evidence of Fraudulent Payroll Reporting" (August 2007).
http://www.dir.ca.gov/chswc/Reports/Split_Class_Codes_13Aug2007.pdf

"Workers' Compensation Anti-Fraud Activities – Report on the CHSWC Public Fact-Finding Hearing" (September 1997).
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

"Report on the Workers' Compensation Anti-Fraud Program" (August 2001).
http://www.dir.ca.gov/CHSWC/Finalfraudreport0801.html

Status: In process

Underground Economy Study

For further information …

See "Projects and Studies" section.

Illegally Uninsured Employers Study

Status: Completed

CHSWC Reports:

"Uninsured Employers Benefits Trust Fund," Background Paper (April 2007).
http://www.dir.ca.gov/CHSWC/Reports/UEBTF-Final.pdf

"Employers Illegally Uninsured for Workers' Compensation – CHSWC Recommendations to Identify Them and Bring Them Into Compliance" (December 1998).
http://www.dir.ca.gov/CHSWC/uefcover.html

IX. INSURANCE INDUSTRY AND COVERAGE

Insurance Insolvency Study

Status: Completed

CHSWC Report:

"California's Volatile Workers' Compensation Insurance Market: Problems and Recommendations for Change," RAND, December 2009.
http://www.dir.ca.gov/chswc/Reports/2009/InsolvencyReport.pdf

Self Insurance Groups

Status: Completed

CHSWC Reports:

"Report on Self Insurance Groups" (December 2009).
http://www.dir.ca.gov/chswc/Reports/2009/CHSWC_SIGReport.pdf

"Issue Paper on Tax Status of Self-Insured Groups (SIGs)" (April 2006).
http://www.dir.ca.gov/CHSWC/Reports/SIG-TaxStatus.pdf

INSURANCE INDUSTRY AND COVERAGE (continued)

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).
http://www.dir.ca.gov/chswc/Reports/2009/CHSWC_TrainingCertificationClaimsAdjusters.pdf
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:
" Study of the California Workers' Compensation Insurance Market Study" (September 2003).
http://www.dir.ca.gov/CHSWC/Reports/CA_InsuranceMarketStudy.pdf
"State of the California Workers' Compensation Insurance Industry," Background Paper (April 2002).
http://www.dir.ca.gov/CHSWC/StateInsuranceIndustry2002/Stateinsuranceindustry042002.html

X. CHSWC ISSUE PAPERS

Study of Labor Code Section 132a
Status: Completed
CHSWC Memorandum:
"Update on Labor Code Section 132a and Employer Termination of Health Insurance Coverage: Calif. Supreme Court Decision in *State of California, Dept of Rehab v. WCAB (Lauher)"* (July 2003).
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).
http://www.dir.ca.gov/chswc/CHSWCReport_IMCDisciplinaryrevJuly2003.doc or
http://www.dir.ca.gov/chswc/CHSWCReport_IMCDisciplinaryrevJuly2003.pdf

CHSWC White Paper on Cost/Benefit of Implementing Electronic Deposit for Unemployment and Disability Benefits in the State of California
Status: Completed
CHSWC Paper:
"CHSWC White Paper on Cost/Benefit of Implementing Electronic Deposit for Unemployment and Disability Benefits in the State of California" (November 2004).
http://www.dir.ca.gov/CHSWC/CHSWC_AccesstoFunds.pdf or
http://www.dir.ca.gov/chswc/CHSWC_Accesstofunds.doc

CHSWC ISSUE PAPERS (continued)

For further information …
See the project synopsis in the "Projects and Studies" section.

Strategic Plan
Status: Completed
CHSWC Report:
"CHSWC Strategic Plan" (November 2002).
http://www.dir.ca.gov/CHSWC/StratPlanReport2002/Stratplan2002.html

XI. DISASTER PREPAREDNESS AND TERRORISM

Impact of Terrorism on Workers' Compensation
Status: Completed
CHSWC Issue Paper:
"CHSWC Background Paper on the Impact of Terrorism and California Workers' Compensation" (April 2006).
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:
"A Report on the Forum on Catastrophe Preparedness: Partnering to Protect Workplaces" (April 2006).
http://www.dir.ca.gov/chswc/forum2006.html

XII. OTHER

Pending Final Feedback:
Liens Study Interim Briefing, June 2010
http://www.dir.ca.gov/chswc/Reports/2010/LiensStudyInterimBriefingslides.pdf
UEBTF Handbook, pending 2010
Memo to Commissioners, November 2009
http://www.dir.ca.gov/CHSWC/LaborEmployerDiscussion/Memo to Commissioners Nov 4 2009.pdf
CHSWC Staff Estimates for Labor-Employer Discussions, November 2009
http://www.dir.ca.gov/CHSWC/LaborEmployerDiscussion/CHSWC Staff Estimates for Labor-Employer Discussions.pdf
Preliminary Legislative Language for Discussion, November 2009
http://www.dir.ca.gov/CHSWC/LaborEmployerDiscussion/Preliminary Legislative Language for Discussion.pdf
"Comparing the costs of delivering medical benefits under group health and workers' compensation—Could integration pay for covering the working uninsured?" (October 2009)
http://www.dir.ca.gov/chswc/Reports/2009/Medical_Overhead_Cost_Comparision_2009.pdf

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 projects and studies, CHSWC partners with other state agencies or other organizations in areas of mutual interest. Key partnerships include the following.

Return-to-Work/FEHA/ADA Process and Handbook and Factsheet 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,* was developed and made available in February 2010. 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 employee: 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.

A Factsheet based on the handbook, **"**Best Practices in Returning an Injured Employee to Work: Factsheet for Employers," was also prepared and made available in February 2010.

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 Workers' Compensation Enforcement Collaborative (WCEC), based in Watsonville, CA, 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 (CAAA).

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. 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.

This initiative began in the Salinas, California I&A Office on June 1, 2009, and was to continue for one year before results were reviewed. However, preliminary results before the year ended were deemed positive enough to expand the pilot to a Southern California office in Anaheim.

Quality-of-Care Indicators Study
Partnership with RAND and Zenith Insurance Company

CHSWC has 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 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 hosted 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. In addition, the National Academy of Social Insurance (NASI) held a national conference in November 2009 on the issue of integration, which focused on the California example.

Forum and Study Regarding Medicare Secondary Payor
Partnership with RAND Corporation

CHSWC and RAND are partnering on a forum and study regarding Medicare secondary payor. The forum, held in September 2010, brought together parties to discuss the potential impact of Medicare set-asides. Since the early 2000s, Medicare has taken a more aggressive stance on the responsibility of insurers and self-insured employers when they settle the future medical liabilities in a workers' compensation case.

CHSWC and RAND are conducting further research and analysis on the impact of Medicare set-asides on the workers' compensation system. Study findings and recommendations will be presented in a final report.

International Forum on Disability Management 2010: *Collaborating for Success*
Partnership with the Department of Industrial Relations and the International Association of Industrial Accident Boards and Commissions

CHSWC partnered 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: *Collaborating for Success,* which was held in Los Angeles, California, September 20-22, 2010. The purpose of the Forum, which is held every two years, is to share information about disability management and to identify barriers and ways to overcome barriers in disability management systems. IFDM 2010 brought together over 400 attendees from 33 countries across the world who represent the health, safety, medical and workers' compensation communities. The diverse audience included 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 participated in the discussion.

The IFDM 2010 Advisory Committee included 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 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; Netherlands Organisation for Applied Scientific Research; RAND Corporation; Unum; Yukon Workers' Compensation Health and Safety Board; and Disability Management Employer Coalition.

More information on IFDM 2010 is available at: http://www.ifdm2010.com; www.dir.ca.gov/chswc.

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) in Northern California on June 21, 2007. 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.

The Consortium addresses 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 also solicits 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. It participated in the International Forum on Disability Management (IFDM) 2010: *Collaborating for Success*, held September 20-22, in Los Angeles.

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 RRTW Unit 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.

School Action for Safety and Health 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 model program, the School Action for Safety and Health (SASH) program, to help schools statewide improve their injury and illness prevention practices and resources. The program includes 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 focuses 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 program was developed based on a needs assessment conducted to determine the types of training and resources that would be most effective. It includes materials and resources, including an online Resource Guide and a SASH Resource Center, implementation throughout the State, and evaluation.

The IIPP template and SASH brochure and binder of materials are available on the SASH section of the CHSWC website. The binder materials include: Factsheets, Tools, Tip Sheets, Resource List, Worksheets, and IIPP Guide and template. Trainings are being offered statewide.

Workplace Wellness: How to Address Both Occupational and Lifestyle Issues on the Job
Partnership with employers of small, medium-size and large companies, labor, medical providers, and federal and state agencies

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 was developed.

The workplace wellness booklet, *The Whole Worker: Integrating Wellness & Occupational Health and Safety Programs*, 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. The booklet is available on the CHSWC website.

Small Business Health and Safety Resources

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 also been developed for the restaurant industry, the janitorial industry, and for the dairy industry.

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 (SBCTC) (with 13 member unions) and the California Apprenticeship Coordinators Association (CACA)

Union, apprenticeship and pre-apprenticeship training programs provide a potential avenue to integrate worker health and safety education. CHSWC 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 revealed opportunities to adapt construction-related health and safety materials that are currently part of the WOSHTEP curriculum for apprenticeship and pre-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.

Health and Safety on the Job for Workers with Disabilities
Partnership with NISH, The ARC in Southern California, and Pride Industries in Northern California

Materials and outreach and training based on the Worker Occupational Safety and Health (WOSH) Specialist curriculum, including a trainer-of-trainers' component, were developed for managers, supervisors and employees in sheltered workshops in California that serve and employ individuals with disabilities on: how to provide health and safety training to their workers with disabilities; and how to design and implement a successful injury and illness prevention program (IIPP) in their workplaces. This program was developed in partnership with NISH – Creating Employment Opportunities for People with Severe Disabilities, The ARC in Southern California, and Pride Industries in Northern California.

The program includes materials from the *Staying Safe at Work: Teaching Workers' with Disabilities and Health & Safety on the Job* curriculum developed in 2009 by the University of California, Berkeley Labor Occupational Health Program (LOHP) and the National Institute for Occupational Safety and Health (NIOSH).

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 partnered 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 included how to improve coordination between the two programs and better serve disabled workers. Sessions focused 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:

Write:

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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
- School Action for Safety and Health (SASH) Program

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 2010

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 Self-Insurers Association
Board Meeting

California Workers' Comp Forum
Executive Officer Briefing

California Workers' Comp Institute
46th Annual Meeting

Department of Industrial Relations
Division of Workers' Compensation
17th Annual Conference

Disability Management Employer Coalition
15th Annual Conference
Executive Officer Briefing

Fraud Assessment Commission
Employers' Fraud Task Force
Chair, Executive Officer

International Association of Industrial Accident Boards and Commissions
96th Annual Convention
Executive Committee Meeting

International Forum on Disability Management 2010
5th International Forum on Disability Management
Advisory Committee Meeting
Chair, Executive Officer

National Academy of Social Insurance
Board of Director Meeting
22nd Annual Conference

National Workers' Compensation and Disability Conference & Expo
19th Annual Conference
Executive Officer Briefing

RAND Corporation
Advisory Board Meeting
Medicare Offset Symposium

Safes Job for Youth Month
Press Conference

Workers' Compensation Research Institute
Advisory Meeting

Workers' Compensation Insurance Rating Bureau
Claims Subcommittee Meeting

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Christine Coakley, Regulatory and Legislative Analyst

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California Applicants' Attorneys Association (CAAA)
Barry Harris Hinden, President
Linda Atcherley, Past President
Mark Gerlach, Esq.

California Chamber of Commerce (CCC)
Allan Zaremberg, President and Chief Executive Officer

California Coalition on Workers' Compensation (CCWC)
Paul J. Yoder, Managing Director
Jason Schmelzer, Legislative Advocate

California Consortium to Promote Stay-at-Work-Return-to-Work
Robin Nagel, Chair

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The Honorable John A. Pérez, Speaker of the Assembly

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Employers' Fraud Task Force

International Association of Industrial Accident Boards and Commissions

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RAND Institute for Civil Justice

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State Building and Construction Trades Council of California

Workers' Compensation Insurance Rating Bureau

Members of the Public

Participants in CHSWC meetings, fact-finding hearings and public forums
Participants in CHSWC project advisory committees

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