# California Commission on Health and Safety and Workers' Compensation

## 2018 Annual Report

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# ABOUT CHSWC

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

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

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

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

CHSWC projects address several major areas, including permanent disability (PD) ratings and related benefits, State Disability Insurance (SDI), return to work, carve-outs and medical fee schedules. Additional projects address benefits, medical costs and quality, fraud and abuse, streamlining of administrative functions, information for injured workers and employers, 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 in which 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 Health-Care 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 in which 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.

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## CHSWC Members Representing Employers

### Daniel Bagan

Daniel Bagan is the West Region Risk Manager for United Parcel Service (UPS), the world's largest package delivery company and a leading global provider of specialized transportation and logistics services.

He serves on the board of the California Coalition on Workers' Compensation and is an active member of the Workers' Compensation Action Network. He is also a member of United Way's Alexis de Tocqueville Society.

Appointed by: Speaker of the Assembly

### Martin Brady

Martin Brady is executive director at Schools Insurance Authority, where he has worked since 1988.

Mr. Brady is a member of the California Joint Powers Authority, California Coalition on Workers' Compensation, Public Agency Risk Managers Association, Public School Risk Institute, Association of Governmental Risk Pools and the Public Risk Management Association.

Appointed by: Governor

## CHSWC Members Representing Employers

### Mona Garfias

Since 1998 Ms. Garfias has been director of claims at DMS Facility Services, a large unionized employer in the janitorial industry with over 1,800 employees. She started her insurance industry career 27 years ago and has held various positions involving workers' compensation claims on both the insurance carrier and insurance brokerage sides.

Ms. Garfias was instrumental in implementing the Ross Pike Memorial Workers' Compensation Carve-Out & Alternative Dispute Resolution (ADR) program and continues to be involved in this program on a daily basis.

Appointed by: Senate Rules Committee

### Sean McNally

Sean McNally is the President of KBA Engineering in Bakersfield, California. He has been certified by the State Bar of California as a specialist in workers' compensation law. He is a licensed general contractor and serves as a trustee for the Self-Insurer's Security Fund. His community activities include serving on the Board of Directors of the Golden Empire Gleaners and the Board of Trustees for Garces Memorial High School. He is the past Vice President of Corporate and Government Affairs and past Vice President of Human Resources for Grimmway Farms.

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's degrees in English and theology. Following that, he did graduate studies at Hebrew University of Jerusalem, Israel.

Appointed by: Governor

## CHSWC Members Representing Labor

### Doug Bloch

Doug Bloch has been the political director at Teamsters Joint Council 7 since 2010. He was the Port of Oakland campaign director for Change to Win from 2006 to 2010 and a senior research analyst at Service Employees International Union (SEIU) Local 1877 from 2004 to 2006.

Mr. Bloch was the statewide political director at the California Association of Community Organizations for Reform Now (ACORN) from 2003 to 2004 and ran several ACORN regional offices, including those in Seattle and Oakland, from 1999 to 2003. He was an organizer at the Non-Governmental Organization Coordinating Committee for Northeast Thailand from 1999 to 2003.

Appointed by: Governor

### Christy Bouma

Christy Bouma is President of Capitol Connection, which she joined in 2000. She was a mathematics and computer science teacher at the Hesperia Unified School District from 1989 to 1999 and an instructor at Victor Valley Community College from 1991 to 1998.

Ms. Bouma has supported the California Professional Firefighters, the California School Employees Association governmental advocacy team, the State Building and Construction Trades Council, and the Service Employees International Union on special legislative projects. She is affiliated with the Institute of Government Advocates, the Leadership California Institute, and the CompScope Advisory Committee of the Workers' Compensation Research Institute. Ms. Bouma holds a master's degree in computer science.

Appointed by: Governor

## CHSWC Members Representing Labor

### Shelley Kessler

Shelley Kessler is the Executive Secretary-Treasurer of the San Mateo County Central Labor Council, which represents 110 affiliated local unions and over 70,000 working member families. She has been at the Labor Council for 29 years, first as the political director and currently as the head of the organization. She is a 32-year member of the International Association of Machinists and Aerospace Workers as well as a vice president of the California State Labor Federation.

Ms. Kessler's experience in working on the floor at General Motors, Fremont, CA, and Westinghouse Electric, Sunnyvale, CA, compelled her to become involved in worker health and safety issues. She joined the boards of the Santa Clara Center for Occupational Safety and Health, Worksafe, and later, the advisory board of the Labor Occupational Health Program at the University of California (UC), Berkeley, in order to pursue her concerns for worker protections. Ms. Kessler holds two bachelor's degrees from Sonoma State College.

Appointed by: Speaker of the Assembly

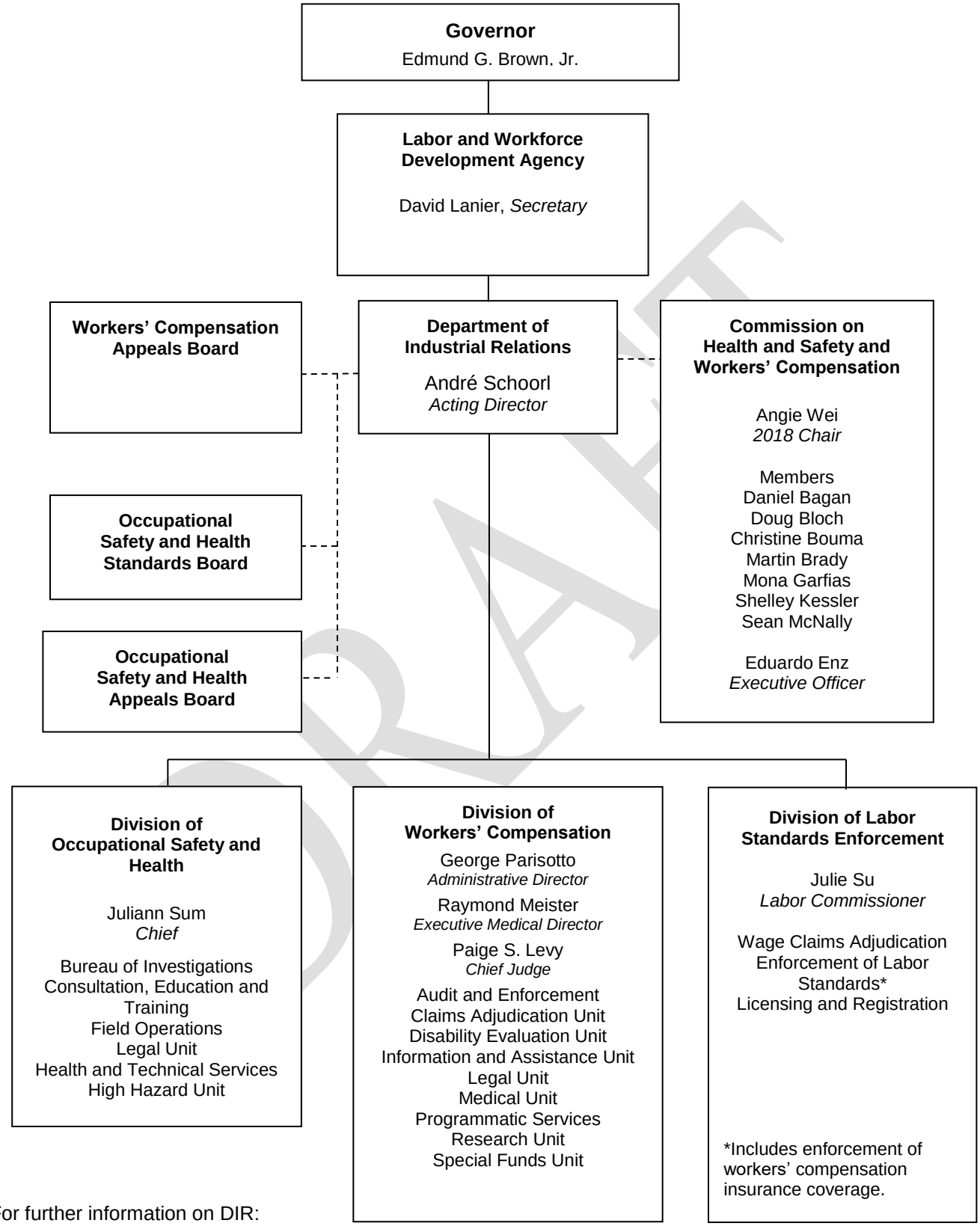
### Angie Wei

Angie Wei is the chief of staff 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 PolicyLink 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's degree in political science and Asian American studies from the University of California, Berkeley, and a master's 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




For further information on DIR:
http://www.dir.ca.gov/org_chart/org_chart.pdf.

## CHSWC RECOMMENDATIONS

The Commission on Health and Safety and Workers' Compensation (CHSWC) recommends steps to prevent workplace injuries and illnesses and to ensure the adequate and timely delivery of indemnity and medical benefits for injured workers.

### WORKERS' COMPENSATION INDEMNITY AND MEDICAL BENEFITS

Senate Bills (SB) 863 and 1160, the workers' compensation reform legislation passed in 2012 and 2016 respectively, incorporated many of CHSWC's previous recommendations for statutory improvements in the workers' compensation system. The Division of Workers' Compensation (DWC) is carrying out many of the commission's recommendations for administrative improvement.

CHSWC will continue to examine the following:

- Return to work
- Wage loss
- Access to and appropriateness and timeliness of care
- Formulary
- Fraud detection
- Friction, administrative delays, and backlogs
- Attorney interaction in the claims process
- Mechanism of injury, risk factors, and cumulative effects, including age

### RETURN-TO-WORK SUPPLEMENT

Labor Code section 139.48 requires the Department of Industrial Relations' (DIR's) program, the Return-to-Work Supplemental Program (RTWSP), to administer a $120 million fund that makes supplemental payments to workers whose permanent disability benefits are disproportionately low in comparison to their earnings losses.[1] A recent CHSWC study by RAND that evaluated the Return-to-Work Fund found a low take-up among eligible workers of the RTWSP.

*Recommendations*

- Ongoing monitoring of the use of this benefit
- Consider the recommendations of the CHSWC study by RAND "Evaluation of the Return-to-Work Fund in the California's Workers' Compensation System,"[2] which include:
    - Automating the RTWSP payment after Supplemental Job Displacement Benefit (SJDB) vouchers are issued to improve participation in the program.
    - Increasing outreach and notification to help increase participation in the RTWSP by eligible workers, such as making the RTWSP website accessible in multiple languages.

[1] http://www.dir.ca.gov/rtwsp/rtwsp.html.
[2] https://www.dir.ca.gov/chswc/meetings/2018/Eval-RTW-Fund-Report-2018.pdf.



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  - Improving the monitoring and collection of SJDB vouchers issued to track emerging changes in the RTWSP-eligible population.
- Continue to explore all methods of increasing application rates for non-represented injured workers.
- Include benefit expenditure trend data and the number of RTWSP disbursements in the CHSWC Annual Report.

## PERMANENT DISABILITY BENEFITS

Research on the impact of the 2012 workers' compensation reforms on earnings losses suggests that SB 863 is likely to meet its primary objective of restoring adequate wage replacement rates, although some inequities in these rates across impairments still exists. The research also determined for the first time that the Great Recession had a severe impact on the earnings of permanently disabled workers, making the higher benefits provided under the recent reforms particularly important for maintaining adequate levels of wage replacement. Additional recent research on wage loss monitoring found that recession impacts were felt broadly but regional and industry differences are seen in the extent of recovery.

*Recommendations*

- Consider the recommendations in the DIR study by RAND "Wage Loss Monitoring for Injured Workers in California's Workers' Compensation System,"[3] which include:
  - Continuing to monitor earnings losses and the adequacy of permanent partial disability (PPD) benefits.

## MEDICAL CARE IN WORKERS' COMPENSATION

### Monitoring Medical Care and Costs

In the past, problems in the medical-legal process included delays in selecting evaluators, obtaining examinations, and producing evaluation reports. Deficiencies also existed in the content of reports when they failed to comply with the legal standards or omitted necessary components and thus necessitated the submission of supplemental reports. These problems contributed to an increase in frictional costs and delays in resolving disputes and delivering benefits to injured workers.

Significant changes in the medical care process for injured workers have resulted from the reform legislation enacted in 2012. One change is that medical necessity disputes are now resolved using Independent Medical Review (IMR). IMR is administered by the DWC Administrative Director, and legislation requires that an injured worker's objection to a utilization review (UR) decision be resolved through IMR. An in-person qualified medical evaluator (QME) will still be used for impairment ratings in unrepresented cases and an agreed medical evaluator (AME) or QME in represented cases.

Additional reform legislation relating to medical care, Senate Bill (SB) 1160, was enacted in September 2016. Senate Bill 1160 aims to expedite medical treatment to injured workers within the first 30 days after their injury by exempting conservative treatment from UR, standardizing UR procedures, modernizing data collection in the system to improve transparency, and implementing

[3] https://www.rand.org/pubs/research_reports/RR2572.html.



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antifraud measures in the filing and collection of medical treatment liens. SB 1160 also requires the DIR to develop a system for the mandatory electronic reporting of UR decisions and the Doctor's First Report of Injury form.[4]

In October 2016, the California Legislature requested that CHSWC update a study of the QME process, first done for CHSWC by UC Berkeley in 2010. That study raised several issues about the QME process and made a number of recommendations for improving the efficiency and equity of evaluations. In 2018, the DWC posted proposed revisions to the Medical-Legal Fee Schedule on the DWC Forum and received extensive public comments.

*Recommendations*

- Continue to study the frequency, severity, and economic consequences of musculoskeletal injuries.
- Promote and support the recommendations in the CHSWC study by RAND "Evaluation of SB 863 Medical Care Reforms."
- Evaluate and monitor the overall impact of SB 1160 on medical treatment to ensure access to quality care. Alternatively: Evaluate and monitor the implementation of SB 1160 provisions.
- Provide system monitoring data on UR decisions and Doctor's First Report, after it becomes available, in the CHSWC Annual Report.
- Monitor utilization of UR and IMR in the California workers' compensation system.
- Consider conducting stakeholder meeting to discuss issues related to the QME process and revisions to the Medical-Legal Fee Schedule.

### Pharmaceuticals

Labor Code section 5307.27 requires the DWC Administrative Director to establish a drug formulary using evidence-based medicine, as part of the medical treatment utilization schedule (MTUS). The DWC formulary took effect January 1, 2018.

*Recommendations*

- Monitor and evaluate the impact of the evidence-based formulary. This should include an assessment of how the formulary affects pharmaceutical use, expenses, and access to medically appropriate care for injured workers.

- Monitor the consultation by the Pharmacy and Therapeutics (P&T) Committee in advising on updates to the MTUS formulary based on evidence of the relative safety, efficacy, and effectiveness of drugs within a class of drugs.

## ANTIFRAUD EFFORTS

### Underground Economy

Although most California businesses comply with laws regarding health, safety, and workers' compensation, some businesses do not and operate in the "underground economy." Such businesses may not have all their employees on the official company payroll or may not report

[4] http://www.dir.ca.gov/dwc/SB1160-AB1244/SB1160.htm.



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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. In addition, the underground economy costs the state economy an estimated $8.5 billion to $10 billion in tax revenues every year.[5]

*Recommendations*

- Continue to research ways to identify the underground economy and ensure compliance with workers' compensation and health and safety laws.

- Support outreach and education efforts, including publicizing the booklet "All Workers Have Rights."

**Workers' Compensation Medical Provider Fraud**

Recent criminal indictments have highlighted the extent of medical provider fraud in the workers' compensation system. Estimates of the cost of this fraud to participants in the workers' compensation system range as high as $1 billion per year. The DWC has estimated the value of liens held by providers charged with or convicted of workers' compensation fraud at $600 million.

Assembly Bill 1244, signed into law in September 2016, provides a mechanism for suspending perpetrators of fraud from the workers' compensation system and for limiting financial recovery related to fraudulent activity. In particular, Assembly Bill 1244 addresses medical fraud in the workers' compensation system by creating a new adjudication and stay process for dealing with convicted and indicted providers in the system that have medical liens.

*Recommendations*

- Monitor and evaluate the outcomes of AB 1244 reforms.
- Monitor the extent of medical provider fraud and efforts to eliminate fraud.

**Workers' Compensation Payroll Reporting by Employers**

The cost of the workers' compensation insurance premium is based on an employer's total payroll. By misreporting payroll costs, some employers avoid the higher premiums they would incur with accurate payroll reporting. Employers can also misreport the total payroll or the number of workers in specific high-risk, high-premium occupation classifications by reporting them in lower-risk, lower-premium occupations. A 2009 follow-up study to a 2007 CHSWC study found that between $15 billion and $68 billion in payroll is underreported annually. A related study on split class codes found that 25 to 30 percent of low-wage payroll is underreported or misreported.

*Recommendations*

- Consider implementing recommendations in the "Report on Anti-Fraud Efforts in the California Workers' Compensation System" to address premium fraud.

[5] http://www.edd.ca.gov/payroll_taxes/Underground_Economy_Cost.htm.

## PUBLIC SELF-INSUREDS

California law requires every employer except the State to secure payment of its workers' compensation obligations by obtaining either insurance or a certificate of consent to self-insure from the Director of DIR (the Director).

Unlike private self-insurers, public-sector employers are not required by law to post a security deposit, and no guarantee association is established by law to pay benefits to injured employees in the event that a public employer or a Joint Powers Authority defaults on its workers' compensation obligations.

SB 863 added Labor Code section 3702.4, which required CHSWC to examine the public-sector self-insured workers' compensation programs and to make recommendations for improving program administration and performance. CHSWC contracted with Bickmore to assist in fulfilling this requirement in 2014. SB 863 also added Labor Code section 3702.2, in which public self-insured employers "shall provide detailed information as the director determines necessary to evaluate the costs of administration, workers' compensation benefit expenditures, and solvency and performance of the public self-insured employers, on a schedule established by the director."

In 2016, Bickmore prepared a study for DIR to identify various data reporting elements that, after having been collected by the DIR Office of Self-Insurance Plans , would further the intent of LC 3702.2 . Specifically, the goal is to establish a database of workers' compensation information for use by public policy makers, regulators, public entities, and the service industry that supports public entity self-insurance in California.

*Recommendations*

- Monitor rulemaking progress to collect critical information on public sector claims and costs for both public sector employers and employees.
- Report on the status of public entity self-insured data reporting as discussed in the 2016 Bickmore report.

## HEALTH AND SAFETY

CHSWC recognizes that injury and illness prevention is the best way to preserve workers' earnings and to limit workers' compensation coverage cost increases for employers.

*Recommendations*

- Continue support by employers and the health and safety and workers' compensation community for the CHSWC statewide Worker Occupational Safety and Health Training and Education Program (WOSHTEP), one of CHSWC's most proactive efforts. WOSHTEP trains and educates workers, including young workers, in a wide range of workplaces and in agriculture on proven injury and illness prevention measures.
- Collaborate with DIR Communications Division to promote and extend WOSHTEP's reach to ensure effective outreach and to promote WOSHTEP messages and services, and its three regional resource centers at the University of California.
- Support ongoing partnerships and continued development of training and outreach materials designed to teach the importance of implementing the required written Injury and Illness Prevention Plan (IIPP).

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- Collaborate with the health and safety and workers' compensation community to extend the reach of CHSWC's School Action for Safety and Health Program, a model program to help schools statewide improve their injury and illness prevention practices for school employees.
- Support efforts to develop and create a California Occupational Research Agenda specific to the needs of California's workforce to prevent workplace injuries and illnesses, while recognizing the coordination made by the National Occupational Research Agenda at National Institute for Occupational Safety and Health.
- Facilitate the development of a model training curriculum for occupational safety and health training for child-care workers and employers.
- Collaborate with the Office of the Director and the Labor Occupational Health Program to develop a training program for janitorial services industry employees and employers to prevent sexual harassment and assault-related workplace injuries
- Monitor the implementation of AB 1978, which requires every janitorial business in California to register annually with the Division of Labor Standards and Enforcement (DLSE), and report on the number of registered janitorial providers in the DLSE License Registration database and the number of penalties for unregistered janitorial providers for the CHSWC Annual Report.

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# SPECIAL REPORT: 2017 LEGISLATION AND REGULATIONS ON HEALTH AND SAFETY AND WORKERS' COMPENSATION

## HEALTH and SAFETY AND WORKERS' COMPENSATION LEGISLATION

The Office of the Director of the California Department of Industrial Relations (DIR) now produces a Legislative Report, which replaces the summaries in this annual report.

The DIR Legislative Digest describes bills chaptered or vetoed during the first half of the 2017/18 Legislative Session that have some impact on the DIR.

The brief summaries do not purport to provide a complete description of the legislation or go into detail on the measures. The summaries provide a brief overview of the bills' intent.

Copies of the legislation referenced in this digest, along with information, such as legislative committee analyses, are available on the Legislative Counsel of California website at www.leginfo.legislature.ca.gov. The chaptered bills go into effect January 1, 2018, unless they contain an urgency clause, in which case they took effect immediately upon the Governor's signature. Alternatively, some measures specify their effective date.

The report is available at: http://www.dir.ca.gov/OPRL/Leg_Digest2017.pdf.

To research legislation enacted into law last year, see: http://www.dir.ca.gov/OPRL/Leg_Digest2016.pdf or for years 2015 and 2014 insert the desired year in the URL.

For earlier years, see CHSWC annual reports for prior years at:
http://www.dir.ca.gov/chswc/AnnualReportpage1.html.

## HEALTH AND SAFETY AND WORKERS' COMPENSATION REGULATIONS

### Health and Safety Regulations

The regulatory activities of the Occupational Safety and Health Standards Board (OSHSB) and any Division of Occupational Safety and Health (DOSH) regulations are available online as noted below. Formal rulemaking is preceded by a notice, the release of a draft rule, and an announcement for a public hearing.

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

Proposed OSHSB standards and rulemaking updates are at:
http://www.dir.ca.gov/OSHSB/proposedregulations.html.

Approved Division of Occupational Safety and Health (DOSH) regulations are at:
http://www.dir.ca.gov/dosh/rulemaking/dosh_rulemaking_approved.html.

Proposed Division of Occupational Safety and Health (DOSH) regulations are at:
http://www.dir.ca.gov/dosh/doshreg/mainregs.html.

Regulations in Title 8 of the California Code of Regulations (CCR) are 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.

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Under CCR, Title 8, Chapter 3.2, DOSH promulgates regulations for the administration of the safety and health inspection program, such as posting, certification, and registration requirements. Under CCR, Title 8, Chapter 4, OSHSB promulgates health and safety orders organized by industry, process, and equipment in subchapters, which are then enforced by DOSH.

**Workers' Compensation Regulations**

The regulatory activities of the Division of Workers' Compensation (DWC) to implement the provisions of the recent workers' compensation reform legislation can be found online. 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. Older regulations can be found on the DWC rulemaking page or 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.

DWC Approved Regulations 2017 are available at:
http://www.dir.ca.gov/dwc/rulemaking/dwc_rulemaking_approved.html.

DWC Proposed Regulations 2017 are available at:
http://www.dir.ca.gov/dwc/rulemaking/dwc_rulemaking_proposed.html.

**Administration of Self Insurance Plans Regulations**

Any regulatory activities of the Office of Self Insurance Plans (OSIP) are discussed on the pages listed below.

Proposed OSIP regulations are at:
http://www.dir.ca.gov/osip/siprule.html.

Approved OSIP regulations are at:
http://www.dir.ca.gov/osip/rulemaking/osip_rulemaking_approved.html.

Regulations in Title 8 of the California Code of Regulations (CCR) are at:
https://www.dir.ca.gov/osip/lawsandregs.htm.

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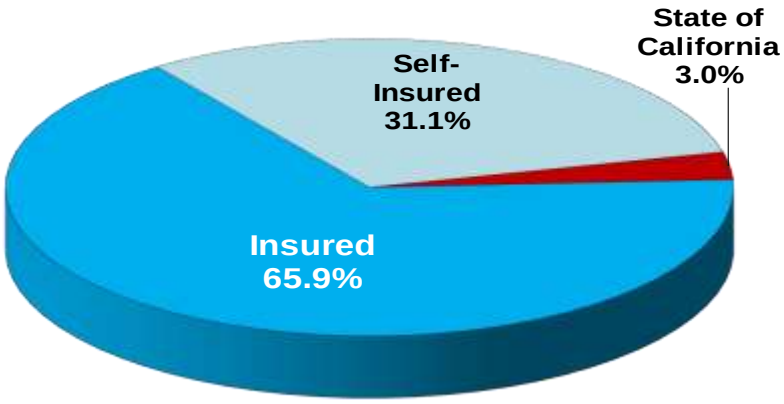
## SYSTEM COSTS AND BENEFITS OVERVIEW

The California workers' compensation system covers 16,471,000 employees[6] working for over 993,387 employers[7] in the State. These employees and employers generated a gross domestic product of $2,746,873,000,000 ($2.7 trillion) in 2017.[8] A total of 670,301 occupational injuries and illnesses were reported for 2017,[9] ranging from minor medical treatment cases to catastrophic injuries and deaths. The total paid cost to employers for workers' compensation in 2017 was $25.1 billion. (See the box "Systemwide Cost: Paid Dollars for 2017 Calendar Year" on page 18.)

Employers range from small businesses with 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. According to Figure 1, based on the claim counts reported to the Workers' Compensation Information System (WCIS), 65.9 percent of injuries occur to employees of insured employers, 31.1 percent of injuries occur to employees of self-insured employers, and 3.0 percent of injuries occur to employees of the State of California.[10] (For calculations based on claim counts and paid loss data, see the box "Method of Estimating the Workers' Compensation System Size" on pp. 16-17.)

**Figure 1: Market Shares Based on Claim Counts Reported to WCIS (2015-2017 average)**




Data Source: DWC - WCIS

[6] NASI Report: Workers' Compensation: Benefits, Costs, and Coverage, 2016. October, 2018. https://www.nasi.org/sites/default/files/WorkersComp2016_FINAL.pdf.

[7] CHSWC estimates are based on an Employment Development Department report, as above, showing 1,538,815 businesses in 2017. Of these, 1,090,856 were businesses with 0 to 4 employees. For this estimate, half of those businesses are assumed to have no employees subject to workers' compensation. 1,538,815– (1,090,856/2) = 993,387. http://www.labormarketinfo.edd.ca.gov/LMID/Size_of_Business_Data_for_CA.html.

[8] California Department of Finance, Economic Research Unit, http://www.dof.ca.gov/Forecasting/Economics/Indicators/Gross_State_Product/.

[9] 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, "FROI and SROI Data Summary, by Year of Injury" June 11, 2018, https://www.dir.ca.gov/dwc/wcis/WCIS_tables/TABLE9-14/2017/Table-9.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.

[10] WCIS, Table 4, "Workers' Compensation Claims by Market Share," June 11, 2018, https://www.dir.ca.gov/dwc/wcis/WCIS_tables/Table-4/WCIS_Reports-Table-4.html.

**Method of Estimating the Workers' Compensation System Size**

The overall system size for 2017 is estimated at 1.52 times the insured sector size. This multiplier is based on claims counts in the Workers' Compensation Information System (WCIS).[1] CHSWC is using a three-year moving average of WCIS claim counts available since 2000 because it blunts the effect of one-time aberrations. Annualy revised estimate of the multiplier is based on updated claims data provided by WCIS as well as updated paid loss amounts from the Workers' Compensation Rating Bureau (WCIRB), the Office of Self-Insured Plans (OSIP), and the California Department of Human Resources (CDHR) in order to examine and substantiate its accuracy.

The number of claims for all sectors increased by 8.8 percent from 614,800 claims in 2012 to 668,987 claims in 2017. The market share of the insured sector ranged from a three-year moving average of 65.3 in 2012-2014 to 65.9 percent from 2015-2017. The market share of the self-insured sector was within the average of 31.1 to 31.3 percent from 2012 through 2017 and the three-year moving average share of the State of California steadily decreased from 3.6 percent in 2012 to 2014 to the average of 3.0 percent in 2015 through 2017. In 2017, the three-year average market shares based on claims counts were 65.9 percent insured, 31.1 percent self-insured, and 3.0 percent state. Using these values, the multiplier for extending the insured sector information to the overall system is 100%/65.9% = 1.52.

**Table 1: Workers' Compensation Claims (in 000s) by Market Share**

| | Insured | | Self-Insured | | State of California | |
|---|---|---|---|---|---|---|
| Year | Number | Market Share (%) | Number | Market Share (%) | Number | Market Share (%) |
| 2015 | 422.2 | 65.7 | 200.7 | 31.2 | 20.2 | 3.1 |
| 2016 | 427.2 | 65.6 | 204.7 | 31.4 | 19.5 | 3.0 |
| 2017 | 444.5 | 66.4 | 205.8 | 30.8 | 18.7 | 2.8 |
| **Average for 3 years** | | **65.9** | | **31.1** | | **3.0** |

Source: WCIS.

[1] WCIS Database as of June 11, 2018, https://www.dir.ca.gov/dwc/wcis/WCIS_tables/Table-4/WCIS_Reports-Table-4.html

**(continued on the next page)**

(**continued)**

**Method of Estimating the Workers' Compensation System Size**

Based on the convergence of market share measurements from two independent methods, the data convincingly demonstrate that the insured market share is 66-68 percent of the workers' compensation system. Depending on the method of measurement, the self-insured sector is 29-31 percent and the State sector is 3 or 4 percent.

Paid loss data indicate that 67.0 percent of the market is insured, 29.4 percent is self-insured, and 3.6 percent is State. These percentages are stable using 2017 data for the insured and private self-insured sectors and either 2016/2017 or 2017/2018 data for the State and public self-insured sector, as shown in Tables 2 and 3. The multiplier for extending insured sector information to the overall system is 100%/67.0% = 1.49 (is in the ballpark of estimated 1.52 based on claim counts).

**Table 2: Distribution of Workers' Compensation Paid Costs by Sectors (excluding Administrative Expenses)—using public self-insured and state data for FY 2017-2018**

| | Indemnity | Medical | Subtotal | % in Total |
|---|---|---|---|---|
| a. Private Self-Insured[1] (2017) | $614,499,454 | $765,002,435 | | |
| b. Public Self-Insured[2] (2017/2018) | $1,214,375,072 | $1,119,293,067 | | |
| **SELF-INSURANCE PLAN (a + b)** | $1,828,874,526 | $1,884,295,502 | **$3,713,170,028** | **29.4%** |
| **INSURED (2017)**[3] | $3,713,690,000 | $4,741,638,000 | **$8,455,328,000** | **67.0%** |
| **STATE (2017/2018)**[4] | $207,641,833 | $257, 864,472 | **$465,506,305** | **3.6%** |
| **Total** | | | **$12,634,004,333** | |

**Table 3: Percent Distribution of Workers' Compensation Paid Costs by Sectors (excluding Administrative Expenses)—using public self-insured and state data for FY 2016-2017**

| | Indemnity | Medical | Subtotal | % in Total |
|---|---|---|---|---|
| a. Private Self-Insured[1] (2016) | $625,387,071 | $787,771,330 | | |
| b. Public Self-Insured[2] (2016/2017) | $1,143,822,475 | $1,046,637,539 | | |
| **SELF-INSURANCE PLAN (a + b)** | $1,769,209,546 | $1,834,408,869 | **$3,603,618,415** | **28.9%** |
| **INSURED (2016)**[3] | $3,594,618,000 | $4,827,928,000 | **$8,422,546,000** | **67.6%** |
| **STATE (2016/2017)**[4] | $185,436,945 | $247,684,621 | **$433,121,566** | **3.5%** |
| **Total** | | | **$12,459,285,981** | |

[1] Private Statewide Summary, http://www.dir.ca.gov/osip/StatewideTotals.html.
[2] Public Statewide Summary, http://www.dir.ca.gov/osip/StatewideTotals.html.
[3] WCIRB, 2017 Losses and Expenses Report, Exhibit 18.1, Released June 26, 2018. https://www.wcirb.com/sites/default/files/documents/2017_ca_wc_losses_and_expenses_report.pdf
[4] Cost Information, http://www.calhr.ca.gov/employees/Pages/workers-compensation-program.aspx.

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 Tables 4 and 5. These figures are based on insurer-paid amounts multiplied by 1.52 to include estimated amounts paid by self-insured employers and the State.

**Systemwide Cost: Paid Dollars for 2017 Calendar Year**

**Table 4: A Claim Counts-Based Estimate of Workers' Compensation System Size (Million $)**

| | ***Insured*** | ***Self-Insured and the State**** | ***All Employers*** |
|---|---|---|---|
| Indemnity* | $3,714 | $1,931 | $5,177 |
| Medical* | $4,742 | $2,466 | $7,552 |
| Changes to Total Reserves | $1,165 | $606 | $4,437 |
| Insurer Pre-Tax Underwriting Profit/Loss | $1,478 | N/A | $1,478 |
| Expenses (see Table 5 below: Breakdown of Expenses) | $6,729 | $2,240 | $8,969 |
| **TOTAL for 2017** | $17,828 | $7,243 | **$25,071** |

*Include CIGA payments

Source for Insured figures in Tables 4 and 5 is WCIRB Losses and Expenses report released on June 26, 2018. Self-insured and state expenses are calculated by CHSWC using 0.52 multiplier for equivalent cost components. The equivalent expense components are estimated as in the Table 5:

**Table 5: Breakdown of Expenses (Million $)**

| | *Insured* | *Self-Insured and State* | *All Employers* |
|---|---|---|---|
| *Loss Adjustment Expense* | $3,338 | $1,736 | $5,074 |
| *Commissions and Brokerage* | $1,399 | N/A | $1,399 |
| *Other Acquisition Expenses* | $674 | N/A | $674 |
| *General Expenses* | $970 | $504 | $1,474 |
| *Premium and Other Taxes* | $348 | N/A | $348 |
| ***Total*** | $6,729 | $2,240 | **$8,969** |

**Estimate of Workers' Compensation System Size Based on Written Premium**

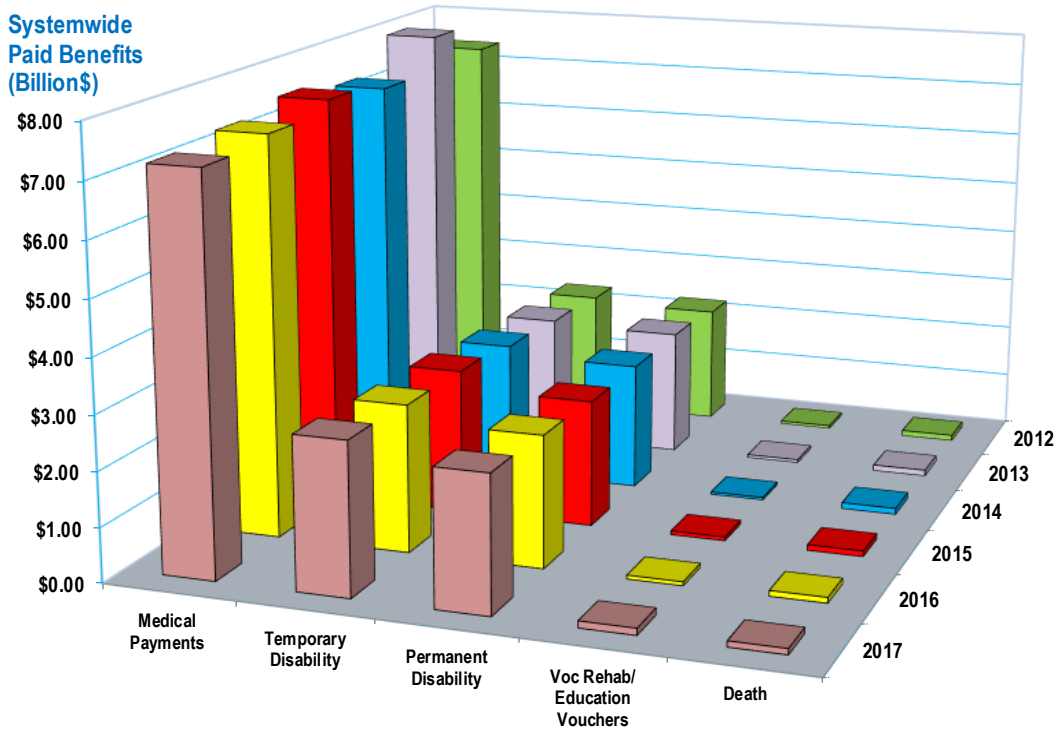
Another way to calculate systemwide costs for employers is by using written premium.

Written premium for insured employers = $17.7 billion in calendar year 2017.[11]

$17.7 billion * 1.52 = $26.9 billion systemwide costs for employers.

[11] WCIRB Report as of December 31, 2017, Insurer Experience, released July, 2018.

**Figure 2: Systemwide Paid Benefits, by Year and Type of Payment (Billion $)**




* System-wide amounts estimated at 1.52 times the amounts reported by insurers

Data Source: WCIRB

### 2012 Workers' Compensation Reforms: Changes in the California System

California made significant legislative reforms in the workers' compensation system with the enactment of Senate Bill (SB) 863 in September 2012. The goal of the reform was to improve benefits for injured workers while reducing costs. SB 863 generally makes changes in: the measurement of permanent disability; the compensation for permanent disability; the physician fee schedule; the process to resolve disputes over appropriate medical treatment, medical fees, and billing and collections; the means of ensuring self-insurance program solvency and the methods of securing the payment of compensation by self-insurance; and other aspects of the workers' compensation system.

Many of the provisions of SB 863 were supported by CHSWC research and recommendations. For a summary of the key provisions of the reforms, see the "Special Report: 2012 Workers' Compensation Reforms" in the 2012 CHSWC Annual Report. For a summary of past reforms, see the "System Costs and Benefits Overview" section in the 2011 CHSWC Annual Report.

The Workers' Compensation Insurance Rating Bureau's (WCIRB's) prospective evaluation of SB 863 indicated significant savings because of the reforms. The WCIRB's estimates in its retrospective evaluation of SB 863 indicate total annual statewide savings of $1.34 billion, an increase of $1.14 billion over the previous projected estimates of $200 million.[12] IMR, IBR, and other SB 863 medical reforms have resulted in over $1 billion in annual savings.

[12] Senate Bill No. 863 WCIRB Cost Monitoring Report—2016 Retrospective Evaluation http://www.wcirb.com/sites/default/files/documents/sb_863_cost_monitoring_report_2016.pdf and WCIRB 2018 report on California's Workers' Compensation System https://www.wcirb.com/sites/default/files/documents/2018_state_of_the_system_report_0.pdf

Table 6, reproduced from WCIRB's November 2016 evaluation, summarizes WCIRB's estimates using various cost categories.

**Table 6: WCIRB's November 2016 Evaluation of Senate Bill (SB) 863 Cost Impact ***

| November 2016 Evaluation of SB 863 Cost Impact | | | | | |
|---|---|---|---|---|---|
| | **WCIRB Prospective Evaluation** | | **November 2016 Retrospective Evaluation** | | |
| | **Total Cost Impact ($ millions)** | **Total % Impact** | **General Impact on Cost Savings**** | **Updated Cost Impact ($ millions)** | **Updated Total % Impact** |
| **Indemnity Cost Components** | | | | | |
| Changes to Weekly PD Min & Max | +$650 | +3.4% | = | +$650 | +3.4% |
| SJDB Benefits | ($10) | -0.1% | **-** | **+$20** | +0.1% |
| Replacement of FEC Factor | +$550 | +2.9% | = | +$550 | +2.9% |
| Elimination of PD Add-ons | ($170) | -0.9% | = | ($170) | -0.9% |
| Three-Tiered Weekly PD Benefits | ($100) | -0.5% | = | ($100) | -0.5% |
| Ogilvie Decision | ($210) | -1.1% | **-** | ($130) | -0.7% |
| **Med and LAE Cost Components** | | | | | |
| Liens | ($480) | -2.5% | = | ($480) | -2.5% |
| Surgical Implant Hardware | ($110) | -0.6% | + | ($110) | -0.6% |
| ASC Fees | ($80) | -0.4% | = | ($80) | -0.4% |
| IMR—Impact of Frictional Costs | ($180) | -0.9% | **-** | **+$70** | +0.4% |
| IMR—Impact of TD Duration | ($210) | -1.1% | **-** | **$0** | 0.0% |
| MPN Strengthening | ($190) | -1.0% | = | ($190) | -1.0% |
| IBR | N/A | N/A | **+** | __ | __ |
| RBRVS Fee Schedule | +$340 | +1.8% | + | **($330)** | -1.7% |
| Indemnity Claim Frequency | Small Increase | __ | = | __ | __ |
| Indemnity Severities (Incl. Trend) | Increases | __ | = | __ | __ |
| Medical Severities (Incl. Trend) | Increases | __ | + | **($1,040)** | -5.5% |
| ALAE and ULAE Severities | Signif. Decline | __ | **-** | __ | __ |
| **TOTAL ESTIMATE—ALL ITEMS** | **($200)** | **-1.1%** | | **($1,340)** | **-7.1%** |

Data Source: WCIRB

* Senate Bill No. 863 WCIRB Cost Monitoring Report—2016 Retrospective Evaluation (Table 1, p. 4). http://www.wcirb.com/sites/default/files/documents/sb_863_cost_monitoring_report_2016.pdf.

** A "+" implies additional savings above those prospectively estimated by the WCRIB, a "--" implies less savings (or additional costs), and a "=" implies savings (or cost) estimates generally consistent with prospective estimates.

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**2015 Workers' Compensation Reforms: Medical Treatment Utilization Schedule (MTUS) and the Drug Formulary (AB 1124)**

AB 1124 required the Administrative Director (AD) of the DWC to establish an evidence-based drug formulary and to update the formulary on at least a quarterly basis to allow for the provision of all appropriate medications, including those that are new to the market. The MTUS Drug Formulary has three essential parts: the ACOEM Treatment Guidelines which are the backbone of the formulary, the MTUS Drug List, which guides prospective review requirements, and the Ancillary Formulary Rules. The MTUS Drug List is not a standalone document and must be used in conjunction with the adopted American College of Occupational and Environmental Medicine (ACOEM) guidelines.[13] The formulary regulations went into effect January 1, 2018, and the actual impacts of implementing the drug formulary will be monitored. According to the WCIRB, the formulary is estimated over time to save about $100 million per year.[14]

**2016 Workers' Compensation Reforms: Fortifying the Anti-Fraud Changes Regarding Liens (AB 1244 and SB 1160)**

SB 863 made changes regarding liens filed against an injured workers' claim, for medical treatment and other services provided in connection with the claim, but not paid for by the employer or insurance carrier. In particular, a filing fee of $150 was required for all liens filed after January 1, 2013, and a $100 activation fee was required for liens filed before then, but activated for a conference or trial after January 1, 2013. There were also provisions for **dismissal of liens** by operation of law after January 1, 2014, if no filing or activation fee has been filed, as well as an 18-month statute of limitations for filing liens for services rendered after July 1, 2013, and a three-year statute of limitations for services provided before then.

After a delay because of court challenges to a related section of the law, the workers' compensation community in particular, district attorneys offices throughout California, especially in San Diego and Los Angeles, realized that suspicious medical bills were still being filed and paid as liens by providers who had ongoing adverse involvement with the criminal justice system and their practice. In 2016, AB 1244 (Gray)[15] passed into law and required the Administrative Director of the DWC to suspend any medical provider, physician, or practitioner from participating in the workers' compensation system in any capacity if the individual or entity meets specific criteria related to fraud. Those criteria include being convicted of a felony or misdemeanor: (1) involving fraud or abuse of the Medi-Cal, Medicare, or workers' compensation systems; (2) relating to patient care; (3) involving fraud or abuse of any patient; or (4) otherwise substantially related to the qualifications and duties of the provider. The medical provider could also be suspended if his or her license, certificate, or approval to provide health care has been surrendered or revoked, or that individual or entity is suspended from participation in the Medicare or Medicaid programs because of fraud or abuse. The bill enabled the barring of a medical provider from submitting or pursuing claims for payment for services or supplies provided, if that provider had been suspended from participation in the workers' compensation system. AB 1244 also made changes in Labor Code section 4906 related to the Attorney Fee Disclosure Statement, including requirements to ensure that the injured worker is informed of the specific district office location at which the injured worker's case will be filed.[16]

Until the passage of SB 1160, fraudulent medical providers could claim no knowledge of billing fraud, citing errors by their office staff as the reason for the fraud. In 2016, SB 1160 (Mendoza)[17] required the medical provider to sign a declaration under penalty of perjury stating that the lien is not subject to independent medical review or independent billing review, and that the lien claimant is submitting a legitimate bill for services rendered. SB 1160 also added section 4615 to the Labor Code, which automatically stays any lien filed by or on behalf of a medical treatment provider who has been criminally charged with an offense involving fraud against the workers' compensation system, medical billing fraud, insurance fraud or fraud

[13] https://www.dir.ca.gov/dwc/MTUS/MTUS-Webinar-Transcript-Nov2017.pdf
[14] https://www.wcirb.com/sites/default/files/documents/2018_state_of_the_system_report_0.pdf
[15] http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1244
[16] https://www.dir.ca.gov/dwc/SB1160-AB1244/AB1244.htm
[17] http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1160

against the Medicare or Medi-Cal programs. SB 1160 also required all lien claimants to file an original bill with their lien.

Leading up to these reforms, CHSWC helped to convene and co-chaired a series of working group roundtable meetings addressing fraud in the workers' compensation system with multiple stakeholders. Many of the recommendations for statutory improvements from these sessions were incorporated into the SB 1160 and AB 1244 anti-fraud reforms signed into law in September 2016.[18] According to the WCIRB, the anti-fraud reforms in addition to SB 863 provisions related to lien filings have been key contributing factors in the decrease in medical severity over the past several years.[19]

**2016 Workers' Compensation Reforms: Utilization Review (SB 1160)[20]**

In addition to anti-fraud provisions regarding liens, SB 1160 also addresses utilization review (UR). SB 1160 reduces UR requirements in the first 30 days following a work-related injury. Commencing July 1, 2018, SB 1160 requires each UR process to be accredited by an independent, nonprofit organization to certify that the UR process meets specified criteria, including, but not limited to, timeliness in issuing a UR decision, the scope of medical material used in issuing a UR decision, and requiring a policy preventing financial incentives to doctors and other providers based on the UR decision. It also mandates electronic reporting of UR data by claims administrators to the DWC, which will enable the division to monitor claim processes and address problems. DWC has posted the utilization review regulations on its forum for public comment in December 2018.[21]

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[18] https://www.dir.ca.gov/fraud_prevention/fraud-white-paper.pdf

[19] WCIRB 2018 report on California's Workers' Compensation System https://www.wcirb.com/sites/default/files/documents/2018_state_of_the_system_report_0.pdf

[20] https://www.dir.ca.gov/dwc/SB1160-AB1244/SB1160.htm; https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1160

[21] https://www.dir.ca.gov/dwc/DWCWCABForum/UR-Regulations.htm

**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 are discussed in the following pages, and the loss and expense analysis for insurers appears later in this section.

***Costs Paid by Insured Employers***

In 2017, workers' compensation insurers' earned premium totaled $17.7 billion paid by California employers.[22]

In the past fifteen years, the cost of workers' compensation insurance in California has undergone dramatic changes due to number of factors.

The 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.

These reforms reduced workers' compensation costs in California, but the cost of insurance began to increase again after 2009. However, the cost of $2.38 per $100 of payroll in the first three months of 2018 was still 62 percent below the second half of 2003 peak of $6.29 per $100 of payroll and 20 percent below the second peak in 2014.[23]

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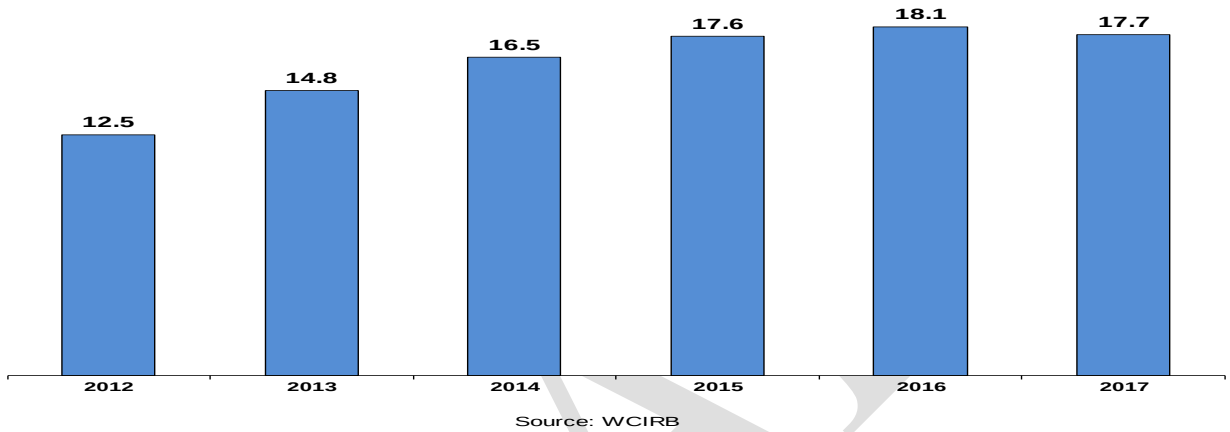
[22] "2017 California's Workers' Compensation Losses and Expenses." WCIRB—June 26, 2018. Note that earned premium is not identical to written premium. The two measurements are related, and the choice of which measurement to use depends on the purpose.
[23] WCIRB Report on March 31, 2018, Insurer Experience, released April, 2018, Chart 2.

*Workers' Compensation Written Premium*

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

As shown in Figure 3, written premium increased by 45 percent from 2012 through 2016 and then experienced a 2 percent decline from 2016 to 2017. The decrease in 2017 following 5 consecutive years of increases is primarily driven by decreases in insurer charged rates, as shown in Figure 4.

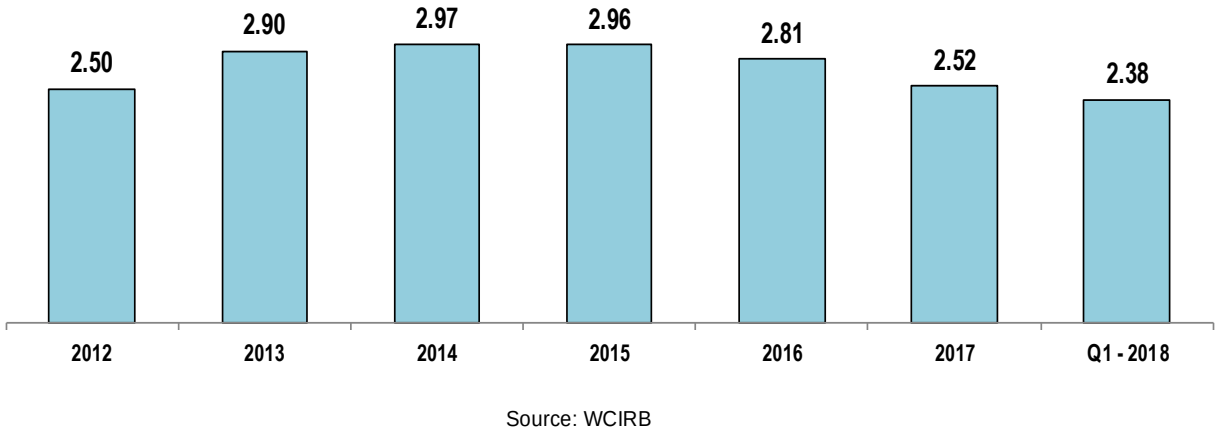
**Figure 3: Workers' Compensation Written Premium, Gross of Deductable Credits as of March 31, 2018 (Billion $)**




*Workers' Compensation Average Premium Rate*

Figure 4 shows the average charged premium rate per $100 of payroll. The average rose by 19 percent from 2012 to its peak in 2014 and then decreased by 20 percent from 2014 to 2017. The average charged rates for the first 3 months of 2018 are 6 percent below those for 2017. The July 1, 2018 approved advisory pure premium rates are on average 37 percent below those for January 1, 2015.[24] According to WCIRB this decrease is due largely to the significant SB 863 savings.[25]

**Figure 4: Average Charged Workers' Compensation Insurer Rate per $100 of Payroll as of March 31, 2018 (Dollar $)**

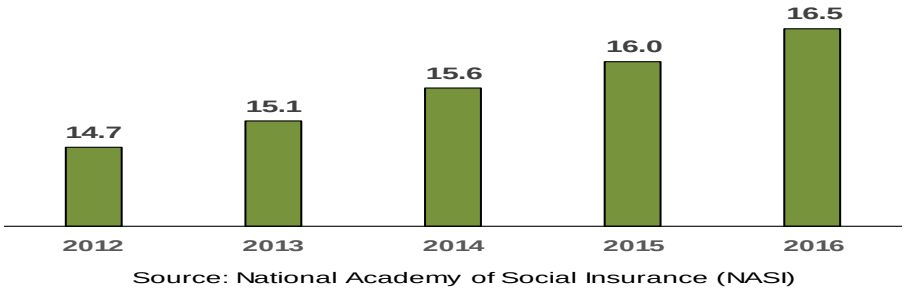



[24] https://www.wcirb.com/sites/default/files/documents/quarterly_experience_report_q1_2018.pdf
[25] WCIRB 2018 report on California's Workers' Compensation System https://www.wcirb.com/sites/default/files/documents/2018_state_of_the_system_report_0.pdf

*Workers Covered by Workers' Compensation Insurance*

The estimated number of California workers covered by workers' compensation insurance grew by 12 percent from 14.7 million in 2012 to 16.5 million in 2016.[26]

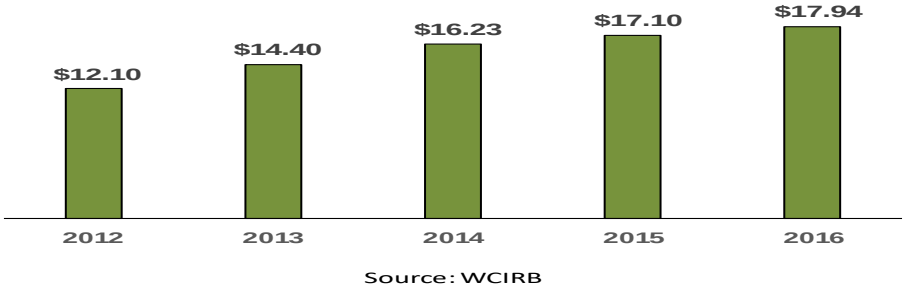
**Figure 5: Estimated Number of Workers Covered by Workers' Compensation Insurance in California (Millions)**




*Total Earned Premium*

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

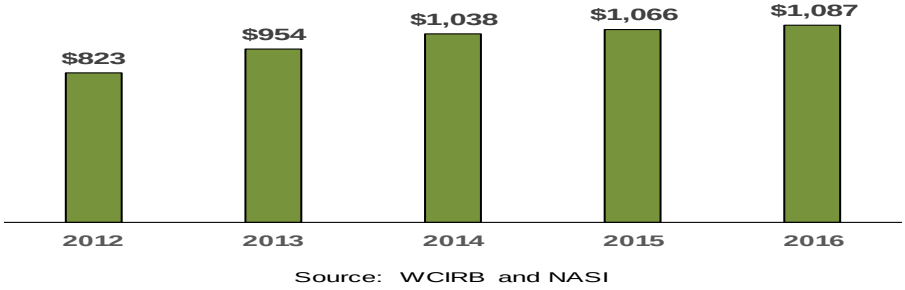
**Figure 6: Workers' Compensation Earned Premium (Billion $)**




*Average Earned Premium per Covered Worker*

As shown in Figure 7, the average earned premium per covered worker increased by 26 percent from 2012 to 2014 and then increased slightly by 5 percent from 2014 to 2016.

**Figure 7: Average Earned Premium per Covered Worker**




[26] Latest available data in 2018 from NASI Report: Workers' Compensation Benefits, Coverage, and Costs, 2016. October 2018. https://www.nasi.org/sites/default/files/WorkersComp2016_FINAL.pdf.

***Costs Paid by Self-Insured Private and Public Employers***

The permissible alternatives to insurance are private self-insurance, public self-insurance for government entities either individually or in joint power authorities (JPAs), and legally uninsured State government.

The Office of Self-Insurance Plans (OSIP) is a program within the Department of Industrial Relations (DIR) Director's Office responsible for the oversight, regulation, and administration of the workers' compensation self-insurance marketplace in California. The self-insurance marketplace consists of more than 9,849 employers, employing more than 4 million workers, with a total payroll exceeding $218 billion. One out of every four California workers is covered by self-insured workers' compensation.

During 2014, OSIP continued to expand on its many initiatives from the previous year designed to streamline its operations, reduce fees to California employers, and increase its accountability, transparency, and commitment to provide the public with a high level of responsive customer service. An example of this was the year-long project to expand a successful E-Filing platform enabling self-insured employers and actuaries to electronically file their required employer's actuarial and financial report. In 2015, OSIP worked on further improving e-filing to make it even easier to file an employer's Annual Report.

Another significant accomplishment was the development and implementation of a streamlined process for California employers who wish to become self-insured to accomplish this process in a "speed-of-business" manner. In 2011, the total time required to complete the private self-insured application process and be issued a certificate of authority to self-insure was nearly nine months. In 2012, this was shortened to four to six months, with additional reductions during 2013 to less than 30 days. In 2014, OSIP successfully worked with private employers and completed this process consistently in less than 14 days. In April 2014, OSIP was able to facilitate and complete this process for a major California employer with more than $1 billion in revenues and over 26,000 employees in just nine days.

OSIP was able to achieve these and many other significant accomplishments during 2015 while conserving expenditures, saving 40 percent in its FY 2015-2016 budget.

In 2016, OSIP moved to a more client-oriented culture, in which each employer had one main contact person for all questions and needs. This led to further efficiency and better communication between the stakeholders and OSIP. OSIP continued to realize the savings of the previous few years.

The focus in 2016 and 2017 was two major projects. Enhancements to the E-filing enhancement were rolled out in mid-2017; OSIP has received numerous compliments on the changes made. The regulations changed the requirements on being self-insured from a net worth requirement to a credit-based requirement. This modern approach allows mid-size companies to become self-insured.

In 2017 and 2018, the two-phase audit process was improved. In previous years, the audit supervisors conducted the first phase, which included a general review of the profile, liabilities, and previous audit performance of employers subject to the three-year routine audit. Employers who fail to meet specific criteria are identified for the second-phase field audit. In 2017 and 2018, the responsibilities for the first-phase audit were moved from the audit supervisor to office staff, with a designated office analyst who coordinates the results from the first-phase audit with the audit supervisor who, in turn, made the decisions on which employers would be subject to the field audit. The change enabled the audit supervisor and the senior compliance officer to have more time to focus on more complicated audits and issues that surface.

The benefits of changes made in previous years were realized in 2018. The credit-based requirement is starting to attract more employers to be self-insured. As employers become more familiar with their main contact person, they are more comfortable asking questions and interacting with OSIP. In 2017 and 2018, OSIP focused on drafting regulations to understand the solvency, performance, and costs of public self-insurers' workers' compensation programs. The regulations were issued for public comments in December 2018.[27]

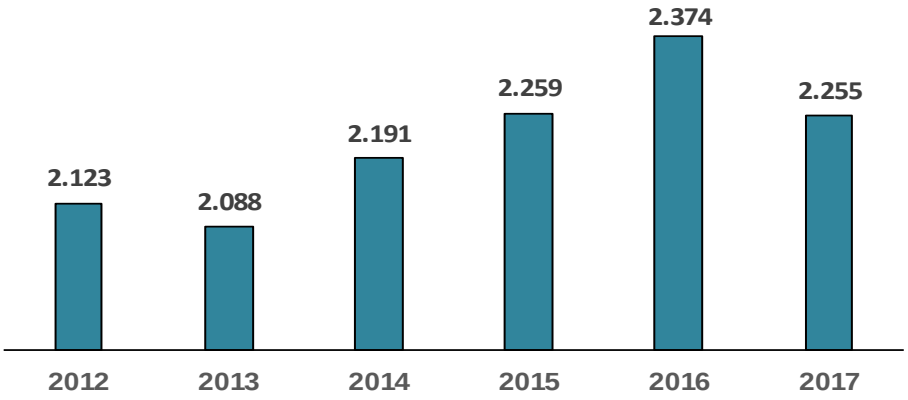
[27] https://www.dir.ca.gov/osip/rulemaking/osip_rulemaking_proposed.html

Part of the cost of workers' compensation for self-insured employers can be estimated using the amount of benefits paid in a given year and changes in reserves. This method is similar to an analysis done by the insurance industry, but the data are less comprehensive for self-insured employers than for insurers. The most complete estimate of the cost to self-insured employers is still obtained by calculating a multiple of the cost to insured employers, excluding the cost elements that apply only to insurance. Using this method yields a multiplier of 0.52 and an estimated cost to self-insured employers and the State for 2017 of $7.2 billion (see the box "Systemwide Cost: Paid Dollars for 2017 Calendar Year" on p.18).

Private Self-Insured Employers[28]

*Number of Employees.* Figure 8 shows the number of employees working for private self-insured employers between 2012 and 2016. A number of factors may affect the year-to-year changes. One striking comparison is 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.

**Figure 8: Number of Employees of Private Self-Insured Employers (Millions)**

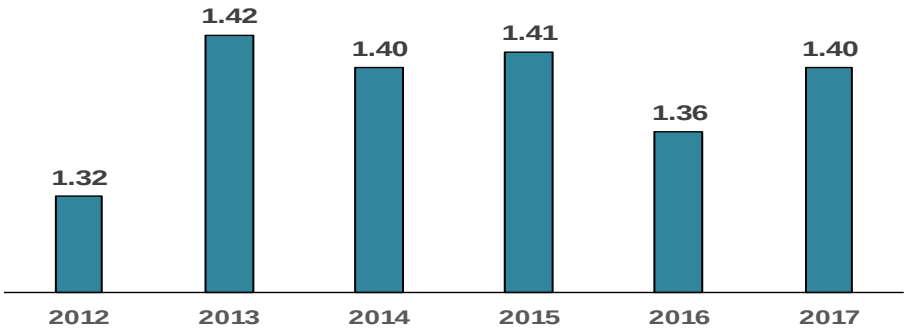



Source: DIR Self-Insurance Plan

*Indemnity Claims.* Figure 9 depicts the rate of indemnity claims per 100 employees of private self-insured employers. The rate of indemnity claims per 100 employees of private self-insured employers increased by 7.5 percent from 2012 to 2013 and then averaged 1.40 claims per 100 employees from 2013 to 2017.

**Figure 9: Number of Indemnity Claims per 100 Employees of Private Self-Insured Employers**

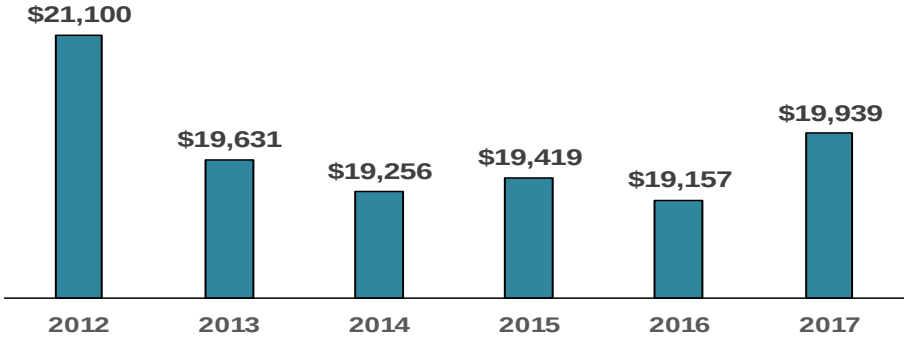
[28] Data for private self-insured employers are from DIR's Office of Self-Insurance Plans correspondence received by CHSWC in June 2017.




Source: DIR Self-Insurance Plan

*Incurred Cost per Indemnity Claim.* Figure 10 shows the incurred cost per indemnity claim for private self-insured employers, which experienced changes similar to the changes for insurance companies. There was a 7 percent decrease in average incurred cost per indemnity claim from 2012 to 2013. From 2013 to 2016, incurred cost per indemnity claim levelled off and then increased by 4 percent from 2016 to 2017

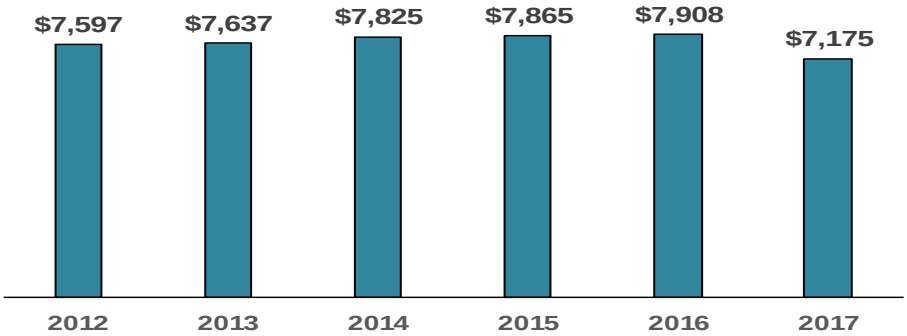
**Figure 10: Incurred Cost Per Indemnity Claim of Private Self-Insured Employers**




Source: DIR Self-Insurance Plan

*Incurred Cost per Indemnity and Medical Claim.* The average cost of all claims, including both indemnity and medical-only claims, is naturally lower than the average cost of indemnity claims. It showed a steady increase from 2012 to 2016, and then decreased by 9 percent from 2016 to 2017.

**Figure 11: Incurred Cost per Claim, Indemnity and Medical of Private Self-Insured Employers**

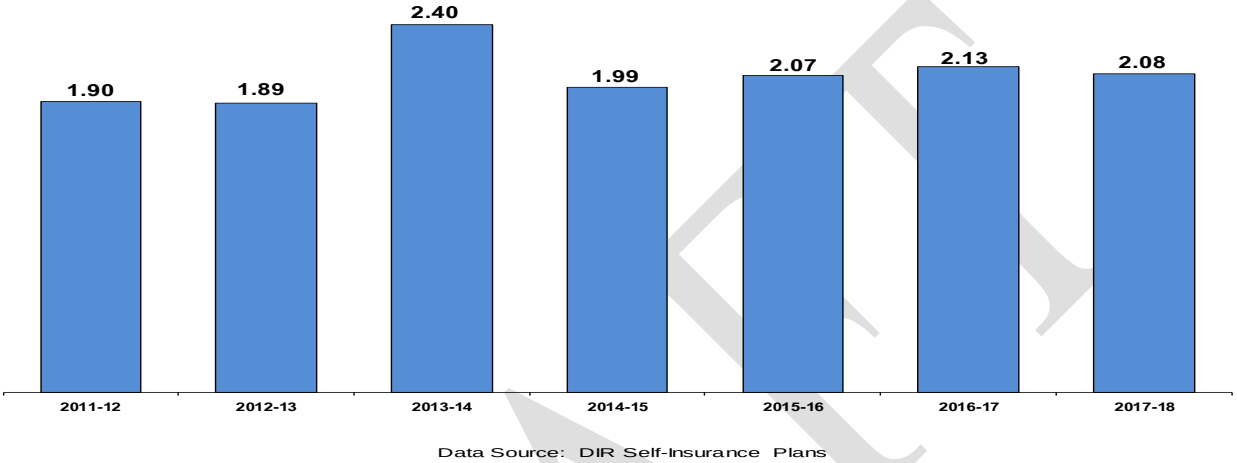



Source: DIR Self-Insurance Plan

Public Self-Insured Employers[29]

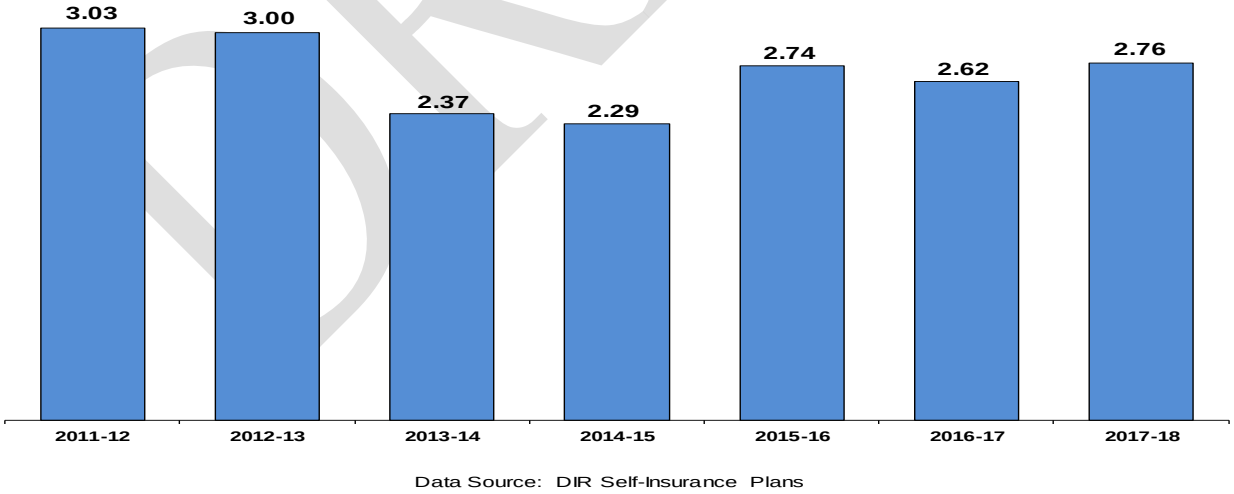
*Number of Employees.* Figure 12 shows the number of employees of public self-insured employers between fiscal years 2011-2012 and 2017-2018. From 2011-2012 to 2012-2013, the number of employees of public self-insured employers stabilized at 1.9 million, spiked in 2013-2014, and then decreased by 17 percent from 2013-2014 to 2014-2015. From 2014-2015 to 2017-2018 the number of employees increased overall by 4 percent.

**Figure 12: Number of Employees of Public Self-Insured Employers (Millions)**




*Indemnity Claims.* The rate of indemnity claims per employees working for public self-insured employers decreased by 24 percent from 2011-2012 to 2014-2015. There was a 21 percent increase in the rate from 2014-2015 to 2017-2018.

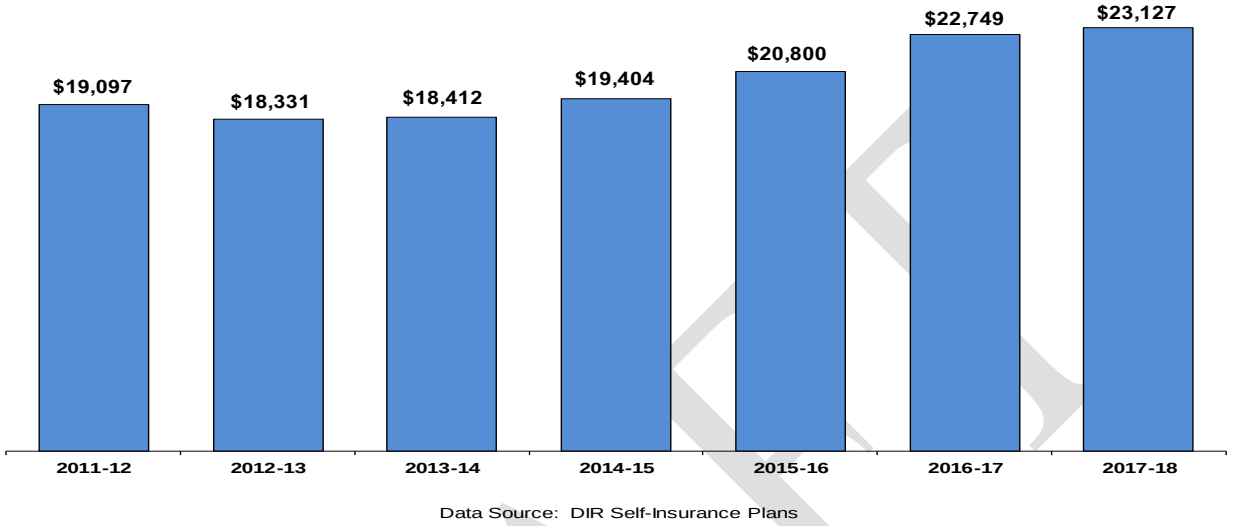
**Figure 13: Number of Indemnity Claims per 100 Employees of Public Self-Insured Employers**




[29] Data for Public Self-Insured Employers are from DIR's Office of Self-Insurance Plans correspondence received by CHSWC in December 2018.

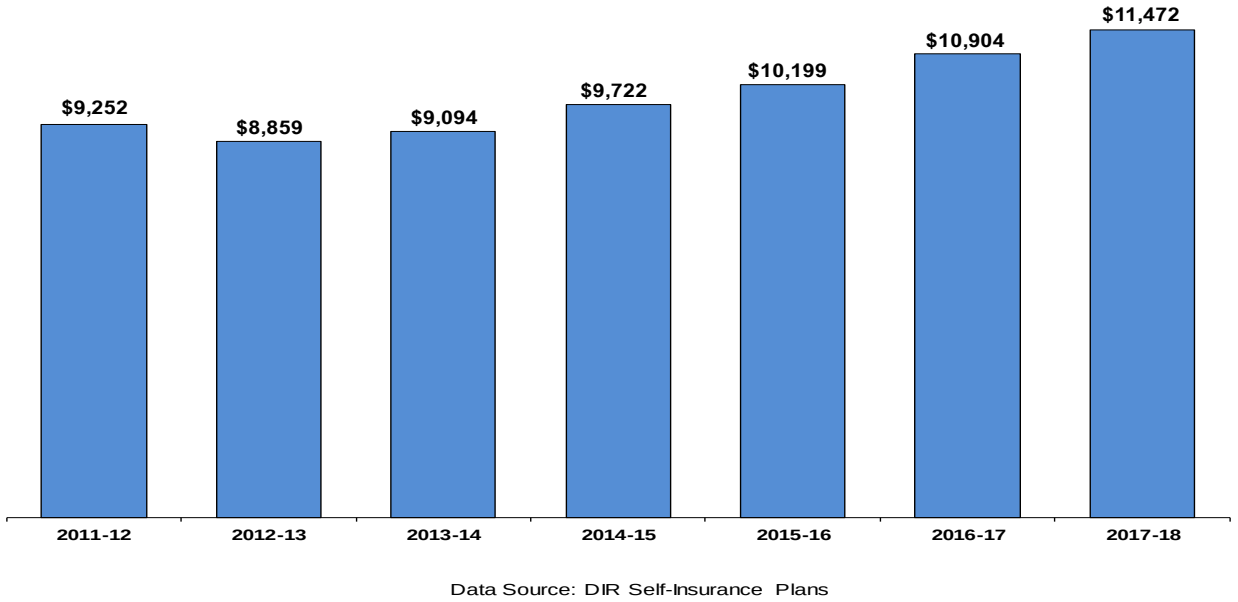
*Incurred Cost per Claim.* Figure 14 shows the incurred cost per indemnity claim for public self-insured employers between 2011-2012 and 2017-2018. After a slight decrease from 2011-2012 to 2012-2013, the incurred cost per indemnity claim increased by 26 percent from $18,331 to $23,127.

**Figure 14: Incurred Cost per Indemnity Claim of Public Self-Insured Employers**




*Incurred Cost per Indemnity and Medical Claim* Figure 15 shows the incurred cost per indemnity and medical claim for public self-insured employers between 2011-2012 and 2017-2018. After a slight decrease from 2011-2012 to 2012-2013, the incurred cost per indemnity and medical claim increased overall by 29 percent from $8,859 to $11,472.

**Figure 15: Incurred Cost per Claim–Indemnity and Medical–Public Self-Insured Employers (in $)**



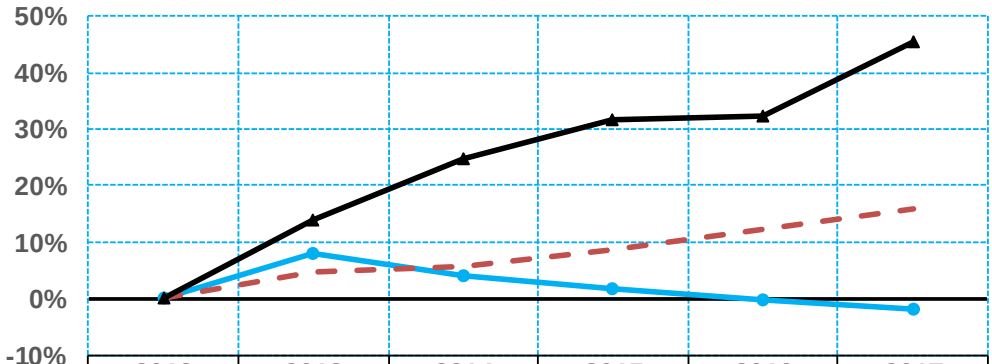
***Workers' Compensation System Expenditures: Indemnity and Medical Benefits***

*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 account for 34.1 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*

**Figure 16: Workers' Compensation Costs: Percent Change by Year Compared with 2012**



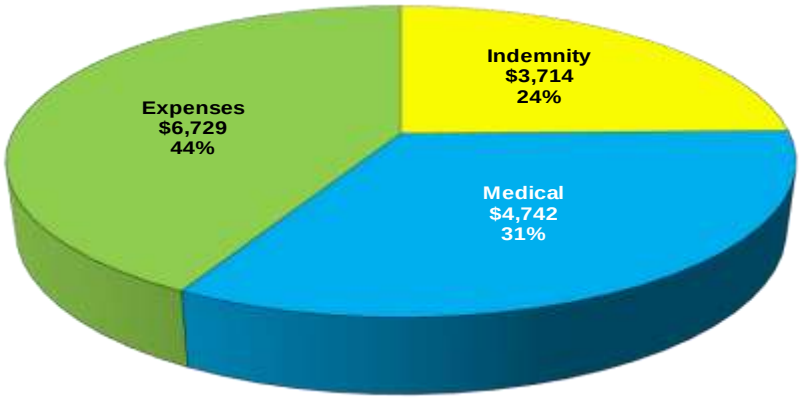

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Medical Paid | 0% | 7.9% | 4.1% | 1.8% | -0.2% | -2.0% |
| Indemnity Paid | 0% | 4.7% | 5.6% | 8.7% | 12.2% | 15.9% |
| Expenses | 0% | 14.0% | 24.9% | 31.6% | 32.4% | 45.3% |

Source: WCIRB

*Distribution of Workers' Compensation Costs by Type.*

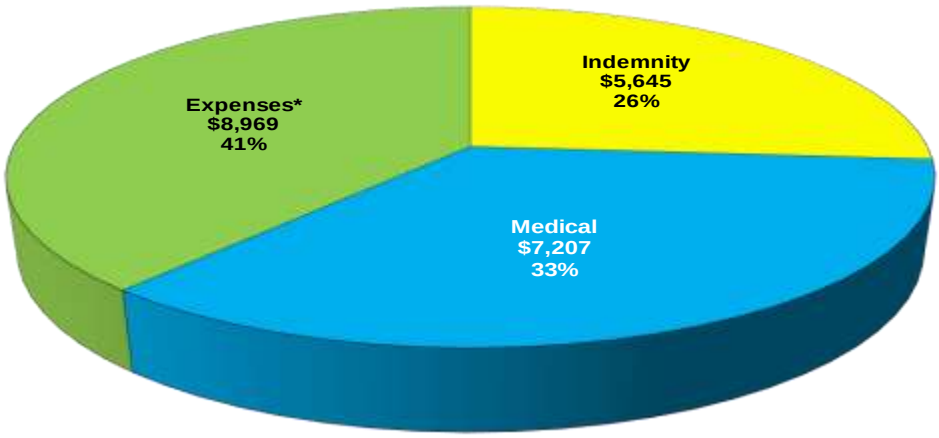
Figures 17 and 18 show the distribution of workers' compensation paid costs for insured employers and systemwide.

**Figure 17: Estimated Distribution of Insured Employers' and Systemwide Workers' Compensation Paid Costs, 2017 (Million $)**




Data Source: WCIRB

**Figure 18: Estimated Distribution of Systemwide Workers' Compensation Paid Costs, 2017 (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.

Data Source: WCIRB with calculations by CHSWC

*Indemnity Benefits*

WCIRB provided data for the cost of indemnity benefits paid by insured employers. Assuming that insured employers comprise approximately 65.9 percent of total California workers' compensation claims, estimated indemnity benefits are shown in Table 7 for the total system, insured employers, self-insured employers, and the State of California.

**Table 7: Systemwide Estimated Costs of Paid Indemnity Benefits**

| **Systemwide, paid by all sectors** | | | |
|---|---|---|---|
| **Indemnity Benefits (Thousand $)** | **2016** | **2017** | **Change** |
| Temporary Disability | $2,711,102 | $2,786,991 | $75,889 |
| Permanent Total Disability | $185,341 | $232,691 | $47,350 |
| Permanent Partial Disability | $2,234,592 | $2,255,823 | $21,231 |
| Death | $93,749 | $107,917 | $14,168 |
| Funeral Expenses | $3,207 | $3,207 | $0 |
| Life Pensions | $137,703 | $133,496 | -$4,207 |
| Voc Rehab/Non-transferable Education Voucher | $98,127 | $124,683 | $26,556 |
| Total | $5,463,821 | $5,644,807 | $180,986 |
| **Paid by Insured Employers** | | | |
| **Indemnity Benefits (Thousand $)** | **2016** | **2017** | **Change** |
| Temporary Disability * | $1,783,620 | $1,833,547 | $49,927 |
| Permanent Total Disability * | $121,935 | $153,086 | $31,151 |
| Permanent Partial Disability * | $1,470,126 | $1,484,094 | $13,968 |
| Death * | $61,677 | $70,998 | $9,321 |
| Funeral Expenses | $2,110 | $2,110 | $0 |
| Life Pensions | $90,594 | $87,826 | -$2,768 |
| Voc Rehab/Non-transferable Education Voucher * | $64,557 | $82,028 | $17,471 |
| Total | $3,594,619 | $3,713,690 | $119,071 |
| **Paid by Self-Insured Employers and the State**** | | | |
| **Indemnity Benefits (Thousand $)** | **2016** | **2017** | **Change** |
| Temporary Disability | $927,482 | $953,444 | $25,962 |
| Permanent Total Disability | $63,406 | $79,605 | $16,199 |
| Permanent Partial Disability | $764,466 | $771,729 | $7,263 |
| Death | $32,072 | $36,919 | $4,847 |
| Funeral Expenses | $1,097 | $1,097 | $0 |
| Life Pensions | $47,109 | $45,670 | -$1,439 |
| Voc Rehab/Non-transferable Education Voucher | $33,570 | $42,655 | $9,085 |
| Total | $1,869,202 | $1,931,118 | $61,916 |

Sources: Calculated by CHSWC, based on data from WCIRB

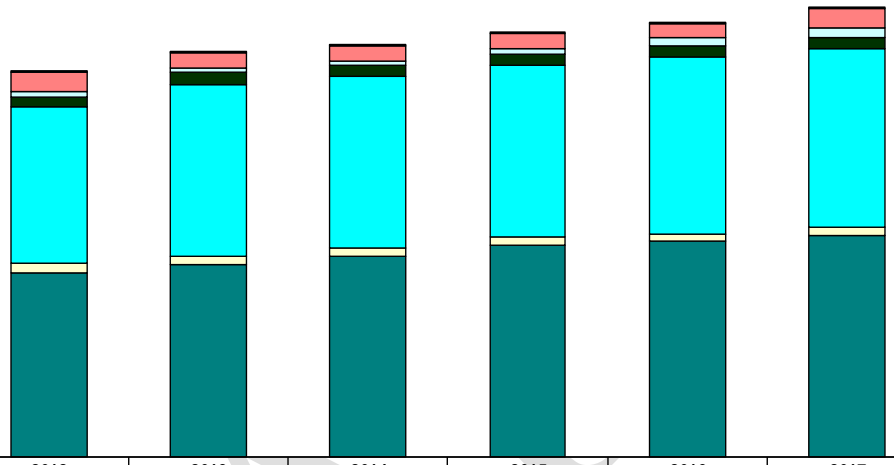
* Single Sum Settlement and Other Indemnity payments have been allocated to the benefit categories.

** Figures estimated based on insured employers' costs. Self-insured employers and the State of California are estimated to comprise 34.1 percent of all California workers' compensation claims.

*Trends in Paid Indemnity Benefits.*

The estimated systemwide paid indemnity benefits for 2012-2017 are displayed in Figure 19. Paid indemnity benefits increased steadily by 16 percent from 2012 to 2017 as the result of SB 863 reforms. From 2012 to 2017, payments for permanent partial disability increased overall by 14 percent and TD benefits increased by 20 percent. Supplemental job displacement benefits (SJDB) increased 2.3 times during the same period.

**Figure 19: Workers' Compensation Paid Indemnity Benefit by Type, Systemwide Estimated Costs (Million $)**



| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Funeral Expenses | $1.6 | $3.5 | $3.3 | $3.7 | $3.2 | $3.2 |
| Permanent Total Disability | $259 | $199 | $188 | $176 | $185 | $233 |
| Voc Rehab/ Vouchers | $55 | $57 | $46 | $70 | $98 | $125 |
| Life Pensions | $133 | $142 | $142 | $143 | $138 | $133 |
| Permanent Partial Disability | $1,977 | $2,164 | $2,165 | $2,163 | $2,235 | $2,256 |
| Death | $106 | $111 | $114 | $104 | $94 | $108 |
| Temporary Disability | $2,323 | $2,422 | $2,519 | $2,670 | $2,711 | $2,787 |
| Total | $4,854 | $5,098 | $5,177 | $5,330 | $5,464 | $5,645 |

Data Source: WCIRB
Calculations: CHSWC

## Supplemental Job Displacement Benefits Costs

The reforms of 2003 eliminated vocational rehabilitation (VR) for injuries arising on or after January 1, 2004, and replaced it with a supplemental job displacement benefit (SJDB). The VR statutes were repealed as of January 1, 2009. Consequently, the expenditures for VR decreased rapidly, as the remaining pre-2004 cases were addressed and essentially ended. SJDB expenditures were made, but at a much lower level.

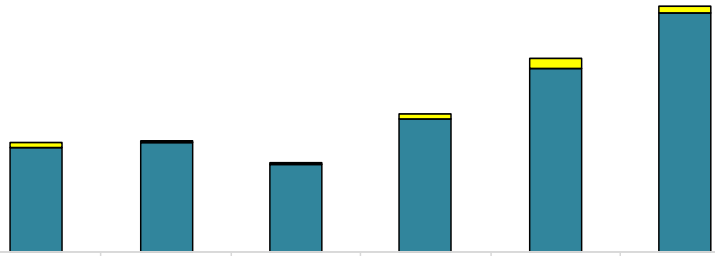
*Supplemental Job Displacement Benefit Vouchers*

Assembly Bill (AB) 227 (Vargas, 2003) created a system of non-transferable educational vouchers effective for injuries that occurred on or after January 1, 2004. WCIRB's estimate of the cost of education vouchers is based on information compiled from its most current Permanent Disability Claim Survey. In total, 18.3 percent of accident year 2004 PD claims involved education vouchers, and the average cost of the education 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 education vouchers, with an estimated average cost of approximately $5,600. SB 863 (De León 2012) revised the SJDB for injuries that occurred on or after January 1, 2013, while preserving the concept of a voucher for education or training for an injured worker who does not have an opportunity to return to work for the at-injury employer. Effective with injuries

that occurred on or after January 1, 2013, Labor Code Section 4658.5 was modified and Labor Code Section 4658.7, which modified the system of supplemental job displacement benefits was created.

Figure 20 shows that the amounts paid for SJDB vouchers by insured employers in 2017 increased almost 2.3 times compared to 2012 and almost 3 times compared to 2014. The proportion of amounts paid for SJDB vouchers in total Vocational Rehabilitation benefits increased from 95 percent to 97 percent from 2012 to 2017.

**Figure 20: Paid Vocational Rehabilitation Benefits, by Insured Employers (Million $)**



| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Other Voc. Rehab | 1.7 | 1.0 | 0.9 | 1.4 | 3.4 | 2.6 |
| Education Vouchers (SJDB) | 34.8 | 36.2 | 29.0 | 44.4 | 61.2 | 79.4 |
| Total | 36.5 | 37.2 | 29.9 | 45.8 | 64.6 | 82.0 |

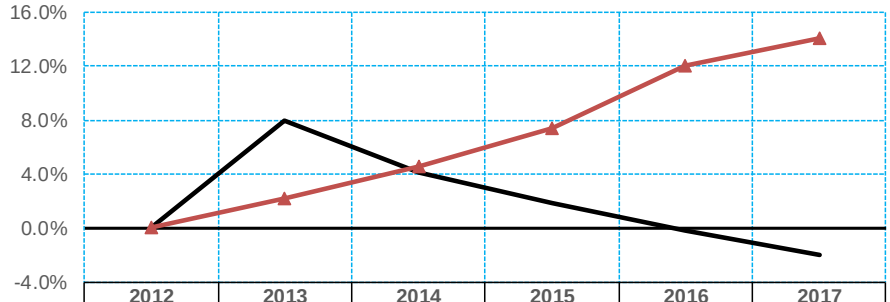
Source: WCIRB

***Medical Benefits***

*Workers' Compensation Medical Costs vs. Medical Inflation*

Figure 21 compares the percent change of California's workers' compensation medical costs paid by insurers and self-insured employers in each consecutive year from 2012 with the percent growth of the medical component of the Consumer Price Index (CPI) in each consecutive year from the same base year. 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. After 2013 the pattern of workers' compensation medical costs has reversed and started to decrease.

**Figure 21: Growth of Workers' Compensation Medical Costs Compared with Growth of Medical Inflation (2012 as a base year)**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Change in Workers' Comp Medical Costs as Compared to 2012 | 0.0% | 7.9% | 4.1% | 1.8% | -0.2% | -2.0% |
| Change in Medical CPI as Compared to 2012 | 0.0% | 2.2% | 4.6% | 7.4% | 12.0% | 14.1% |

Source: WCIRB; Bureau of Labor Statistics (BLS)

*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 65.9 percent of total California workers' compensation claims, estimated medical benefits are shown in Table 8 for the total system, insured employers, self-insured employers, and the State of California.

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**Table 8: Systemwide Estimated Costs—Medical Benefits Paid**

| **Systemwide Medical Benefits (Thousand $)** | **2016** | **2017** | **Change** |
|---|---|---|---|
| Physicians | $1,880,486 | $1,912,067 | $31,581 |
| Hospital (Inpatient and Outpatient) | $892,891 | $1,006,441 | $113,550 |
| Medical Supplies and Equipment | $352,863 | $407,957 | $55,094 |
| Pharmacy | $471,658 | $260,189 | -$211,468 |
| Medical-Legal Evaluation | $517,441 | $488,776 | -$28,666 |
| Payments Made Directly to Patients* | $2,043,611 | $2,043,166 | -$445 |
| Medical Cost-Containment Programs** | $268,873 | $239,830 | -$29,043 |
| Medicare Set-aside and Reimbursements | $347,747 | $388,228 | $40,481 |
| Capitated Medical | $17,202 | $24,790 | $7,588 |
| Other (Med Liens, Dental, Interpreter****, & Copy Services****) | $541,784 | $435,846 | -$105,938 |
| Total | $7,334,556 | $7,207,290 | -$127,267 |
| **Paid by Insured Employers*** ** | | | |
| **Medical Benefits (Thousand $)** | **2016** | **2017** | **Change** |
| Physicians | $1,237,162 | $1,257,939 | $20,777 |
| Hospital (Inpatient and Outpatient) | $587,428 | $662,132 | $74,704 |
| Medical Supplies and Equipment | $232,147 | $268,393 | $36,246 |
| Pharmacy | $310,301 | $171,177 | -$139,124 |
| Medical-Legal Evaluation | $340,422 | $321,563 | -$18,859 |
| Payments Made Directly to Patient* | $1,344,481 | $1,344,188 | -$293 |
| Medical Cost-Containment Programs** | $176,890 | $157,783 | -$19,107 |
| Medicare Set-aside and Reimbursements | $228,781 | $255,413 | $26,632 |
| Capitated Medical | $11,317 | $16,309 | $4,992 |
| Other (Med Liens, Dental, Interpreter****, & Copy Services****) | $356,437 | $286,741 | -$69,696 |
| Total | $4,827,928 | $4,741,638 | -$86,290 |
| **Paid by Self-Insured Employers*** ** | | | |
| **Medical Benefits (Thousand $)** | **2016** | **2017** | **Change** |
| Physicians | $643,324 | $654,128 | $10,804 |
| Hospital (Inpatient and Outpatient) | $305,463 | $344,309 | $38,846 |
| Medical Supplies and Equipment | $120,716 | $139,564 | $18,848 |
| Pharmacy | $161,357 | $89,012 | -$72,344 |
| Medical-Legal Evaluation | $177,019 | $167,213 | -$9,807 |
| Payments Made Directly to Patient* | $699,130 | $698,978 | -$152 |
| Medical Cost-Containment Programs** | $91,983 | $82,047 | -$9,936 |
| Medicare Set-aside and Reimbursements | $118,966 | $132,815 | $13,849 |
| Capitated Medical | $5,885 | $8,481 | $2,596 |
| Other (Med Liens, Dental, Interpreter****, & Copy Services****) | $185,347 | $149,105 | -$36,242 |
| Total | $2,509,190 | $2,465,652 | -$43,539 |

Sources: Calculated by CHSWC, based on WCIRB's Medical Data Call (MDC).

* Med payments made directly to patient include amounts paid directly to injured workers on lump sum settlements for future med expenses; to a much lesser extent they may also include payments for transportation related to medical care.

** Medical cost-containment programs (MCCP) costs on claims covered by incepting July 1, 2010 and beyond are considered Allocated Loss Adjustment Expenses (ALAE). The amount of MCCP costs reported as ALAE for 2017 is $285 million.

*** Figures estimated are based on insured employers' costs. Self-insured employers and the State of California are estimated to comprise 34.1 percent of all California workers' compensation claims.

**** Based on WCIRB surveys of insurer medical payments.

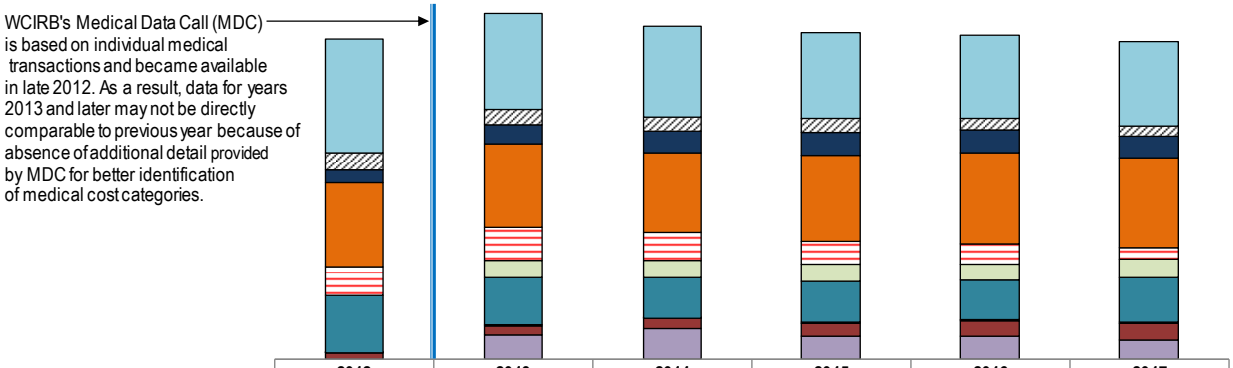
*Trends in Paid Medical Benefits*

The estimated systemwide paid medical costs for the past several years are shown in Figure 22. The following trends may result from the impact of SB 863.

The cost of the total medical benefit decreased by 8 percent from 2013 to 2017. Payments to physicians decreased by 14 percent from 2013 to 2016 and then slightly increased by 2 percent from 2016 to 2017. Hospital costs decreased by 17 percent from 2013 to 2016 and then increased by 13 percent from 2016 to 2017. Medical supplies and equipment stabilized at an average of $372 million per year from 2013 to 2016 and then increased by 16 percent from 2016 to 2017. Medical-legal evaluation costs increased by 16 percent from 2013 to 2016, but decreased by 6 percent from 2016 to 2017. Pharmacy costs decreased almost 3 times from $728 million in 2013 to $260 million in 2017. This decline was primarily driven by a decrease in utilization which may reflect the impact of Independent Medical Review (IMR), including the reduction in utilization of opiates. Direct payments to patients increased increased overall by 8 percent from 2013 to 2017. Expenditures on medical cost-containment programs decreased by 35 percent from 2013 to 2017.[30]

The apparent increases in the medical payments made to injured workers and medical-legal evaluation costs were in part the result of availability of more detailed reporting of payments into specific recipient/payee categories.

**Figure 22: Workers' Compensation Paid Medical Benefits by Type, Systemwide Estimated Costs (Million $)**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Physicians | $2,587 | $2,177 | $2,061 | $1,945 | $1,880 | $1,912 |
| Med Cost Cntnmnt Prgrms* | $367 | $329 | $313 | $305 | $269 | $240 |
| Medical-Legal Evaluation | $288 | $446 | $505 | $514 | $517 | $489 |
| Direct Payments to Patients | $1,918 | $1,895 | $1,808 | $1,960 | $2,044 | $2,043 |
| Pharmaceuticals | $626 | $728 | $625 | $509 | $472 | $260 |
| Medical Supplies & Equipm | | $392 | $369 | $373 | $353 | $408 |
| Hospitals** | $1,317 | $1,073 | $926 | $941 | $893 | $1,006 |
| Capitated Medical | $8 | $23.5 | $15 | $27 | $17.2 | $25 |
| Medicare Set-aside*** | $144 | $196 | $227 | $272 | $348 | $388 |
| Other **** | | $572 | $704 | $542 | $542 | $436 |
| Total | $7,257 | $7,832 | $7,552 | $7,389 | $7,335 | $7,207 |

**Source: WCIRB's MDC (Calculations by CHSWC)**

* Medical cost-containment program (MCCP) costs on claims covered by policies incepting July 1, 2010 and beyond are considered Allocated Loss Adjustment Expenses (ALAE). The amount of MCCP costs reported as ALAE for calendar year 2017 is 285 million.

** Hospitals include Outpatient and Inpatient services that became separately identifiable begginning from 2013.

*** Medicare Set-aside Payments include Medical Payments and Reimbursements.

****Other includes Medical Liens, Dental, Interpreter, and Copy services.

[30] Medical cost-containment program costs on claims covered by policies incepting prior to July 1, 2010, are considered medical loss, and those covered by policies incepting July 1, 2010, and beyond are considered allocated loss adjustment expenses.

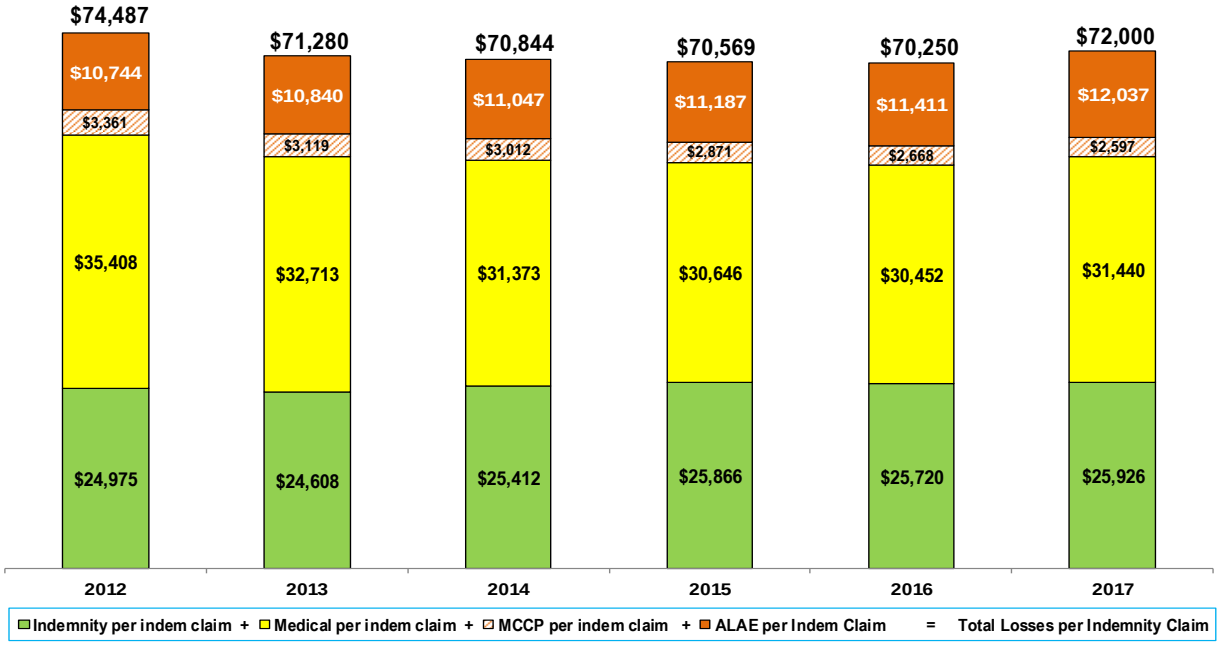
### *Average Ultimate Total Loss*

Figure 23 shows changes in indemnity and medical components of the projected ultimate total loss per workers' compensation indemnity claim.

Beginning with claims incurred on policies incepting on or after July 1, 2010, the cost of medical cost containment programs (MCCP) is reported to WCIRB as allocated loss adjustment expenses (ALAE) rather than as medical loss.

WCIRB projects the average cost or "severity" of a 2017 indemnity claim to be $72,000, which is 2.5 percent higher than the projected severity for 2016, following several years of relatively flat severities.[31] The projected average indemnity cost showed relatively modest increase in 2017, primarily a result of SB 863 increases to permanent disability benefits effective in 2013 and 2014. The projected average medical cost of a 2017 indemnity claim is 3 percent above that for 2016, which follows decreases in medical severities from 2011 to 2015 driven by medical cost savings arising from SB 863. It is unclear whether this increase will develop downward like in recent years or it represents a return of more typical rates as in post-reform medical inflation.[32] The projected average ALAE cost of a 2017 indemnity claim is 5 percent above that of 2016 and 11 percent higher than the average ALAE severity for 2013. Average ALAE costs tend to rise shortly after the implementation of reforms, even during periods where medical costs have declined.[33]

**Figure 23: Estimated Ultimate Total Loss* per Indemnity Claim as of March 31, 2018**




* Excluded medical-only

Note: Before July 1, 2010, the costs of Medical Cost Containment Program (MCCP) that could be allocated to a particular claim were reported as medical losses. After July 1, 2010, MCCP is reported as ALAE. The Medical per indemnity claim data starting 2011 and on exclude the MCCP costs.

Source: WCIRB

Please note that WCIRB's estimates of average indemnity claim costs have not been indexed to take into account wage increases and medical inflation.

[31, 29, 30] WCIRB Report on March 31, 2018, Insurer Experience, released April, 2018, Charts 8 – 11.

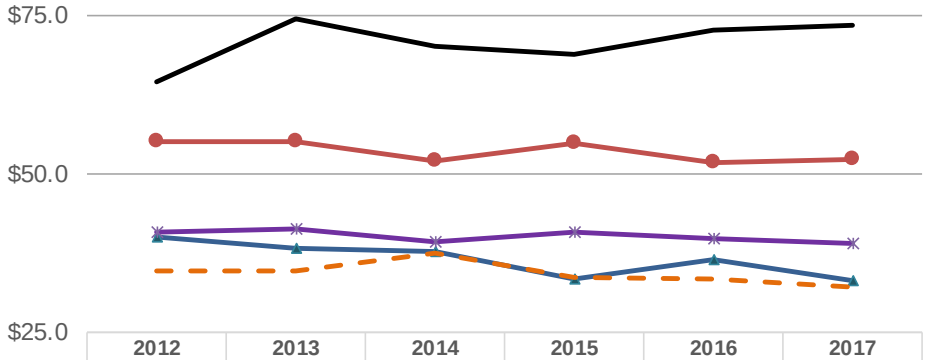
*Average Cost per Claim by Type of Injury*

Figure 24 shows the average medical and indemnity costs of permanent disability claims.

The average cost of the most expensive type of injury, the slip and fall, increased from 2012 to 2013, decreased by 7.5 percent from 2013 to 2015, and then increased by 6 percent from 2015 to 2017. The average cost of back injuries fluctuated between $52,000 and $55,000 from 2012 to 2017. The average cost of carpal tunnel (RMI) stabilized at around $40,000 per year from 2012 and 2017. The average cost of other cumulative injuries decreased by 16 percent from 2012 to 2015 and then fluctuated from 2015 to 2017.

The average costs of psychiatric and mental stress claims decreased overall by 7 percent from 2012 to 2017, except for a one time 6 percent increase from 2013 to 2014.

**Figure 24: Average Cost per PD Claim by Type of Injury, 2012-2017 (Thousand $)**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Slip and Fall | $64.6 | $74.6 | $70.1 | $69.0 | $72.8 | $73.4 |
| Back Injuries | $55.0 | $55.1 | $52.1 | $55.0 | $51.9 | $52.2 |
| Other Cumulative Injuries | $40.0 | $38.3 | $37.9 | $33.4 | $36.4 | $33.3 |
| Carpal Tunnel / RMI | $40.7 | $41.4 | $39.2 | $40.9 | $39.8 | $38.9 |
| Psychiatric and Mental Stress | $34.7 | $34.7 | $37.6 | $33.6 | $33.5 | $32.2 |

Source: WCIRB

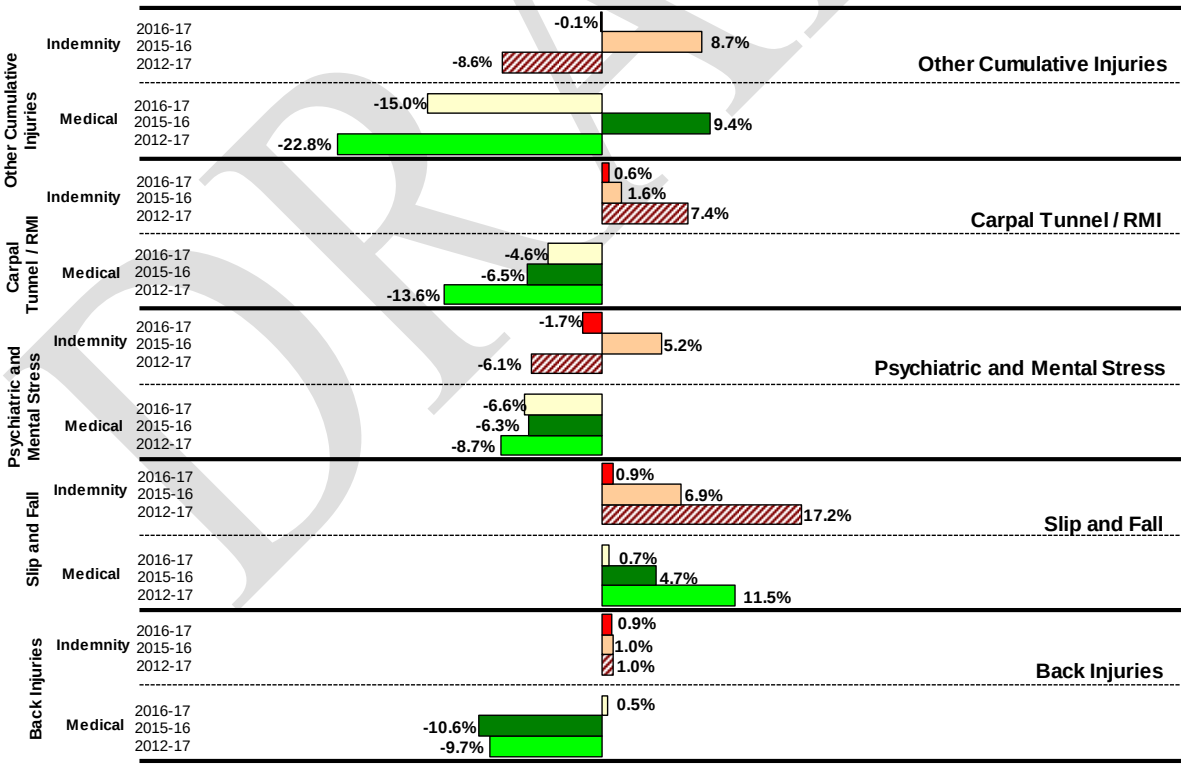
*Changes in Average Medical and Indemnity Costs per Claim by Type of Injury*

Figure 25 illustrates the impact of the reforms on selected types of injury. The five-year trend from 2012 to 2017 shows decreases in medical costs for almost all types of injuries, except for a 11.5 percent increase for slip and fall injuries. The same five-year long trend for indemnity costs showed increases in indemnity costs in slip and fall, carpal tunnel/RMI, and back injuries and decreases in psychiatric and mental stress and other cumulative injuries. Slip and fall injuries were the only category that showed a significant five-year increase in both average indemnity and medical costs.

From 2015 to 2016, medical costs increased by 9.4 percent for other cumulative injuries and by 0.7 percent for slip and fall injuries. In the same period, there was a 10.6 percent decrease in the average medical cost of claim for back injuries, a 6.5 percent decrease for carpal tunnel/RMI, and a 6.3 percent decrease for psychiatric and mental stress disorders. In the same year, indemnity costs increased for all types of injuries: other cumulative injuries – 8.7 percent, slip and fall injuries – 6.9 percent, psychiatric and mental stress disorders - 5.2 percent, carpal tunnel (RMI) – 1.6 percent, and back injuries – 1.0 percent.

From 2016 to 2017, medical costs decreased 15 percent for other cumulative injuries and 6.6 and 4.6 percent for psychiatric and mental stress disorders and carpal tunnel (RMI) correspondingly. In the same year, medical costs showed a 0.7 percent increase in slip and fall injuries and 0.5 percent increase in back injuries. Indemnity costs increased 0.9 percent for both slip and fall and back injuries and 0.6 percent - for carpal tunnel/RMI injuries. In the same period, indemnity costs decreased by 1.7 percent for psychiatric and mental stress disorders and 0.1 percent for other cumulative injuries.

**Figure 25: Percent Change in Average Medical and Indemnity Costs per Claim by Type of Injury (From 2012 through 2017, from 2015 to 2016, and from 2016 to 2017)**




Data Source: WCIRB

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**Medical-Legal Expenses**

In California's workers' compensation system, the medical-legal evaluations result in medical-legal reports addressing specific medical and legal questions based on review of all the medical information concerning a work-related injury. The medical-legal examinations do not provide any medical treatment and the medical treatment-related evaluations for resolving disputes are outside the scope of medical-legal services. A medical-legal report is conducted to determine multiple compensability and disability threshold issues:

- Worker's eligibility for benefits: Arising out of Employment (AOE)/Course of Employment (COE).
- Permanent and stationary status of injured worker.
- Existence and extent of permanent and temporary disabilities.
- Apportionment.
- Ability to return to work.
- Injured worker's ability to engage in his/her usual occupation.
- Need for future medical treatment in cases settled by Compromise and Release.

SB 863, which took effect January 1, 2013, did not directly address the medical-legal process, but its several provisions introduced a significant change to medical-legal evaluations in how medical treatment disputes are resolved. As of January 1, 2013, for injuries occurring on or after that date, and as of July 1, 2013, for all dates of injury, disagreements about a specific course of medical treatment recommended by the treating physician can be resolved only through a process called independent medical review (IMR). In this environment, medical-legal evaluations by QME and AME are limited to disagreements about whether a claim is covered by workers' compensation (compensability) and disability threshold issues.

According to the DWC, under the former system, it typically took 9 to 12 months to resolve a dispute over the treatment needed for an injury. The process required: (1) negotiating over the selection of an agreed medical evaluator, (2) obtaining a panel, or list, of state-certified medical evaluators if agreement could not be reached, (3) negotiating over the selection of the state-certified medical evaluator, (4) making an appointment, (5) awaiting the examination, (6) awaiting the evaluator's report, and then, if the parties still disagree, (7) awaiting a hearing with a workers' compensation judge, and (8) awaiting the judge's decision on the recommended treatment. In many cases, the treating physician could also rebut or request clarification from the medical evaluator, and the medical evaluator could be required to follow up with supplemental reports or answer questions in a deposition.

SB 863 replaced those eight steps with an IMR process similar to the one used in group health plans, which takes approximately 40 (or fewer) days to arrive at a determination to obtain appropriate treatment.

By the WCIRB's estimates, the number of medical-legal reports was expected to be reduced by the IMR, lien, medical provider network (MPN), and independent bill review (IBR) provisions of SB 863. The retrospective medical-legal payments showed that utilization measured as number of transactions per claim declined only modestly subsequent to SB 863, while amounts paid per transaction and the total share of medical payments generated by medical-legal services have risen each calendar year from 2012 to 2016. According to WCIRB, the most expensive ML-104 report accounted for two-thirds of all medical-legal payments from service year 2013 to 2015, contributing to the increase in medical-legal costs. From 2014 to 2016, the increase in costs was attributable, in part, to an increased use of ML-106, a supplemental medical-legal evaluation report and to a lesser degree by increased usage of the complex ML-104 code.

Beginning from 2016, the analyses in the CHSWC Annual Report are based on the WCIRB's medical transaction data from its Medical Data Call (MDC). The MDC began with mandatory medical transactions in the third quarter of 2012 that were reported to the WCIRB by December 31, 2012.

The historical medical-legal analysis ending in 2015 and based on the WCIRB's Permanent Disability Survey data for 2012, the latest one available, can be found in the CHSWC Annual Report:

http://www.dir.ca.gov/chswc/allreports.html

### *Workers' Compensation Claims with Medical-Legal Expenses*

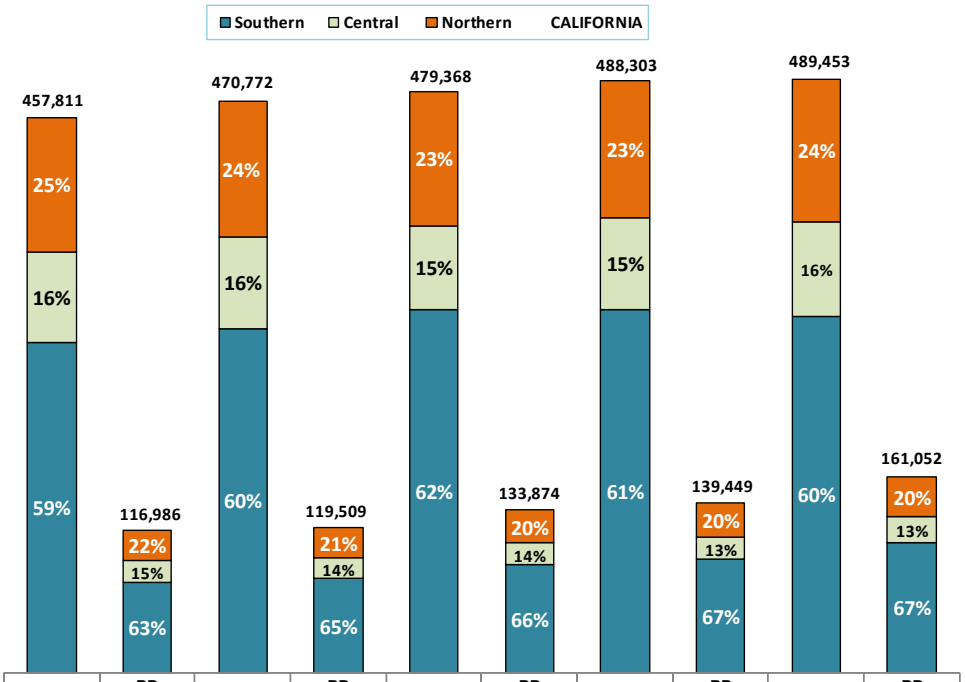
The WCIRB's MDC provides two sets of medical-legal data. The first is for all claims with total and partial disabilities, temporary disabilities, medical only, and denied claims as well. The second set is only for claims with total and permanent partial disability which usually have higher severity and a longer life cycle. Claims reported to MDC include claims with any medical transaction and, for this report, are grouped by the service year of a transaction.

The data for 2012 are only for six months of medical-legal services provided from July 1, 2012 to December 31, 2012 and are not included in this report.

Figure 26 shows the number of permanent disability (PD) and all claims originating in three California regions in Service Years (SY) 2013 to 2017. The share of claims statewide, involving a permanent disability, increased steadily from 25 percent in 2013 and 2014 to 33 percent in 2017.

Around 60 percent of all claims and 63-67 percent of PD claims originated in Southern California and 24 percent of all claims and 20 percent of PD claims originated in Northern California. Different regions in California have different patterns of medical-legal reporting. Regions with a higher share of workers' compensation claims in the system have a bigger impact on both the average number of medical-legal evaluations per claim and the average cost of medical-legal evaluations statewide.

**Figure 26: Workers' Compensation Claims, All and with Permanent Disability, by California Regions, SY 2013-SY 2017**



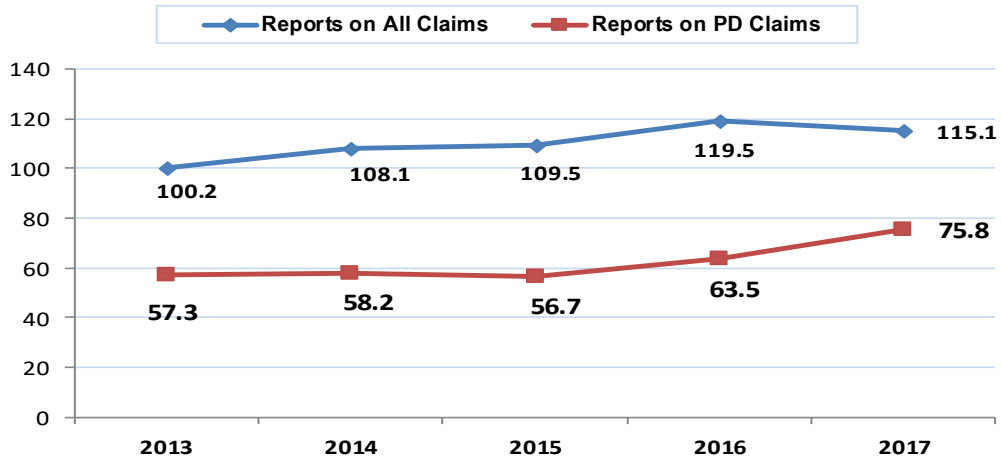

| | 2013 All Claims | 2013 PD Claims | 2014 All Claims | 2014 PD Claims | 2015 All Claims | 2015 PD Claims | 2016 All Claims | 2016 PD Claims | 2017 All Claims | 2017 PD Claims |
|---|---|---|---|---|---|---|---|---|---|---|
| Northern | 110,768 | 24,697 | 111,639 | 24,867 | 110,818 | 27,299 | 113,574 | 28,352 | 117,605 | 32,375 |
| Central | 74,830 | 18,117 | 75,452 | 17,253 | 69,565 | 18,210 | 75,255 | 17,797 | 78,255 | 21,486 |
| Southern | 272,213 | 74,172 | 283,681 | 77,389 | 298,985 | 88,365 | 299,474 | 93,300 | 293,593 | 107,191 |
| CALIFORNIA | 457,811 | 116,986 | 470,772 | 119,509 | 479,368 | 133,874 | 488,303 | 139,449 | 489,453 | 161,052 |

Source: WCIRB

Figure 27 shows the number of medical-legal reports conducted on PD and all claims in California for SY 2013 to SY 2017. The share of all medical-legal reports in California conducted on PD claims increased

from an average of 54 percent yearly from 2013 through 2016 to 66 percent in 2017. The number of medical-legal reports on all claims increased steadily by almost 20 percent from SY 2013 to SY 2016 and then decreased by 4 percent from 2016 to 2017. From 2013 to 2015, this growth could be explained by an increase in non-PD claims with medical-legal reports since the number of medical-legal reports on PD claims did not change in that period. At the same time, the number of medical-legal reports on PD claims stabilized at an average of 57,400 medical-legal reports per year from 2013 through 2015, and then increased by 34 percent from 2015 to 2017, including a 19 percent increase from 2016 to 2017.

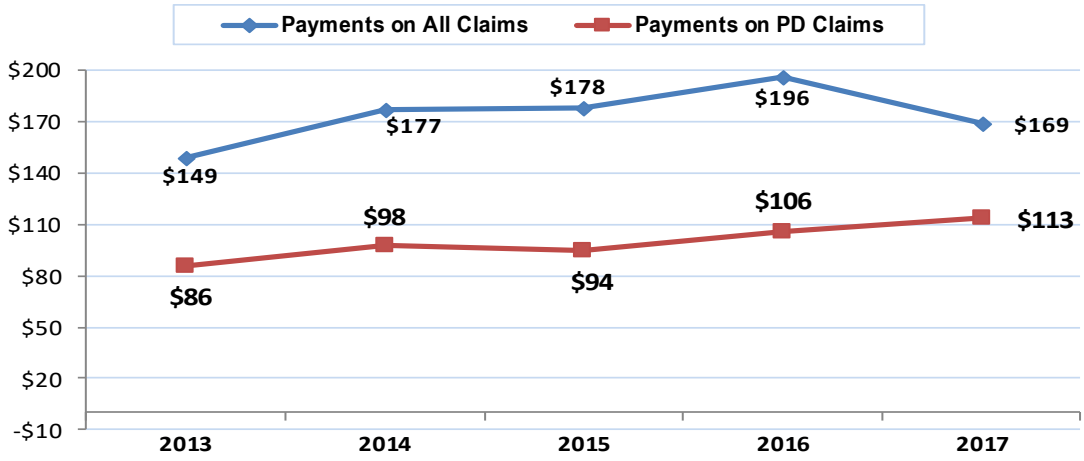
**Figure 27: Number of Medical-Legal Reports on PD and All Claims (Thousands)**




Source: WCIRB

Figure 28 shows statewide medical-legal payments on PD and all claims in California for SY 2013 to SY 2017. On average, around 55 percent of all yearly medical-legal payments were for PD claims from SY 2013 to SY 2016. That share increased 12 points up to 67 percent from SY 2016 to SY 2017. The medical-legal payments on all claims increased by 32 percent from SY 2013 to SY 2016, based in part on an overall 23 percent increase in medical-legal payments on PD claims during the same time period. This trend also reflects the increase in number of medical-legal evaluations on PD claims from SY 2015 to SY 2017. From SY 2016 to SY 2017, the medical-legal payments on all claims decreased by 14 percent.

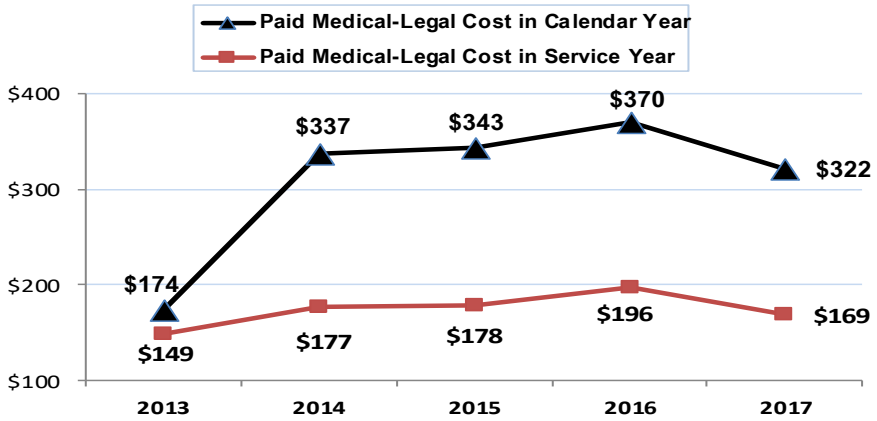
**Figure 28: Medical-Legal Payments on PD and All Claims (Million $)**




Source: WCIRB

The total medical-legal cost is reported by the WCIRB as a component of the total medical cost. The WCIRB's widely used and referenced Losses and Expenses Report[34] has estimates of the "paid medical-legal amount" or amounts paid in a certain calendar year (CY). The WCIRB's MDC, on which the total amounts in Figure 28 are based, covers medical-legal evaluations only for a certain service year. Payments reported for a calendar year are for medical-legal services with service dates in different years and therefore cover more services, while payments discussed in this report are limited to services during the same calendar year. Figure 29 shows paid medical-legal amounts in CY 2013 to CY 2017 from the Losses and Expenses Report against the medical-legal amounts in SY 2013 to SY 2017 from the current CHSWC report.

**Figure 29: WCIRB's Medical-Legal Costs Reported in Calendar vs. Service Years (Million $)**




Source: WCIRB

The total medical-legal expenses could be of different amounts for different organizations and even within the same organization, depending on how the data are collected, the type of reporting year applied (calendar, accident, service, or fiscal), methods of estimation, and on inclusion or exclusion of insured, self-insured, and legally uninsured employers.

The Losses and Expenses Report estimated amounts paid for medical services before CY 2014 ($174 million in Figure 29) based on the WCIRB's Aggregate Indemnity and Medical Costs Call and Call for California Workers' Compensation Calendar Year Experience. These medical payments were segregated into categories, including the medical-legal category, based on the type of medical provider receiving payment and not necessarily the procedures performed, as is done in the MDC. Starting in CY 2014, the amounts paid for medical services are based on the WCIRB's Aggregate Indemnity and Medical Costs Call, Call for California Workers' Compensation Calendar Year Experience, and MDC that provide a better reporting of payments into specific categories.

Another consideration when the dollar amounts of medical-legal reports are estimated as a share of medical bills is that the bill review data are based on the fee schedules and not all medical costs are captured in the data-bases, especially medical costs not covered by the fee schedule.

Also, the methods for calculating medical expenses could differ by the inclusion or exclusion of different categories of medical expenses, such as medical cost containment program (MCCP) expenses, thereby increasing or decreasing the total.

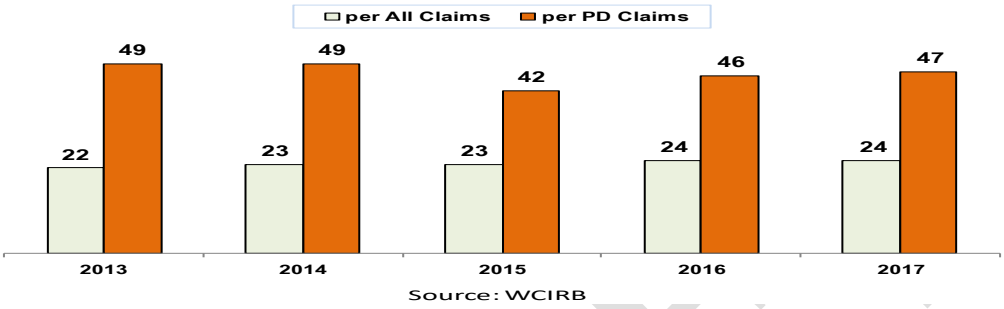
The changes in total medical-legal cost for insurers reflect changes in its three components: the number of workers' compensation claims, the average number of medical-legal evaluations per claim, and the average cost of a medical-legal evaluation.

[34] WCIRB, 2017 Losses and Expenses Report, Exhibit 1.1, June 26, 2018

### *Medical-Legal Evaluations per Claim*

Figure 30 compares the frequency of medical-legal reports for all claims and PD claims statewide from SY 2013 to SY 2017. The average number of medical-legal evaluations per 100 PD claims is about a double of the rate for all claims. While the average number of medical-legal evaluations per 100 all claims changed slightly between the SY 2013 and SY 2017, the same rate for PD claims decreased by 14 percent from 49 reports per 100 PD claims in SY 2013 and SY 2014 to 42 reports per 100 PD claims in SY 2015, and then increased by 12 percent from SY 2015 to SY 2017.

**Figure 30: Number of Medical-Legal Evaluations per 100 Workers' Compensation Claims (PD and All) in California**



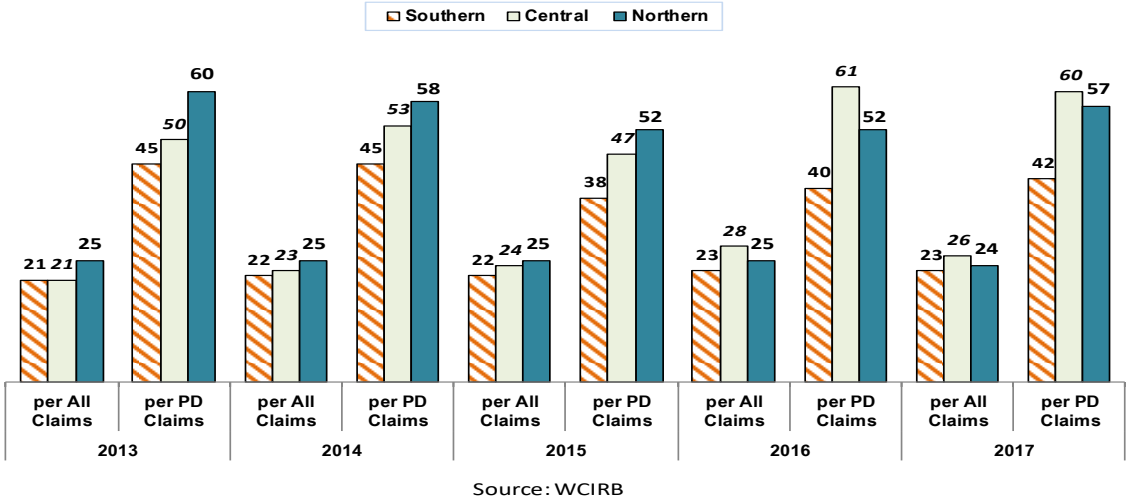

*Medical-Legal Reporting by the California Regions*

The different regions in California are often thought to have different patterns of medical-legal reporting.

Figure 31 compares the frequency of medical-legal reports for all claims and PD claims in three California regions from SY 2013 to SY 2017.

Between 2013 and 2016, the average number of medical-legal evaluations per 100 PD claims decreased for both Northern and Southern California, with a 13 percent decrease in the North and an 11 percent decrease in the South. From 2016 to 2017, both Northern and Southern California experienced a slight increase in average number of medical-legal evaluations per 100 PD claims. The number of medical-legal evaluations per 100 PD claims in Northern California exceeded that in Southern California in all 5 years. In the same period, the average number of medical-legal evaluations per 100 all claims did not change in both regions, the origin of the majority of PD claims and medical-legal evaluations in California.

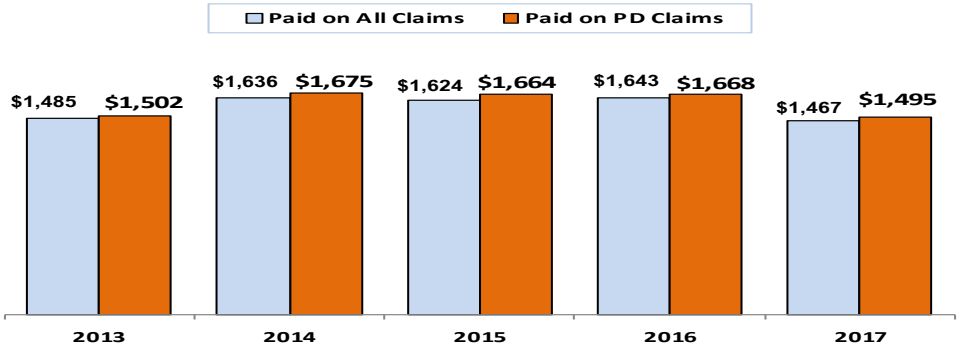
**Figure 31: Average Number of Medical-Legal Evaluations per 100 Claims (PD and All), by Region**



### Average Cost per Medical-Legal Evaluation

According to Figure 32, after a similar increase at around 10-11 percent in average costs from SY 2013 to SY 2014, both the average cost of a medical-legal evaluation on PD claims and the average cost of a medical-legal evaluation on all claims were stable and did not change until SY 2016. From SY 2016 to SY 2017, the average cost of a medical-legal evaluation on PD claims decreased by 12 percent and the average cost of a medical-legal evaluation on all claims declined by 10 percent.

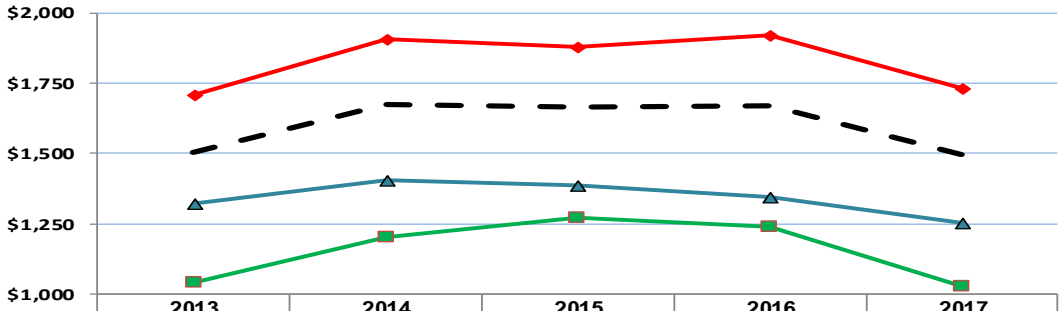
**Figure 32: Average Cost of a Medical-Legal Evaluation on All and PD Claims, California**




Source: WCIRB

According to Figure 33, from 2013 to 2014, the average cost of a medical-legal evaluation on PD claims increased in all three regions, with an increase of 12 percent in Southern California and a 6 percent increase in Northern California. The historical data show that, on average, medical-legal evaluations in Southern California have always been substantially more expensive. Both Southern and Northern California showed no change in the average cost of a medical-legal evaluation on PD claims from 2014 to 2016. In that period, a medical-legal evaluation on PD claims averaged $1,905 per year in Southern and $1,380 per year in Northern California. The statewide changes in the average cost of a medical-legal evaluation on PD claims mirrored the pattern in Southern California, with an increase of 11 percent from 2013 to 2014 and no change from 2014 to 2016. From SY 2016 to SY 2017, the average cost of a medical-legal evaluation on PD claims decreased by 10 percent in Southern and - by 7 percent in Northern regions.

**Figure 33: Average Cost of a Medical-Legal Evaluation on PD Claim, by Region**




| | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| Southern | $1,709 | $1,908 | $1,877 | $1,918 | $1,729 |
| Central | $1,043 | $1,204 | $1,273 | $1,239 | $1,028 |
| Northern | $1,321 | $1,406 | $1,388 | $1,344 | $1,255 |
| CALIFORNIA | $1,502 | $1,675 | $1,664 | $1,668 | $1,495 |

Source: WCIRB

Trends in both the average number of medical-legal evaluations per claim and the average cost of an evaluation in California are being driven by medical-legal evaluations in Southern California, as seen in Figure 34 and Table 9. About 60 percent of medical-legal evaluations originated in Southern California in SY 2013 to SY 2017, reflecting the similar share of Southern California in workers' compensation claims.

**Table 9: Distribution of Medical-Legal Reports on PD Claims by California Regions**

| | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| **Southern** | 58% | 60% | 60% | 60% | 59% |
| **Central** | 16% | 16% | 15% | 17% | 17% |
| **Northern** | 26% | 25% | 25% | 23% | 24% |

Source: WCIRB

**Medical-Legal Cost Drivers**

The primary cost driver for California and its Southern region is not the price paid for specific types of evaluations. Rather, the mix of codes used for billing the evaluations continues the historical pattern of including a higher percentage of the most complex and expensive evaluations and a lower percentage of the least expensive type. The Medical-Legal Fee schedule adopted by the Administrative Director in 2006 increased the cost per medical-legal evaluation for dates of services on or after July 1, 2006. Table 10 shows the costs and description from the Medical-Legal Fee Schedule.

**Table 10: Medical-Legal Evaluation Cost for Dates of Service on or After July 1, 2006**

| Evaluation Type | Amount Presumed Reasonable |
|---|---|
| ML-100 Missed Appointment | Some claims administrators will not pay |
| ML-101 Follow-up | $62.50/15 minutes or $250/hr. |
| ML-102 Basic (flat rate) | $625 |
| ML-103 Complex (flat rate) | $937.50 |
| ML-104 Extraordinary | $62.50/15 minutes or $250/hr. |
| ML-105 Testimony | $62.50/15 minutes or $250/hr. |
| ML-106 Supplemental | $62.50/15 minutes or $250/hr. |

Note: Two categories ML-105 and ML-106, created by CCR Title 8, Sections 9793 & 9795, June 2006, were applicable to 2008 and later claims. The functions of medical testimony and supplemental evaluations were moved into these two new categories from their previous status.

The distribution of medical-legal evaluations by categories of "fee schedule type" in Figure 34 show that, from SY 2013 to SY 2016, on average, one-third of medical-legal evaluations in Southern California region were classified as Extraordinary (ML-104). Although, within that average, the share of ML-104 reports in Southern region had been steadily decreasing from 37 percent in SY 2014 to 28 percent in SY 2017, as the share of Supplemental reports was increasing from 27 percent in SY 2013 to 37 percent in SY 2017. In 2017, 66 percent of medical-legal evaluations in Northern/Central California and 71 percent in Southern California were billed under the time-based codes, such as ML-101, ML-104, or ML-106, which are priced at $62.50 for every 15 minutes for QMEs or $78.13 for every 15 minutes for AMEs. Some medical-legal evaluation activities are not billable separately under all medical-legal fee codes. For example, reviewing medical-legal consultation reports could not be billed separately under flat-rated codes as ML-102 or ML-103, as opposed to time-based codes. This makes billing a medical-legal evaluation under a time-based code more profitable in the majority of evaluations.

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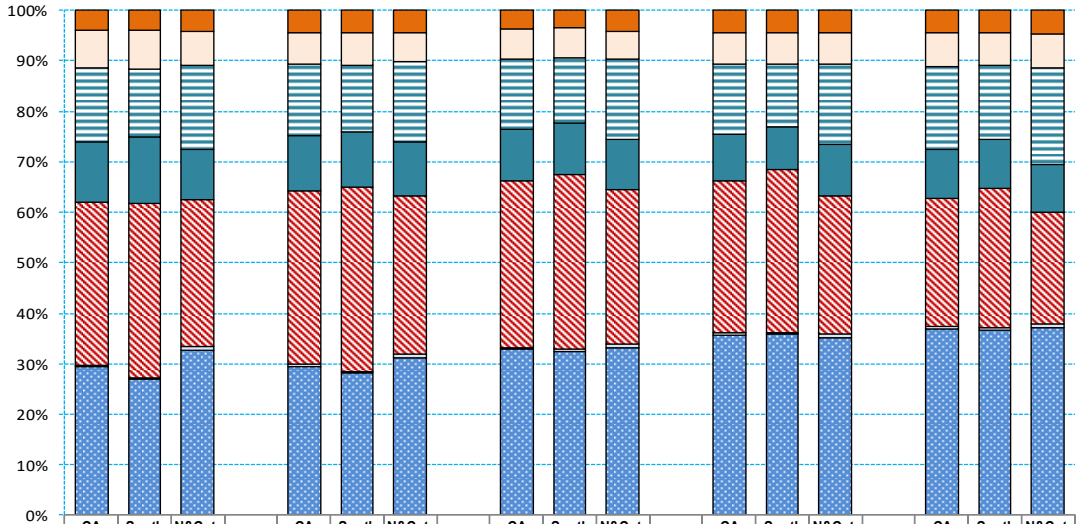
In addition to a higher share of extraordinary evaluations (ML-104) compared to other types of medical-legal reports (see Figure 34), the medical-legal evaluations in California have a higher average cost of extraordinary reports (see Figure 35).

**Figure 34: Distribution of Medical-Legal Evaluations on PD Claims by Procedure Code in California and Regions SY 2013 - SY 2017**




| | 2013 | | | 2014 | | | 2015 | | | 2016 | | | 2017 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CA | South | N&Cntr | CA | South | N&Cntr | CA | South | N&Cntr | CA | South | N&Cntr | CA | South | N&Cntr |
| ML - 100 Missed app-nt | 4% | 4% | 4% | 4% | 4% | 4% | 4% | 3% | 4% | 4% | 5% | 4% | 4% | 4% | 5% |
| ML - 101 Follow-up | 7% | 8% | 7% | 6% | 6% | 6% | 6% | 6% | 5% | 6% | 6% | 6% | 7% | 6% | 7% |
| ML - 102 Basic | 15% | 14% | 17% | 14% | 13% | 16% | 14% | 13% | 16% | 14% | 12% | 16% | 17% | 15% | 19% |
| ML - 103 Complex | 12% | 13% | 10% | 11% | 11% | 11% | 10% | 10% | 10% | 9% | 8% | 10% | 10% | 10% | 9% |
| ML - 104 Extraordinary | 32% | 34% | 29% | 34% | 37% | 31% | 33% | 35% | 31% | 30% | 32% | 27% | 25% | 28% | 22% |
| ML - 105 Testimony | 0.5% | 0.3% | 0.7% | 0.5% | 0.4% | 0.8% | 0.5% | 0.3% | 0.7% | 0.4% | 0.3% | 0.7% | 0.6% | 0.5% | 0.7% |
| ML - 106 Supplemental | 29% | 27% | 33% | 29% | 28% | 31% | 33% | 33% | 33% | 36% | 36% | 35% | 37% | 37% | 37% |

"N&Cntr" - Northern and Central regions

Data Source: WCIRB

Table 11 shows that every year, around two-thirds of medical-legal payments were spent on the most highly reimbursed Medical Legal procedure (ML104) in all three regions. ML104 involves claims with four or more complexities, is reimbursed at a rate of over $3,000 per report (see Figure 35) and increases costs on a per-transaction basis as well. The average cost of a medical-legal report per transaction increased by 10 percent from CY 2013 to CY 2015, and according to WCIRB, there was a modest 3 percent increase in payments per transaction between CY 2014 and CY 2016. All these factors explain why the average cost of a medical-legal evaluation on PD claims did not show a notable decrease in the last four years covered in this report. Also, the extraordinary report has the highest frequency among other procedure codes, from 11 to 18 per 100 PD claims in SY 2013 to SY 2017.

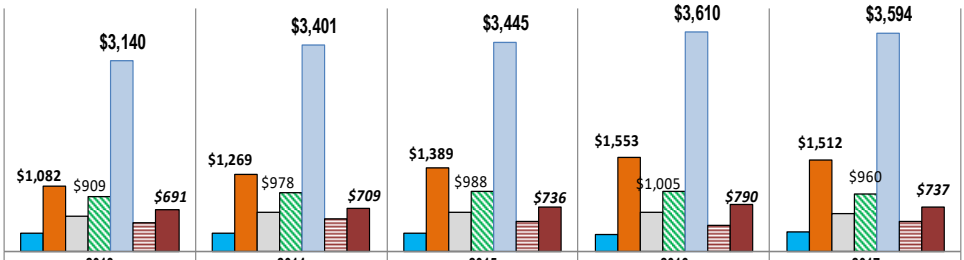
**Table 11: Characteristics of ML-104 coded Reports done on PD Claims in California Regions**

| | | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| **Southern** | Share of region in Total Med-Legal Payments | 66% | 68% | 68% | 67% | 67% |
| | Share of ML-104 in regional payment | 69% | 72% | 69% | 66% | 62% |
| | Avg Cost of ML-104 Report | $3,418 | $3,738 | $3,754 | $3,952 | $3,770 |
| | ML-104 Reports per 100 PD Claims | 15 | 16 | 13 | 13 | 11 |
| **Central** | Share of region in Total Med-Legal Payments | 11% | 11% | 12% | 13% | 12% |
| | Share of ML-104 in regional payment | 63% | 66% | 64% | 63% | 47% |
| | Avg Cost of ML-104 Report | $2,356 | $2,595 | $2,856 | $2,924 | $2,892 |
| | ML-104 Reports per 100 PD Claims | 14 | 16 | 14 | 16 | 13 |
| **Northern** | Share of region in Total Med-Legal Payments | 23% | 21% | 21% | 20% | 20% |
| | Share of ML-104 in regional payment | 64% | 67% | 67% | 63% | 54% |
| | Avg Cost of ML-104 Report | $2,868 | $2,955 | $2,955 | $3,081 | $3,232 |
| | ML-104 Reports per 100 PD Claims | 18 | 18 | 16 | 14 | 13 |

Source: WCIRB

According to Figure 35, the average cost of all medical-legal evaluations billed under the time-based codes, such as ML-101, ML-104, or ML-106, showed an overall increase from SY 2013 to SY 2016 and a slight decrease from SY 2016 to SY 2017. The cost of an extraordinary report increased by 15 percent from $3,140 in SY 2013 to $3,610 in SY 2016 and then decreased by mere 0.4 percent from SY 2016 to SY 2017.

**Figure 35: Average Cost of a Medical-Legal Evaluation for a PD Claims in California by Procedure Code**




| | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| ML - 100 Missed app-nt | $297 | $312 | $312 | $296 | $335 |
| ML - 101 Follow-up | $1,082 | $1,269 | $1,389 | $1,553 | $1,512 |
| ML - 102 Basic | $595 | $657 | $647 | $659 | $621 |
| ML - 103 Complex | $909 | $978 | $988 | $1,005 | $960 |
| ML - 104 Extraordinary | $3,140 | $3,401 | $3,445 | $3,610 | $3,594 |
| ML - 105 Testimony | $488 | $547 | $502 | $426 | $492 |
| ML - 106 Supplemental | $691 | $709 | $736 | $790 | $737 |

Source: WCIRB

Another possible explanation for the differing trends in the average cost per evaluation and the increasing frequency of the most complex evaluations in California could be both the frequency and the number of psychiatric and psychological/behavioral evaluations per claim.

On average, psychiatric and psychological/behavioral evaluations are around $3,000, the most expensive evaluations by specialty of provider, and are nearly always billed under the ML-104 code. Table 12 shows that the average cost of a psychiatric evaluation in California increased by 26 percent from SY 2013 to SY 2016 and then decreased by 12 percent from SY 2016 to SY 2017. The average cost of a psychological/behavioral evaluation increased by 28 percent from SY 2013 to SY 2016, mirroring a 26 percent increase in Southern California, and then decreased by 3 percent from SY 2016 to SY 2017.

**Table 12: Average Cost of a Psychiatric or Psychological/Behavioral Report by Region**

| | | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| **Southern** | Psychiatry | $3,157 | $3,503 | $3,617 | $3,952 | $3,622 |
| | Psychologist/Behavioral | $2,515 | $3,054 | $2,942 | $3,171 | $3,270 |
| **Central** | Psychiatry | $2,129 | $2,492 | $2,870 | $2,853 | $2,165 |
| | Psychologist/Behavioral | $1,933 | $2,685 | $2,761 | $2,717 | $2,440 |
| **Northern** | Psychiatry | $2,662 | $2,917 | $3,015 | $3,228 | $2,760 |
| | Psychologist/Behavioral | $2,268 | $2,589 | $2,612 | $2,841 | $2,481 |
| **CALIFORNIA** | Psychiatry | $2,897 | $3,233 | $3,352 | $3,642 | $3,197 |
| | Psychologist/Behavioral | $2,345 | $2,863 | $2,829 | $3,001 | $2,907 |

Source: WCIRB

Southern California is the origin of about 68 percent of the psychiatric and 67 percent of the psychological/behavioral evaluations in California and has the biggest impact on both the frequency and cost of medical-legal evaluations statewide. The frequency of psychiatric and psychological/behavioral evaluations in Southern California averaged 5.5 per 100 PD reports and 7 per 100 PD reports yearly from SY 2013 to SY 2017 (Tables 13 and 14).

**Table 13: Rate of Psychiatric Evaluations per 100 PD Reports**

| | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| **Southern** | 6 | 6 | 5 | 5 | 5 |
| **Central** | 5 | 5 | 5 | 4 | 4 |
| **Northern** | 5 | 6 | 6 | 4 | 4 |
| **CALIFORNIA** | 6 | 6 | 5 | 4 | 5 |

Source: WCIRB

**Table 14: Rate of Psychiatric and Psychologist/Behavioral Evaluations per 100 PD Reports**

| | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| **Southern** | 7 | 5 | 6 | 9 | 9 |
| **Central** | 8 | 6 | 5 | 8 | 9 |
| **Northern** | 8 | 7 | 6 | 9 | 9 |
| **CALIFORNIA** | 7 | 6 | 6 | 9 | 9 |

Source: WCIRB

Table 15 shows that the psychiatric and psychological/behavioral evaluations combined make up about one fifth of total medical-legal payments in California, which makes them important cost drivers of California's medical-legal expenses.

**Table 15: Share of Payments for Psychiatric and Psychological Reports in California Medical-Legal Payments, by Region**

| | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| **Southern** | 22% | 20% | 19% | 16% | 18% |
| **Central** | 25% | 23% | 22% | 19% | 20% |
| **Northern** | 25% | 24% | 24% | 19% | 19% |

Source: WCIRB

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# WORKERS' COMPENSATION ADMINISTRATIVE 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 participating in the workers' compensation system, 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 figures and tables.

- Workers' Compensation Appeals Board (WCAB) Workload
  - Division of Workers' Compensation (DWC) Opening Documents
  - DWC Hearings
  - DWC Decisions
  - DWC Lien Filings and Decisions
- DWC Audit and Enforcement Program
- DWC Medical Unit (MU)
- DWC Disability Evaluation Unit
- DWC Medical Provider Networks and Health Care Organizations
- DWC Information and Assistance Unit
- DWC Uninsured Employers Benefits Trust Fund
- DWC Adjudication Simplification Efforts
  - DWC Information System (WCIS)
  - DWC Electronic Adjudication Management System (EAMS)
  - 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. Figure 36 shows the number 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, DWC workload adjudication data were available from the legacy system. After August 2008, DWC transitioned to a new computer-based system, the Electronic Adjudication Management System (EAMS).

As Figure 36 shows, the total number of Opening Documents increased by 5 percent from 2012 to 2013, stabilized at an average of 171,700 applications per year from 2014 to 2016, and then decreased by 2 percent from 2016 to 2017. The number of Applications, the most numerous component of the Opening

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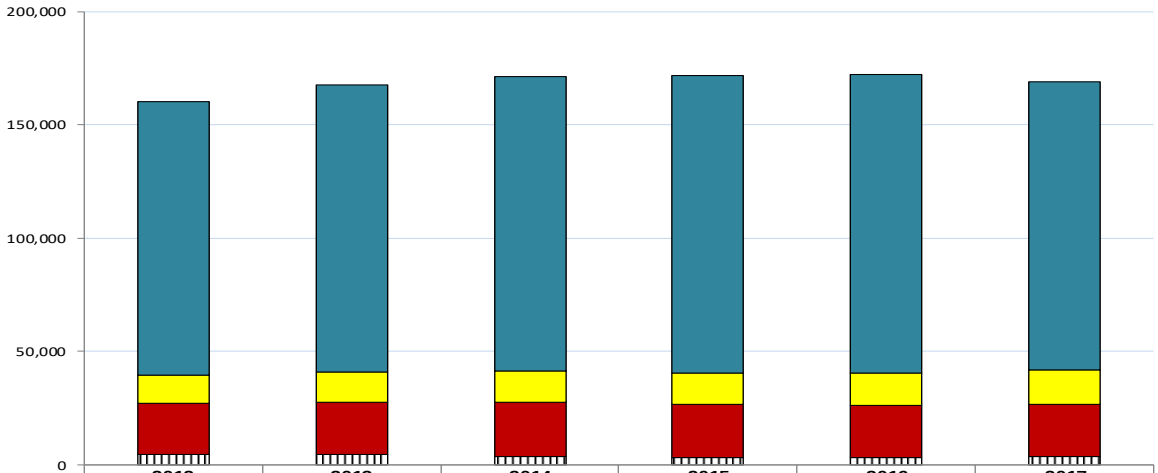
Documents, increased by 5 percent from 2012 to 2013, grew by another 4 percent from 2013 to 2016, and then decreased by 3 percent from 2016 to 2017.

**Figure 36: DWC Opening Documents**



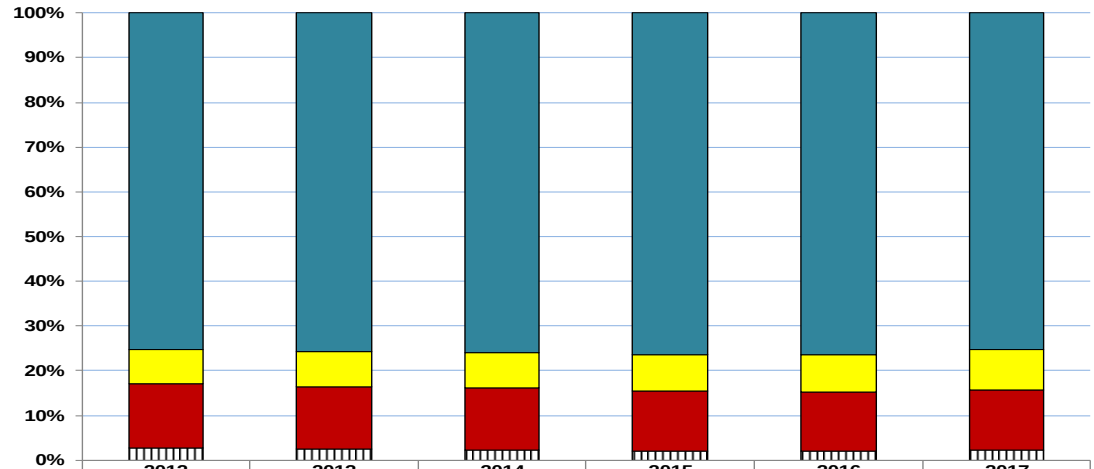

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Applications | 120,698 | 126,785 | 129,851 | 131,129 | 131,561 | 127,265 |
| Original C&R | 12,337 | 13,380 | 13,637 | 14,057 | 14,346 | 15,081 |
| Original Stips | 22,870 | 23,030 | 23,870 | 23,245 | 22,798 | 22,892 |
| Other | 4,389 | 4,339 | 3,760 | 3,345 | 3,390 | 3,683 |
| Total | 160,294 | 167,534 | 171,118 | 171,776 | 172,095 | 168,921 |

Data Source: DWC

### *Mix of DWC Opening Documents*

As Figure 37 shows, the Applications comprised three-fourth of all Opening Documents from 2012 to 2017. The proportion of Original (case-opening) Stips leveled off at 13-14 percent per year from 2012 to 2017. In the same period, the proportion of original C&Rs also stabilized at 8-9 percent.

**Figure 37: Percentage by Type of Opening Documents**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Applications | 75% | 76% | 76% | 76% | 76% | 75% |
| Original C&R | 8% | 8% | 8% | 8% | 8% | 9% |
| Original Stips | 14% | 14% | 14% | 13.5% | 13% | 14% |
| Other | 3% | 3% | 2% | 2% | 2% | 2% |

Data Source: DWC

***Division of Workers' Compensation Hearings***

*Numbers of Hearings*

Labor Code Section 5502 hearings are the first hearings only. The hearings covered are expedited hearings, status, priority, and mandatory settlement conferences, and trials that follow a mandatory settlement conference (MSC). The timelines are measured from the filing of a Declaration of Readiness to Proceed (DOR) to the hearing. The time frames for each of these hearings are prescribed as follows:

A. Expedited Hearing and Decision. Labor Code Section 5502(b) directs the Court Administrator to establish a priority calendar for issues requiring an expedited hearing and decision. These cases must be heard and decided within 30 days following the filing of a DOR.

B. Priority Conferences. Labor Code Section 5502(c) directs the Court Administrator to establish a priority conference calendar for cases when the employee is represented by an attorney and the issues in dispute are employment or injury arising out of employment (AOE) or in the course of employment (COE). The conference shall be conducted within 30 days after the filing of a DOR to proceed.

C. For cases in which the employee is represented by an attorney and the issues in dispute are employment or injury arising out of employment or in the course of employment and good cause is shown why discovery is not complete for trial, then status conferences shall be held at regular intervals.

D. MSC and Ratings MSC. Labor Code Section 5502(e) establishes time frames to schedule MSCs and trials in cases involving injuries and illnesses occurring on and after January 1, 1990. MSCs are to be conducted not less than 10 days and not more than 30 days after filing a DOR.

E. Trials. Labor Code Section 5502(e) mandates that if the dispute is not resolved at the MSC, a trial is to be held within 75 days after filing the DOR.

Figure 38 indicates the number of different types of LC 5502 hearings held in DWC from 2012 through 2017. The total number of hearings held increased by 17 percent from 2012 to 2016 and then decreased by 4 percent from 2016 to 2017. The number of mandatory settlement conferences (MSCs), the most numerous hearings, averaged 72,500 cases per year from 2012 to 2014, increased by 12 percent from 2014 to 2016, and then decreased by 5 percent from 2016 to 2017. Rating MCSs decreased steadily by 33 percent from 2012 to 2017. The number of expedited hearings increased 1.6 times from 2012 to 2015 and then fluctuated between 15,900 and 16,700 from 2015 to 2017. The number of status conferences increased steadily by total of 37 percent from 2012 to 2017. The priority conferences increased by 39 percent from 2012 to 2015 and then declined by 7 percent from 2015 to 2017. The number of trials decreased by 21 percent from 2012 to 2014, increased by 8 percent to an average of 17,700 trials per year in 2015 and 2016, and then decreased by 9 percent from 2016 to 2017.

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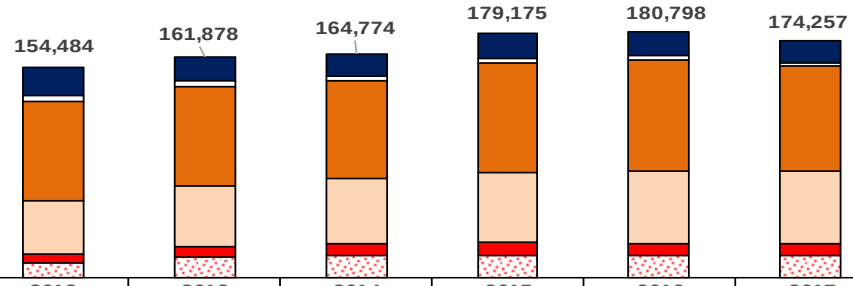
**Figure 38: DWC Labor Code 5502 Hearings Held**



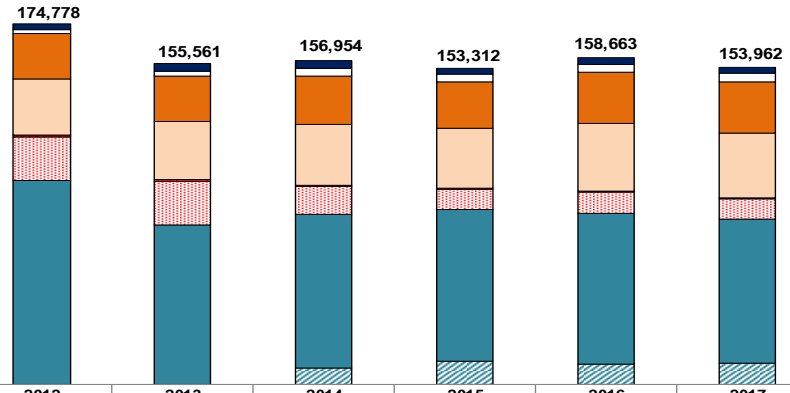

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Trials | 20,726 | 17,737 | 16,407 | 17,801 | 17,661 | 16,144 |
| Rating MSCs | 4,415 | 4,214 | 3,819 | 3,805 | 3,544 | 2,948 |
| Mand. Settl. Conf.(MSC) | 72,911 | 72,628 | 71,864 | 80,277 | 81,066 | 76,711 |
| Status Conferences | 39,598 | 44,710 | 47,627 | 51,724 | 53,812 | 54,095 |
| Priority Conferences | 6,389 | 7,372 | 8,451 | 8,868 | 8,831 | 8,229 |
| Expedited Hearings | 10,445 | 15,217 | 16,606 | 16,700 | 15,884 | 16,130 |
| TOTAL | 154,484 | 161,878 | 164,774 | 179,175 | 180,798 | 174,257 |

Source: DWC

The non-Section 5502 hearings are continuances or additional hearings after the first hearing. Figure 39 shows non-Section 5502 hearings held from 2012 to 2017.

The number of MCSs increased by 21 percent from 2012 to 2016 and then decreased by 4 percent from 2016 to 2017. The rating MCSs decreased almost 2.5 times from 2012 to 2017. The number of status conferences increased overall by 15 percent from 2012 to 2017. The number of priority conferences doubled from 2012 to 2016 and then decreased slightly from 2016 to 2017. The number of expedited hearings increased by 37 percent from 2012 to 2014, decreased by 24 percent from 2014 to 2015, and then fluctuated around an average of 3,050 cases from 2015 to 2017. The lien conferences decreased steadily by 30 percent from 2012 to 2017. Lien trials data available from 2014 showes a fluctuation between 8,300 and 11,200 trials per year up to 2017. The number of trials decreased overall by 54 percent from 2012 to 2017.

**Figure 39: DWC Non-5502 Hearings Held**

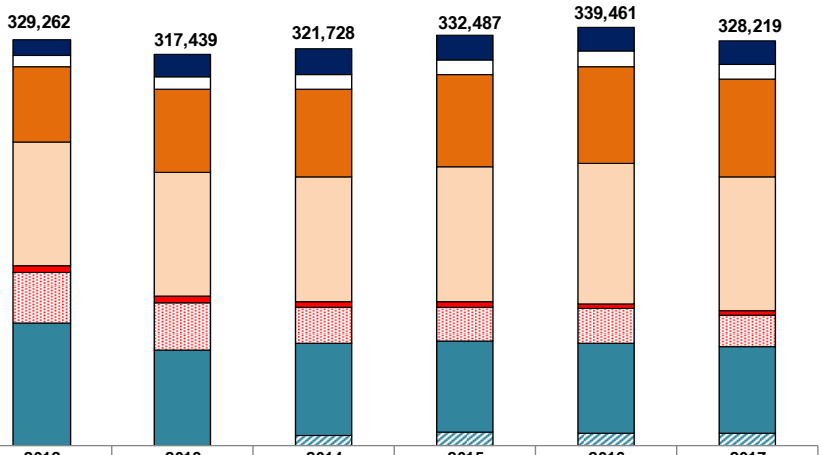



| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Expedited Hearings | 2,648 | 3,431 | 3,638 | 2,755 | 3,316 | 3,086 |
| Priority Conferences | 1,965 | 2,641 | 3,544 | 3,582 | 3,986 | 3,797 |
| Status Conferences | 21,724 | 21,901 | 23,385 | 22,784 | 24,471 | 24,912 |
| Mandatory Settlement Conferences(MSC) | 27,399 | 28,292 | 29,725 | 28,965 | 33,050 | 31,778 |
| Rating MSCs | 749 | 698 | 536 | 515 | 434 | 315 |
| Trials | 21,188 | 21,314 | 13,387 | 9,666 | 10,324 | 9,663 |
| Lien Conferences | 99,105 | 77,284 | 74,457 | 73,807 | 73,180 | 69,830 |
| Lien Trials | N/A | N/A | 8,282 | 11,238 | 9,902 | 10,581 |
| TOTAL | 174,778 | 155,561 | 156,954 | 153,312 | 158,663 | 153,962 |

Data Source: DWC

Figure 40 shows the total hearings held from 2012 to 2017 including Labor Code Section 5502 hearings, non-Section 5502 hearings, and lien conferences.

**Figure 40: DWC Total Number of Hearings Held (LC 5502 and non-5502)**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Expedited Hearings | 13,093 | 18,648 | 20,244 | 19,455 | 19,200 | 19,216 |
| Priority Conferences | 8,354 | 10,013 | 11,995 | 12,450 | 12,817 | 12,026 |
| Status Conferences | 61,322 | 66,611 | 71,012 | 74,508 | 78,283 | 79,007 |
| Mandatory Settlement Conferences(MSC) | 100,310 | 100,920 | 101,589 | 109,242 | 114,116 | 108,489 |
| Rating MSCs | 5,164 | 4,912 | 4,355 | 4,320 | 3,978 | 3,263 |
| Trials | 41,914 | 39,051 | 29,794 | 27,467 | 27,985 | 25,807 |
| Lien Conferences | 99,105 | 77,284 | 74,457 | 73,807 | 73,180 | 69,830 |
| Lien Trials | N/A | N/A | 8,282 | 11238 | 9,902 | 10,581 |
| TOTAL | 329,262 | 317,439 | 321,728 | 332,487 | 339,461 | 328,219 |

Data Source: DWC

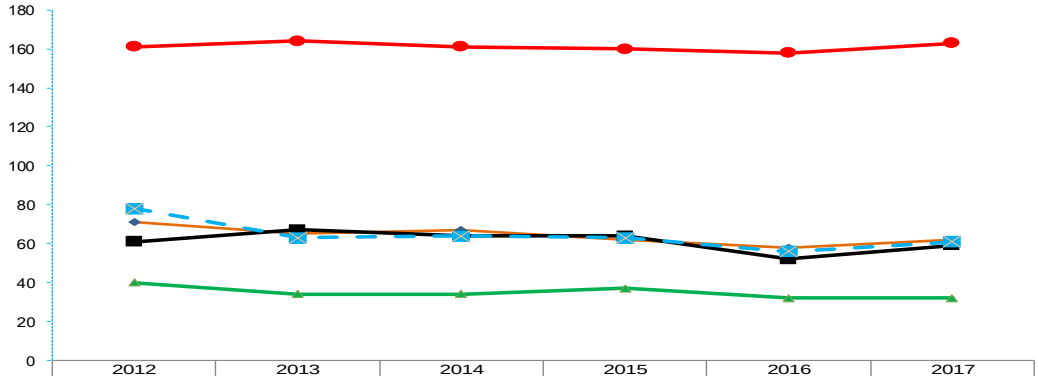
*Timeliness of Hearings*

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

- An expedited hearing must be held within 30 days of the receipt of a DOR.
- The conference shall be conducted within 30 days after the filing of a DOR.
- MSCs, rating MSCs, and priority conferences are required to be held within 30 days of the receipt of a request in the form of a DOR.
- A trial must be held within 75 days of the request if a settlement conference has not resolved the dispute.

Figure 41 shows the average elapsed time from a request to a DWC hearing in the fourth quarter of each year, from 2012 to 2017. All types of DWC hearings showed an overall decrease in average elapsed time from a request to hearing from 2012 to 2016 followed by an increase from 2016 to 2017, except for expedited hearings. For expedited hearings, the average elapsed time from a request to hearing showed an uninterrupted and steady 20 percent decrease from 40 days in 2012 to 32 days in 2017. The average elapsed time for MSCs decreased by 18 percent from 2012 to 2016 and then increased by 7 percent from 2016 to 2017. Similarly, the average elapsed time from a request to hearing for priority conferences decreased by 28 percent from 2012 to 2016 and then increased by 9 from 2016 to 2017. The average elapsed time from a request to a DWC trial changed slightly around an average of 161 days from 2012 to 2016 and then increased to its 2013 level of 164 days in 2017.

**Figure 41: Elapsed Time in Days from Request to DWC Hearing (4th Quarter)**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| MSCs * | 71 | 65 | 67 | 62 | 58 | 62 |
| Rating MSC ** | 61 | 67 | 64 | 64 | 52 | 59 |
| Expedited Hearing | 40 | 34 | 34 | 37 | 32 | 32 |
| Priority Conf ** | 78 | 63 | 64 | 63 | 56 | 61 |
| Trials | 161 | 164 | 161 | 160 | 158 | 163 |

* Mandatory Settlement Conferences.
** Data for the period from 2001 to 2007 are unavailable.

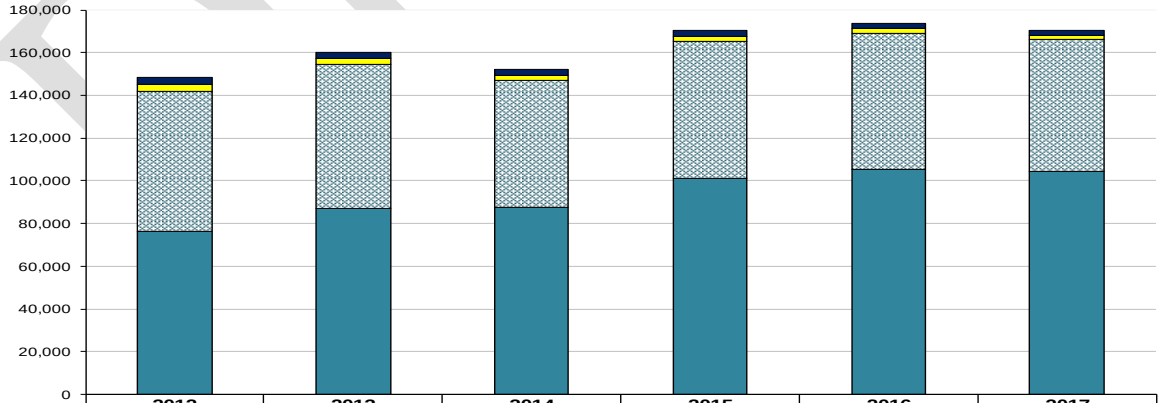
Data Source: DWC

## Division of Workers' Compensation Decisions

*DWC Case-Closing Decisions*

Figure 42 shows that after an 8 percent increase from 2012 to 2013, the total number of case-closing decisions decreased by 5 percent from 2013 to 2014. This decrease in the number of case-closing decisions was due to decreases in Findings & Award (F&A) from 2012 to 2014, in Findings & Order (F&O) from 2012 to 2014, and in Stipulations from 2013 to 2014. From 2014 to 2016, the total number of case-closing decisions increased by 14 percent as a result of a steady 38 percent increase in Compromise and Releases (C&Rs) from 2012 to 2016 and a 7.5 percent increase in Stipulations from 2014 to 2016. From 2016 to 2017, the total number of case-closing decisions decreased by 2 percent, as both Compromise and Releases (C&Rs) and Stipulations decreased in the same period.

**Figure 42: DWC Case-Closing Decisions**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| F & O | 3,338 | 3,042 | 2,899 | 2,861 | 2,395 | 2,408 |
| F & A | 2,879 | 2,701 | 2,314 | 2,257 | 2,295 | 2,156 |
| Stipulation | 65,876 | 67,154 | 59,127 | 64,357 | 63,590 | 61,794 |
| C & R | 76,200 | 87,265 | 87,804 | 101,122 | 105,436 | 104,246 |
| TOTAL | 148,293 | 160,162 | 152,144 | 170,597 | 173,716 | 170,604 |

Data Source: DWC

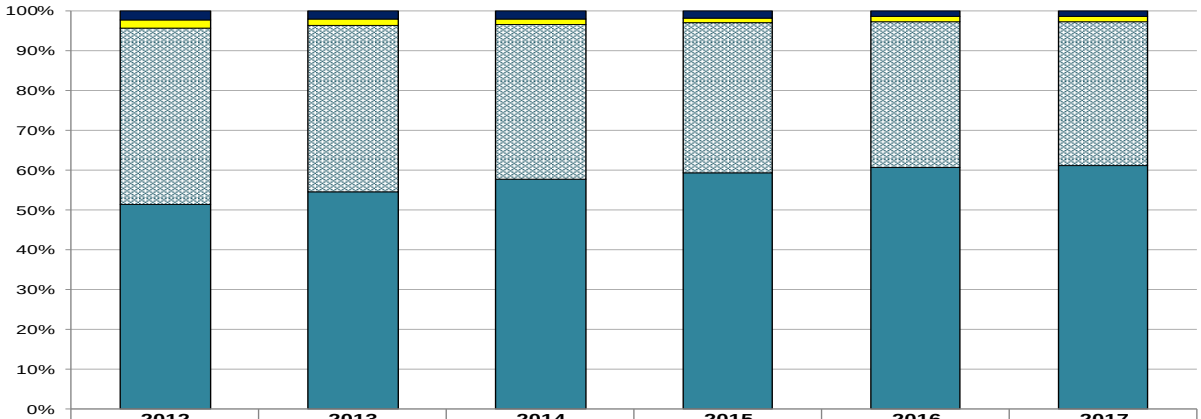
*Mix of DWC Decisions*

As shown in the previous figures and in the figure below, again, the vast majority of the case-closing decisions were in the form of a WCAB judge's approval of Stips and C&Rs, which were originally formulated by the case parties.

From 2012 to 2017, the proportion of Stips decreased from 44 to 36 percent and the proportion of C&Rs increased from 51 to 61 percent.

In the figure that follows, only a small percentage of case-closing decisions evolved from a Findings & Award (F&A) or Finding & Order (F&O) issued by a WCAB judge after a hearing. That pattern continued with an overall decrease for both types of decisions from 2012 to 2017.

**Figure 43: DWC Decisions: Percent Distribution by Type of Decisions**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| F & O | 2.3% | 1.9% | 1.9% | 1.7% | 1.4% | 1.4% |
| F & A | 1.9% | 1.7% | 1.5% | 1.3% | 1.3% | 1.3% |
| Stips | 44.4% | 41.9% | 38.9% | 37.7% | 36.6% | 36.2% |
| C & R | 51.4% | 54.5% | 57.7% | 59.3% | 60.7% | 61.1% |

Data Source: DWC

*Division of Workers' Compensation Lien Filings and Decisions*

SB 863 became effective January 1, 2013 and introduced changes regarding liens filed against an injured workers' claim, for medical treatment and other services provided in connection with the claim, but not paid for by the employer or insurance carrier. The bill introduced a filing fee of $150 required for all liens filed after January 1, 2013 and a $100 activation fee required for liens filed before January 1, 2013. These fees served as tools for dismissal of liens by operation of law after January 1, 2014 if no filing or activation fee has been filed. Other measures included an 18-month statute of limitations for filing liens for services rendered after July 1, 2013 and a 3-year statute of limitations for services provided before then. Assignments of lien claims were also strictly limited and allowed only where the assignor had gone out of business.

Senate Bill 1160 and Assembly Bill 1244, both of which became effective on January 1, 2017, added important new provisions that significantly decreased the number of liens filed in 2017:

- Labor Code section 4615 places an automatic stay on liens filed by or on behalf of physicians and providers who are criminally charged with certain types of fraud. The automatic stay prevents those liens from being litigated or paid while the prosecution is pending.

- Provider suspension activities undertaken pursuant to Labor Code section 139.21 include consolidation and dismissal of all pending lien claims in a special lien proceeding for providers who have been suspended due to conviction of a covered crime. The Special Adjudication Unit (SAU) was designed and implemented to conduct lien consolidation proceedings.

- Labor Code section 4903.05(c), as amended by SB 1160, introduced the lien dismissals by operation of law. This provision requires lien claimants to file a declaration verifying the legitimacy of liens for medical treatment or medical-legal expenses. Claimants who had filed liens between January 1, 2013 and December 31, 2016, were required to file the declarations by July 1, 2017, to avoid having those liens dismissed.

As Table 16 shows, the number of liens filed in 2012 peaked to 1.2 million in expectation of lien filing fees introduced by SB 863. The number of liens filed decreased by over 50 percent between 2011 and 2014 due to the introduction of SB 863 lien provisions. Between 2014 and 2016, there was an 86 percent increase in lien filings, followed by more than a 50 percent decrease from 2016 to 2017 due to the SB 1160 and AB 1244 reforms enacted in 2016.

The number of decisions regarding liens filed on WCAB cases showed a significant increase of 59 percent from 2011 to 2013, thereby increasing concomitant expenditure of DWC staff resources on resolution of those liens. Between 2013 and 2016, the number of DWC lien decisions fluctuated and then decreased by 7 percent from 2016 to 2017. Because of the addition of Labor Code 4615, many liens are stayed and cannot be decided until the criminal case is resolved.[35]

**Table 16: Numbers of Liens Filed and DWC Lien Decisions, 2011-2017**

| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|---|
| Liens Filed | 469,190 | 1,236,704 | 206,858 | 229,730 | 398,940 | 426,792 | 206,828 |
| DWC Lien Decisions | 41,395 | 64,300 | 65,800 | 58,321 | 64,360 | 56,079 | 52,140 |

Source: DWC & OIS

See "Report on Liens" (CHSWC, 2011) for a complete description.
http://www.dir.ca.gov/chswc/Reports/2011/CHSWC_LienReport.pdf

## 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 in 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

[35] https://www.dir.ca.gov/dwc/SB1160-AB1244/Special-Adjudication-Unit-Calendar.htm

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 be required to pay penalties only for unpaid or late paid 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 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 WCAB rather than by application for a writ of mandate in the Superior Court. Judicial review of the WCAB'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).

***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 California Code of Regulations (CCR) 8, Section 10106.1(c), effective January 1, 2003:

- Complaints regarding claims handling received by DWC.
- Failure to meet or exceed FCA performance standards.
- A high number 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.

***Audit and Enforcement Unit Data***

*Routine and Targeted Audits*

Figures 44 to 50 depict workload data from 2012 through 2017. Figure 44 shows the number of routine and targeted audits and the total number of audits conducted each year.

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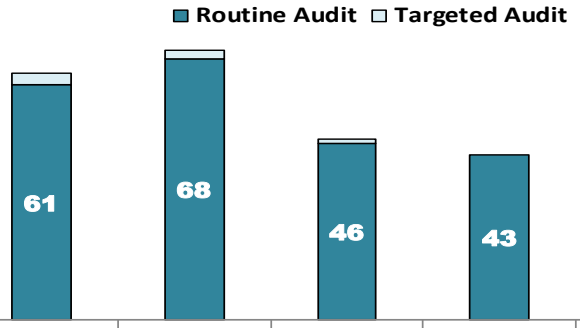
**Figure 44: Routine and Targeted Audits**



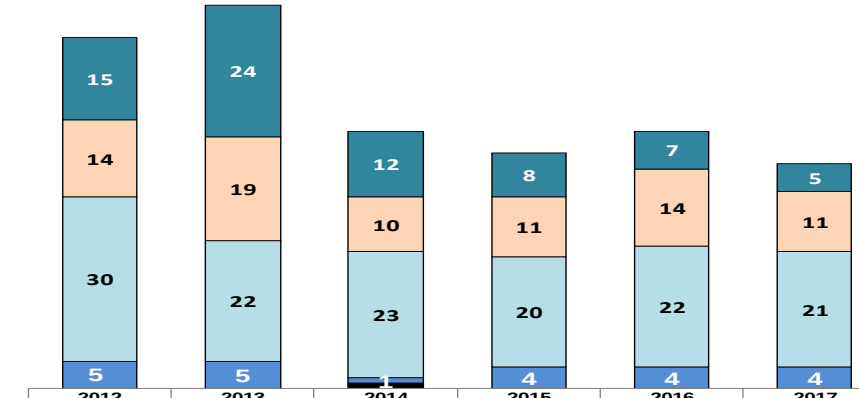

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Targeted Audit | 3 | 2 | 1 | 0 | 0 | 1 |
| Routine Audit | 61 | 68 | 46 | 43 | 47 | 40 |
| TOTAL | 64 | 70 | 47 | 43 | 47 | 41 |

Data Source: DWC Audit and Enforcement Unit

*Audits by Type of Audit Subject*

Figure 45 depicts the total number of audit subjects each year, broken down by whether the subject is an insurance company (insurer), a self-insured employer, or a third-party administrator.

**Figure 45: DWC Audits by Type of Audit Subject**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Insurance Companies | 15 | 24 | 12 | 8 | 7 | 5 |
| Self-Insured Employers | 14 | 19 | 10 | 11 | 14 | 11 |
| Third-Party Administrators | 30 | 22 | 23 | 20 | 22 | 21 |
| Insurer and TPA | 5 | 5 | 1 | 4 | 4 | 4 |
| Self-Insured and TPA | 0 | 0 | 1 | 0 | 0 | 0 |
| TOTAL | 64 | 70 | 47 | 43 | 47 | 41 |

Data Source: DWC Audit and Enforcement Unit

*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 selected based on the number of claims in each of those populations of the audit subject:

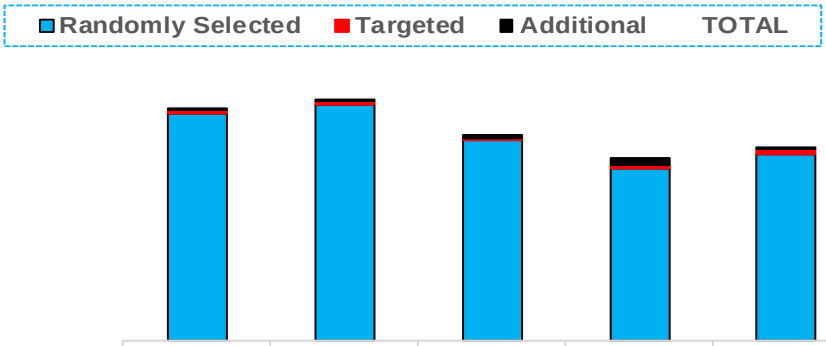
- Targeted files are based on complaints received by the DWC.
- Additional files include claims chosen based on criteria relevant to a targeted audit but for which no specific complaints had been received.
- The number of claims audited is based upon the total number of claims at the adjusting location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

Figure 46 shows the total number of claim files audited each year broken down by the method used to select them. In 2017, within the PAR/FCA audits, compliance officers audited 2,638 claim files, of which 2,529 were randomly selected claims in which some form of indemnity benefits was paid. Targeted claims audited included 35 files based on complaints received by the DWC. Another 74 audited claims were designated as an "additional" file.

"Additional" files include the following:

- Claims audited as a companion file to a randomly selected file.
- Claims chosen based on criteria relevant to a target audit but for which no specific complaints had been received.
- Claims in excess of the number of claims in the random sample, audited because the files selected were incorrectly designated on the log.

**Figure 46: Files Audited by Method of Selection**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Additional | 4 | 1 | 31 | 120 | 3 | 74 |
| Targeted | 53 | 55 | 46 | 47 | 66 | 35 |
| Randomly Selected | 3,387 | 3,496 | 2,972 | 2,562 | 2,774 | 2,529 |
| TOTAL | 3,445 | 3,678 | 3,049 | 2,729 | 2,843 | 2,638 |

Source: DWC Audit and Enforcement Unit

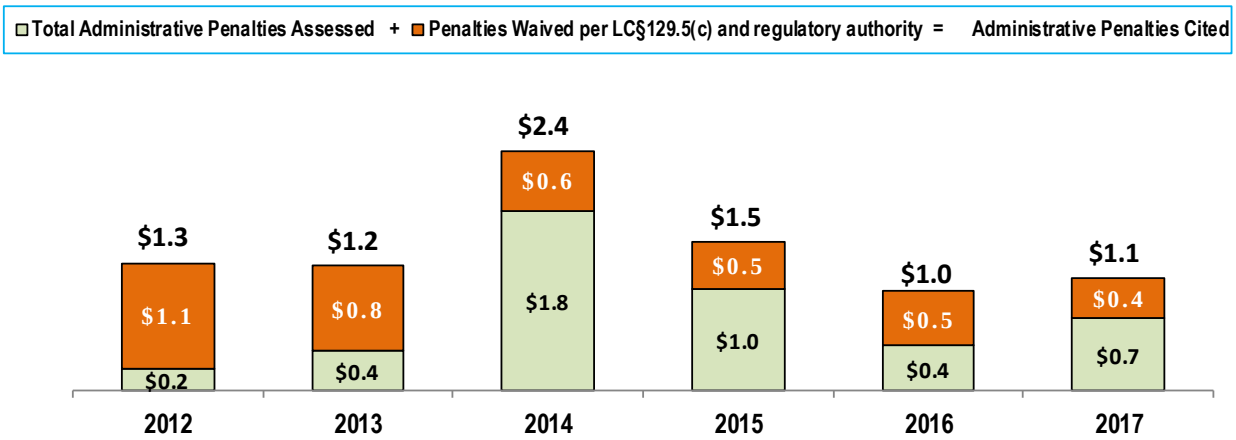
*Administrative Penalties*

Figure 47 shows the administrative penalties cited from 2012 to 2017. As a result of PAR/FCA audits conducted during the calendar year 2017, the Audit & Enforcement Unit found and cited 4,510 violations against claims administrators, with administrative penalties totaling $1,115,605.

Not all administrative penalties are subject to collection. Under the Labor Code, no penalties are assessed on those "cited" violations unless the audit subject fails the audit at a specific level.

In accordance with Labor Code section 129.5(c) and regulatory authority, the Audit & Enforcement Unit did not assess or waived $393,423 for administrative penalties of the cited violations. The violations which, by law, were not assessed occurred within 41 of the audits that met or exceeded the PAR performance standard. All violations cited in the audit that failed the FCA performance standard were assessed. The assessed penalties subject to collection from claims administrators for FCA audits came to a total of $722,182.

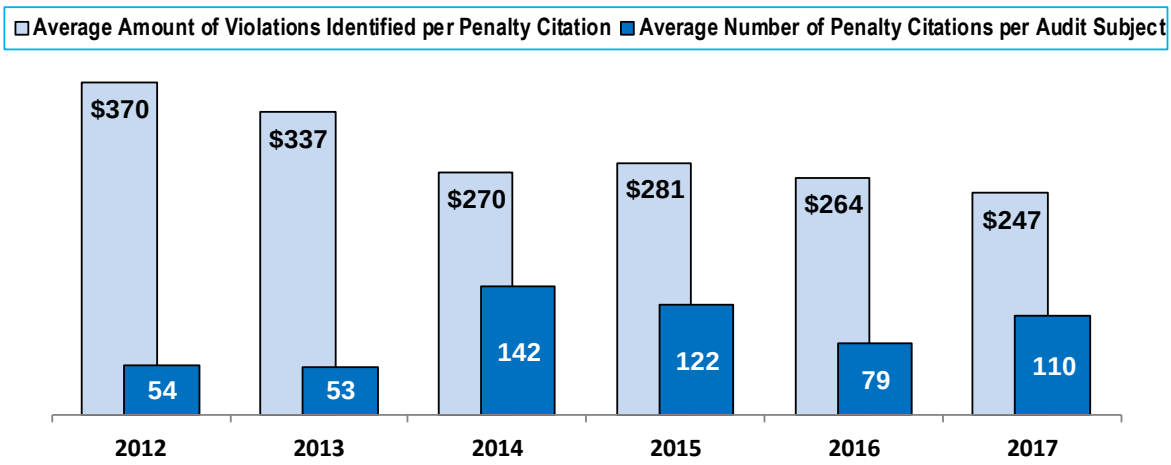
**Figure 47: DWC Audit Unit—Administrative Penalties (Million $)**




Data Source: DWC Audit and Enforcement Unit

Figure 48 shows the average number of penalty citations per audit subjects each year and the average dollar amount per penalty citation. In 2017, the average number of penalty citations per 41 audits was 110 and the average amount of penalties cited per 4,510 violations was about $247.

**Figure 48: Average Amount per Penalty Citation and Average Number of Penalty Citations per Audit Subject**



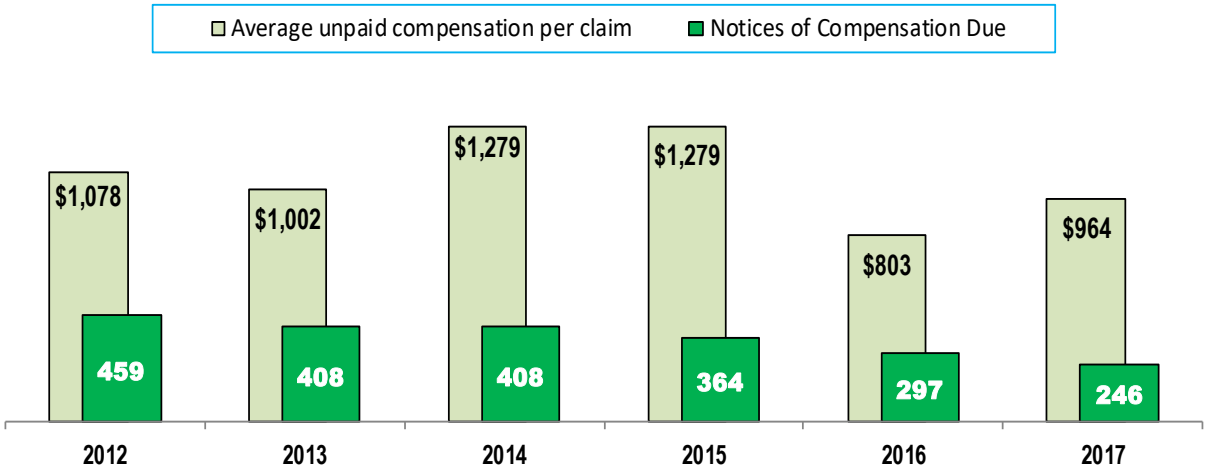

Data Source: Audit and Enforcement Unit

*Unpaid Compensation Due to Claimants*

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

Figure 49 depicts the average number of claims per audit where unpaid compensation was found and the average dollar amount of compensation due per claim.

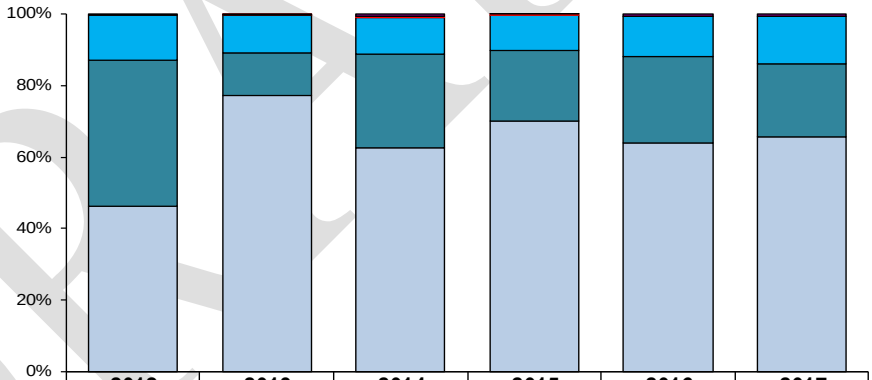
**Figure 49: Average Amount of Unpaid Compensation per Claim and Number of Notices of Compensation**




Data Source: Audit and Enforcement Unit

Figure 50 shows yearly distribution of unpaid compensation by specific type.

**Figure 50: Distribution of Unpaid Compensation by Type**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Interest and penalty and/or unreimbursed medical expenses | 0.2% | 0.3% | 1% | 0.1% | 1% | 1% |
| Death Benefits | N/A | 0.1% | 0.04% | 0.1% | 0.0% | 0.0% |
| Self-imposed increases for late indemnity payments | 13% | 10% | 10% | 10% | 11% | 13% |
| Permanent Disability | 41% | 12% | 26% | 20% | 24% | 21% |
| TD & salary continuation in lieu of TD | 46% | 77% | 62% | 70% | 64% | 66% |

Note: Due to rounding, percentages may exceed 100%.

Data Source: DWC Audit and Enforcement Unit

*For further information …*

DWC Annual Audit Reports are available 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.

**DIVISION OF WORKERS' COMPENSATION DISABILITY EVALUATION UNIT**

The DWC Disability Evaluation Unit (DEU) determines permanent disability ratings by assessing physical and mental impairments presented in medical reports. Physical impairments for injuries after 2005 are described in accordance with the AMA *Guide,* 5th ed., and disability is determined in accordance with the 2005 Permanent Disability Rating Schedule (PDRS). A final permanent disability rating (PDR) is obtained only after the whole person impairment rating obtained from a treating physician is adjusted for diminished future earning capacity (FEC), occupation and age at the time of injury. For injuries prior to 2005 and after April 1, 1997, the 1997 PDRS or an earlier edition is utilized, depending on date of injury. For injuries that occur on or after January 1, 2013, the FEC modifier has been replaced with a 1.4 modifier in accordance with changes to Labor Code Section 4660.1 as a result of SB 863.

The DEU's mission is to prepare timely and accurate ratings to facilitate the resolution of workers' compensation cases. Ratings are used by workers' compensation judges, injured workers, insurance claims administrators and attorneys to determine appropriate permanent disability benefits. DEU prepares three types of ratings:

- Formal Ratings—ratings per workers' compensation judges as part of expert testimony in a litigated case.
- Consultative Ratings—ratings on litigated cases at the request of an attorney, DWC Information & Assistance Officer, or other party to the case in order to advise parties to the level of permanent disability.
- Summary Ratings—ratings on non-litigated cases done at the request of a claims administrator or injured worker.

A permanent disability can range from 0 to 100 percent. Zero percent signifies no reduction of earning capacity, while 100 percent represents permanent total disability. A rating between 0 and 100 percent represents a partial loss of earning capacity. Partial permanent disability correlates to the number of weeks that an injured employee is entitled to permanent disability (PD) benefits, according to the percentage of PD.

In addition to written ratings, DEU provides oral consultations on PD issues and commutations to determine the present value of future indemnity payments to assist in case settlements.

Figure 51 illustrates DEU's workload from 2012 through 2017 and shows the total ratings and ratings by type.

The total number of DEU written ratings averaged around 59,700 yearly between 2012 and 2017. The conbined share of consultative ratings in total ratings increased from 62 percent in 2012 to 72 percent in 2017 as the number of non-walk-in consultative ratings increased by 29 percent from 2012 to 2017. The combined share of summary ratings by panel QMEs and treating doctors in all ratings decreased from 36 percent in 2012 to 26 percent in 2017. Overall from 2012 and 2017, the number of summary ratings by panel QMEs fell by 31 percent, the number of summary ratings by treating doctors decreased by 8 percent, the number of consultative walk-in rates fell by 17 percent, and the number of formal ratings decreased by 17 percent.

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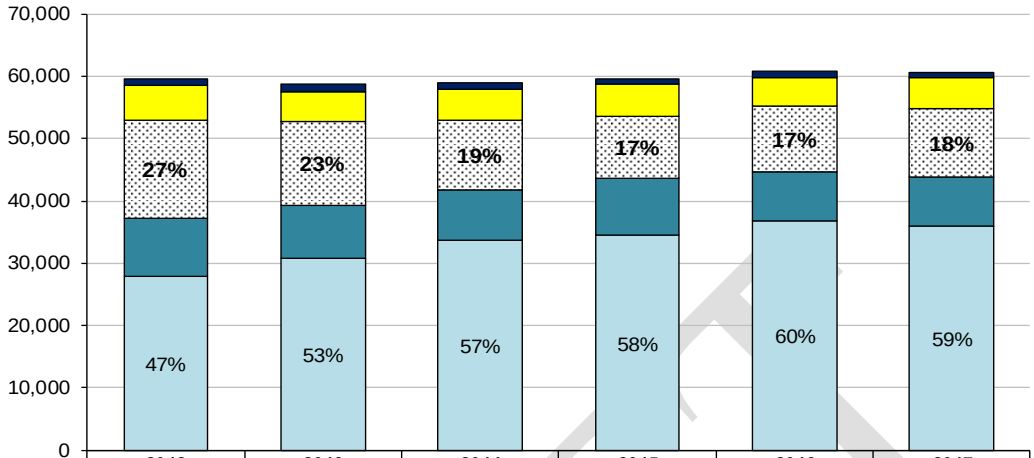
**Figure 51: DEU Written Ratings, 2012-2017**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Formal Ratings | 1,008 | 1,093 | 934 | 863 | 966 | 839 |
| Summary-Treatng Doc | 5,460 | 4,948 | 5,025 | 5,100 | 4,692 | 5,035 |
| Summary - Panel QME | 15,931 | 13,290 | 11,277 | 10,069 | 10,607 | 10,978 |
| Consultative - Walk-In | 9,213 | 8,539 | 8,089 | 9,127 | 7,815 | 7,689 |
| Consultative - Other | 27,895 | 30,808 | 33,618 | 34,420 | 36,749 | 36,044 |
| TOTAL | 59,507 | 58,678 | 58,943 | 59,579 | 60,829 | 60,585 |

Data Source: DWC Disability Evaluation Unit

Table 17 shows the number of ratings issued in 1997, 2005, and 2013 by type and rating schedules in effect.

**Table 17: DEU Ratings in 2017 by Type and Rating Schedules in Effect**

| Year that rating schedules went into effect | 1997 | 2005 | 2013 |
|---|---|---|---|
| Summary rating based on QME report | 20 | 6,326 | 4,632 |
| Summary rating treating based on physician report | 6 | 2,483 | 2,546 |
| Walk-in consultative ratings | 144 | 4,733 | 2,812 |
| Other consultative ratings | 1,057 | 21,032 | 13,955 |
| Formal ratings requested by judge | 52 | 542 | 245 |
| **TOTAL** | **1,279** | **35,116** | **24,190** |
| Percent of each rating schedule in effect in grand total number of ratings (=60,585) | 2% | 58% | 40% |

Data Source: DWC Disability Evaluation Unit

**DEU Backlog**

DEU decreased the ratings backlog by 37 percent from 1,950 cases in 2012 to 1,222 in 2017, as seen in Figure 52. From 2016 to 2017, there was a 31 percent decrease in requested ratings. The reduction in the backlog provides quicker delivery of benefits to injured workers and resolution of workers' compensation cases.

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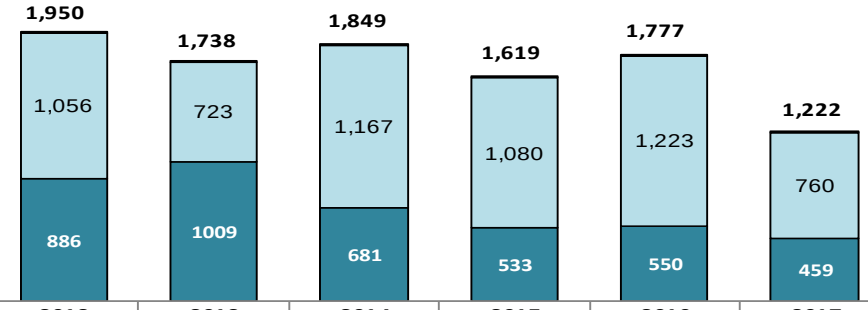
**Figure 52: DEU Backlogs**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Formal Ratings | 8 | 6 | 1 | 6 | 4 | 3 |
| Consult Ratings | 1,056 | 723 | 1,167 | 1,080 | 1,223 | 760 |
| Summary Ratings | 886 | 1009 | 681 | 533 | 550 | 459 |
| TOTAL BACKLOG | 1,950 | 1,738 | 1,849 | 1,619 | 1,777 | 1,222 |

Data Source: DWC Disability Evaluation Unit

### Commutation Calculations

DEU also performs commutations of future indemnity payments involving present-value calculations. These commutation calculations assist parties in the resolution of claims involving lump-sum settlements, including calculation of attorney fees on litigated cases.

For injuries that occurred on or after January 1, 2003, life pension and total PD payments are increased according to the annual increase of the state average weekly wage (SAWW) starting January 1 after the payment commences and each January thereafter. The increase in benefits based upon annual SAWW increases the complexity of commutation calculations. DEU performed 1,473 commutations, averaging 122.8 commutation calculations per month in 2016 and 1,463 commutations, averaging 121.9 commutation calculations per month in 2017.

### Staffing

Current staffing levels are 42 Disability Evaluators (41 WCC and 1 WCA positions) with two vacancies in the hiring process, 3 supervisors, and 1 unit manager. DEU is supported clerically by staff assigned to the Adjudication Unit.

## DIVISION OF WORKERS' COMPENSATION MEDICAL UNIT

The Medical Unit is responsible for the oversight of the physicians who perform disability evaluations in the workers' compensation system, educating physicians on medical-legal issues, and advising the Administrative Director on various medical issues. The Medical Unit sets standards and issues regulations governing Qualified Medical Evaluators (QMEs) and enforces the regulations governing QME disciplinary actions. The Medical Unit issues panels of three randomly selected QMEs to both represented and unrepresented injured workers who need a medical-legal evaluation in order to resolve a claim.

The Medical Unit also reviews, certifies, monitors, and evaluates Health Care Organizations (HCOs) and Medical Provider Networks (MPNs). Additionally, the Medical Unit reviews utilization review (UR) plans from insurers and self-insured employers and develops and monitors treatment guidelines. The unit also participates in studies to evaluate access to care, medical quality, treatment utilization, and costs. Finally, the Medical Unit recommends reasonable fee levels for various medical fee schedules.

### Qualified Medical Evaluator Panels

DWC assigns panels composed of three QMEs, from which an injured worker without an attorney can select an evaluator to resolve a medical dispute. Before April 19, 2004, only an unrepresented injured worker

could request a panel. SB 899, which went into effect April 19, 2004, allowed the claims administrator to request a panel in an unrepresented case if the injured worker failed to do so within 10 days. Likewise, in a represented case, both the applicant's attorney and the defense could request a panel if they could not agree on an AME in cases involving a date of injury on or after January 1, 2005. Although both sides attempt to request the panel in the medical specialty of their choice, the first valid request is processed and subsequent requests are returned as a duplicate.

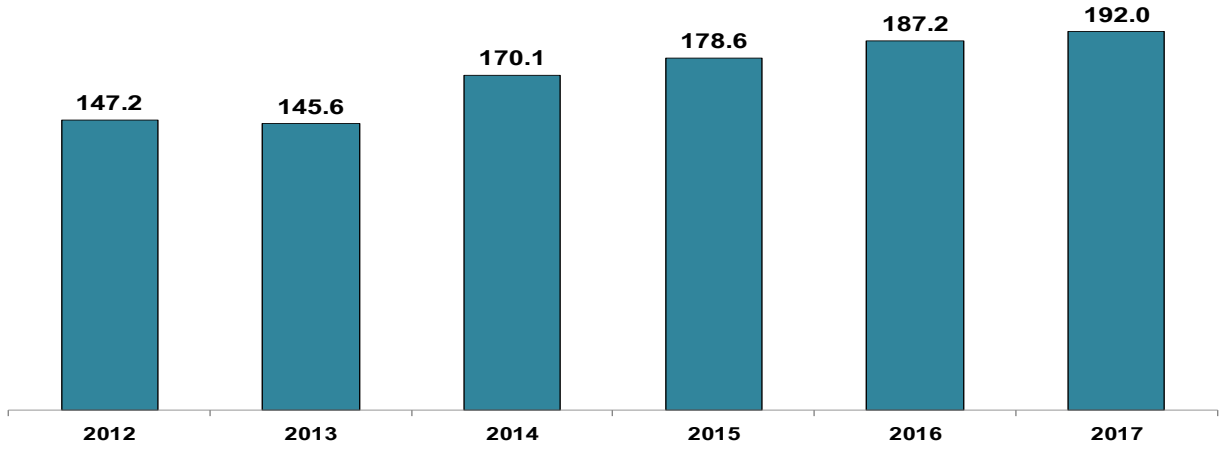
Effective January 1, 2013, SB 863 no longer requires the parties to confer on using an AME before requesting a panel. Additionally, this reform created a new framework for resolving current medical treatment disputes through an independent medical review (IMR) process. This means that a QME can no longer address current medical treatment disputes. QMEs are also limited to having no more than 10 offices, whereas formerly the number of offices for which they could be certified was unlimited.

An increase in the volume of panel requests has been evident over the past decade because of various legislative reforms, WCAB decisions, and changes in reporting requirements. An online system was implemented on October 1, 2015 to expedite the assignment of initial panels in represented cases. WCAB decisions such as the Romero decision (2007), the Messele decision (2011), and the Navarro decision (2014) also contributed to an increase in panel requests. These changes have contributed to the increase in the number of QME panels, as seen in Figures 54 and 55.

Figure 53 shows the total number of QME Panel Requests including represented initial requests submitted online that became effective on October 1, 2015 and initial, additional, and replacement panel requests received as mailed paper submissions. Data for 2012 and 2013 were incomplete and missing a full count of all panels received. With Panel Request counts improving in 2014, their volume increased by about 17 percent from 2013 to 2014. From 2014 to 2017, the number of QME Panel Requests increased steadily by 13 percent.

Represented panel requests make up the largest share of incoming panels. The online panel system introduced in October of 2015, received 27,339 panel requests from October 1, 2015 to December 31, 2015, 87,982 requests in 2016, and 89,999 - in 2017. The count of online requests with assigned panels was 20,818 from October 1, 2015 to December 31, 2015, 66,490 panels in 2016, and 67,934 panels in 2017. From 2015 to 2017, 76 percent of online panel applications were assigned panels and about 24 percent were returned as ineligible.

**Figure 53: Number of Qualified Medical Evaluator (QME) Panel Requests* (Thousand)**



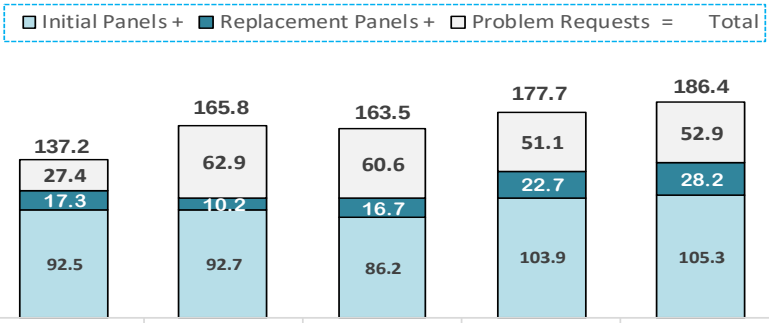

* The numbers account for all incoming mail for initial, replacement, additional, judge orders, and change of specialty panels.
Note: Data for 2012 and 2013 were incomplete and are missing a full count of all panels received.

Data Source: DWC

Figure 54 reflects the count of panels issued and returned as problem requests each year. The Medical Unit has 20 business days to issue an initial panel in an unrepresented case and 30 calendar days to issue an initial panel in a represented case. An online panel request system went into effect on October 1, 2015, allowing parties in a represented case to obtain an initial panel immediately upon online submission. Title 8, California Code of Regulations ("CCR") §31.7 applies to requests for obtaining additional specialty panels under certain specified conditions. Replacement QME panels[36] are issued pursuant to 8 CCR§ 31.5 that applies to requests for replacement of one or more QMEs from a panel that meets the conditions specified under this section.

According to Figure 54, the number of QME initial panels issued decreased by 7 percent from an average of 92,600 initial panels per year in 2012 and 2013 to 86,200 initial panels in 2014 when the count of panel requests improved. From 2014 to 2015, the number of QME initial panels issued increased by 20.5 percent and then continued to increase from 2015 to 2017. The replacement panels decreased by 41 percent from 2012 to 2013, more than doubled from 2013 to 2015, and then continued to steadily increase by 38 percent from 2015 to 2017. The number of problem requests decreased by 19 percent from 2013 to 2015 and then increased slightly by 5 percent from 2015 and 2017.

**Figure 54: Number of QME Initial Panels* and Replacement Panels Issued and Returned as Problem Requests (Thousand)**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Problem Requests = | 27.4 | 62.9 | 60.6 | 51.1 | 52.9 | 53.6 |
| Replacement Panels + | 17.3 | 10.2 | 16.7 | 22.7 | 28.2 | 31.4 |
| Initial Panels + | 92.5 | 92.7 | 86.2 | 103.9 | 105.3 | 107.4 |
| Total | 137.2 | 165.8 | 163.5 | 177.7 | 186.4 | 192.4 |

*The numbers account for both initial and additional panels issued.

Data Source: DWC

Table 18 reflects the panel processing activity detailed in Figure 54. The total number of panels issued includes the initial panels issued and replacement panels. Panels returned are ineligible panels. There was a drop in the share of issued panels in 2013 and 2014 as stakeholders adjusted to new filing requirements introduced by SB 863 in 2013. From 2014 to 2015 the number of panels issued increased by 8 percentage points to 71 percent and stabilized at that level from 2015 to 2017.

**Table 18: Percent of QME Panels Issued and Returned**

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Panels issued | 80% | 62% | 63% | 71% | 72% | 72% |
| Panels returned | 20% | 40% | 37% | 29% | 28% | 28% |

Source: DWC

[36] The term "replacement" is referenced as "second" panels in-house to communicate the type of handling needed for the panel request.

**Utilization Review**

The utilization review (UR) process includes utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve treatment recommendations by physicians, as defined in Labor Code Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code Section 4600. UR begins when the completed DWC Form RFA (request for authorization of medical treatment) accepted as complete under 8 CCR Section 9792.9.1(c)(2) is first received by the claims administrator or, in the case of prior authorization, when the treating physician satisfies the conditions described in the UR plan for prior authorization (§ 9792.6.1(y)).

Each employer, either directly or through its insurer or an entity with which an employer or insurer contracts for utilization review services, is required to establish a utilization review process via written policies and procedures. A UR plan is the written plan filed with the Administrative Director (AD) pursuant to Labor Code Section 4610, setting forth the policies and procedures and a description of the UR process (Section 9792.6.1(x)). The UR plan ensures that UR decisions are consistent with a medical treatment utilization schedule (MTUS). The MTUS, which is adopted by the AD, incorporates evidence-based, peer-reviewed, nationally recognized standards of care. (Labor Code §§ 4610(c) and 5307.27(a)).
Effective January 1, 2004, each employer is required to file a UR plan with the AD. UR is a review of the treating physician's requests for treatment (RFAs) and the decisions made about the medical necessity of the requests. The Utilization Review Organization (URO) can be an internal or external group (from the claims administrator or employer) that performs most of the UR. The UR regulations (8 CCR Section 9792.6 et seq.) were adopted on September 22, 2005, and UR enforcement regulations were adopted on June 7, 2007. The enforcement regulations (8 CCR Section 9792.11–9792.15) gave the DWC the authority to investigate all UROs that have submitted a UR plan. New regulations were introduced as Emergency Regulations on January 1, 2013, and adopted on February 12, 2014, in response to the adoption of SB 863. These new regulations include the enforcement sections 9792.11, .12, and .15. Sections 9792.13 and .14 were not changed and therefore are not found in the newly adopted regulations, but are still considered part of the UR enforcement regulations. Effective January 1, 2018, the Division of Workers' Compensation has also adopted a drug formulary to implement Assembly Bill 1124. The regulations (8 CCR §§9792.27.1–9792.27.23) established an evidence-based drug formulary consistent with MTUS.

Investigations to enforce UR requirements have been conducted every five years as required by law. Investigations can be either routine or targeted. Routine investigations are conducted by randomly selecting files from all UR requests that the specific URO has received within a three-month period. The period selected is the previous three full months from the start of the investigation. The DWC notifies the URO by sending a Notice of Utilization Review Investigation (NURI); generally these also say "Routine," unless performing a specific targeted investigation. After the DWC has the information requested, including a list of all requests for authorization (RFAs) for the three-month period, files are randomly selected for review and a list of those files is sent to the URO with the Notice of Investigation Commencement (NIC). The URO has 14 days from receipt of the NIC to provide copies of each selected file. When the correct number of UR files is obtained, they are reviewed to determine whether:

- The requests were answered on time.
- Decisions were made with the required criteria and rationale.
- The decision is communicated on time and to the appropriate parties.
- Independent Medical Review (IMR) application is sent to appropriate parties with all denial or modification decisions.
- Other related regulatory requirements are followed.

Files found to have violations are given a set penalty. The entire investigation is given a score, depending on how many violations of certain types are cited. The passing score is 85 percent or higher. After the score is determined, the URO is notified through a Preliminary Report with all exhibits to verify how the score was compiled and any next steps to be taken. The URO may request a post-investigation conference and may send further documentation to verify that it actually performed the UR correctly. After the conference and

review of additional documentation, the DWC completes the Final Investigation Report. If the URO has a failing score or has any mandatory violation (Sections 9792.12(a)(1-17) and (c)(1-4)), DWC also sends an Order to Show Cause (OSC) and a Stipulation and Order, with the Final Report.

**Table 19: Status of UR Investigations**

| | 2014 | 2015 | 2016 | 2017 | 2018 (Jan-Aug) |
|---|---|---|---|---|---|
| Number of UR investigations completed | 6 | 27 | 11 | 4 | 5 |
| Number of UR investigations pending | 0 | 0 | 2 | 0 | 2 |
| Number of failed investigations | 0 | 2 | 0 | 0 | 0 |
| Amount of UR penalty assessments | $0 | $39,000 | $8,000 | $30,500 | $2,000 |

Source: DWC

SB 1160 was signed into law in September 2016. Among other provisions, it revises and recasts provisions relating to UR with regard to injuries occurring on or after January 1, 2018. The bill sets forth the medical treatment services that would be subject to prospective UR. It authorizes retrospective UR for treatment provided under limited circumstances. The bill also establishes procedures for prospective and retrospective UR. On and after January 1, 2018, the bill establishes new procedures for reviewing determinations regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted by the Administrative Director.

In addition, commencing July 1, 2018, the bill requires each UR to be accredited by an independent nonprofit organization to certify that it meets specified criteria, including timeliness in issuing a UR decision and the scope of medical material used in issuing a UR decision.

The bill also requires the Administrative Director to develop a system for the electronic reporting of documents related to UR performed by each employer, to be administered by the division.

Text of the bill is at:
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1160/

The rulemaking process related to SB 1160 is described at:
http://www.dir.ca.gov/dwc/DWCWCABForum/1.asp#DWC/
http://www.dir.ca.gov/dwc/rulemaking/dwc_rulemaking_proposed.html

**Independent Medical Review**

Senate Bill (SB) 863 adopted several provisions that affect how medical necessity determinations are made for medical care provided to injured workers. One of the key provisions was putting in place the Independent Medical Review (IMR) process for resolving medical treatment disputes. Effective January 1, 2013, for injuries occurring on or after that date, and effective July 1, 2013, for all dates of injury, IMR is being used to decide medical necessity disputes for injured workers. The DWC administers the IMR program with costs borne by the employer, and it is similar to the group health process for medical treatment dispute resolution.

The IMR program is now in its sixth year. Following an initial ramp-up period that occurred when the program was open for all dates of injury, IMR applications held remarkably steady from 2014 to 2017. Figure 56 shows the quarterly numbers of IMR applications with duplicates, the number of unique medical review requests, and IMR determinations between 2013 and 2017.

In 2013, when IMR became effective, the quarterly number of unique IMR requests received increased 426 times from 95 requests in 2013 Q1 to 40,450 in 2013 Q4. By the end of 2013, the first year of the program, 83,920 IMR applications were received. The quarterly number of IMR determinations completed increased from 2 determinations in 2013 Q1 to 3,159 determinations in 2013 Q4.

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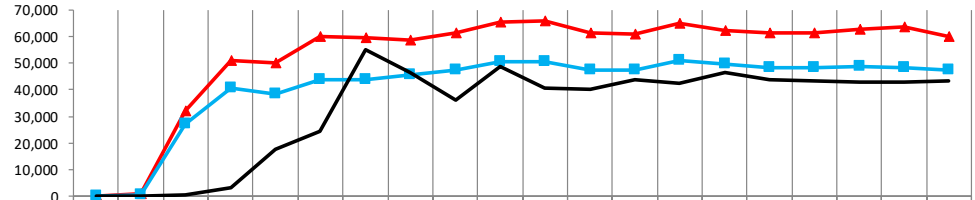
Over one million IMR requests (1,063,593) were filed in the first five years of the program (2013-2017). Since 2014, the number of IMR applications received ranges from 228,207 to 253,779 each calendar year. The number of IMR determinations completed from 2013 to 2016 totaled 488,600.

The number of unique IMR requests received from 2013 to 2017 totaled 824,344. The number of IMR determinations completed from 2013 to 2017 totaled 661,507. The total number of IMR decisions issued per year increased each of the first four years of the program. A peak of 176,002 issued decisions in 2016 followed by a 2 percent decrease to 172,194 decisions in 2017.

**Figure 55: Quarterly Numbers of Independent Medical Review Requests (IMR) Received and Determinations Completed, 2013 - 2017**




| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2013 | | | | 2014 | | | | 2015 | | | | 2016 | | | | 2017 | | | |
| IMR Requests w. Duplicates | 102 | 776 | 31,950 | 51,092 | 49,929 | 60,023 | 59,678 | 58,577 | 61,142 | 65,418 | 65,889 | 61,330 | 60,780 | 64,910 | 62,426 | 61,320 | 61,253 | 62,773 | 63,380 | 60,125 |
| Unique IMR requests | 95 | 724 | 27,091 | 40,450 | 38,494 | 43,873 | 43,662 | 45,675 | 47,299 | 50,531 | 50,340 | 47,503 | 47,487 | 50,948 | 49,423 | 48,199 | 48,060 | 48,897 | 48,098 | 47,483 |
| IMR determinations completed | 2 | 127 | 515 | 3,159 | 17,421 | 24,417 | 54,959 | 46,512 | 36,314 | 48,628 | 40,603 | 39,950 | 43,543 | 42,336 | 46,352 | 43,762 | 43,194 | 42,866 | 42,836 | 43,298 |

Data Source: DWC

*For further information …*

DWC, "Annual IMR Report: Analysis of 2016 Data" (2017).
https://www.dir.ca.gov/dwc/imr/reports/2017_IMR_Annual_Report.pdf

**Independent Bill Review**

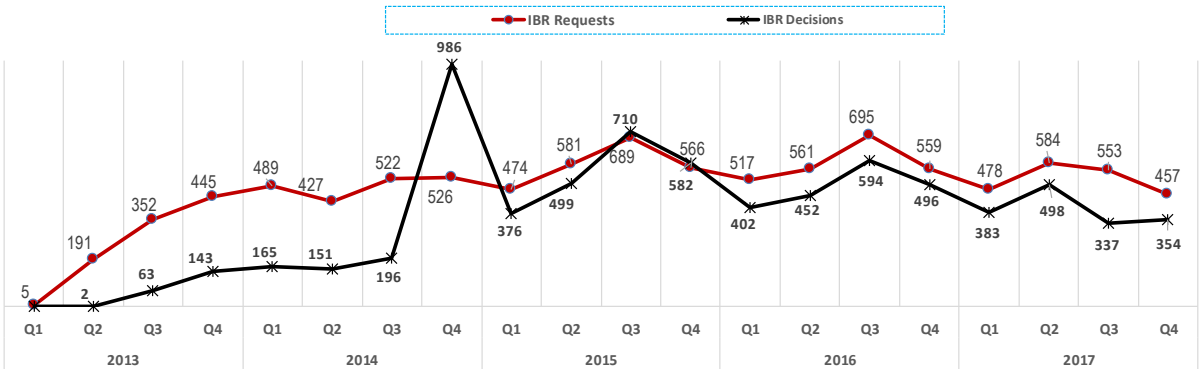
Senate Bill (SB) 863 adopted several provisions to provide a quick, efficient way of resolving disputes over medical billing and eliminate litigation at the appeals board over billing disputes. One of the key provisions was putting in place the Independent Bill Review (IBR) process for resolving medical treatment and medical-legal billing disputes. Effective January 1, 2013, for medical services provided on or after that date and in cases in which the fee was determined by a fee schedule established by the DWC, the IBR is used to decide disputes when a medical provider disagrees with the amount paid by a claims administrator. The DWC administers the IBR program, which refers applicants to an independent bill review organization (IBRO). The reasonable fees for IBR are paid by the applying physician. If the independent bill reviewer determines that the claims administrator owes the physician additional payment on the bill, the claims administrator must reimburse the physician for the review fee.

Figure 57 shows the quarterly numbers of IBR requests received and IBR decisions completed between 2013 and 2017. In 2013, when IBR became effective,the quarterly number of IBR requests received increased from 5 in 2013 Q1 to 445 in 2013 Q4. In 2013, when IBR became effective, 990 applications were received and 208 IBR decisions were completed. The number of IBR requests received doubled from 990 in 2013 to 1,964 in 2014. Activity peaked the following two years, with approximately 2,300 applications filed each year, then decreased 10 percent in 2017 (2,092). As of December 2017, the number of IBR requests received totaled 9,688 and the number of decisions completed totaled 7,390.

According to the Figure 56, the number of IBR requests received increased by 18 percent from an average of 425 requests per quarter in 2014 to 580 in 2016, and then decreased by 11 percent to 518 requests per quarter in 2017.

The quarterly numbers of IBR decisions increased from 2 in Q2 to 143 in Q4 of 2013, and then increased almost 7 times from 143 decisions in 2013 Q4 to a peak of almost 1,000 decisions in 2014 Q4. The average number of decisions completed per 100 IBR requests decreased from 95 per quarter in 2015 to about 85 per quarter in 2016, and then continued its decrease to an average of 75 decisions completed per 100 IBR requests per quarter in 2017.

**Figure 56: Quarterly Numbers of Independent Bill Review Requests and Decisions, 2013 – 2016**




Data Source: DWC

## Medical Provider Networks and Health Care Organizations[37]

### *Medical Provider Networks*

*Background*

Between 1997 and 2003, the California workers' compensation system had significant increases in medical costs. During that period, workers' compensation medical treatment expenses in California increased by an estimated 138 percent,[38] outpacing the cost of equivalent medical treatment in non-industrial settings. To slow this rise in costs, major reforms were enacted in 2003 and 2004. One such effort was the passage of Senate Bill (SB) 899 in April 2004. A major component of SB 899 was the option to establish a medical provider network (MPN), as promulgated in Labor Code Section 4616 et seq. MPNs were implemented beginning January 1, 2005. On September 18, 2012, another round of major workers' compensation reforms was signed into law in SB 863. SB 863 incorporates significant changes to MPNs, including but not limited to: expanding who can qualify to become an MPN applicant; limiting the MPN approval period to four years and requiring MPN plans to be reapproved; providing the right to petition for MPN suspension or revocation; and authorizing the adoption of administrative penalties to ensure that MPN applicants comply with regulations. Most of these changes took effect on January 1, 2014.

On October 6, 2015, SB 542 was signed into law with additional changes, including: clarifying the MPN independent medical review process from the independent medical review process that resolves UR disputes; requiring every MPN to post on its website information on how to contact the MPN, on medical access assistance and how to obtain a copy of any notification regarding the MPN that is required to be given to an employee by regulations; creating efficiencies for approving MPNs when a modification is made during a four-year approval period; clarifying who provides for the completion of treatment when there is a continuity-of-care issue; and giving a statutory definition of an entity that provides physician network services. These changes took effect on January 1, 2016.

[37] The information in this section was provided by the DWC Medical Unit, with minor edits by CHSWC staff.
[38] Based on the WCIRB annual report *California Workers' Compensation Losses and Expenses* Report, prepared pursuant to the California Insurance Code, Section 11759.1.

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

The establishment of an MPN gives employers significant medical control. With the exception of employees who have a predesignated 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 employer medical control they had prior to the passage of SB 899. Having an MPN means the employer has more control with regard to who is in the network and whom the injured worker sees for care for the life of the claim. The employer chooses to whom the injured worker goes on the first visit; after the first visit, the injured worker can go to a doctor of his/her choice in the MPN.

Before the implementation of an MPN, insurers, employers or entities that provide physician network services are required to file an MPN application with the DWC for review and approval, pursuant to 8 CCR Section 9767.1 et seq.

The DWC provides all the data on MPNs in this section.

*Application Review Process*

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

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

The full review of an application involves thorough scrutiny, using a standard checklist, to see whether the application followed the statutory and regulatory requirements set forth in California Labor Code Section 4616 et seq. and CCR 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. This process is repeated until the application is approved or withdrawn.

Material modification filings go through a review process similar to the one for an initial application. Except in cases in which an MPN application was approved prior to January 1, 2014, the material modification must include all updates to ensure that the MPN complies with the current regulations.

*Applications Received and Approved*

Table 20 summarizes the number of MPN activities from their inception in November 1, 2004, to December 31, 2017. During this time, the MPN program received 2,592 MPN applications. Of these, 49 were ineligible, as they were erroneously submitted by employers, insurers, or other entities that, under the MPN regulations, are not eligible to set up an MPN. As of December 31, 2017, 2,384 applications were approved. The DWC revoked 31 approved applications. The reason for revocation was the applicants' erroneous reporting of their status as self-insured when in fact they were insured entities or an insurer no longer eligible to transact workers' compensation in California. Three hundred and ninety three (393) were withdrawn after approval. The reasons for the withdrawals were either that the applicant decided not to pursue an MPN or that a duplicate application was submitted. One thousand five hundred and thirty (1,530) applications were terminated after approval. The reason for the termination was the applicant's decision to stop using the MPN. In 2017, the DWC reached out to expired MPNs that were past their four-year approval period. In

response, the DWC received confirmation that over 500 MPNs were no longer being used and were terminated.

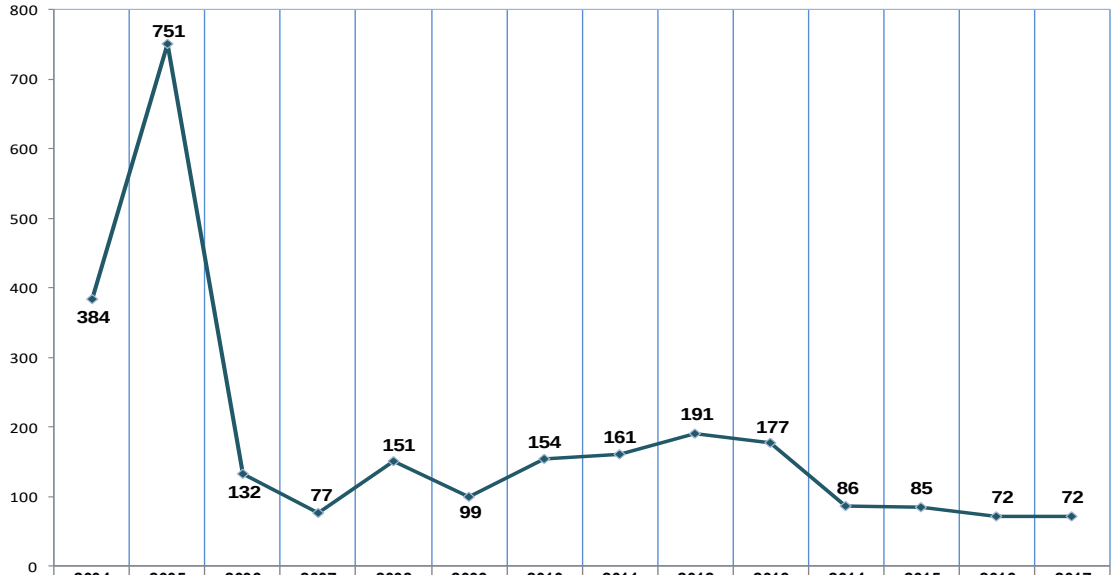
**Table 20: MPN Program Activities from November 1, 2004, to December 31, 2017**

| MPN Application Status: | Number |
|---|---|
| Received | 2,592 |
| Approved | 2,384 |
| Material Modifications | 4,014 |
| Withdrawn | 393 |
| Revoked | 31 |
| Ineligible | 49 |
| Terminated | 1,530 |

Source: DWC

Figure 57 shows the receipt of MPN applications from 2004 to 2017. The bulk of applications, 29 percent, were received in 2005 (751). The number of applications decreased almost 10 times from 751 in 2005 to 77 in 2007 and then averaged 155 applications per year from 2008 to 2013. From 2014 to 2017, the number of MPN applications received by DWC averaged 78 applications per year.

**Figure 57: Number of MPN Applications Received by Month and Year of Receipt, 2004-2017 (Total = 2,592)**

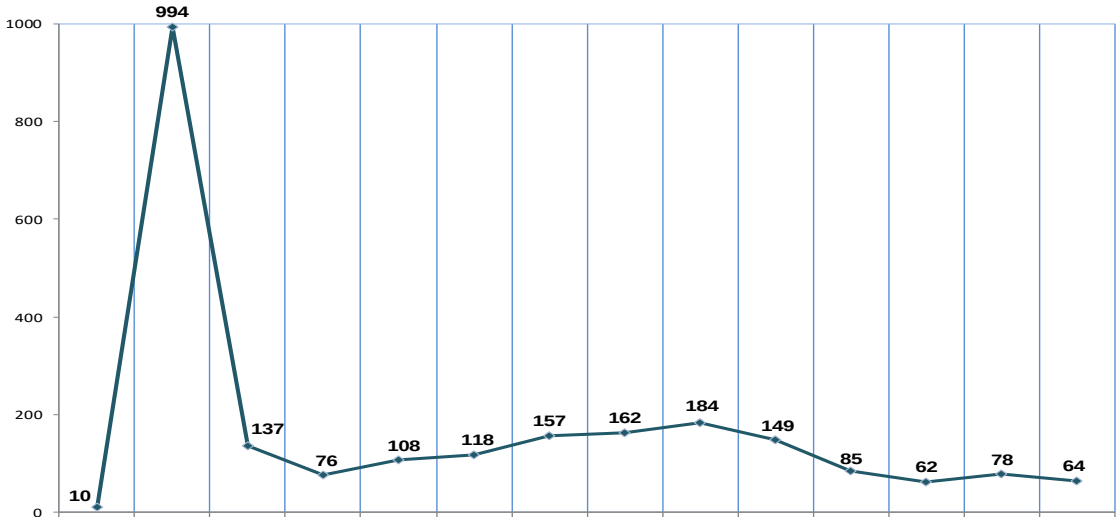



| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Applications received | 384 | 751 | 132 | 77 | 151 | 99 | 154 | 161 | 191 | 177 | 86 | 85 | 72 | 72 |
| | | | | | | | | | | | | | | |
| Percent Distrib | 15% | 29% | 5% | 3% | 6% | 4% | 6% | 6% | 7% | 7% | 3% | 3% | 3% | 3% |

Data Source: DWC

Figure 58 shows the MPN applications approved from 2004 to 2017. To recap, 42 percent (994) of MPN applications were approved in 2005. As the number of MPN applications decreased ten-fold from 2005 to 2007, the number of approved applications decreased accordingly. From 2008 to 2013, the number of approved MPN applications averaged 146 per year and then decreased to an average of 72 approvals per year from 2014 to 2017.

**Figure 58: Number of MPN Applications Approved by Month, 2004-2017 (Total = 2,384)**




| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 10 | 994 | 137 | 76 | 108 | 118 | 157 | 162 | 184 | 149 | 85 | 62 | 78 | 64 |
| | | | | | | | | | | | | | | |
| Percent Distrib | 0.4% | 41.6% | 6% | 3% | 5% | 5% | 7% | 7% | 8% | 6% | 4% | 3% | 3% | 3% |

Data Source: DWC

*Material Modifications*

MPN applicants are required by 8 CCR Section 9767.8 to provide notice to the DWC for required material changes to their approved MPN application. Modifications are required when the MPN Liaison or Authorized Individual or employee notification material change, among other reasons. Modifications go through a review, and an approval process similar to the one for a new application, within the same regulatory time frame.

As of December 31, 2016, 1,574 applicants had filed material modifications with the DWC. Some applicants had filed more than one material modification. Nine hundred and seven (907) applicants had filed 2 or more material modification filings, and 1 applicant had 39 filings.

Figure 60 shows the number of material modification filings received by the DWC. The number of material modifications received increased from 65 to 357 from 2005 to 2007 and then fluctuated between 280 and 500 from 2008 to 2013. After the SB 863 changes took effect in 2014, the number of material modification filings decreased to 154 in 2014 and then went back to fluctuating between 240 and 380 per year from 2015 to 2017.

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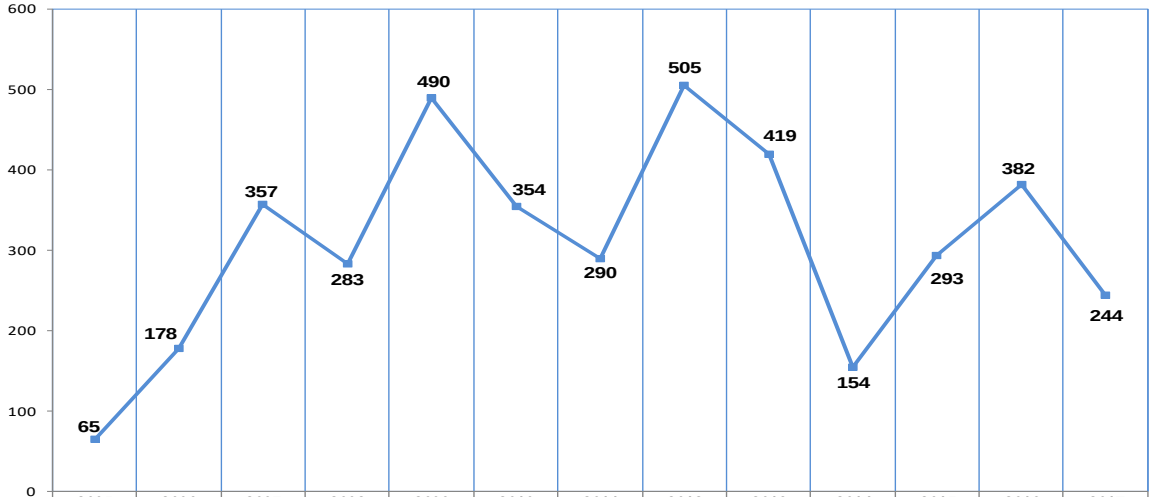
**Figure 59: Number of MPN Material Modifications Received by Month, 2005-2017 (Total = 4,014)**




| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 65 | 178 | 357 | 283 | 490 | 354 | 290 | 505 | 419 | 154 | 293 | 382 | 244 |
| | | | | | | | | | | | | | |
| Percent Distrib | 2% | 4% | 9% | 7% | 12% | 9% | 7% | 13% | 10% | 4% | 7% | 10% | 6% |

* Monthly data are not available

Data Source: DWC

*Plan for Reapproval Process*

Beginning January 1, 2014, SB 863 introduced the four-year approval period for existing and newly approved MPN plans. The MPN applicant is required to submit a complete plan to the DWC for reapproval at least six months before the expiration of the four-year approval period. The amended MPN regulations that became effective August 27, 2014, set the expiration date for those MPN plans with a most recent application or material modification approval date prior to January 1, 2011, to December 31, 2014. For all plans with an application approval date on or after January 1, 2014, the expiration date is four years from the application approval date.

The MPN application plan for reapproval review is similar to the application review process except that the Administrative Director has 180 days rather than 60 to act from the date an MPN application plan for reapproval is received by the DWC.

As in the original application review process, a full review of a plan for a reapproval application involves thorough scrutiny, using a standard checklist, to see whether the application followed the statutory and regulatory requirements set forth in California Labor Code Section 4616 et seq. and CCR Sections 9767.1 et seq. The full review culminates in an approval letter if no deficiency is discovered in the submitted application; if deficiencies are identified, the MPN applicant is sent a disapproval letter, listing the deficiencies that need to be corrected. A correct and complete resubmission is required to ensure that the MPN approval does not expire, which will result in corrective action initiated by the DWC for a noncompliant plan.

Table 21 shows the number of MPN approved plans that will require a filing for a plan for reapproval through 2021. These numbers are expected to change as approved MPNs are terminated because of consolidation into new approved MPNs created by entities that provide physician network services. In addition, these numbers may change because MPN applicants will proactively ensure that the MPN is reapproved more than six months before the plan's expiration.

**Table 21: Expiring MPN Application Plans by Quarter and Year Through December 31, 2021**

| Quarter | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|---|
| **Q1** | | 6 | 88 | 34 | 9 | 15 | 41 | **34** |
| **Q2** | | 11 | 45 | 36 | 12 | 25 | 57 | **76** |
| **Q3** | | 15 | 17 | 36 | 17 | 14 | 56 | **38** |
| **Q4** | 165 | 10 | 35 | 156 | 20 | 44 | 23 | **48** |
| **TOTAL** | **165** | **42** | **185** | **262** | **58** | **98** | **177** | **196** |

Source: DWC

Table 22 shows the number of MPN application plans for reapprovals received and approved at DWC from 2014 through 2017.

**Table 22: MPN Application Plans for Reapproval Received and Approved by Month Through December 31, 2017**

| | | Jan | Feb | Mar | Apr | May | Jun | July | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2014** | **Received** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 | 17 | 42 | **74** |
| | **Approved** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 30 | **30** |
| **2015** | **Received** | 25 | 14 | 3 | 30 | 2 | 6 | 1 | 0 | 4 | 4 | 29 | 23 | **141** |
| | **Approved** | 6 | 3 | 1 | 27 | 3 | 1 | 4 | 0 | 2 | 5 | 37 | 22 | **111** |
| **2016** | **Received** | 12 | 13 | 10 | 8 | 5 | 10 | 11 | 8 | 9 | 1 | 4 | 0 | **91** |
| | **Approved** | 0 | 2 | 4 | 0 | 8 | 1 | 4 | 11 | 9 | 1 | 1 | 1 | **42** |
| **2017** | **Received** | 6 | 4 | 3 | 4 | 10 | 3 | 2 | 4 | 8 | 3 | 5 | 1 | **53** |
| | **Approved** | 1 | 8 | 5 | 2 | 4 | 4 | 7 | 9 | 2 | 2 | 8 | 7 | **59** |

Source: DWC

*MPN Applicants*

MPN applicants are allowed to have more than one MPN. As a result, MPN applicants with more than one approved MPN account for 74 percent of all MPNs, including 651 applicants with 21 to 71 MPNs (see Figure 60). The names of MPN applicants with 10 or more approved MPNs are shown in Table 22. ACE American Insurance Company leads with 77 MPNs, followed by Zurich American Insurance Company with 46 MPNs, and National Union Fire Insurance Company of Pittsburg, PA with 43 MPNs.

**Figure 60: Distribution of Approved MPNs by Number of MPNs per Applicant, 2017**

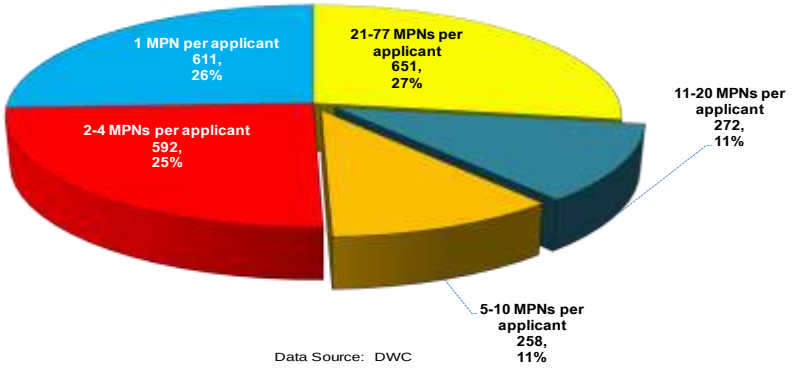



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**Table 23: Names of MPN Applicants with 10 or More Approved MPNs**

| Name of Applicant | Number of MPNs |
|---|---|
| ACE American Insurance Company | 77 |
| Zurich American Insurance Company | 46 |
| National Union Fire Insurance Company of Pittsburgh, PA | 43 |
| American Home Assurance Company | 42 |
| OCM Coastal Acquisition Co., LLC | 38 |
| Safety National Casualty Corporation | 36 |
| Federal Insurance Company | 35 |
| The Insurance Company of the State of Pennsylvania | 35 |
| Old Republic Insurance Company | 32 |
| Fidelity and Guaranty Insurance Company | 32 |
| New Hampshire Insurance Company | 31 |
| ARCH Insurance Company | 29 |
| Hartford Accident and Indemnity Company | 27 |
| Discover Property & Casualty Insurance Company | 27 |
| United States Fidelity and Guaranty Company | 26 |
| Fidelity and Guaranty Insurance Underwriters, Inc. | 25 |
| XL Specialty Insurance Company | 25 |
| American Zurich Insurance Company | 24 |
| Hartford Insurance Company of the Midwest | 21 |
| Commerce and Industry Insurance Company | 19 |
| AIG Property Casualty Company | 18 |
| Travelers Property Casualty Company of America | 18 |
| Medex Healthcare | 17 |
| Twin City Fire Insurance Company | 16 |
| Continental Casualty Company | 16 |
| American Guarantee and Liability Insurance Company | 16 |
| Granite State Insurance Company | 15 |
| Hartford Fire Insurance Company | 15 |
| Hartford Underwriters Insurance Company | 15 |
| Praetorian Insurance Company | 14 |
| United States Fire Insurance Company | 13 |
| Greenwich Insurance Company | 13 |
| Landmark Insurance Company | 12 |
| Indemnity Insurance Company of North America | 11 |
| Sentinel Insurance Company, Ltd. | 11 |
| The North River Insurance Company | 11 |
| American Casualty Company of Reading, Pennsylvania | 11 |
| Zurich American Insurance Company of Illinois | 11 |
| SPARTA Insurance Company | 10 |
| Hartford Casualty Insurance Company | 10 |
| XL Insurance America, Inc | 10 |
| St. Paul Fire and Marine Insurance Company | 10 |
| Sparta American Insurance Company | 10 |
| Tokio Marine & Nichido Fire Insurance Co., Ltd. | 10 |

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Table 24 shows the number of MPN applicants by type of applicant. From 2004 to 2013, the majority (on an average of 62 percent per year) of MPN applications were filed by insurers, followed by self-insured employers (28 percent). SB 863 added the option for the MPN applicant to change the type of applicant to an entity that provides physician network services, which is reflected in the numbers reported in this table. The share of MPN applications filed by insurers fell to 46 percent in a transitional year of 2014 and then continued its decrease to an average of 29 percent per year from 2015 to 2017. At the same time, the number of MPN applicants filed by entities that provides physician network services increased from a total of 4 in 2004-2013 to an average of 36 per year from 2015 to 2017.

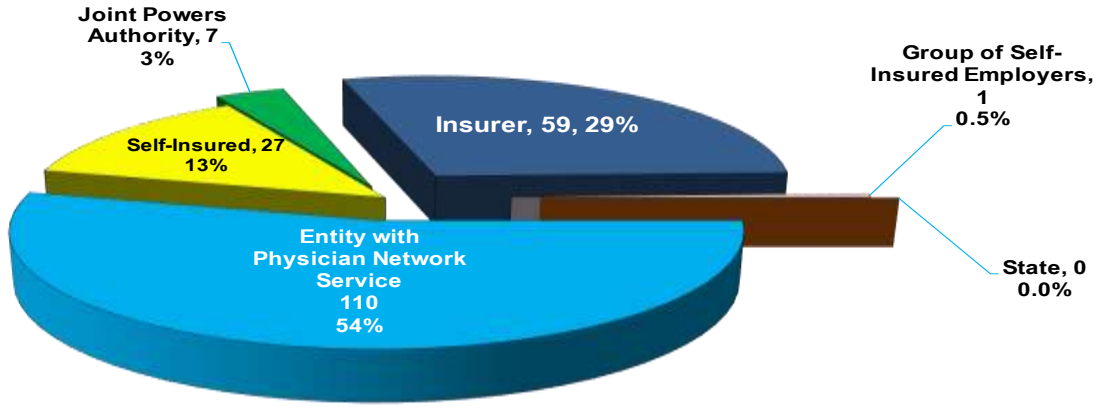
**Table 24: Number of Approved MPN Applications by Type of Applicant, 2004–2017**

| Type of Applicant | 2004-2013 | 2014 | 2015 | 2016 | 2017 | TOTAL |
|---|---|---|---|---|---|---|
| Insurer | 1,377 | 39 | 17 | 24 | 18 | 1,457 |
| Self-Insured | 614 | 29 | 9 | 5 | 13 | 670 |
| Joint Powers Authority | 56 | 3 | 3 | 4 | 0 | 66 |
| State | 4 | 0 | 0 | 0 | 0 | 4 |
| Group of Self-Insured Employers | 40 | 0 | 1 | 0 | 0 | 41 |
| Entity with Physician Network | 4 | 14 | 32 | 45 | 33 | 128 |
| **Total** | **2,095** | **85** | **62** | **78** | **64** | **2,384** |

Source: DWC

Figure 62 shows the distribution of MPN applications approved from 2015 to 2017 by the type of applicant.

**Figure 61: Distribution of All Approved MPN Applications by Type of Applicant, 2015-2017**




Data Source: DWC

### *MPN Plans Using HCO Networks*

Health Care Organizations (HCOs) networks are used by 183 (8 percent) of the approved MPNs. This number excludes MPNs that were revoked, terminated, or withdrawn after approval. The distribution of MPNs by HCOs is shown in Table 25. Corvel HCO has an MPN market share of 4 percent, followed by Medex, which has a share of 2 percent, and CompAmerica (First Health), which has a share of 2 percent.

**Table 25: Number of MPN Applicants Using HCO Networks**

| Name of HCO | Approved MPN Plans Using HCO Network | Percentage of Applications Received | Percentage of Applications Approved |
|---|---|---|---|
| Corvel | 89 | 3.4% | 3.7% |
| Medex | 48 | 1.9% | 2.0% |
| CompAmerica (First Health) | 45 | 1.7% | 1.9% |
| Promesa | 1 | 0.0% | 0.0% |
| **Total Using HCO** | **183** | **7.1%** | **7.7%** |

Source: DWC

*Status of the MPN Program*

The MPN program is in its thirteenth year and continues to develop as more MPNs are being used. The MPN plan monitoring and review processes have evolved with the regulations and as agency resources permit. SB 863 brought about important changes to the MPNs to improve efficiencies, promote greater accuracy, and ensure regulatory compliance. Effective January 1, 2016, SB 542 has added clarifying information regarding MPN requirements.

To implement the important changes brought about by the passage of SB 863, the MPN regulations were amended, and these amendments took effect August 27, 2014. The changes in the MPN regulations include a more efficient streamlined application process that allows electronic submission of MPN applications, modifications, and reapprovals. The regulatory amendments also include the requirements for an MPN to qualify as an entity that provides physician network services. Allowing these entities to qualify as an MPN applicant better aligns legal with operational responsibility. Additional changes in the MPN regulations include the assignment of unique MPN identification numbers to each MPN in order to easily identify a specific MPN. The amended MPN regulations establish the standards MPNs must meet with the MPN Medical Access Assistants to properly assist injured workers to find and schedule medical appointments with MPN physicians. The amended regulations clarify access standards and now require an MPN to have at least three available physicians from which an injured worker can choose, and if the time and location standards are not met, MPNs shall have a written policy permitting out-of-network treatment. Moreover, the amended MPN regulations set forth the physician acknowledgment requirements to ensure physicians in the MPN have affirmatively elected to be a member of the network and a streamlined process for obtaining acknowledgments from medical groups. To promote greater accuracy and ensure statutory and regulatory compliance, MPNs are approved for a period of four years and must file a reapproval before the expiration of this four-year period. Finally, the DWC's oversight of MPNs is strengthened with the formal complaint process, the Petition for Suspension or Revocation of MPNs, the ability to conduct random reviews of MPNs and the authority to assess administrative penalties against MPNs to ensure regulatory compliance.

**Health Care Organization Program**

Health Care Organizations (HCOs) were created by the 1993 workers' compensation reforms. The laws governing HCOs are California Labor Code, Sections 4600.3 through 4600.7, and 8 CCR Sections 9770 through 9779.8.

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 (WCHPO) can be certified as an HCO.

Qualified employers who contract with an HCO can direct treatment of injured workers from 90 to 180 days depending on whether the employer offers qualified health-care coverage to its employees for non occupational injuries or illnesses.

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An HCO must file an application and be certified by the DWC according to Labor Code Section 4600.3 et seq. and 8 CCR Sections 9770 et seq. Due to regulatory changes in 2010, HCOs now 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 thereafter. In addition, HCOs are required to pay an annual assessment of $250, $300, or $500 based on their enrollments of covered employees as of December 31 of each year.

Currently, the HCO program has eight certified HCOs, only four of them have enrollees; the rest are keeping their certification and using their HCO provider network as a deemed network for MPNs. Certified HCOs and their most recent certification/recertification date are listed in Table 26.

**Table 26: Currently Certified HCOs by Date of Certification/Recertification, 2017**

| Name of HCO | Date of Certification/Recertification |
|---|---|
| CompPartners | 07/24/2008 |
| Corvel Corporation | 12/30/2011 |
| First Health/ CompAmerica Primary | 10/05/2016 |
| First Health/ CompAmerica Select | 10/05/2016 |
| Kaiser On The Job HCO | 12/03/2015 |
| MedeEx Health Care | 03/16/2010 |
| MedEx 2 Health Care | 10/10/2009 |
| Promesa | 04/16/2010 |

Source: DWC

***HCO Enrollment***

At its peak in mid-2004, HCOs had approximately half a million enrollees. However, with the enactment of MPNs, employee enrollment under the large HCOs, such as First Health and Corvel, declined considerably. Compared to enrollment in 2004, First Health lost 100 percent of its enrollees, while Corvel's enrollment declined by 96.6 percent, to 3,384 by December 2008. As of December 2011, the total employee enrollment under HCOs fell by 66.4 percent to 161,413 from 481,337 in 2004. In 2017, HCO enrollment increased to 288,235.Table 27 on the next page shows the number of enrollees as of December 31 of each year from 2004 through 2017.

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**Table 27: HCOs by Number of Enrollees for 2004 through 2017**

| | Medex/Medex 2 | Kaiser-on-the-Job | CompPartners | Promesa | CorVel | Intracorp | NetWork | First Health CompAmerica Primary/Select (First Health) | Prudent Buyer (Blue Cross | Sierra | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **2004** | 62,154 | 30,086 | 60,935 | na | 100,080 | 6,329 | 1,204 | 218,919 | 1,390 | 240 | **481,337** |
| **2005** | 66,304 | 67,147 | 61,403 | na | 20,403 | 3,186 | 0 | 2,403 | 0 | 0 | **220,846** |
| **2006** | 46,085 | 66,138 | 53,279 | na | 3,719 | 2,976 | 0 | 0 | 0 | 0 | **172,197** |
| **2007** | 69,410 | 69,602 | 13,210 | na | 3,050 | 2,870 | 0 | 0 | 0 | 0 | **158,142** |
| **2008** | 69,783 | 77,567 | 1,765 | 21,197 | 3,384 | 0 | 0 | 0 | 0 | 0 | **173,696** |
| **2009** | 34,378 | 72,469 | 1,729 | 16,467 | 1,983 | 0 | 0 | 0 | 0 | 0 | **127,026** |
| **2010** | 46,838 | 74,223 | 2,884 | 17,602 | 435 | 0 | 0 | 0 | 0 | 0 | **141,982** |
| **2011** | 61,442 | 76,263 | 4,200 | 19,041 | 467 | 0 | 0 | 0 | 0 | 0 | **161,413** |
| **2012** | 67,606 | 75,253 | 11,561 | 23,772 | 405 | n/a | 0 | 0 | n/a | n/a | **178,597** |
| **2013** | 75,183 | 74,122 | 554 | 28,222 | 0 | n/a | 0 | 0 | n/a | n/a | **178,081** |
| **2014** | 86,550 | 73,939 | 396 | 30,701 | 0 | n/a | 0 | 0 | n/a | n/a | **191,586** |
| **2015** | 145,352 | 77,521 | 422 | 29,448 | 0 | n/a | 0 | 0 | n/a | n/a | **252,743** |
| **2016** | 182,034 | 84,637 | 486 | 26,397 | 0 | n/a | n/a | 0 | n/a | n/a | **293,554** |
| **2017** | 175,387 | 88,260 | 729 | 23,859 | 0 | n/a | n/a | 0 | n/a | n/a | **288,235** |
| | **1,188,506** | **1,007,227** | **213,553** | **236,706** | **133,926** | **15,361** | **1,204** | **221,322** | **1,390** | **240** | **2,725,881** |

Source: DWC

***Health Care Organization Program Status***

HCO enrollment decreased approximately 2 percent between 2016 and 2017. HCOs are still being certified for use of their networks as deemed networks for MPNs. The DWC is attempting to complete recertification of the following HCOs: CompPartners; CorVel; Medex; Medex 2; and Promesa.

*For further information …*

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

## DIVISON OF WORKERS' COMPENSATION INFORMATION & ASSISTANCE UNIT

The 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 I&A Unit, often the first DWC contact for injured workers, plays a major role in reducing litigation before the WCAB. The Unit gets approximately 1,500 calls a week on its toll-free line, 800-736-7401, or 78,000 calls a year. These callers get prerecorded messages in English and Spanish about the workers' compensation system and can request forms, fact sheets, or guides.

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**Table 28: Information & Assistance Unit Workload**

| Number of: | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Calls from public handled | 301,517 | 300,515 | 308,221 | 307,242 | 311,473 | 299,674 |
| Outgoing calls placed | 35,985 | 33,965 | 33,015 | 34,017 | 31,985 | 29,922 |
| Settlements reviewed and assisted | 13,515 | 13,055 | 14,129 | 14,535 | 13,988 | 10,841 |
| Face-to-face meetings with walk-ins | 25,911 | 24,588 | 25,105 | 26,858 | 25,715 | 20,987 |
| Injured Worker Workshop presentations | 217 | 243 | 239 | 245 | 229 | 238 |
| Workshops for injured workers attended | 3,215 | 3,013 | 2,615 | 2,377 | 2,714 | 1,593 |
| Correspondence written | 12,983 | 13,005 | 12,996 | 11,557 | 13,511 | 14,805 |
| Conference with Workers' Comp Judge to resolve issue or settlement | NA | NA | 9,125 | 9,334 | 9,313 | 7,314 |
| Audit Unit referrals | NA | NA | 70 | 58 | NA | 46 |

Source: DWC

Spanish Outreach Attendance data by the type of outreach was available only for 2017 (see Table 29). In 2016, the bilingual staff of I&A Unit participated in 69 workshops, fairs, farmworker breakfasts, and consulate presentations, sometimes alone, and sometimes with other DIR staff, such as Labor Commissioners. No attendance figures were available for 2016, as many of these presentations were organized by other entities.

**Table 29: Spanish Outreach Attendance**

| | Number of Events | Avrg Num of Attendees per Event |
|---|---|---|
| | 2017 | 2017 |
| Mexican Consulates | 27 | 60 |
| Radio | 1 | NA |
| Workshops | 3 | 50-75 |
| Farmworker-related fairs/events | 27 | 200-300 |

Source: DWC

**Table 30: DWC Educational Conferences Attendance, 2012–2017**

| | Los Angeles | | | | | | Oakland | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
| Attendees | 1,015 | 1,091 | 1,058 | 1,162 | 1,191 | 1,190 | 939 | 762 | 740 | 836 | 878 | 803 |
| Exhibitors | 64 | 87 | 85 | 89 | 95 | 91 | 59 | 53 | 53 | 61 | 59 | 66 |

Source: DWC

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The I&A Unit provides the DWC Tele-Learning classes on different workers' compensation issues for the Department of Industrial Relations (DIR) employees. The enrollment numbers in these classes are as follows:

**Table 31: Number of Enrollees in DWC Tele-Learning Classes for DIR employees**

| Courses | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| Disability Management/RTW | Not offered | 12 | 10 | 6 |
| Basic Claims | 24 | 23 | 23 | 22 |
| Basic PD | 6 | 12 | 16 | 11 |
| Medical Management | 27 | Not offered | 9 | 6 |
| Advanced Claims | Not offered | 17 | 16 | 12 |
| Advanced PD | 15 | 3 | 5 | 7 |
| **Total** | **72** | **67** | **79** | **64** |

Source: DWC

**DIVISION OF WORKERS' COMPENSATION INFORMATION SERVICE CENTER**

The DWC Information Service Center (ISC) is located in San Bernardino. The main function of the ISC is to screen all incoming calls for all 24 DWC District offices. Any combination of a district office's main number and I&A Unit, Disability Evaluation Unit, and Rehabilitation Unit lines are directed through ISC, which answers questions and provides information in both English and Spanish on workers' compensation and EAMS issues for the general public. In addition, all EAMS help desk emails and Notice of Representation (NOR) questions go through ISC. ISC staff members monitor and resolve questions sent via email to the EAMS Help Desk, process NOR updates received through the e-File system, and answer Virtual EAMS Support Team (VEST Issue Tracker) questions sent by both internal and external users. In September 2014, some members of DWC ISC's staff started participating in the new DIR Cloud call center several days a week. No statistics are available yet on DIR Cloud call center's workload.

**Table 32: DWC's Information Service Center Workload**

| Activities | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| Incoming calls | 131,628 | 174,398 | 180,144 | 198,232 | 184,463 |
| Outgoing calls* | 4,100 | 5,325 | 3,532 | 184 | 312 |
| Calls in Spanish | 8,695 | 13,359 | 14,908 | 13,465 | 12,609 |
| Calls transferred to district offices | 31,158 | 27,365 | 33,191 | 47,271 | 45,851 |
| EAMS Help Desk emails | 11,925 | 20,222 | 21,000 | 16,208 | 20,025 |
| Correspondence mailed out | 5,076 | 5,233 | 5,346 | 5,492 | 4,697 |
| NOR-related questions processed | 39,123 | 39,524 | 47,548 | 30,243 | 29,547 |
| VEST/Issue tracker of EAMS related problems | 278 | 103 | 53 | 18 | 47 |

* Decrease in manual outgoing calls due to new phone system.

Source: DWC

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## DIVISION OF WORKERS' COMPENSATION UNINSURED EMPLOYERS BENEFITS TRUST FUND

### Introduction

All California employers 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 payment of workers' compensation benefits to injured employees of illegally uninsured employers. Labor Code Sections 3710-3732 describe the operation of the Fund, and Labor Code Section 62.5 describes the funding mechanism for UEBTF.

The director of the Department of Industrial Relations (DIR) administers the UEBTF. 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 DIR represented by the Office of the Director Legal Unit.

### Funding Liabilities and Collections

#### *UEBTF Funding Mechanisms*

UEBTF funding comes from annual assessments on all insured and self-insured employers, 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."[39]

The assessment for 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 pursuant to Labor Code Section 62.5 was $40.7 million for fiscal year (FY) 2014-2015, $24.2 million for FY 2015-2016, $23.3 million for FY 2016-2017, and $22.0 million for FY 2017-2018.

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

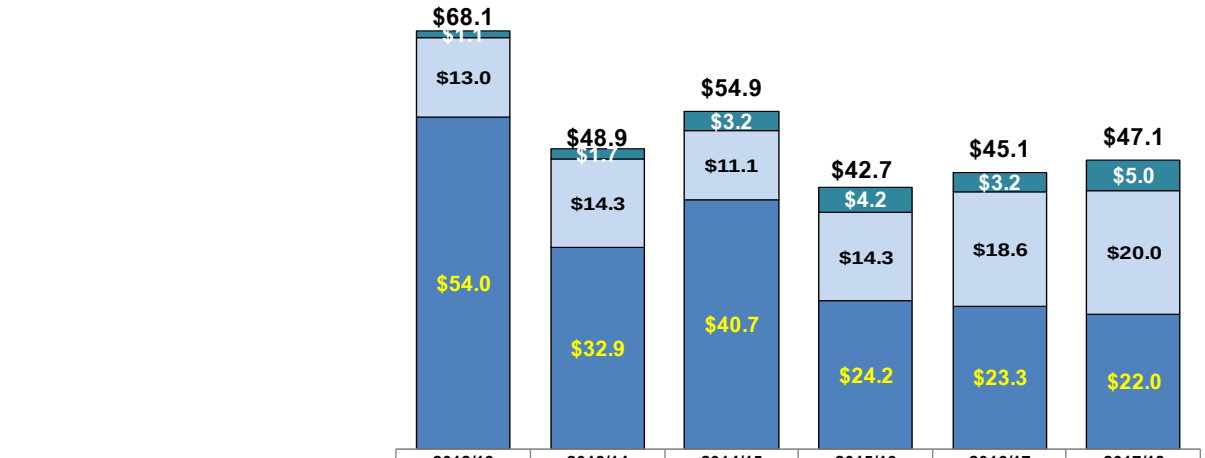
- Fines and penalties collected by DIR. These include both the Division of Labor Standards Enforcement (DLSE) penalties as well as Labor Code Section 3701.7 penalties on self-insured employers.

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

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

Figure 62 shows monies collected by the source of the revenue.[40]

**Figure 62: UEBTF Revenues, FY 2012-2013 to FY 2017-2018 (Million $)**

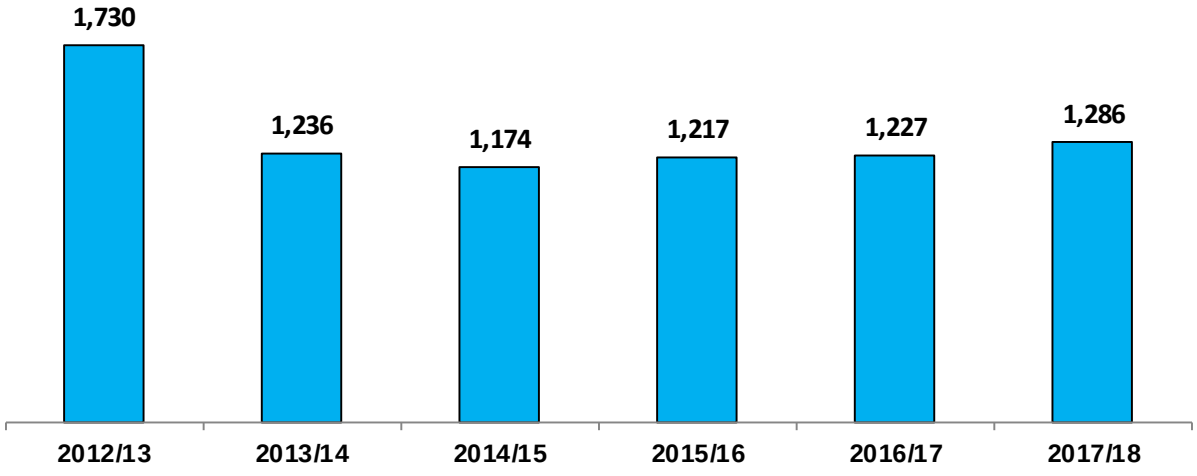



| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| Revenue Collected Pursuant to Labor Code Section 3717 | $1.1 | $1.7 | $3.2 | $4.2 | $3.2 | $5.0 |
| Fines and Penalties Collected | $13.0 | $14.3 | $11.1 | $14.3 | $18.6 | $20.0 |
| Assessments Collected Pursuant to Labor Code Section 62.5 | $54.0 | $32.9 | $40.7 | $24.2 | $23.3 | $22.0 |
| Total Revenue | $68.1 | $48.9 | $54.9 | $42.7 | $45.1 | $47.1 |

Data Source: DWC

The number of new UEBTF cases and dollar amounts associated with new opened claims are shown in Figures 63 and 64.

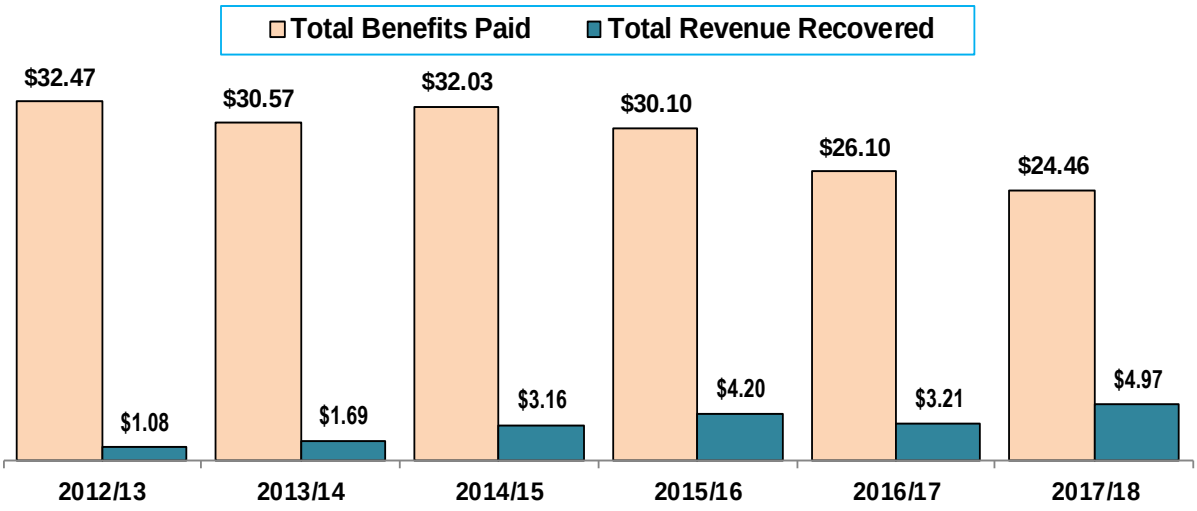
**Figure 63: New UEBTF Cases Opened, FY 2012-2013 to FY 2017-2018**




Data Source: DWC

[40] The data in Figure 63 found at the DWC/Special Funds Unit/UEBTF website are updated on an ongoing basis, http://www.dir.ca.gov/dwc/UEF/UEF_LC3716_1.pdf.

**Figure 64: UEBTF Total Benefits Paid and Total Revenue Recovered, FY 2012-2013 to FY 2017-2018 (Million $)**

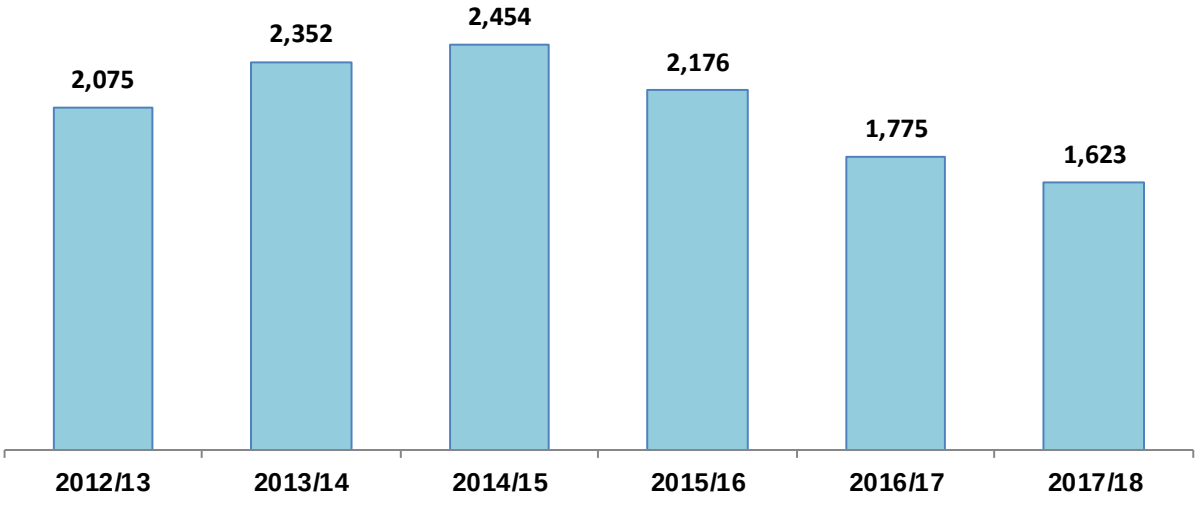



Data Source: DWC

***Costs of the Uninsured Employers Benefits Trust Fund***

According to Figure 65, the number of uninsured claims paid increased by 18 percent from FY 2012-2013 to FY 2014-2015 and then decreased by 34 percent from FY 2014-2015 to FY 2017-2018.

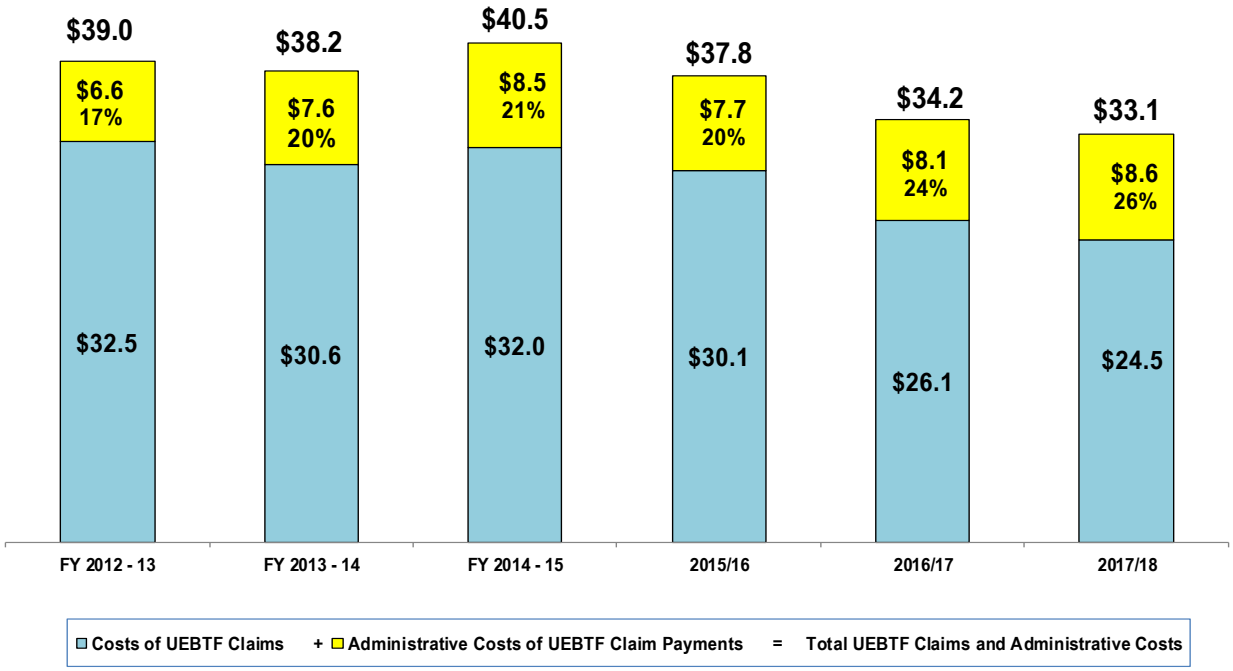
**Figure 65: Number of Uninsured Claims Paid, FY 2012-2013 to FY 2017-2018**




Data Source: DWC

Figure 66 shows that the cost of claims averaged around $32 million from FY 2012-2013 to FY 2014-2015. From FY 2014-2015 to FY 2017-2018, the cost of claims decreased by 24 percent. Administrative costs associated with claim payment activities fell once from FY 2014-2015 to FY 2015-2016 after a 29 percent increase from FY 2012-2013 to FY 2014-2015 and then increased again by 12 percent from FY 2015-2016 to FY 2017-2018.

**Figure 66: UEBTF Amounts Paid and Administrative Costs, FY 2012-2013 to FY 2017-2018 (Million $)**




Data Source: DWC

## ADJUDICATION SIMPLIFICATION EFFORTS

### Division of Workers' Compensation Information System(TO BE UPDATED)

California's Workers' Compensation Information System (WCIS) uses electronic data interchange (EDI) to collect comprehensive information from claims administrators to help oversee the state's workers' compensation system. The information collected facilitates evaluation of the system and helps measure the adequacy of benefits for injured workers and their dependents and provides statistical data for internal and external research. Electronic transmission of first reports of injury (FROI) was required beginning March 1, 2000, and electronic versions of benefit notices (subsequent reports of injury, SROI) were mandated as of July 1, 2000. Electronic reporting of medical billing data was required for medical services beginning September 22, 2006.

WCIS operates with joint efforts from DIR's Office of Information Services (OIS) staff and DIR/DWC's Research Unit staff. The OIS staff provides technical support while the Research Unit staff provides business knowledge and research support.

WCIS accepts FROI/SROI transactions from 157 public, private, insured and self-insured claim administrators.

The WCIS's medical billing data collection underwent a major change in 2016. As of April 6, 2016, the WCIS adopted the IAIABC Medical Bill Data Reporting Implementation Guide (Release 2.0, February 2014). This change made it possible to collect medical bill data using the same standard as adopted in DWC e-billing regulations. WCIS is actively receiving medical data from 57 senders (claims administrators and bill review companies sending data on behalf of claims administrators).

Since the adoption of the new CA Medical Version 2.0 standard in 2016, the WCIS Medical Bill Payment data collection system has collected 22,244,736 lines of data. Including data collected in the old CA Version 1.1 standard, the WCIS currently has over 400 million bill lines of data.

***Maintenance and Improvements to the System***

System improvement continued.

Following the adoption of new reporting regulations and a new implementation guide on March 27, 2017, WCIS FROI and SROI completed all the Change Requests (CRs) required for the adoption of the new system. The new system will take effect March 27, 2018.

A plan to switch file transfer from FTP (file transfer protocol) to SFTP (secure file transfer protocol) commenced in 2016. The development work for this started in 2014.

***New Projects***

With the adoption of CA Medical Version 2.0, the WCIS initiated the use of the ANSI file translator developed by the DIR Office of Information (OIS). This tool removed WCIS's reliance on an outside vendor for the translation of incoming and outgoing ANSI files and gave OIS employees the ability to maintain the system internally.

The WCIS and OIS continue to monitor the accuracy and completeness of the WCIS data. To this end, medical bill data senders received reports listing the types and volume of errors. The WCIS medical team is developing a report to indicate outstanding errors pending correction. In addition, other reports are in development that are tailored to each data sender, illustrating the completeness and specific characteristics of data elements.

***Data Extracts***

In 2016, WCIS data extracts were provided to several state organizations, researchers in academia, and other government organizations.

The WCIS continues to supply regular data extracts for the California Division of Occupational Safety and Health (Cal/OSHA), the California Department of Public Health, and the California Department of Health Care Services. The WCIS also provided data to the DIR Directors Office on several subjects related to legislative efforts.

The RAND studies on Medical Access and the formulary also used the WCIS data. The University of California at Berkeley also received data.

The medical data was also provided to the public pursuant to the California Public Records Act.

The WCIS data was also provided to numerous research organizations and the public at large. Organizations that received WCIS data include:

- The University of California at San Francisco
- University of California at Los Angeles
- The Kaiser Foundation Health Plan, Inc.

***Data Quality***

In order to improve the quality of incoming data, California Medical Version 2.0 implemented a more stringent data validation program. In addition the WCIS team also sent out individual data quality reports

to each sender and discussed data quality issues with data reporters at the DWC Education Conference and at the WCIS advisory meeting.

The WCIS team continues to work on improving the quality and completeness of data being reported by claims administrators. To this end, the WCIS team developed reports to send out to data senders and communicated with them using meetings and electronic media. WCIS holds an annual advisory meeting to discuss trends, issues, and proposed system changes with trading partners and other stakeholders. WCIS staff have continued to answer data sender questions, distribute Online Training Bulletins, and provide one-on-one training to trading partners to improve their FROI/SROI reporting. During the coming year, WCIS staff will be working with DWC's legal unit to develop, draft, and engage in the regulatory process to implement WCIS penalty provisions.

*For further information…*
http://www.dir.ca.gov/dwc/WCIS.htm.

**Division of Workers' Compensation Electronic Adjudication Management System**

Senate Bill (SB) 863 requires electronic lien filing as well as electronic payment of filing or activation fees on some liens. The Division of Workers' Compensation (DWC)/Department of Industrial Relations (DIR) Electronic Adjudication Management System (EAMS) team successfully deployed the lien filing and activation fee processes to e-Forms, Jet, and Public Search on January 1, 2013.

Upgrades to the new payment processes, including a shopping cart function and increased capacity, were rolled out in March, April, and June 2013. Improvements to these processes are continuing.

The electronic Notice and Request for Allowance of Lien and the Declaration of Readiness forms have been revised, and a new form, the Request for Factual Correction of an Unrepresented Panel Qualified Medical Examiner (QME) Report, was created.

EAMS regulations for e-Form filing, Jet filing, and lien fees were approved. Due to a preliminary injunction ordered by a federal district judge in Angelotti Chiropractic, Inc., et al. v. Baker, et al., effective November 19, 2013, the DWC/DIR EAMS team suspended the collection of activation fees for liens filed before January 1, 2013. Resolution of the appeal of the injunction are discussed below. Through EAMS, DWC continues to collect the filing fee for liens filed after January 1, 2013.

Check processing for the Uninsured Employers Benefit Trust Fund (UEBTF) shifted from DIR Accounting to the State Controller's Office.

Check processing for the Subsequent Injuries Benefit Trust Fund (SIBTF) shifted from DIR Accounting to the State Controller's Office.

To better track Senate Bill (SB) 863 changes, modifications were made to Expedited Hearings, Liens, and reasons for filing Liens.

Tools were created to reschedule multiple court hearings at the same time and change Uniform Assigned Name addresses on multiple cases. The improved Notice of Hearing data mailer shows all cases set for hearing when companion cases are scheduled.

New software tools enable EAMS staff to systematically add or change law firms and claims administrators on multiple cases.

EAMS venue adjustments allow case assignment and hearing scheduling at the Santa Barbara satellite district office.

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The upgraded EAMS Case Participants list shows internal and external users the complete addresses of all case parties on a single page.

The EAMS staff is working to better incorporate other portions of SB 863, including Independent Medical Review (IMR) and Independent Bill Review (IBR). Many requests for changes to improve EAMS have been implemented.

In 2015 and 2016, DIR created a more robust and secure network for EAMS by refreshing servers, adding security features, and updating infrastructure software and Cognos reporting software.

2015 activities:

- DIR enriched workflows for document processing for judge review, lien processing (to systematically add the lien claimant and lien claimant representative as case participants), and expanded workflows for the Uninsured Employers Benefits Trust Fund (UEBTF). Document processing was improved by adding document titles and updating classifications for case participants to our current needs. The ability to match a new case to a previously injured worker was improved by adding a portion of the worker's first name in the matching criteria.

- In November, we made changes in the Declaration of Readiness and resumed the collection of lien activation fees in compliance with a ruling issued by Judge George Wu of the US District Court for the Central District of California in *Angelotti Chiropractic, Inc., et al. v. Baker, et al.*

- In December, DIR implemented changes to halt the collection of lien activation fees, in compliance with the ruling issued in *Angelotti Chiropractic, Inc., et al. v. Baker, et al.*

2016 activities:

- DIR enlarged the comment fields in EAMS, created additional case participant roles, and enhanced the Public Information Search Tool. DIR streamlined the workflow for settlement notification to the judges. JET filing internal processes were improved. DIR enhanced document processing by updating zip code lists, adding more document titles and enforcing the lien claimant UAN (Uniform Assigned Name) on all lien submissions.

- DIR streamlined the process for setting hearings before judges and developed new UEBTF and SIBTF processes for those hearings. We improved UEBTF document processing, data reliability, and communication templates.

In 2017, DIR began implementation of Assembly Bill 1244 and Senate Bill 1160.

2017 activities:

- EAMS support for the special Adjudication Unit (SAU) was designed and implemented to conduct lien consolidation proceedings.

- Processes were created in EAMS to identify liens of medical providers that have been criminally indicted or suspended in EAMS. Those changes are displayed in EAMS and in the Lien Search results of the Public Information Search Tool.

- DIR revised the electronically filed Notice and Request for Allowance of Lien form to include medical provider information, created the Supplemental Lien Form and Section 4903.05(c) Declaration and updated DWC Document Cover and Separator Sheets to allow submission of SAU case documents into EAMS.

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- In August, DIR processed liens that were dismissed by operation of law that did not meet the statutory requirements of Labor Code Section 4903.05.

- DIR improved SIBTF and UEBTF business analytics.

In 2018, DIR completed implementation of Assembly Bill 1244 and Senate Bill 1160 and updated EAMS software and hardware, FileNet storage and scanning software.

2018 activities:

- DIR expanded workflows in document processing for SAU judge review. It improved scheduling of hearings and created communication templates for SAU.

- DIR reduced redundancy and increased efficiency in EAMS software by updating Curam case management software according to current industry standards.

**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. In 2003, the Legislature extended the program to cover alternative dispute resolution labor-management agreements outside the construction industry. This is codified in LC 3201.7.

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

*CHSWC Study of Carve-Outs*

CHSWC engaged in a study to identify the various methods of alternative dispute resolution (ADR) which 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 (2003)*

Senate Bill (SB) 228 (2003) added Labor Code Section 3201.7, establishing the creation of a new carve-out program for any unionized industry that meets the requirements. This was in addition to the existing carve-out program in the construction industry (already covered under 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.

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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 (2004)*

In 2004, 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, were 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.

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*Requirements of ADR program reports to DWC under 8 CCR Section 10203*

The ADR data reporting requirements, initially adopted by DWC in 1996, can be found in the California Code of Regulations, Title 8, Section 10203. Section 10203 requires that every employer subject to either Labor Code Section 3201.5 or 3201.7 shall provide the DWC with the required information for the previous calendar year on or before March 31 of each year. For each claim with a date of injury on or after January 1, 2004, the information shall be updated annually for the previous four calendar years, thereby allowing longer-term claims trajectories and costs to be determined. In order to fulfill the reporting requirement, groups of employers must, on behalf of their members, either submit data directly to the DWC, or "(a)(2)(B) provide the Administrative Director with written authorization to collect the information from the appropriate claims administrator. However, if the Administrative Director is unable to obtain the information with the written authorization, the employer shall remain responsible for obtaining and submitting the information." Employers are required to submit data using the Aggregate Employer Annual Report (DWC Form GV-1) (8 CCR Section 10103.1) and the Individual Employer Annual Report (DWC Form GV-2) (8 CCR Section 10103.2).

*Person hours and payroll covered by agreements filed*

As Table 33 shows, for calendar year 2017, 28 of 39 reporting programs reported payroll and person-hours. Carve-out programs reported that for the 2017 calendar year, they covered 94 million work hours and $3.0 billion in payroll. The reported average wage per carve-out person-hours worked is $20 per hour.

**Table 33: Estimated Person-Hours Worked and Payroll, 2006 - 2016**

| Calendar Year (Reporting Year) | Reporting Programs | Employers | Payroll (Million$) | Person-Hours Worked (Millions) | FTE (estimated) | Average Hourly Wage |
|---|---|---|---|---|---|---|
| **2006** | 19 | 981 | $1,378 | 56 | 28,000 | $25 |
| **2007** | 16 | 1,087 | $1,777 | 56 | 28,000 | $32 |
| **2008** | 19 | 1,274 | $2,782 | 93 | 46,500 | $30 |
| **2009** | 21 | 876 | $3,393 | 100 | 50,000 | $34 |
| **2010** | 19 | 1,177 | $1,976 | 67 | 33,500 | $29 |
| **2011** | 22 | 1,586 | $2,418 | 78 | 39,000 | $31 |
| **2012** | 25 | 1,508 | $1,849 | 69 | 34,500 | $27 |
| **2013** | 22 | 1,815 | $1,226 | 51 | 25,600 | $24 |
| **2014** | 27 | 1,901 | $3,255 | 122 | 60,900 | $27 |
| **2015** | 23 | 1,552 | $2,553 | 89 | 44,600 | $29 |
| **2016** | 34 | NA | $3,203 | 159 | 79,400 | $20 |
| **2017** | 28 | NA | $3,000 | 94 | | $32 |

Data Source: DWC

**Status of Carve-out Agreements**

The following websites are updated regularly and 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 Labor Code Section 3201.5**
http://www.dir.ca.gov/dwc/Carveout/ConstructionCarveOut.htm.
**Non-Construction Industry Carve-out Participants Labor Code Section 3201.7**
http://www.dir.ca.gov/dwc/Carveout/NonConstructionCarveOut.htm.

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*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 BUREAU OF FIELD ENFORCEMENT (TO BE UPDATED)**

The Bureau of Field Enforcement (BOFE) in the Division of Labor Standards Enforcement (DLSE) is responsible for investigation and enforcement of statutes covering workers' compensation insurance coverage, child labor, cash pay, unlicensed contractors, and Industrial Welfare Commission orders, as well as group claims involving minimum wage and overtime claims. BOFE also handles criminal investigations involving these group claims.

Table 33 lists the citations from FY 2015-2016 enforcement actions. It illustrates the Bureau's performance inclusive of all special programs, such as non-public works field enforcement and prevailing wage enforcement through the Public Works Unit.

**Table 34: DLSE Citations by Category, FY 2015–2016**

| Citation Category | Number of Citations | Penalties Assessed | Penalties Collected |
|---|---|---|---|
| **Workers' Compensation** | **859** | **$19,278,262** | **$3,563,390** |
| Itemized Statement | 449 | $4,229,225 | $2,013,975 |
| Non-registration* | 141 | $1,058,400 | $402,739 |
| Overtime | 192 | $678,107 | $127,480 |
| Rest and Meal Period | 103 | $297,375 | $80,253 |
| Minimum Wage | 180 | $520,178 | $71,438 |
| Child Labor | 59 | $84,000 | $68,150 |
| Unlicensed Construction Contractor | 39 | $283,200 | $46,566 |
| Garment | 37 | $87,500 | $13,983 |
| Unlicensed Farm Labor Contractor | 5 | $42,600 | $12,600 |
| Misclassification | 2 | $17,000 | $0 |
| Other | 6 | $40,950 | $10,045 |
| ***Subtotal*** | **2,072** | **$26,616,798** | **$6,410,618** |
| Public Works | 636 | $25,078,769** | $5,344,426 |
| *LESS citations dismissed/modified* | | *($8,354,480)* | |
| **TOTAL** | **2,708** | **$43,341,087** | **$11,755,044** |

* "Non-registration" includes penalties for non-registration issued for car washes and garment manufacturers.
** Includes Labor Code Section 1777.7 penalty assessments.

Source: DLSE

*For further information …*

https://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 California Department of Insurance (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).

The former Insurance Commissioner Steve Poizner convened an Advisory Task Force on Insurance Fraud in May 2007 to address major issues relating to insurance fraud. Christine Baker, a former executive officer of CHSWC and now the retired director of DIR chaired the Task Force's Workers' Compensation Expert Working Group. 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.
- 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 in the State so that 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 CDI's outreach efforts about the consequences of fraud and how the public can recognize 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 reported by the insurers and does not necessarily reflect the whole picture of fraud since many fraudulent activities have not been identified or investigated.

According to CDI Fraud Division data, the quality of SFCs continues to improve each fiscal year. Several reasons for this trend include:[41]

- The extensive efforts to provide training to the insurance claim adjusters and SIU personnel by the Fraud Division and District Attorneys.

[41] 2014 Annual Report of the Insurance Commissioner, August 1, 2015.

- Changing submission of SFCs by filling out the FD-1 Form electronically on the Internet.

- Promulgating 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 was 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.

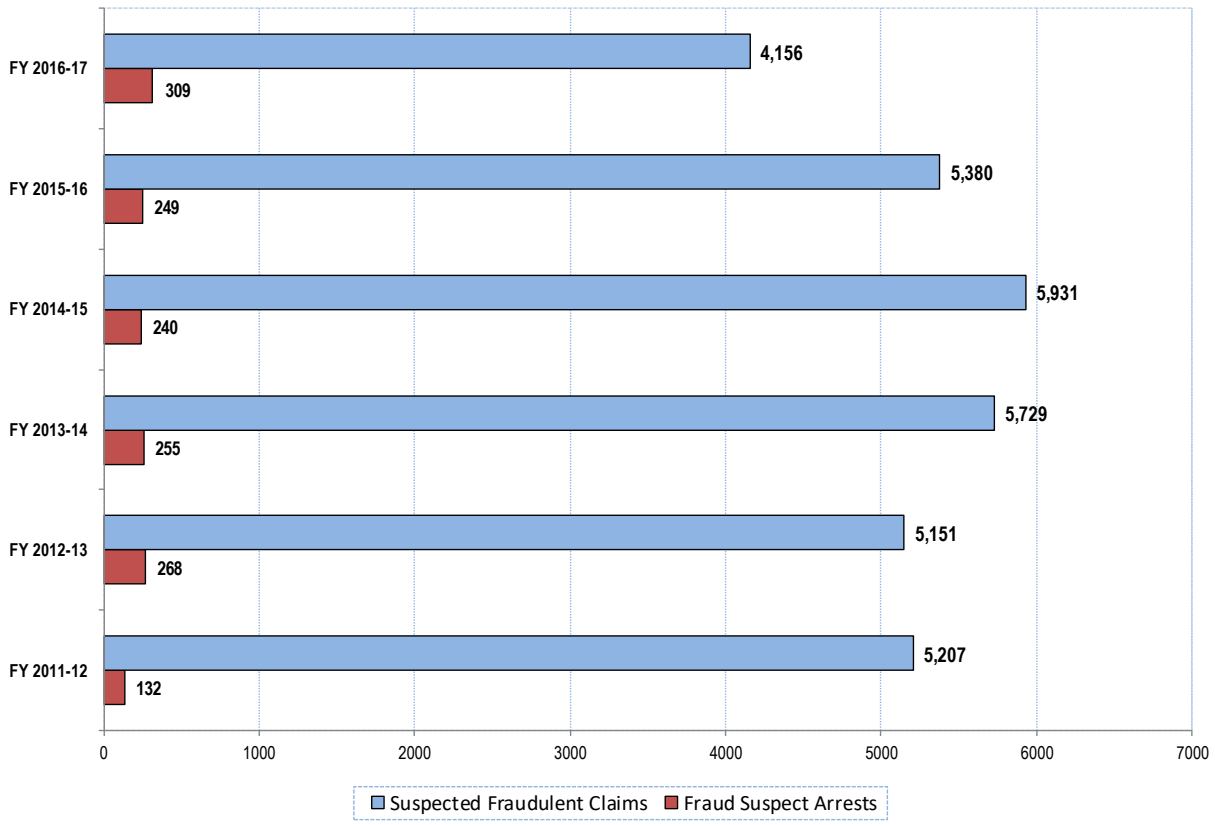
- CDI is strengthening its working relationship with the Workers' Compensation Insurance Rating Bureau (WCIRB) to support the Department's anti-fraud efforts.

For fiscal year 2016-2017, the total number of SFCs reported is 4,156.

**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 Figure 67).

**Figure 67: Suspected Workers' Compensation Fraudulent Claims and Suspect Arrests**

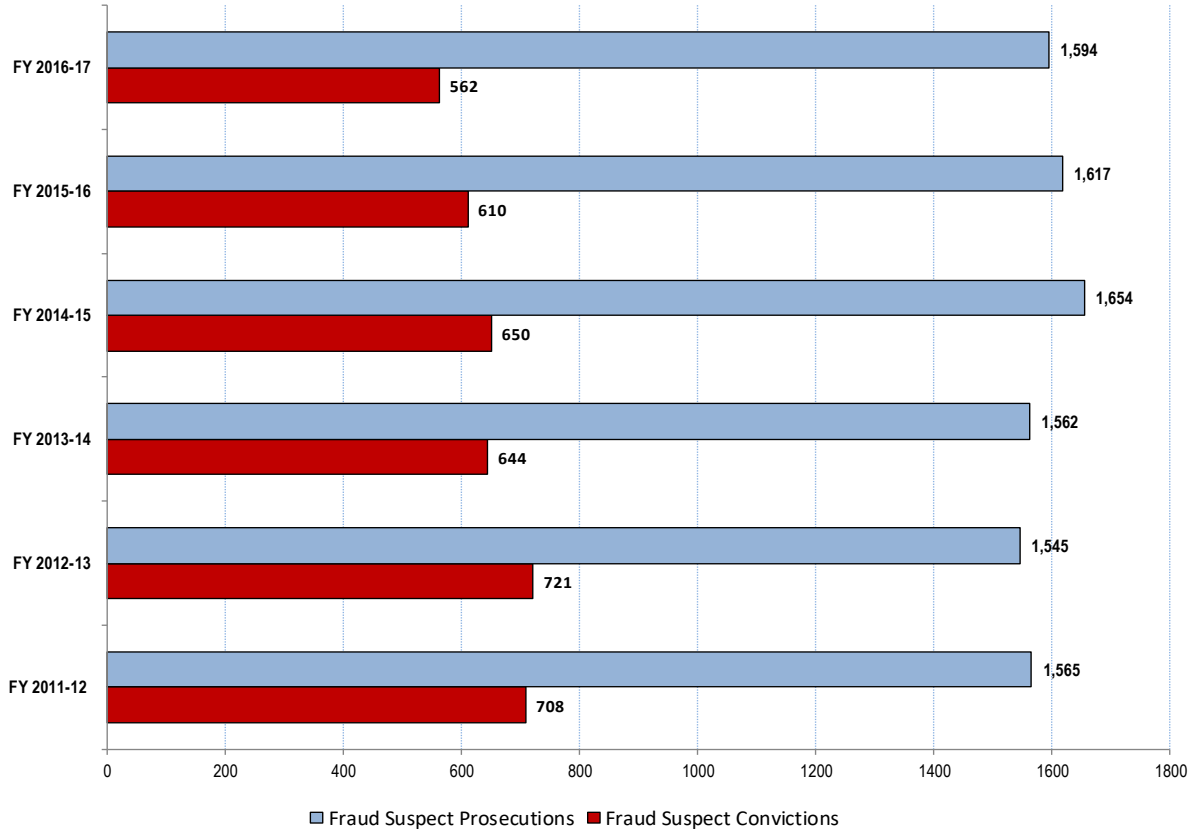



Data Source: CDI - Fraud Division and CWCI

### 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 Figure 68.

**Figure 68: Workers' Compensation Fraud Suspect Prosecutions and Convictions**




Data Source: CDI - Fraud Division and CWCI

### Workers' Compensation Fraud Investigations

#### *Types of Workers' Compensation Fraud Investigations*

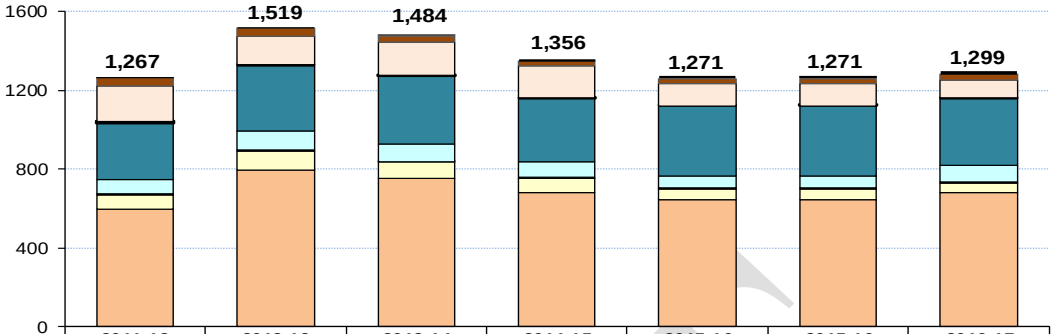
Figures 69 and 70 indicate the number and type of investigations opened and carried from fiscal years FY 2011-2012 to FY 2016-2017 reported by district attorneys. Applicant fraud appears to be the area generating the most cases followed by premium fraud and uninsured employer fraud.

Some of the categories for fraud-related investigations were changed in FY 2005-2006, FY 2006-2007, and FY 2007-2008. In FY 2008-2009, two new categories, Legal Provider and Pharmacy, were introduced as separate categories.

#### *Trends in Workers' Compensation Fraud Investigations*

Figure 69 shows that the number of workers' compensation fraud investigations increased by 20 percent from FY 2011-2012 to FY 2012-2013 and then decreased overall by 14 percent from FY 2012-2013 to FY 2016-2017.

**Figure 69: Caseload by Type of Fraud Investigations, FY 2011-2012–FY 2016-2017**



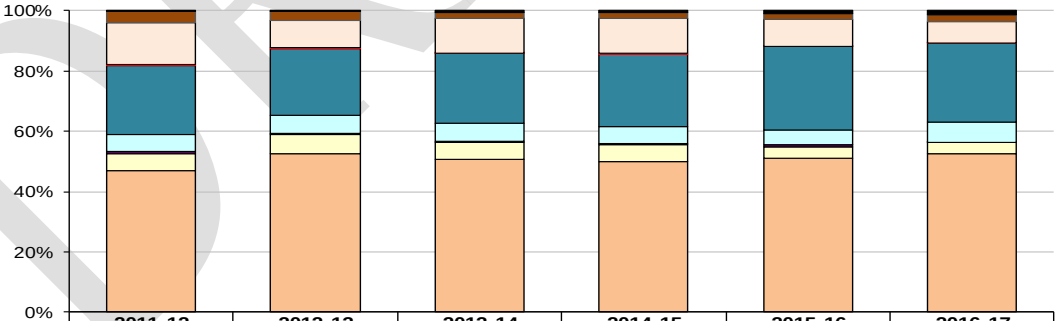

| | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 | 2015-16 | 2016-17 |
|---|---|---|---|---|---|---|---|
| Legal Provider | 5 | 4 | 9 | 9 | 12 | 12 | 17 |
| Defrauding Employee | 43 | 43 | 30 | 23 | 23 | 23 | 29 |
| Uninsured Employer | 177 | 140 | 169 | 161 | 115 | 115 | 91 |
| Pharmacy | 7 | 6 | 2 | 2 | 1 | 1 | 2 |
| Premium* | 290 | 333 | 346 | 324 | 353 | 353 | 343 |
| Medical Provider** | 68 | 94 | 88 | 79 | 63 | 63 | 84 |
| Insider | 11 | 6 | 5 | 6 | 5 | 5 | 3 |
| Other | 71 | 96 | 84 | 74 | 52 | 52 | 48 |
| Applicant | 595 | 797 | 751 | 678 | 647 | 647 | 682 |
| Total | 1,267 | 1,519 | 1,484 | 1,356 | 1,271 | 1,271 | 1,299 |

* Includes Misclassification, Underreported Wages, and X-Mod Evasion
** Includes Capping and Fraud Rings

Data Source: California Department of Insurance, Fraud Division

As seen in Figure 70, the focus of the investigations experienced some changes during the observed period. Applicant fraud investigations increased overall from 47 percent of the total in FY 2011-2012 to 52.5 percent in FY 2016-2017. During the same period, the percentage of investigations of premium fraud increased on average by 4 points in the last two years. From FY 2011-2012 to FY 2016-2017, investigations of uninsured employer fraud decreased seven-percentage-points and for defrauding employee – decreased by 1.2 percentage points.

**Figure 70: Distribution by Type of Fraud Investigations, FY 2011-2012–FY 2016-2017**




| | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|---|---|---|
| Legal Provider | 0.4% | 0.3% | 0.6% | 0.7% | 0.9% | 1.3% |
| Defrauding Employee | 3.4% | 2.8% | 2.0% | 1.7% | 1.8% | 2.2% |
| Uninsured Employer | 14.0% | 9.2% | 11.4% | 11.9% | 9.0% | 7.0% |
| Pharmacy | 0.6% | 0.4% | 0.1% | 0.1% | 0.1% | 0.2% |
| Premium * | 22.9% | 21.9% | 23.3% | 23.9% | 27.8% | 26.4% |
| Medical Provider** | 5.4% | 6.2% | 5.9% | 5.8% | 5.0% | 6.5% |
| Insider | 0.9% | 0.4% | 0.3% | 0.4% | 0.4% | 0.2% |
| Other | 5.6% | 6.3% | 5.7% | 5.5% | 4.1% | 3.7% |
| Applicant | 47.0% | 52.5% | 50.6% | 50.0% | 50.9% | 52.5% |

* Includes Misclassification, Underreported Wages, and X-Mod evasion.
** Includes Capping and Fraud Rings.

Data Source: California Department of Insurance, Fraud Division

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In addition, the *2017 Annual Report of the Insurance Commissioner* notes that the majority of suspected fraudulent claims in calendar year 2017 came from Los Angeles County (1,507, or 36.5 percent of total cases) followed by Orange County (434, or 10.5 percent) and San Diego County (284, or 7 percent).

**Underground Economy**

Although most California businesses comply with health, safety, and workers' compensation regulations, some do not and operate 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. The underground economy costs the California state economy an estimated $8.5 billion to $10 billion in tax revenues every year.[42]

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

CHSWC has conducted many studies that focus on improving workers' compensation anti-fraud efforts and co-chaired stakeholder meetings on fraudulent activity in the workers' compensation system. In September 2016, Governor Brown signed Assembly Bill 1244 and Senate Bill SB 1160 that provide a mechanism for suspending perpetrators of fraud from the workers' compensation system and for limiting financial recovery related to fraudulent activity. More information on the Department of Industrial Relations (DIR) efforts related to AB 1244 and SB 1160 can be found at http://www.dir.ca.gov/fraud_prevention/.

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

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The Administrative Director of the Division of Workers' Compensation is now required to suspend any medical provider, physician, or practitioner from participating in the workers' compensation system in any capacity when the individual or entity meets specific criteria as related to fraud. Those criteria include conviction of a felony or misdemeanor: (1) involving fraud or abuse of the Medi-Cal, Medicare, or workers' compensation systems; (2) relating to patient care; (3) involving fraud or abuse of any patient; or (4) otherwise substantially related to the qualifications and duties of the provider. The medical provider is also to be suspended when his or her license, certificate, or approval to provide health care has been surrendered or revoked, or when that individual or entity has been suspended from participation in the Medicare or Medicaid programs due to fraud or abuse. A medical provider is now barred from submitting or pursuing claims for payment for services or supplies provided, if that provider has been suspended from participation in the workers' compensation system.

For the period of 2017-2018, over 150 criminally charged individuals have had their liens stayed under LC 4615, representing over 560,000 liens stayed. Over 340 providers have been suspended under LC 139.21.[43]

More information on the Department of Industrial Relations (DIR) efforts related to AB 1244 and SB 1160 can be found at http://www.dir.ca.gov/fraud_prevention/.

[42] https://www.edd.ca.gov/payroll_taxes/underground_economy_cost.htm.

[43] Data as of 11/21/2018; provided by DIR, Office of the Director Anti-Fraud Unit

# WORKPLACE HEALTH AND SAFETY PERFORMANCE MEASURES

## OCCUPATIONAL INJURY AND ILLNESS PREVENTION EFFORTS (FATALITIES TO BE UPDATED ON RELEASE)

Workplace health and safety are 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 discusses the number and incidence rate 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 and California.

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

### Occupational Injuries, Illnesses, and Fatalities

The number 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 listed and discussed in this subsection. Fatality statistics for 2017 are preliminary.

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, regardless of whether there is also job transfer or restricted work activity.

The National Academy of Social Insurance (NASI) estimated that in 2016 (latest available year in 2018) 138.3 million workers were covered by workers’ compensation in the U.S., including 16.5 million in California.

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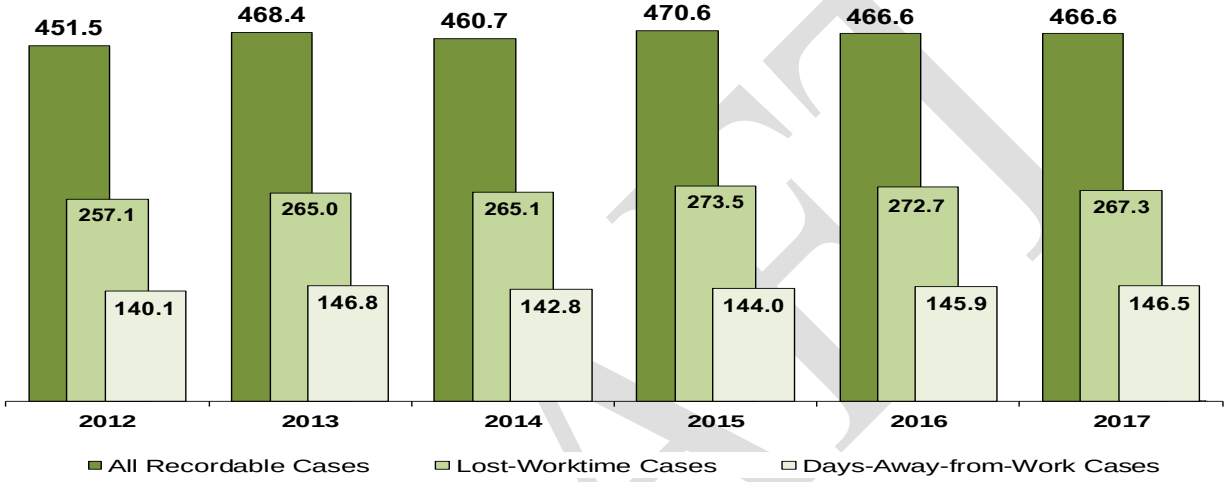
## Comparison of the Public and Private Sectors

*Non-Fatal Occupational Injuries and Illnesses*

Figure 71 shows the number of occupational injuries and illnesses in California's private industry and state and local government. The number of all recordable cases for occupational injury and illness in California fluctuated slightly around an average of 464,000 cases between 2012 and 2016, but did not change from 2016 to 2017. The number of lost-work-time cases increased by 6 percent from 2012 to 2015, and then decreased by 2 percent from 2015 to 2017. The days-away-from-work cases increased by 5 percent from 2012 to 2013, decreased slightly from 2013 to 2014, and then increased by 3 percent from 2014 to 2017.

**Figure 71: California Non-Fatal Occupational Injuries and Illnesses: Private Industry and State and Local Governments (Thousands)**

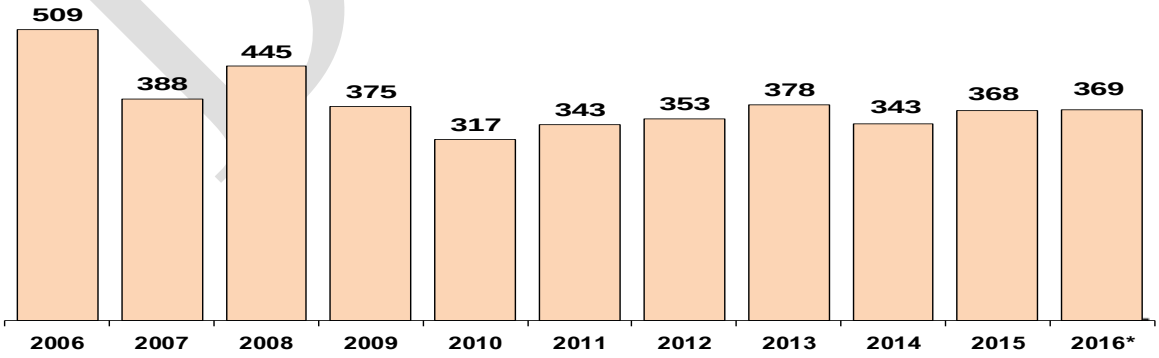



Source: DIR, Director's Office of Policy, Research and Legislation

*Fatal Occupational Injuries and Illnesses*

Fatal occupational injuries and illnesses in California have also decreased overall, as shown in Figure 73. Fatal occupational injuries and illnesses in California reached its peak in 2006, decreased 23.8 percent from 2006 to 2007, increased 14.7 percent from 2007 to 2008, and then decreased by 29 percent from 2008 to 2010. The number of fatal injuries in California increased by 19 percent from 2010 to 2013, decreased by 9 percent from 2013 to 2014, and then increased by 0.8 percent from 2015 to 2016.

**Figure 72: California Fatal Occupational Injuries and Illnesses—Private Industry and State and Local Governments****




* Preliminary data.
** Total, excluding Federal Government.

Data Source: BLS and DIR, Director's Office of Policy, Research and Legislation

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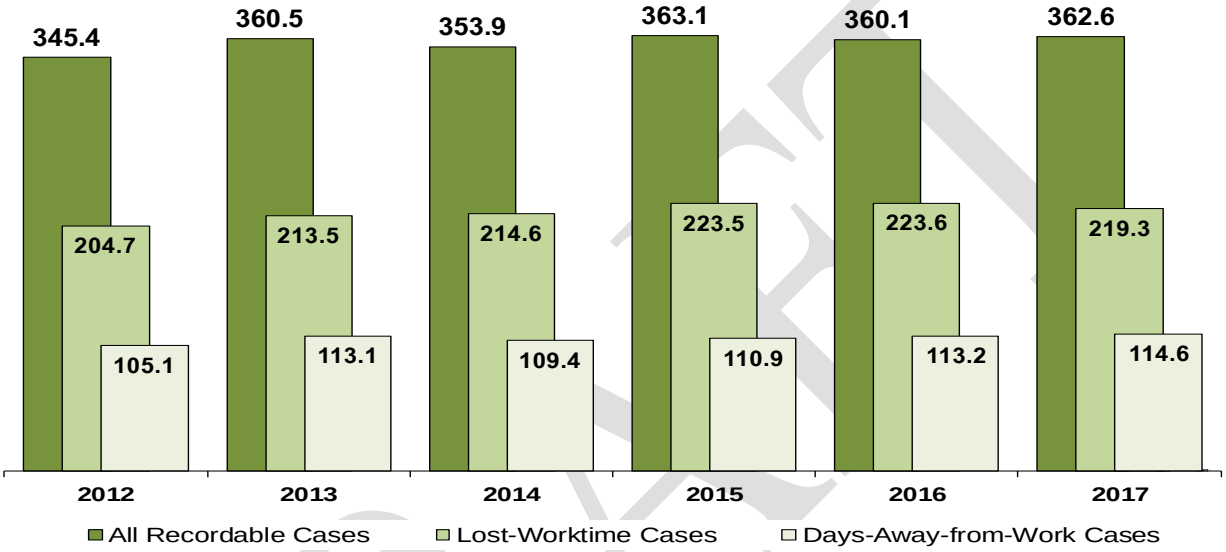
**Private Sector**

*Non-Fatal Occupational Injuries and Illnesses*

The total number of recordable injury and illness cases fluctuated slightly between 345,000 and 363,000 cases between 2012 to 2017. The number of lost-work-time cases increased by 9 percent from 2012 to 2016, and then decreased slightly by 2 percent from 2016 to 2017. The number of days-away-from-work cases increased by 8 percent from 2012 to 2013, decreased slightly from 2013 to 2014, and then increased by about 5 percent from 2014 to 2017.

**Figure 73: California Non-Fatal Occupational Injuries and Illnesses: Private Industry (Thousands)**

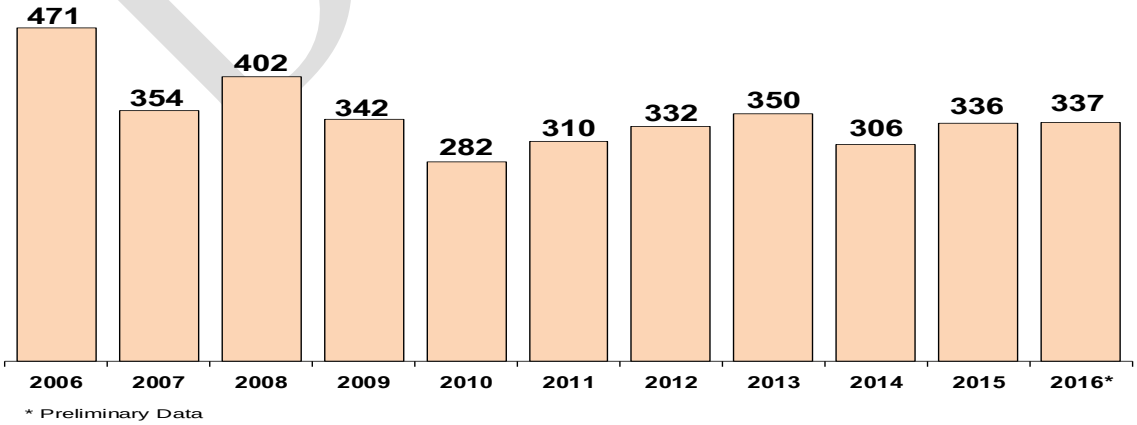



Source: DIR, Director's Office of Policy, Research and Legislation

*Fatal Occupational Injuries and Illnesses*

Fatal occupational injuries and illnesses in California private industry reached its peak in 2006, decreased by 25 percent from 2006 to 2007, increased 13.6 percent from 2007 to 2008, and then decreased by 30 percent from 2008 to 2010. A 24 percent increase in the number of fatal injuries in California from 2010 to 2013 was followed by a 15 percent decrease from 2013 to 2014 and almost no change from 2015 to 2016.

**Figure 74: California Fatal Occupational Injuries and Illnesses—Private Industry**



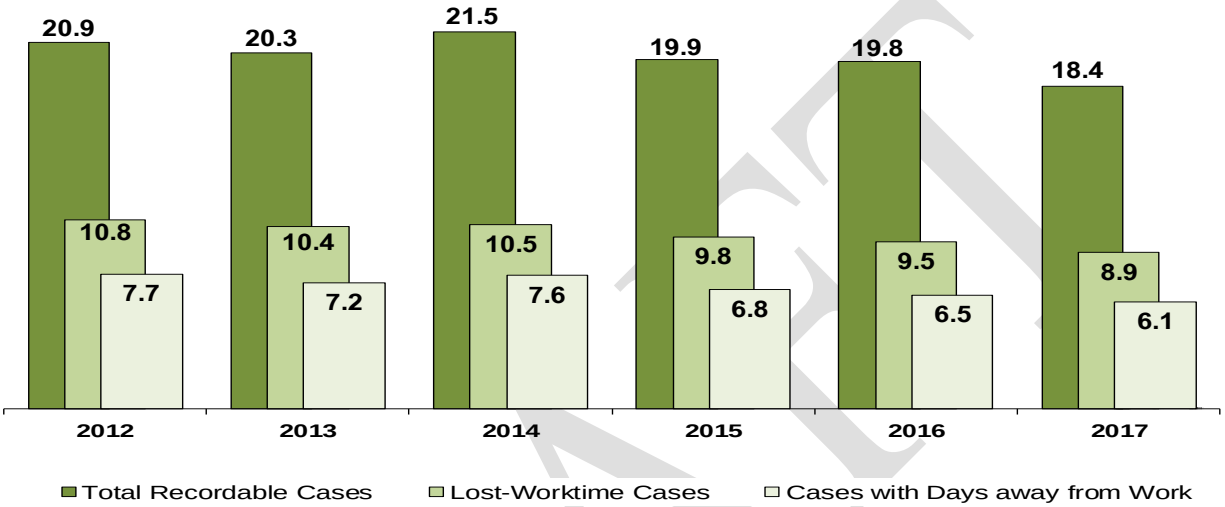

Source: BLS and DIR, Director's Office of Policy, Research and Legislation

**Public Sector: State Government**

*Non-Fatal Occupational Injuries and Illnesses*

The number of all recordable injury and illness cases in California state government averaged at 20,600 cases in 2012 and 2013, increased by 4 percent from 2013 to 2014, and then decreased by 14 percent from 2014 to 2017. It should be noted that many state and local government occupations are high risk, such as law enforcement, firefighting, rescue, and other public safety operations.

**Figure 75: California Non-Fatal Occupational Injuries and Illnesses: State Government (Thousands)**

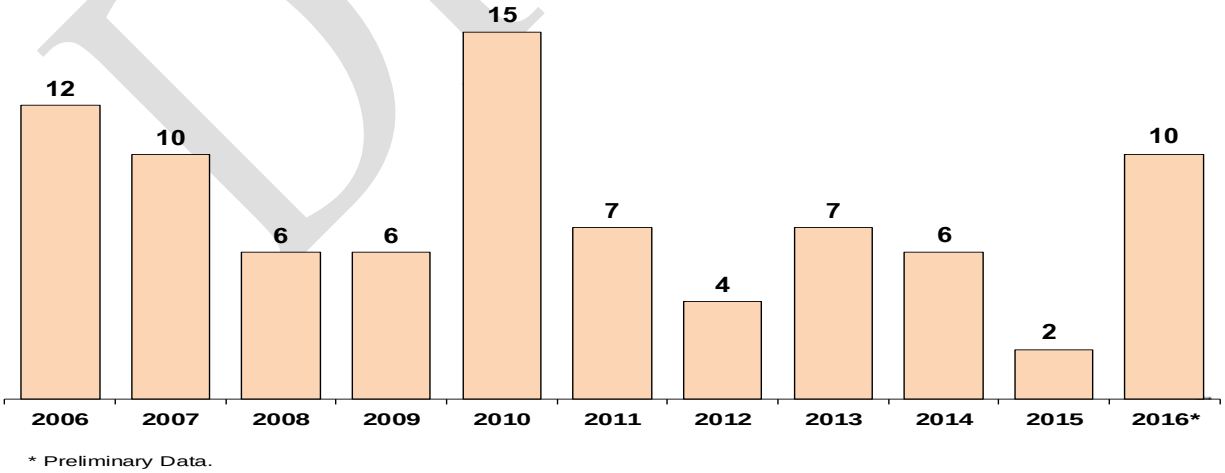



Source: DIR, Director's Office of Policy, Research and Legislation

*Fatal Occupational Injuries and Illnesses*

Fatal occupational injuries and illnesses in California state government decreased from 12 in 2006 to 6 in 2008, and then averaged 6 fatalities for most years from 2008 through 2016, except for a spike of 15 fatalities in 2010.

**Figure 76: California Fatal Occupational Injuries and Illnesses—State Government**




Source: DIR, Director's Office of Policy, Research and Legislation

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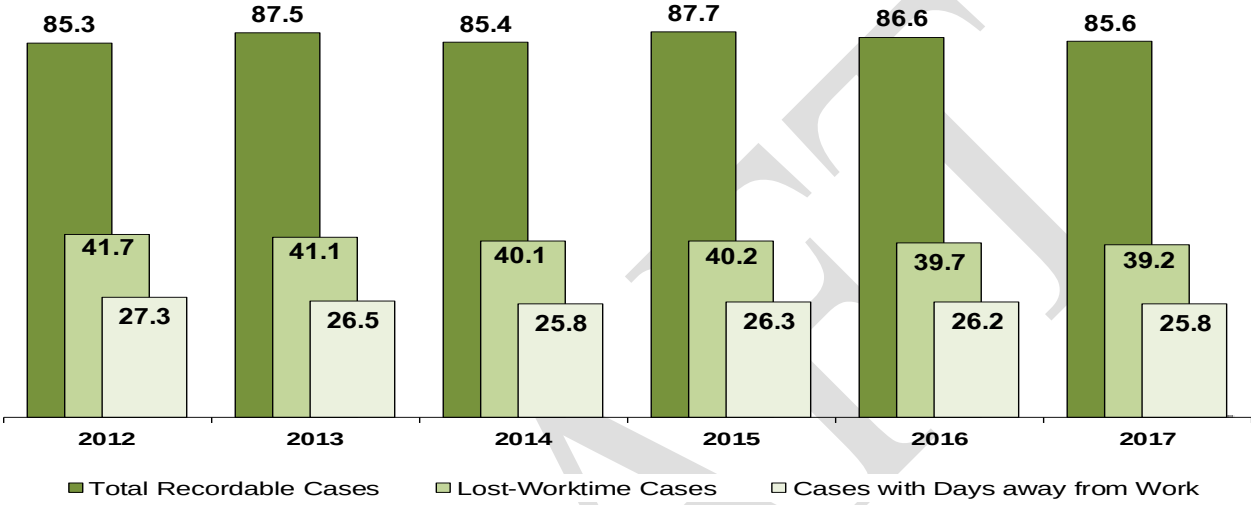
**Public Sector: Local Government**

*Non-Fatal Occupational Injuries and Illnesses*

The total number of non-fatal occupational injuries and illnesses in local government fluctuated between 85,000 and 88,000 cases between 2012 and 2015 and then decreased slightly from 2015 to 2017. From 2012 to 2017, the number of lost-worktime cases in this sector decreased steadily by 6 percent. The number of cases with days away from work decreased overall by 5.5 percent from 2012 to 2017.

**Figure 77: California Non-Fatal Occupational Injuries and Illnesses: Local Government (Thousands)**

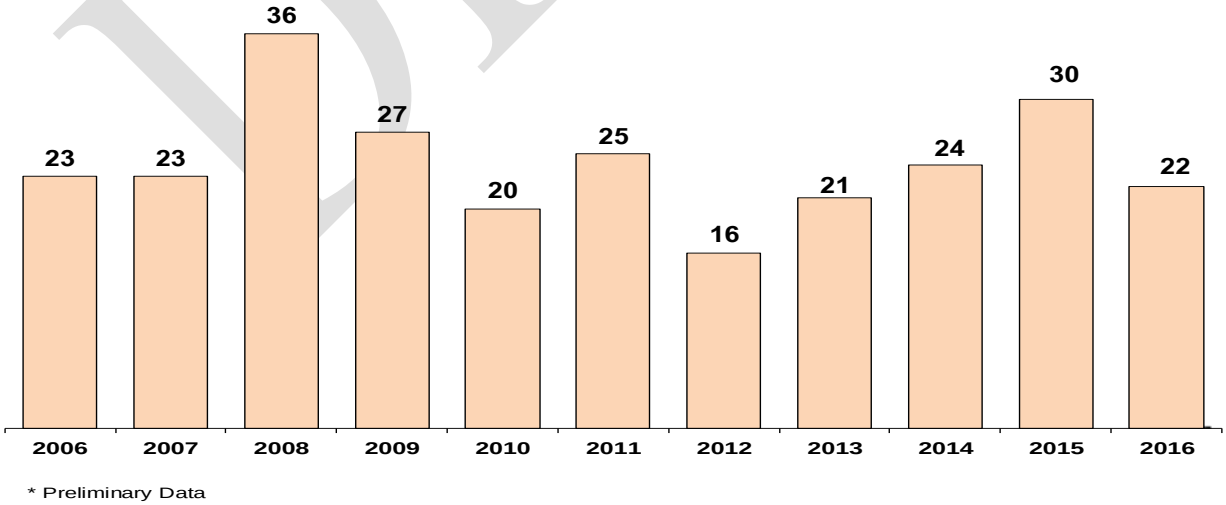



Source: DIR, Director's Office of Policy, Research and Legislation

*Fatal Occupational Injuries and Illnesses*

The number of fatal occupational injuries and illnesses in California's local governments averaged 22 fatalities between 2006 and 2016 with a spike of 36 fatalities in 2008 and an increase to 30 fatalities in 2015.

**Figure 78: California Fatal Occupational Injuries and Illnesses—Local Government**




* Preliminary Data

Source: BLS and DIR, Director's Office of Policy, Research and Legislation

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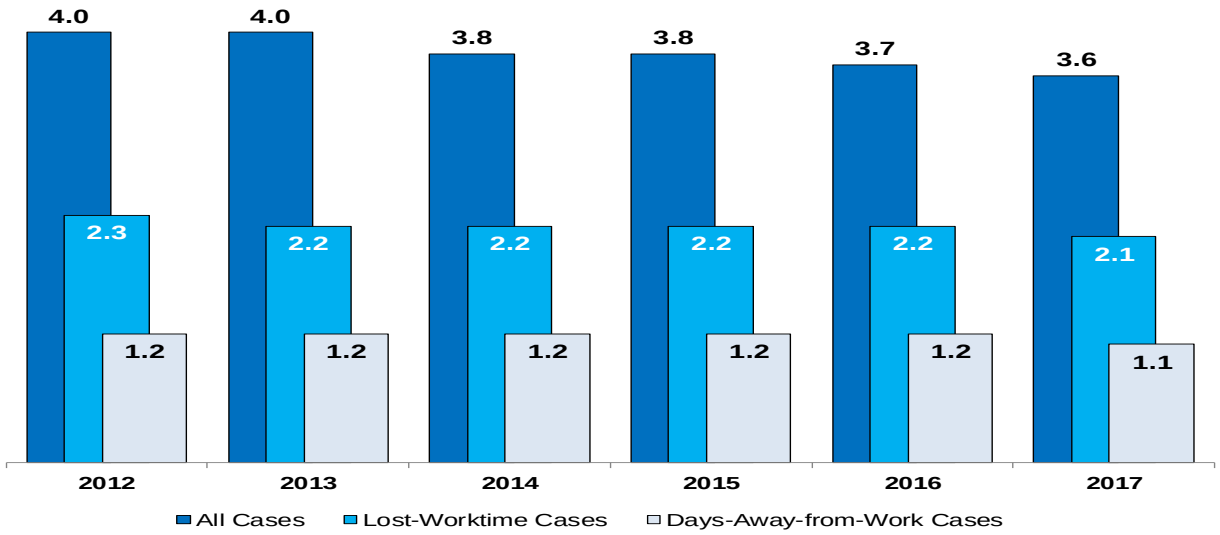
## Occupational Injury and Illness Incidence Rates

*Comparison of Public and Private Sectors*

Overall, the incidence rate for all three types of cases in California—all cases, lost-work-time, and days-away-from-work—declined from 2012 to 2017.

**Figure 79: California Occupational Injury and Illness Incidence Rates: Private, State and Local (Cases per 100 Full-Time Employees)**

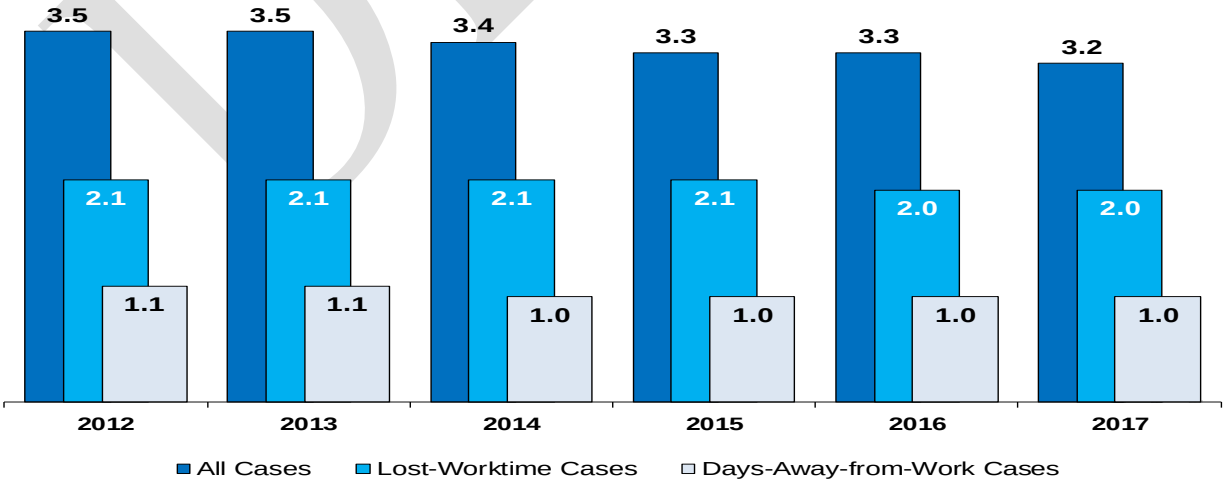



Data Source: DIR, Director's Office of Policy, Research and Legislation

*Private Sector*

According to figure 80, the occupational injury and illness incidence rate for all three types of cases in California's private sector—all cases, lost-work-time, and days-away-from-work—declined from 2012 to 2017.

**Figure 80: California Occupational Injury and Illness Incidence Rates: Private Industry (Cases per 100 Full-Time Employees)**

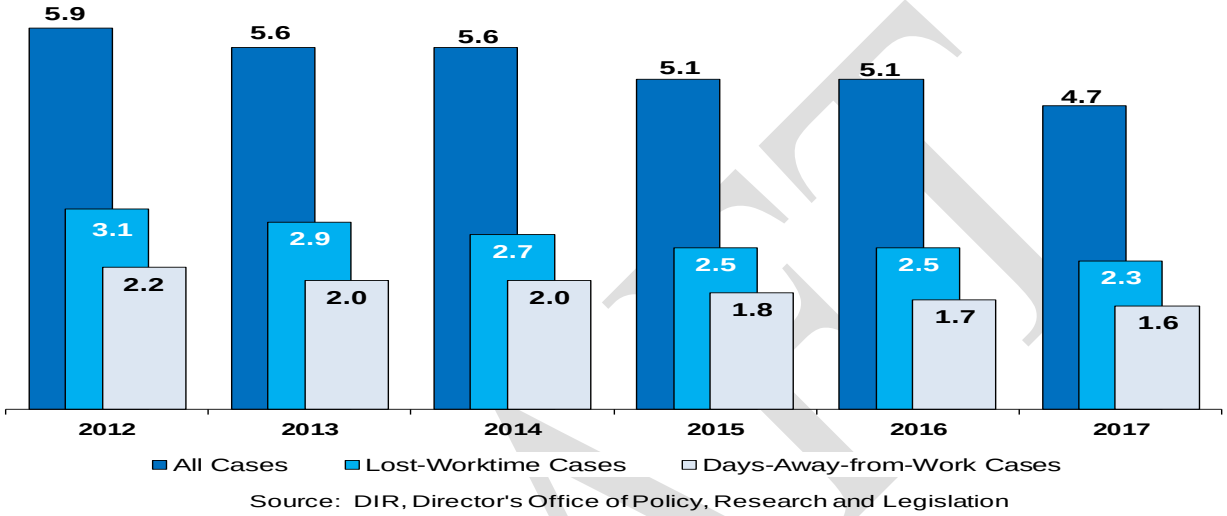



Data Source: DIR, Director's Office of Policy, Research and Legislation

### Public Sector: State Government

California state government occupational injury and illness incidence rates for all cases decreased by 20 percent from 2012 to 2017. The incidence rate for lost-time cases decreased from 3.1 to 2.3 cases per 100 full-time employees between 2012 and 2017. The changes of incidence rate for days-away-from-work cases remained within the narrow range of 1.6 and 2.2 cases per 100 full-time employees from 2012 to 2017.

**Figure 81: California Occupational Injury and Illness Incidence Rates: State Government (Cases per 100 Full-Time Employees)**

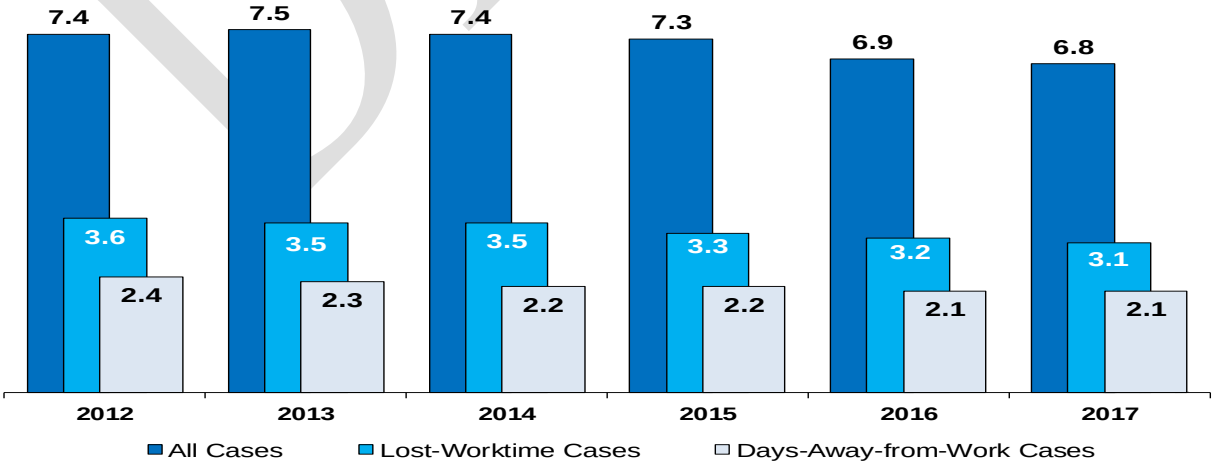



Source: DIR, Director's Office of Policy, Research and Legislation

### Public Sector: Local Government

Local government occupational injury and illness incidence rates for all cases averaged at 7.4 cases per 100 full-time employees from 2012 to 2015 and then decreased by 8 percent from 2015 to 2017. The incidence rate for lost-time cases decreased from 3.6 to 3.1 cases per 100 full-time employees from 2012 to 2017. The incidence rate for days-away-from-work cases decreased slightly from 2012 to 2017.

**Figure 82: California Occupational Injury and Illness Incidence Rates: Local Government (Cases per 100 Full-Time Employees)**




Source: DIR, Director's Office of Policy, Research and Legislation

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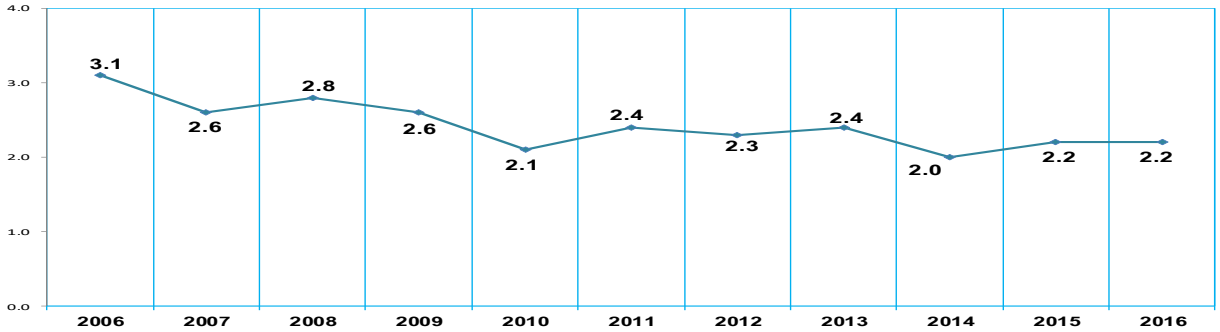
### California Fatality Incidence Rates

Fatality per employment rates can be used to compare the risk of incurring injury among worker groups with varying employment levels. From 2006 to 2016, the fatality rates in California fluctuated between 2.0 and 3.1 per 100,000 full-time workers.

**Figure 83: California Fatal Occupational Injuries*—Incidence Rate** (per 100,000 employed)**



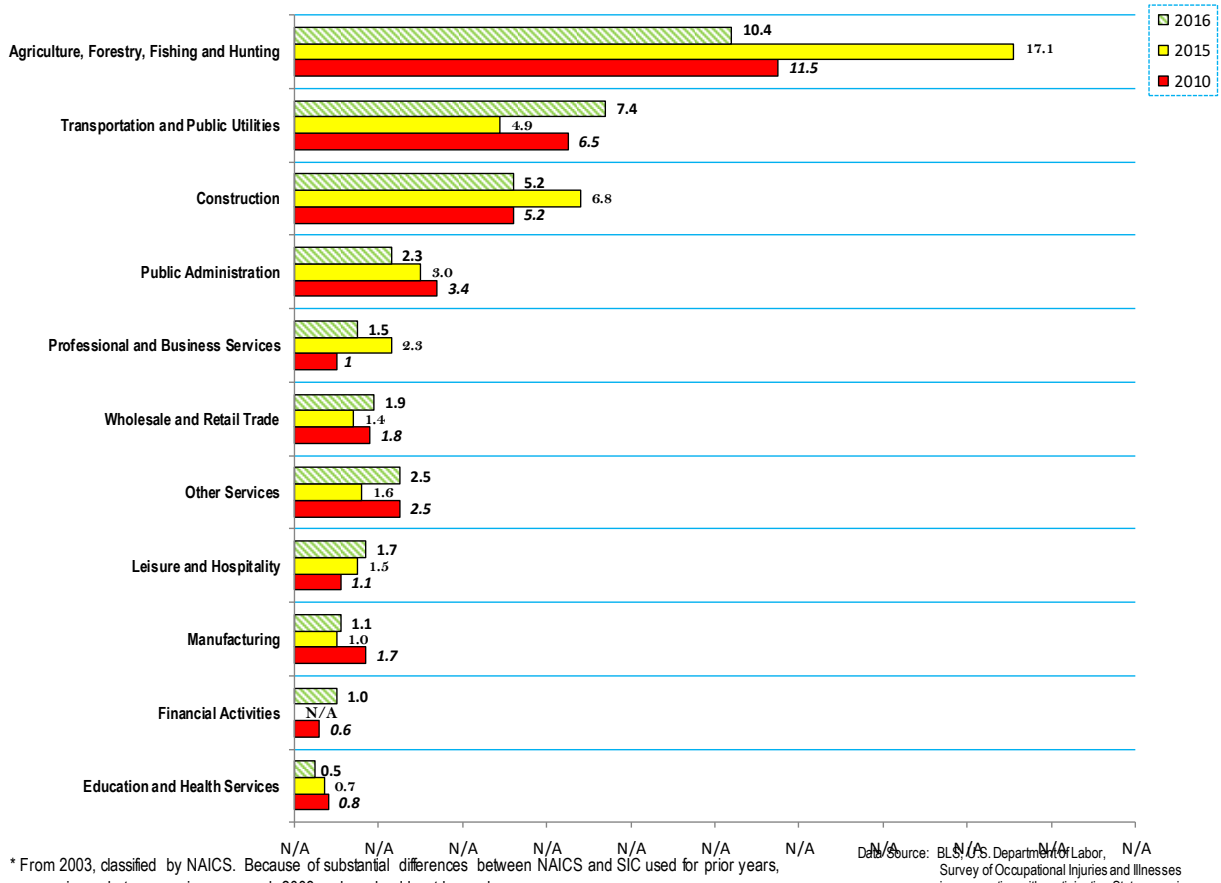

* California Fatal Occupational Injuries exclude military personnel and workers under age 16 and include all self-employed, family business, and wage and salary workers.

** Incidence Rates for Fatal Occupational Injuries 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.

Figure 85 shows the fatality incidence rates by major industries in 2010, 2015, and 2016.

**Figure 84: California Fatality Rates by Industries (per 100,000 employed), 2010, 2015, and 2016**



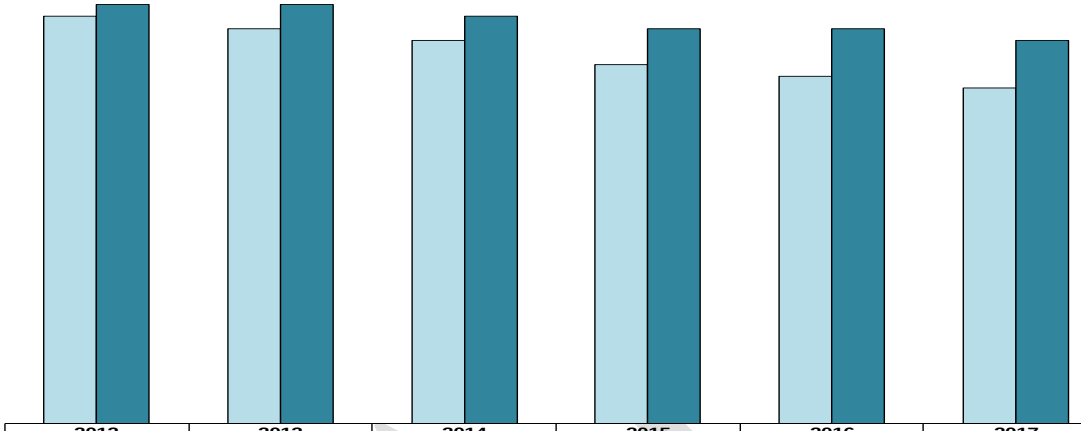

* From 2003, classified by NAICS. Because of substantial differences between NAICS and SIC used for prior years, comparisons between prior years and 2003 and on should not be made.

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

### Comparison of Incidence Rates in the United States and California

Both the U.S. and California experienced a decrease in occupational injury and illness incidence rates from 2012 through 2017. During that time, U.S. incidence rates dropped by about 18 percent, and California incidence rates decreased by about 9 percent. Since 2012, the incidence rate in California has been slightly above the national average during the whole period.

**Figure 85: Injury and Illness Incidence Rate per 100 Full-Time Workers: Private Industry, Total Recordable Cases. U.S. and California**

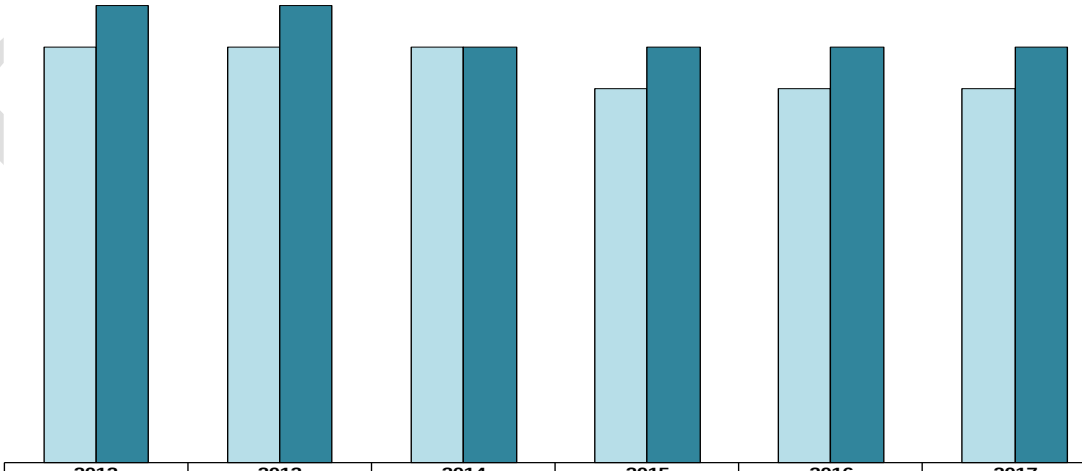


| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| USA | 3.4 | 3.3 | 3.2 | 3.0 | 2.9 | 2.8 |
| California | 3.5 | 3.5 | 3.4 | 3.3 | 3.3 | 3.2 |

Source: US Department of Labor, Bureau of Labor Statistics

The incidence rate of occupational injury and illness days-away-from-work cases also declined slightly in both the U.S. and California, from 1.0 and 1.1, respectively, to 0.9 and 1.0 from 2012 to 2017.

**Figure 86: Injury and Illness Incidence Rate per 100 Full-Time Workers: Private Industry Cases with Days Away from Work. U.S. and California**



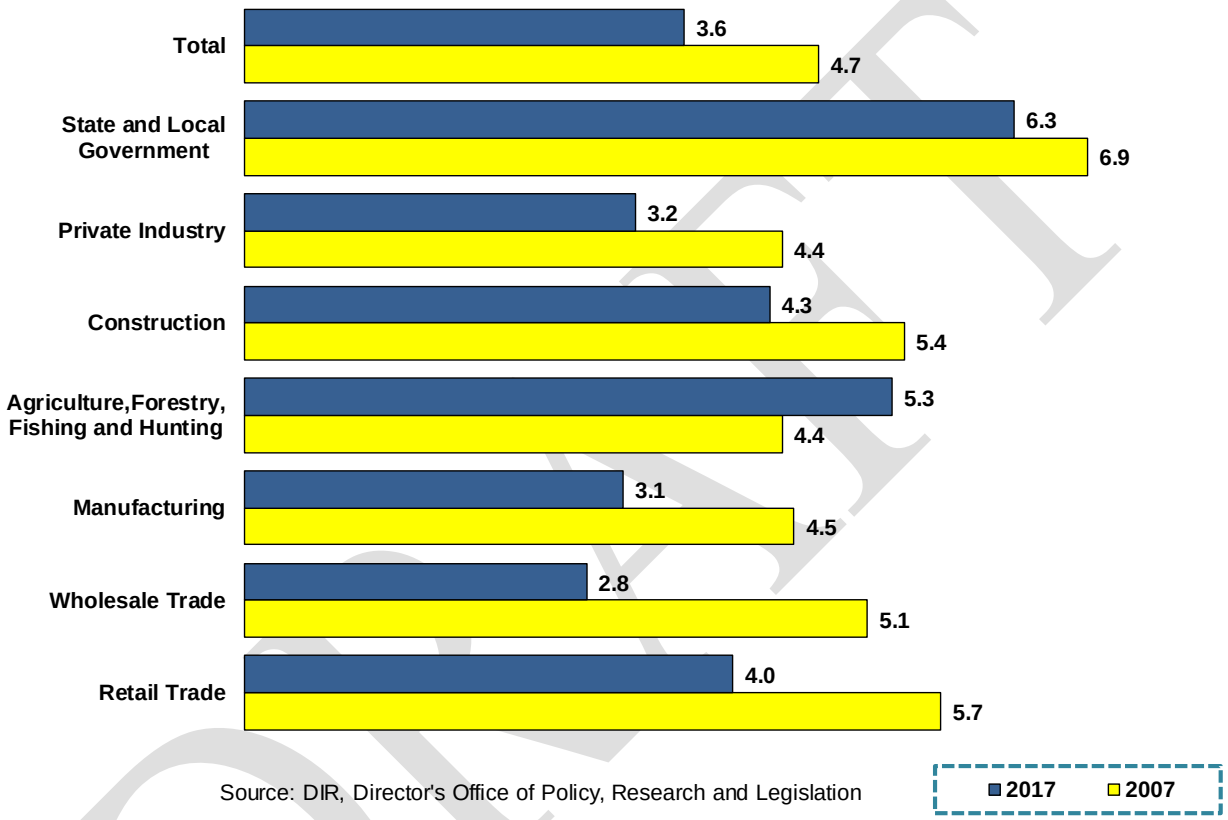
| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| USA | 1.0 | 1.0 | 1.0 | 0.9 | 0.9 | 0.9 |
| California | 1.1 | 1.1 | 1.0 | 1.0 | 1.0 | 1.0 |

Source: US Department of Labor, Bureau of Labor Statistics

### Characteristics of California Occupational Injuries and Illnesses

Figure 87 compares incidence rates for total recordable cases in 2007 and 2017 by the type of major industry, including state and local governments.The overall California occupational injury and illness incidence rates for all industries including State and local government declined by 30.5 percent from 2007 to 2017. The incidence rates in major industries, excluding agriculture, forestry, fishing, and hunting, also declined. The biggest decline in incidence rates (45 percent) was in wholesale trade.

**Figure 87: Injury Rates by Industry, 2017 vs. 2007**




Source: DIR, Director's Office of Policy, Research and Legislation

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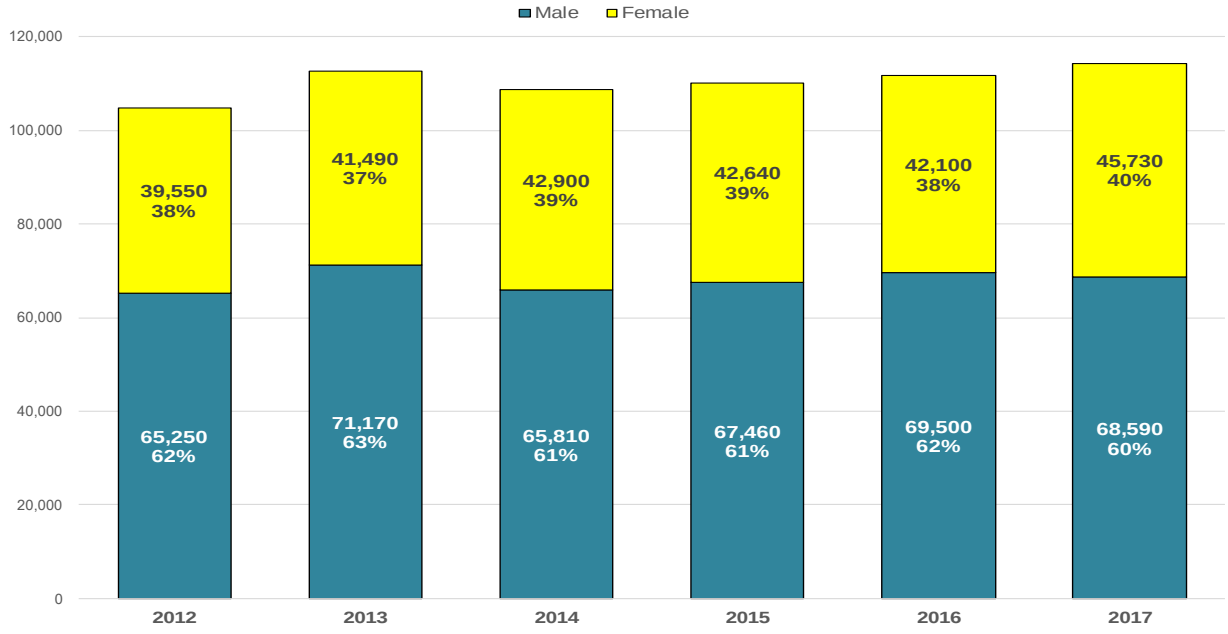
## Characteristics of California Non-Fatal Occupational Injuries and Illnesses

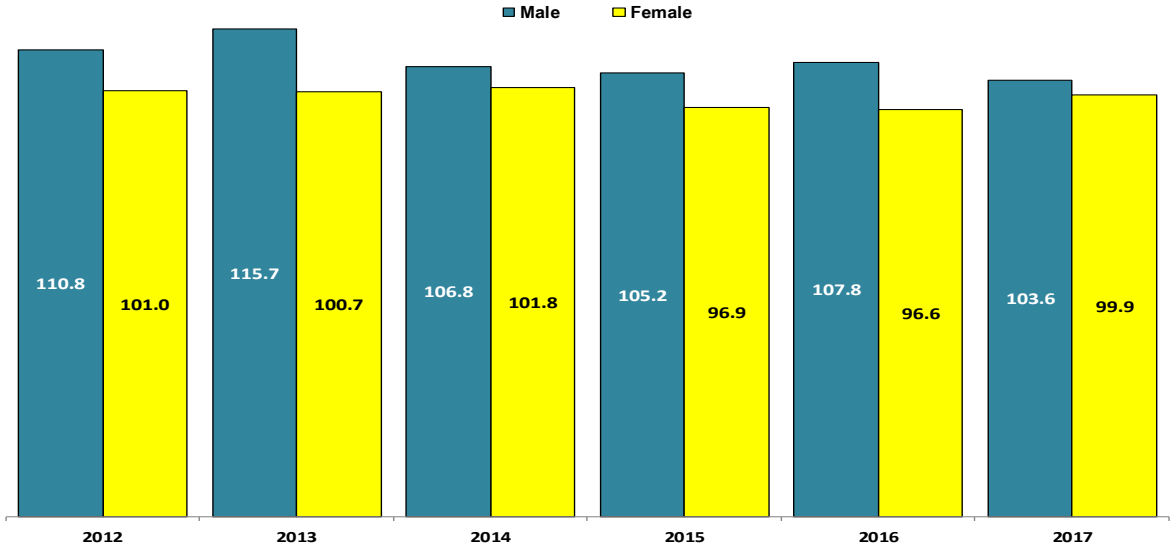
Figures 88-93 illustrate various demographic characteristics of non-fatal occupational injuries and illnesses in private industry in California.

**Figure 88: Number of Non-Fatal Occupational Injuries and Illnesses in California by Gender, Private Industry, 2012-2017**




Source: DIR, Director's Office of Policy, Research and Legislation

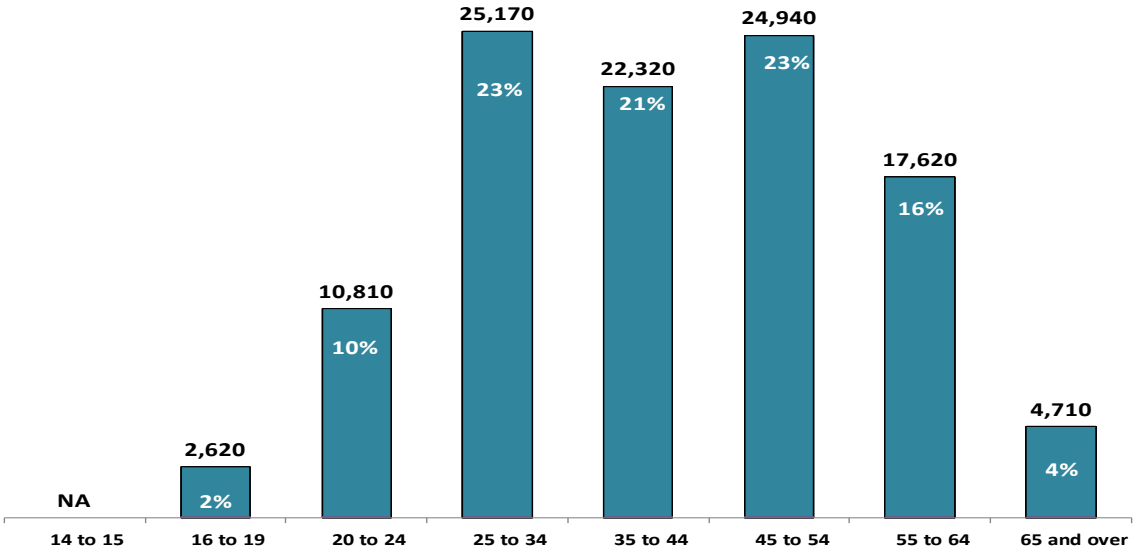
**Figure 89: California Non-Fatal Occupational Injuries and Illnesses Incidence Rates by Gender, Private Industry, 2012-2017 (Cases per 10,000 full-time employees)**




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

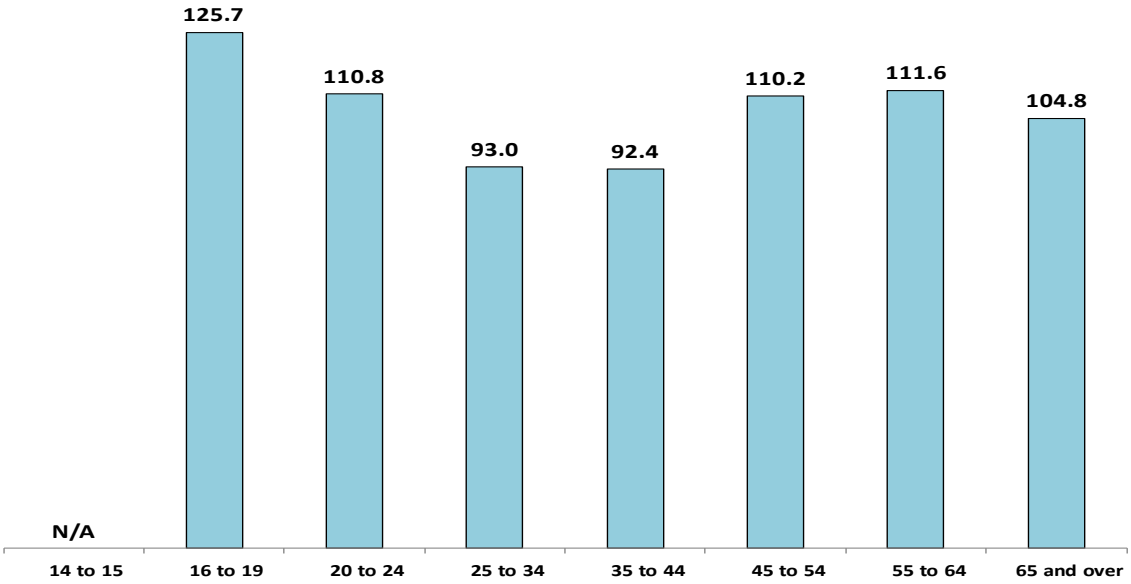
Data Source: BLS, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses in cooperation with participating State agencies.

**Figure 90: Number of Non-Fatal Occupational Injuries and Illnesses in California by Age, Private Industry, 2017**



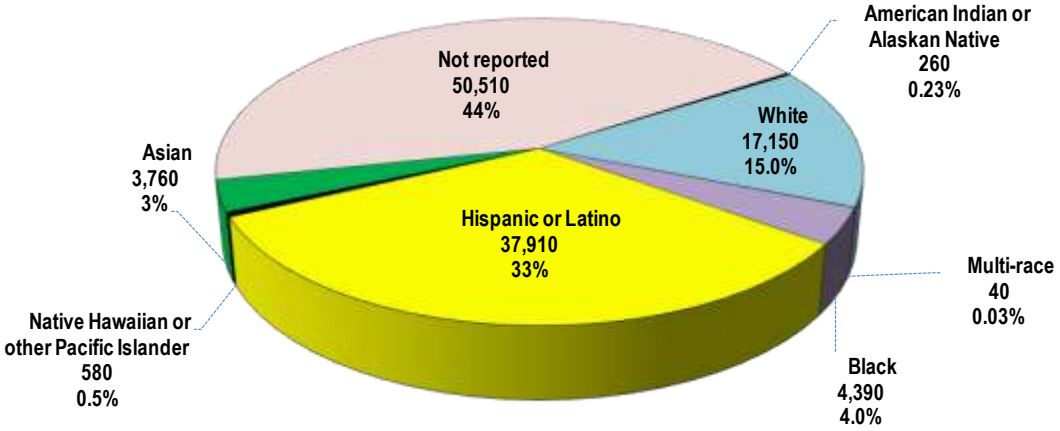

Data Source: DIR, Director's Office of Policy, Research and Legislation

**Figure 91: California Occupational Injury and Illness Incidence Rates by Age, Private Industry 2017 (per 10,000 Full-Time Workers)**



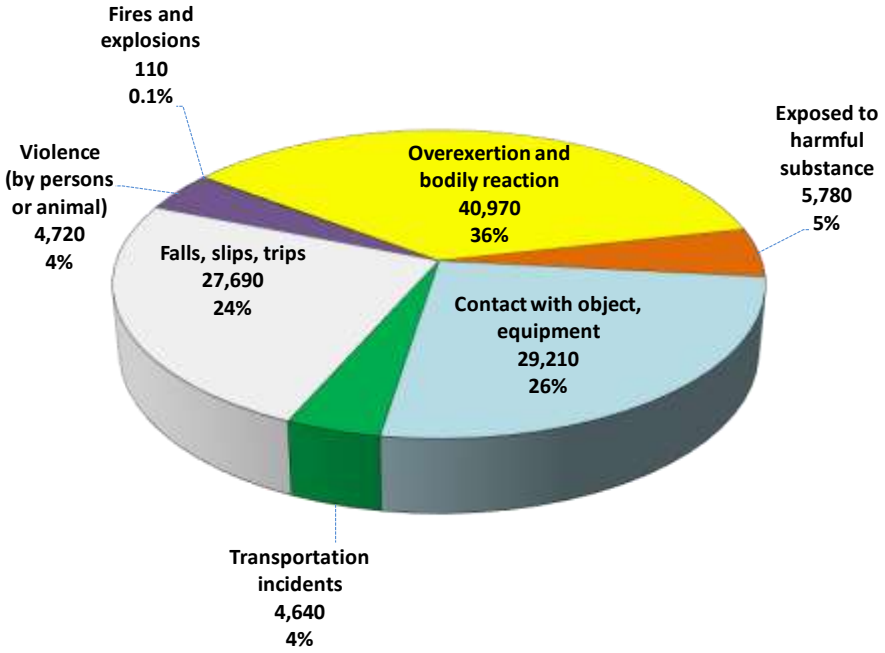

Data Source: BLS, Department of Labor, Survey of Occupational Injuries and Illnesses in cooperation with participating State Agencies

**Figure 92: California Non-Fatal Occupational Injuries and Illnesses by Race or Ethnic Origin, Private Industry, 2017**




Data Source: DIR, Director's Office of Policy, Research and Legislation

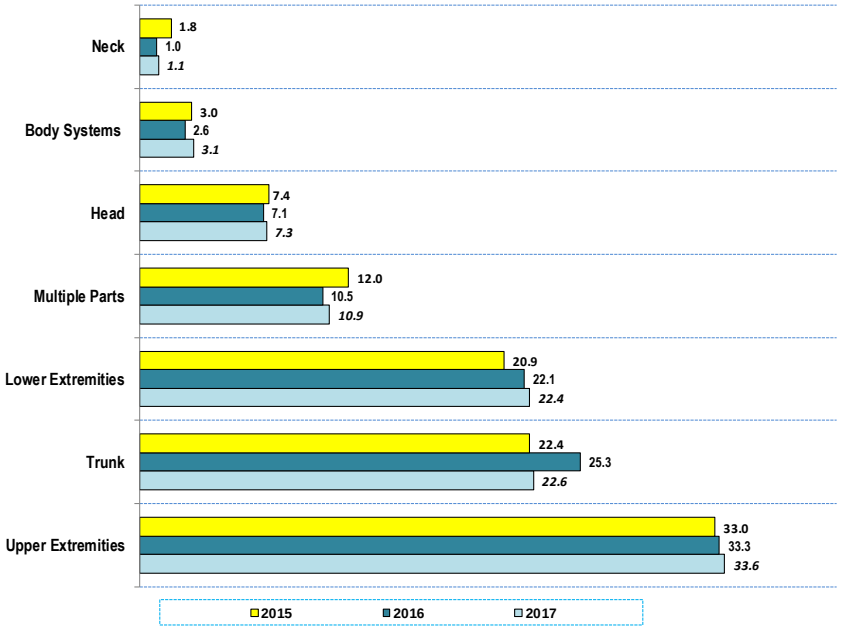
**Figure 93: California Non-Fatal Occupational Injuries and Illnesses by Event and Exposure, Private Industry, 2017**




Data Source: DIR, Director's Office of Policy, Research and Legislation

Figure 94 shows that the upper extremities and trunk were the major body parts with the highest incidence rates in 2015, 2016, and 2017.

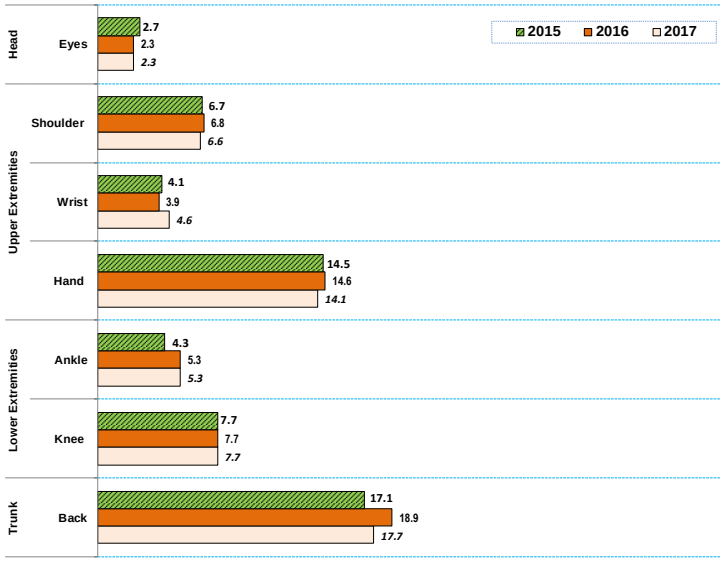
**Figure 94: Incidence Rates for Non-Fatal Occupational Injuries and Illnesses by Major Body Parts, Private Industry, 2015, 2016, and 2017 (per 10,000 Full-Time Workers)**




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

Figure 95 shows that the back was the body part with the highest incidence rate in 2015, 2016, and 2017.

**Figure 95: Incidence Rates for Non-Fatal Occupational Injuries and Illnesses by Major Body Parts, Private Industry, 2015, 2016, and 2017 (per 10,000 Full-Time Workers)**




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

Figures 96 to 98 compare the median days away from work for private industry and state and local government occupations. Business and financial operation occupations for private industry, computer and

mathematical for state government, and architecture and engineering occupations for local government had the greatest median days away from work in 2017.

**Figure 96: Non-Fatal Injuries and Illnesses by Major Occupational Group: Median Days Away from Work, Private Industry, 2017**

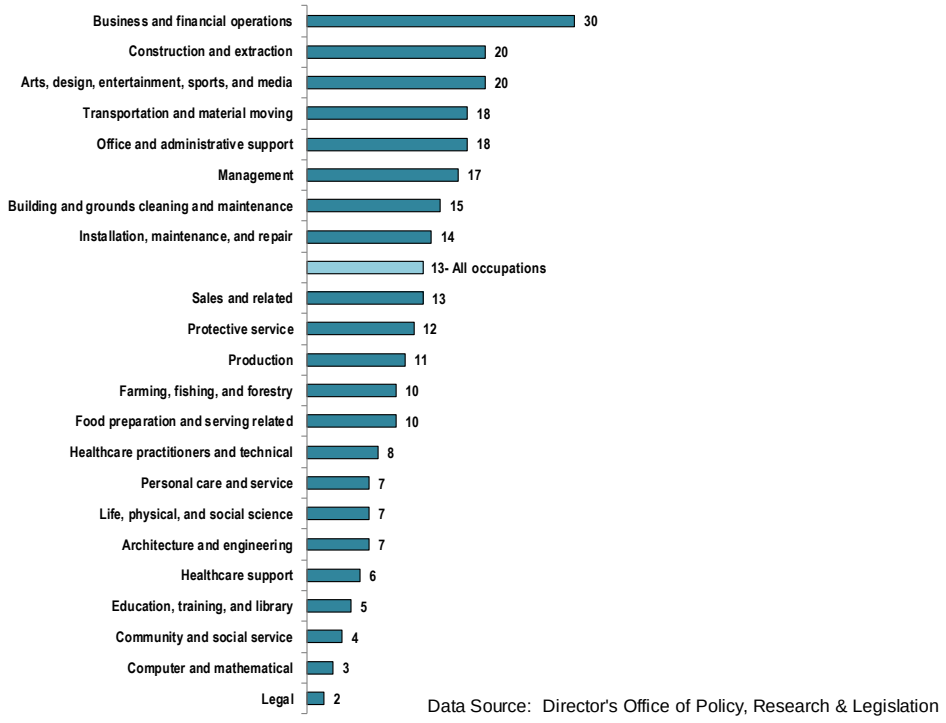



**Figure 97: Non-Fatal Injuries and Illnesses by Major Occupational Group: Median Days Away from Work, State Government, 2017**

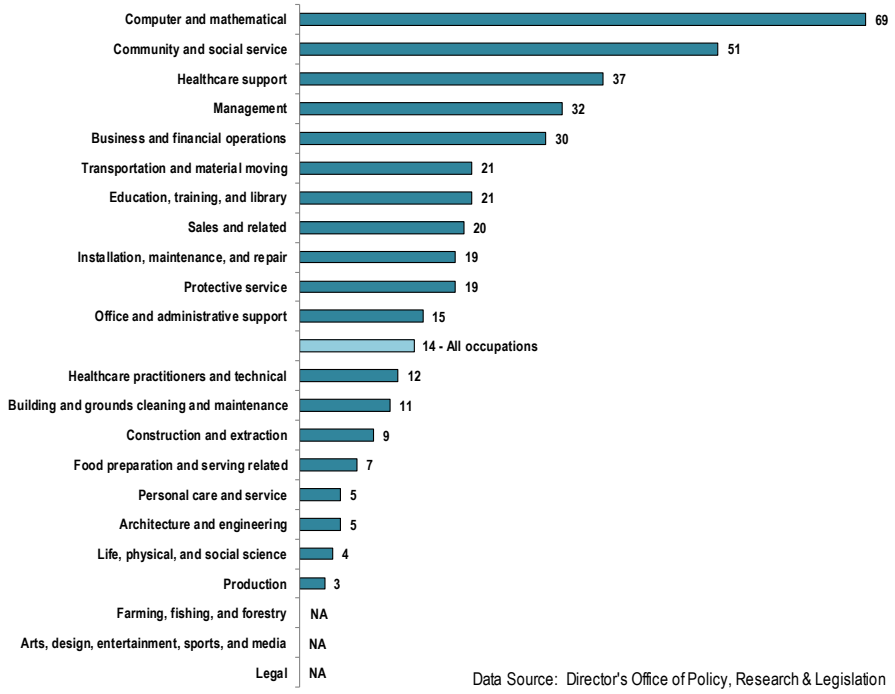
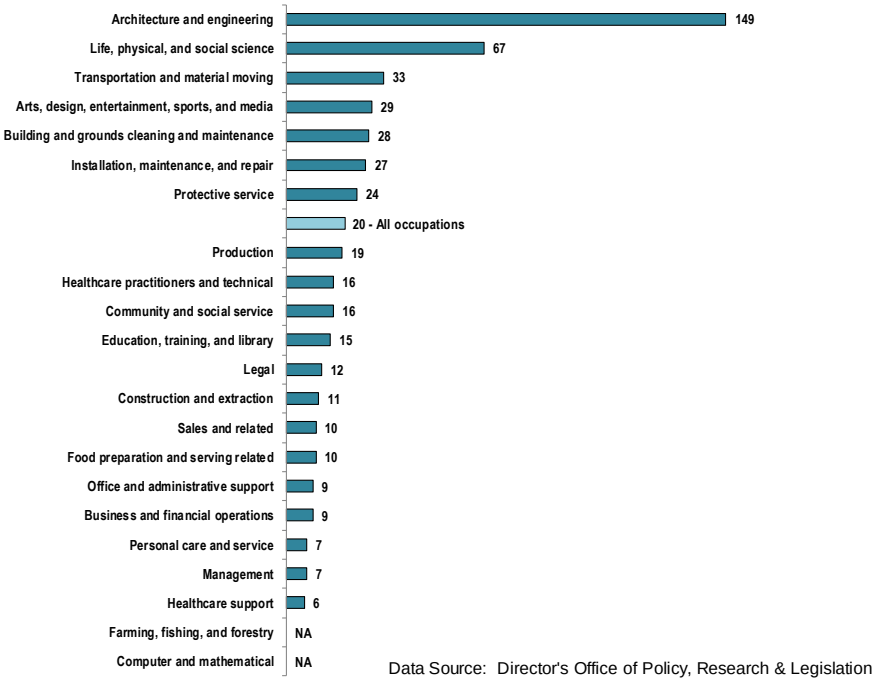


**Figure 98: Non-Fatal Injuries and Illnesses by Major Occupational Group: Median Days Away from Work, Local Government, 2017**




Figures 99 and 100 compare the injury and illness incidence rates, including back injury, for various occupations. The building and ground cleaning and maintenance occupations had the highest incidence rate in 2017, followed by the construction and extraction occupations.

**Figure 99: Incidence Rates by Private Sector Occupational Group (per 100 Full-Time Workers) Non-Fatal Occupational Injuries and Illnesses with Days Away from Work, 2017**

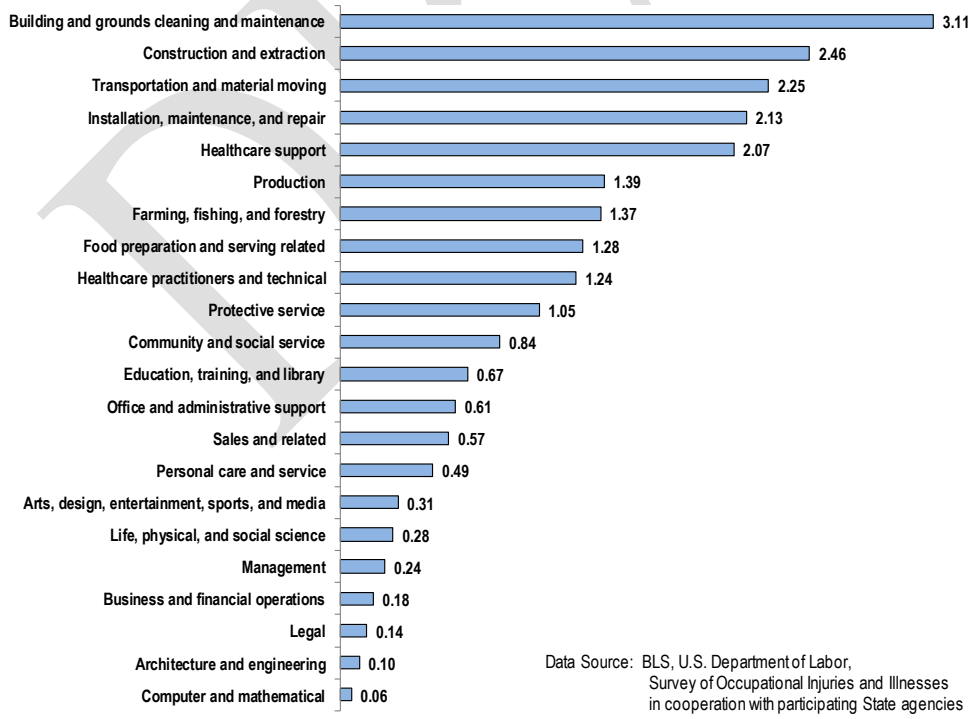
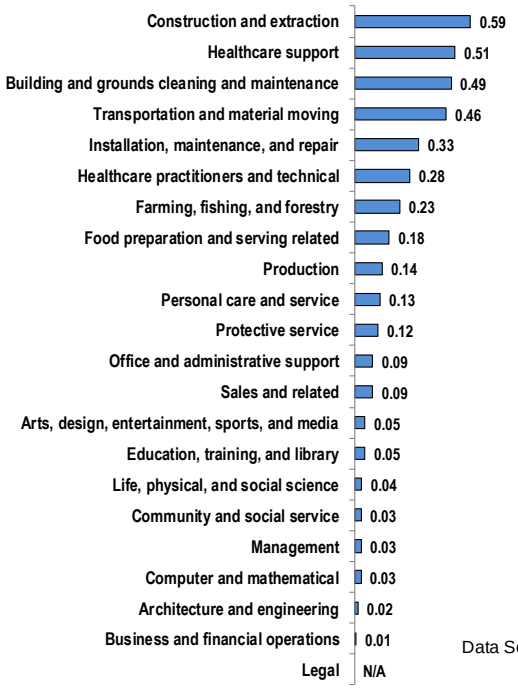


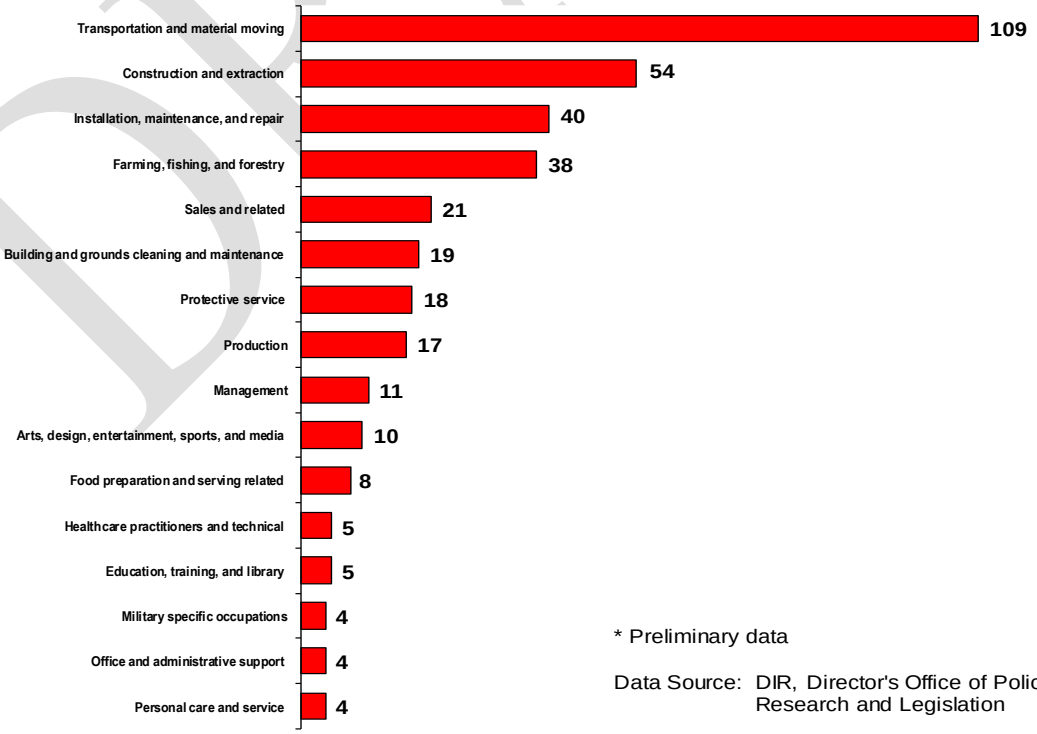
**Figure 100: Back Injury Incidence Rates by Private Sector Occupational Group (per 100 Full-Time Workers) Non-Fatal Occupational Injuries and Illnesses with Days Away from Work, 2017**




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

Figure 101 compares the number of fatalities for various occupations. The transportation and material-moving occupation had the highest number of fatalities in 2016, followed by the construction and extraction occupations.

**Figure 101: Fatal Occupational Injuries by Selected Occupations, All Ownerships, 2016***



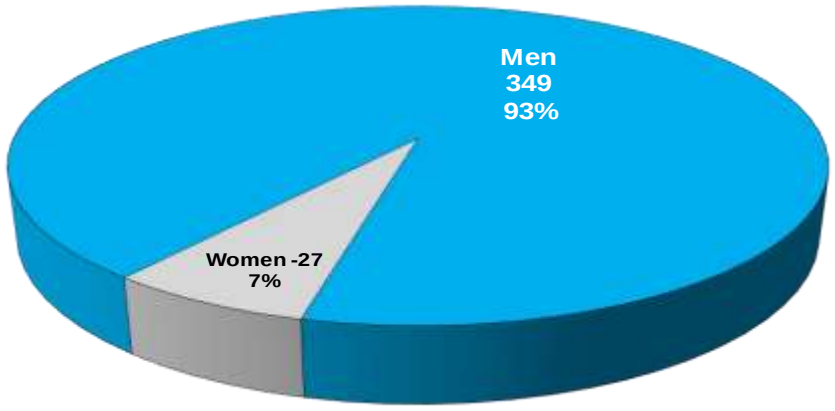

* Preliminary data

Data Source: DIR, Director's Office of Policy, Research and Legislation

**Characteristics of California Fatal Occupational Injuries and Illnesses**

Figures 102 and 103 illustrate various characteristics of fatal occupational injuries and illnesses in private industry and federal, state, and local governments in California.

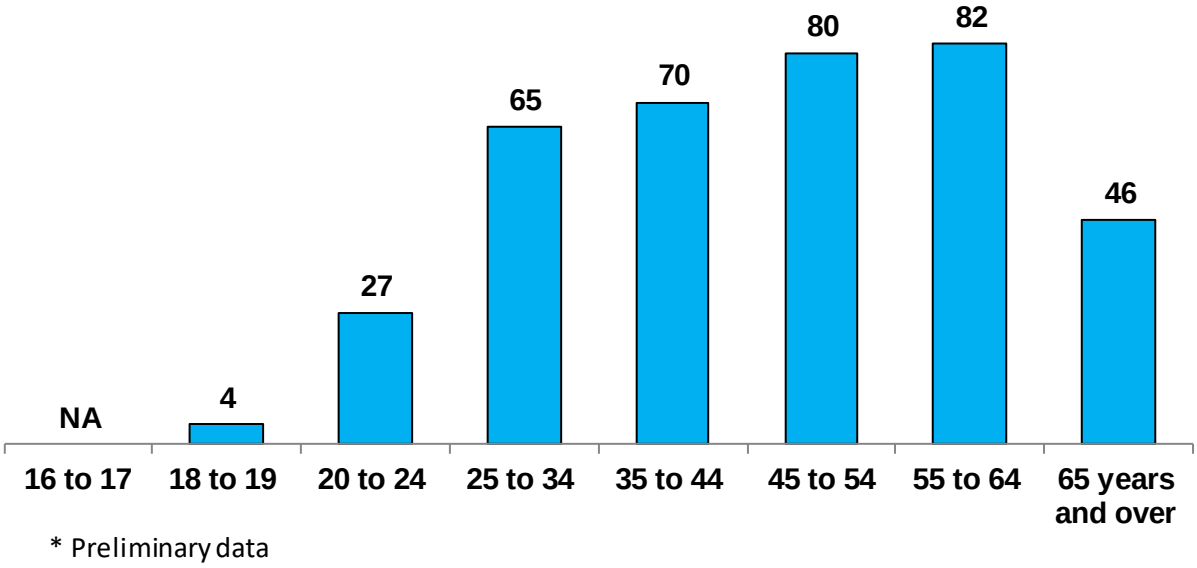
**Figure 102: California Fatal Occupational Injuries and Illnesses by Gender, 2016***




* Preliminary data

Data Source: BLS

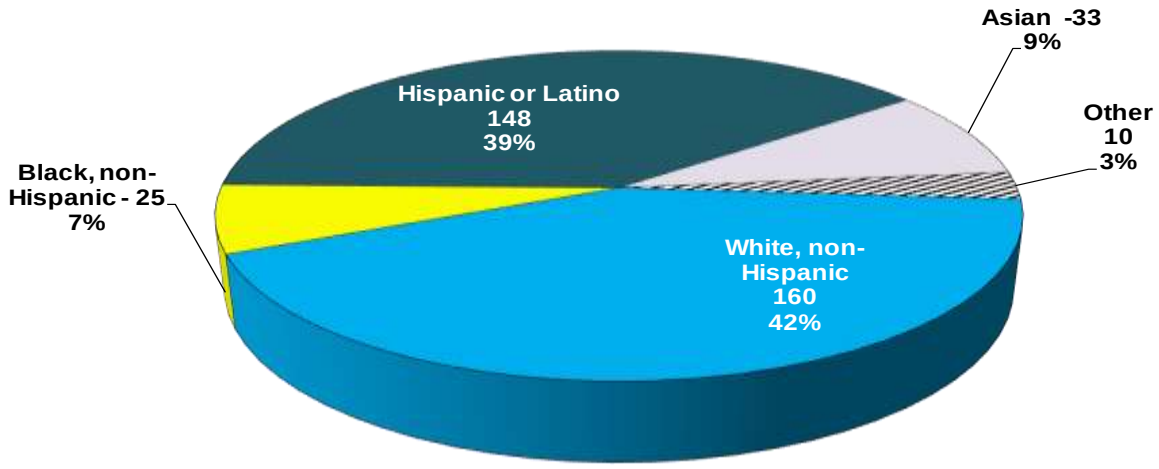
**Figure 103: California Fatal Occupational Injuries and Illnesses by Age of Worker, 2016***




* Preliminary data

Source: BLS

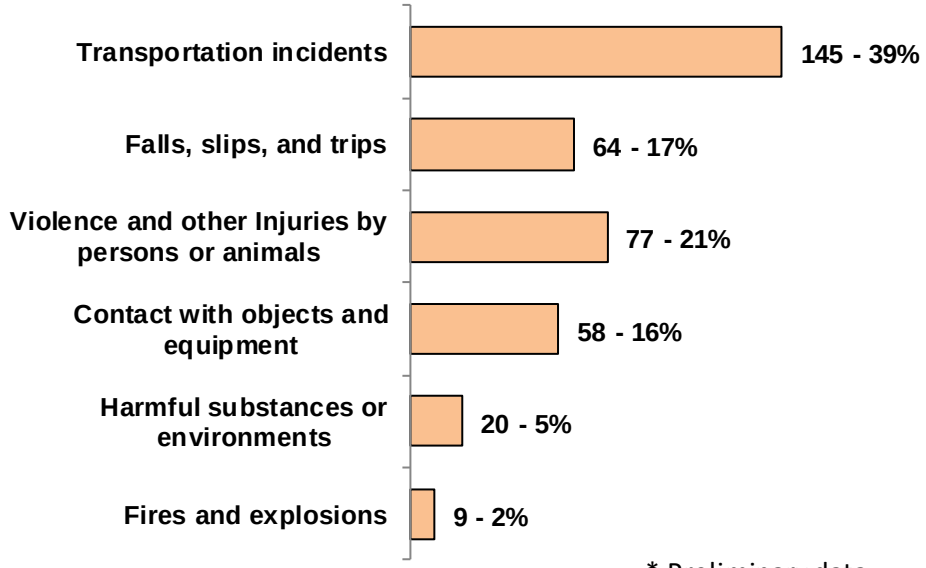
**Figure 104: California Fatal Occupational Injuries and Illnesses by Race and Ethnic Origin, 2016***




* Preliminary data

Data Source: BLS

**Figure 105: California Fatal Occupational Injuries and Illnesses by Event and Exposure, 2016***




* Preliminary data

Source: BLS

**Profile of Occupational Injury and Illness Statistics: California and the Nation**

Data for the following analyses, except where noted, came from the Department of Industrial Relations (DIR), Director's Office of Policy, Research, and Legislation (OPRL) and the U.S. Department of Labor (DOL) Bureau of Labor Statistics (BLS).

***Incidence Rates***

- California's work injury and illness statistics for 2017 indicate a non-fatal injury and illness rate of 3.2 cases per 100 full-time employees in the private sector. This is a 9 percent decline from the 2012 level of 3.5 and a slight decrease of 3 percent from the previous year's rate of 3.3.
- The trend in California mirrors a national trend. DOL figures for private employers show that from 2012 to 2017, the work injury and illness rate across the U.S. fell from 3.4 to 2.8 cases per 100 employees in the private sector. The reduced incidence of job injuries is likely due to factors including a greater emphasis on job safety and the shift from manufacturing to 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 significantly higher than in the private sector. California's state and local government rate for 2017 is 6.3 cases per 100 full-time employees. This is an 11 percent decline from the 2012 rate of 7.1. At the same time, the state and local government rate in California is 27 percent higher than the national rate of 4.6 for state and local government.
- The national fatality rate decreased by 8 percent between 2006 and 2016 from 3.9 to 3.6 cases per 100,000 employed, and California's fatality rate decreased from 3.1 to 2.2 cases per 100,000 employed during the same period.[44] This was a 29 percent decline from the 2006 level and no change from 2015.
- Among the Western region states (Alaska, Arizona, California, Hawaii, Nevada, Oregon, and Washington), Arizona's (2.9), California's (3.2), and Nevada's (3.7) private industry rates in 2017 for non-fatal occupational injuries and illnesses were the lowest.[45]

***Duration***

- Days-away-from-work cases in the private sector, including those that result in days away from work with or without a job transfer or restriction, decreased slightly from 1.1 to 1.0 case per 100 full-time employees from 2012 to 2017. This also mirrors the national trend, in which the number of days-away-from-work cases fell from 1.0 to 0.9 cases in the private sector during the same period.
- Nationally, the overall days-away-from-work rate in 2017 did not change from the 2016 rate. Similarly, California's days-away-from-work rate in 2017 did not change from the 2016 rate.

***Industry Data***

- In 2017, injury and illness incidence rates varied greatly among private industries ranging from 0.7 injury/illness per 100 full-time workers in the mining, quarrying, and oil and gas extraction industries to 5.3 in both agriculture, forestry, fishing and hunting and transportation and warehousing. California's private industry rates for total cases were higher than the national rates in every major industry division, except for mining, quarrying, and oil and gas extraction (0.7 and 1.5), utilities (1.4 and 2.0), manufacturing (3.1 and 3.5), and information (1.2 and 1.3).
- The California private industry total case rate for non-fatal injuries decreased slightly in 2017 from 3.3 per 100 full-time worker injuries in 2016, and the rate for the public sector (state and local government) decreased from 6.5 in 2016 to 6.3 in 2017.
- According to the Director's Office of Policy, Research, and Legislation, the largest decrease in injury and illness by major industry category was in the mining, quarrying, and oil and gas extraction services, from 1.5 to 0.7 and utilities, from 2.4 to 1.4, per 100 full-time worker injuries in 2016 and 2017

[44] Beginning in 2007, the Census of Fatal Occupational Injuries (CFOI) adopted hours worked estimates to measure fatal injury risk per standardized length of exposure, which is generally considered more accurate than previously used employment-based rates.
[45] The comparisons of industry rates have not been adjusted for industry mix in each state.

respectively, followed by a decrease in finance and insurance from 1.2 to 0.8 per 100 full-time worker injuries in 2016 and 2017, and by a decrease in the other services (except public administration), from 3.2 to 2.4 per 100 full-time worker injuries in 2016 and 2017[46]

- According to the Director's Office of Policy, Research and Legislation, the largest increase in injury and illness by industry sectors was in the construction industry, from 3.8 to 4.3 per 100 full-time worker injuries in 2016 and 2017 respectively, followed by educational services, with an increase from 2.0 to 2.2 and accommodation and food services, with an increase from 4.0 to 4.3 per 100 full-time worker injuries in 2016 and 2017, and wholesale trade, from 2.7 to 2.8 between 2016 and 2017.[47]
- From 2006 to 2016, the number of fatal injuries[48] declined by 27.5 percent, from 509 to 369.[49] From 2015 to 2016, there was no change in the number of fatal injuries. In 2016, the highest number of fatal injuries was in transportation and warehousing (66), followed by construction (55) and agriculture, forestry, fishing and hunting (38).
- In private industry, the top ten occupations with the most non-fatal injuries and illnesses in 2017 were: laborers and freight, stock, and material movers, hand; heavy and tractor-trailer truck drivers; janitors and cleaners, except maids and housekeeping cleaners; stock clerks and order fillers; farm workers and laborers, crop, nursery, and greenhouse; maids and housekeeping cleaners; construction laborers; registered nurses; retail salespersons; carpenters.
- In California state government, the top ten occupations with the most non-fatal injuries and illnesses in 2017 were: correctional officers and jailers; psychiatric technicians; firefighters; registered nurses; janitors and cleaners, except maids and housekeeping cleaners; police and sheriff's patrol officers; landscaping and groundskeeping workers; first-line supervisors of police and detectives; operating engineers and other construction equipment operators; first-line supervisors of fire fighting and prevention workers.
- In local government, the top ten occupations with the most non-fatal injuries and illnesses in 2017 were: police and sheriff's patrol officers; janitors and cleaners, except maids and house-keeping cleaners; teacher assistants; firefighters; first-line supervisors of fire fighting and prevention workers; maintenance and repair workers, general; first-line supervisors of police and detectives; elementary school teachers, except special education; bus drivers, transit and intercity; water and wastewater treatment plant and system operators.
- Transportation and material moving (109), construction and extraction (54), and installation, maintenance, and repair (40) occupations accounted for 54 percent of the fatal injuries in 2016. Farming, fishing, and forestry (38), sales and related occupations (21), building and grounds cleaning and maintenance (19), protective service (18); and production (17) were the other occupations with the most number of fatal injuries in 2016. Transportation and material-moving occupations were the number one cause of fatal injuries accounting for 29 percent of fatal injuries in 2016.
- Transportation incidents (including the Federal government) accounted for 38.5 percent of fatal injuries in 2016 and were a major cause of fatalities among: transportation and material moving (71); farming, fishing, and forestry (18); and installation, maintenance, and repair (12) occupations.

[46] DIR, Director's Office of Policy, Research and Legislation, Table 1: Incidence rates of non-fatal occupational injuries and illnesses by selected industries and case types, 2016, 2017.
[47] Ibid.
[48] BLS preliminary data.
[49] The number of fatalities excludes those for the Federal government.

***Establishment Size and Type***

- The lowest rate for the total recordable non-fatal cases in 2017 was experienced by the smallest private employers. Employers with 1 to 10 and 11 to 49 employees had incidence rates of 1.2 and 2.8 cases, respectively, per 100 full-time employees. Employers with 1 to 10 and 1,000 and more employees experienced a 2 percent and 3 percent decreases correspondingly from 2016 to 2017. The incidence rates for employers with 11 to 49 and 250 to 999 employees did not change from 2016 and 2017.
- Establishments with 50 to 249 employees reported the highest rate of 4.1 per 100 full-time employees, followed by 3.8 cases per 100 full-time employees for establishments with 250 to 999 employees in 2017. Establishments with 50 to 249 employees experienced a slight increase in incidence rates from 4.0 to 4.1 cases per 100 full-time employees from 2016 to 2017.

***Types of Injuries***

- All types of work injuries, excluding multiple traumatic injuries and soreness and pain increased from 2012 to 2017 in the private sector. The number of sprains, strains, and tears increased by 6 percent from 2012 to 2017; these injuries remain by far the most common type of work injury accounting for 36 percent of days-away-from-work cases in the private sector in 2017. The biggest increase (100 percent) from 2012 to 2017 was in amputations. Bruise and contusions and tendonitis injuries experienced increases of 50 and 42 percent, respectively, and fractures experienced an increase of 39 percent between 2012 and 2017. Multiple traumatic injuries and soreness and pain experienced a decrease of 49 and 31 percent respectively between 2012 and 2017.
- In the private sector, overexertion and bodily reaction were the leading causes of days-away-from-work injuries, cited in 36 percent of cases in 2017. Contact with objects and equipment was the second common cause of injury, accounting for 26 percent of injuries.
- In California state government, the two main causes of injury were overexertion and bodily reaction and falls, slips, and trips, accounting for about 38 and 22 percent of days-away-from-work cases, respectively, in 2017.
- In local government, the main causes of injury were overexertion and bodily reaction and falls, slips, and trips, accounting for 40 and 24 percent of days-away-from-work cases, respectively, in 2017.
- The most frequently injured body part was the back, accounting for about 14 percent of the cases in state government and 16 percent of the cases in local government in 2017. In the private sector, back injuries account for about 18 percent of the non-fatal cases.
-

***Demographics***

- Over the period from 2012 to 2017 in the California private sector, the number of days-away-from-work cases for women increased by 16 percent. Days-away-from-work cases for men decreased by 21 percent. Some of this increase can be attributed to an increase in employment and total hours worked.
- Between 2012 and 2017, in private industry, all age groups, except for groups 45–54 and 35-44, experienced an increase in the numbers of cases with days away from work. The biggest increase (75 percent) occurred among 16 to 19-year-old workers. The 65 and over age group experienced a 65 percent increase, the 55–64 age group experienced a 24 percent growth, the 25–34 age group experienced an 8 percent increase, and the 20–24 age group experienced a 6 percent growth. The age groups 45 to 54 and 35 to 44 experienced a 1 and 0.4 percent decrease, respectively, in the numbers of cases with days away from work.
- In 2016, out of 376 fatalities (including the Federal government), approximately 93 percent were male and 7 percent were female. Compared to 2006, the biggest decrease in the number of fatalities (71

percent) was in the 18-19 age group (from 14 to 4 cases), followed by a 41 percent decrease in the 20–24 age group (from 46 to 27 cases), a decrease of 40 percent from 116 to 70 cases in the 35-44 age group, a 39 percent decrease from 132 to 80 in the 45-54 age group, and a 37 percent decrease in age group 25-34 age group (from 103 to 65). There was a 5 percent decrease in the number of fatalities in age group 55-64. The age groups that experienced an increase in the number of fatalities was the 65 and over (31 percent increase) from 35 to 46 cases.

- The highest number of fatalities by race or ethnic origin categories in 2016 was experienced by “White, non-Hispanic” and “Hispanic or Latino” groups, accounting for 43 and 40 percent of the fatalities respectively. From 2006 to 2016, there was a decrease in fatal injuries for “Hispanic or Latino” and “White, non-Hispanic” ethnic groups. The highest decrease in fatal injuries, 36 percent, was in the “Hispanic or Latino” group (from 231 to 148 cases), followed by a 33 percent decrease in the “White, non-Hispanic” group (from 239 to 160 cases). There were increases from 23 to 25 cases in the “Black, non-Hispanic” group, from 31 to 33 cases in the “Asian” group, from 0 to 4 in “American Indian or Alaska Native” group, and from 0 to 3 cases in “Native Hawaiian or Pacific Islander” group.

***Occupational Injury and Illness Reporting***

Occupational injury and illness information is the responsibility of BLS in the U.S. and DOL and the Director's Office of Policy, Research, and Legislation in the California DIR. Occupational injuries and illnesses are recorded and reported by California employers through several national surveys administered by DOL with DIR assistance.

*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 some employers are exempt from keeping Cal/OSHA injury and illness records, all California employers must report injuries to the Director's Office of Policy, Research and Legislation. Every employer must also report any serious occupational injuries, illnesses or deaths to California OSHA (Cal/OSHA) in 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 come from this survey. In California, the DIR Director's Office of Policy, Research, and Legislation conducts the survey for BLS.

*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 employers that 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 in order to improve worker health and safety.

*Cal/OSHA Program*

The Cal/OSHA Program is responsible for enforcing California's 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 workplaces in California based on worker complaints, accident reports, and high hazard industries. Twenty-eight Cal/OSHA Enforcement Unit district offices are located throughout California. Specialized enforcement units, such as the High Hazard Compliance Unit, augment the efforts of district offices in protecting California's 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 on crane safety and the prevention of exposure to asbestos.

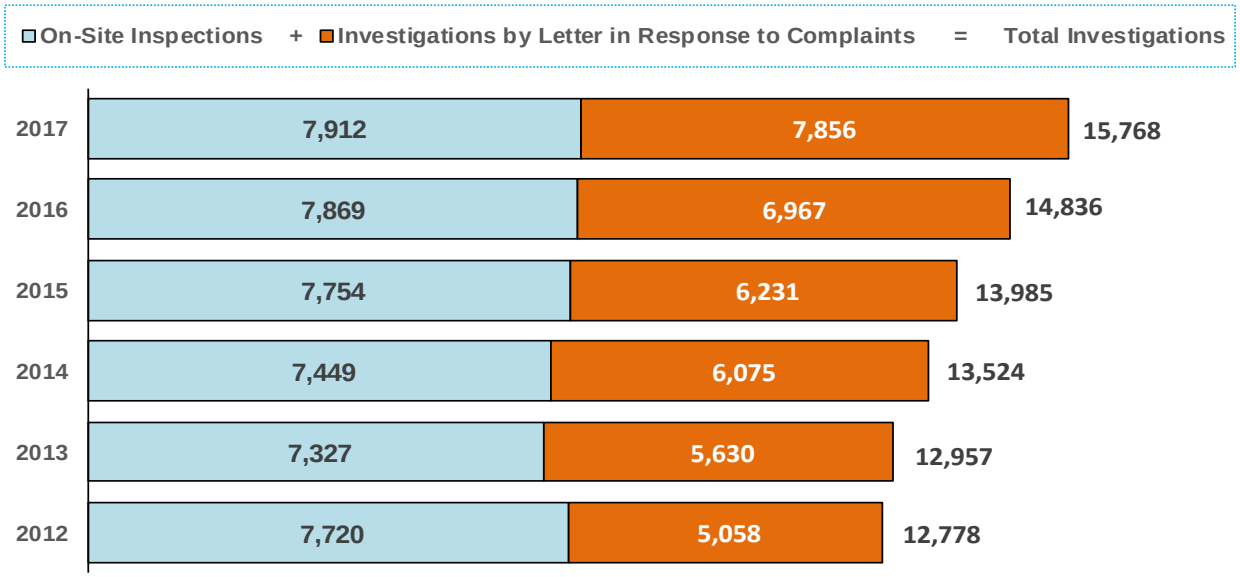
The Cal/OSHA Consultation Service provides assistance to employers and workers about workplace safety and health issues through on-site assistance, high hazard consultation, and other programs with a particular emphasis. The Consultation Service also develops educational materials on workplace safety and health topics.

DRAFT

**Profile of Division of Occupational Safety and Health (DOSH) On-Site Inspections and Violations Cited**

Figure 106 shows the number of on-site inspections and investigations by letter[50] in response to complaints for the period from calendar year (CY) 2012 to CY 2017.[51] The on-site inspections decreased by 5 percent from 2012 to 2013 and then increased by 8 percent from 2013 to 2017. Investigations by letter in response to complaints increased by 55 percent from 2012 to 2017. Accordingly, reflecting DOSH enforcement activities, the total number of investigations increased increased by 23 percent from 2012 through 2017.

**Figure 106: DOSH Enforcement Activities, CY 2012–CY 2017**




Source: DOSH

Figure 107 shows the distribution of DOSH on-site inspections with and without violations from 2012 through 2017.

Unprogrammed inspections triggered by accidents increased overall from 25 percent of all programmed and unprogrammed inspections in 2012 to 32 percent in 2017.

Unprogrammed inspections triggered by complaints decreased overall from 33 percent in 2012 to 28 percent from 2012 to 2017.

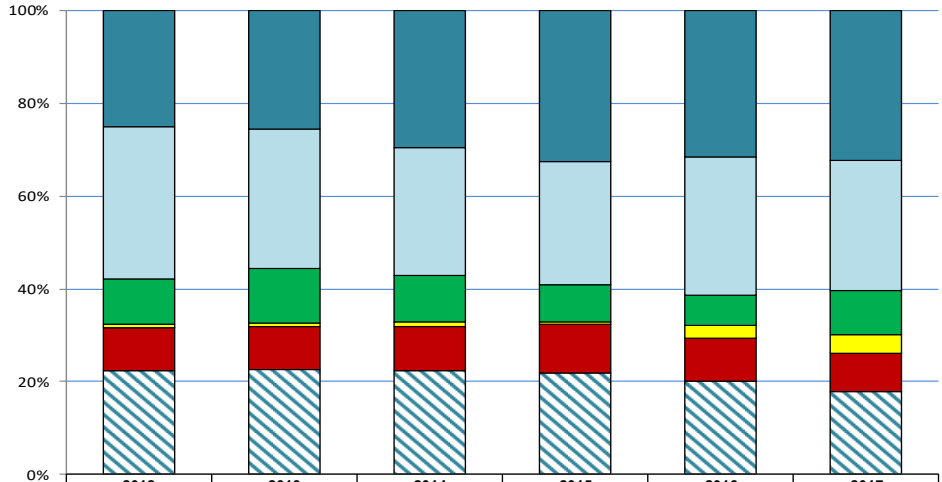
Programmed inspections decreased from an average of 22 percent per year from 2012 through 2015 to 18 percent in 2017. This trend in programmed inspections took place as the share of unprogrammed inspections triggered by accidents and complaints increased in around the same period.

From 2012 to 2017, Accidents and Complaints were consistently predominant types types of inspections.

[50] Investigations by letter are conducted in response to non-formal complaints. https://www.dir.ca.gov/dosh/caloshacomplaintflowchart.html; items 3D and 3E

[51] The number of investigations, on-site inspections, and violations for calendar years could differ from those in fiscal years below in this section.

**Figure 107: DOSH On-Site Inspections by Type (All–With and Without Violations), CY 2012–CY 2017**

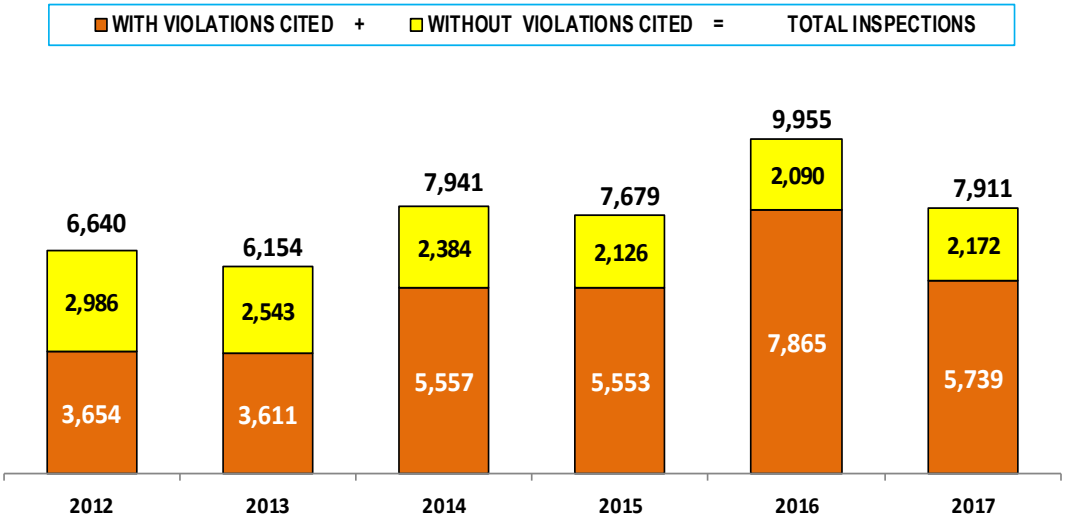



| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Accident (unprogrammed) | 25% | 26% | 30% | 33% | 32% | 32% |
| Complaint (unprogrammed) | 33% | 30% | 28% | 27% | 30% | 28% |
| Referral (unprogrammed) | 10% | 12% | 10% | 8% | 7% | 10% |
| Follow-up (unprogrammed) | 1% | 1% | 1% | 1% | 3% | 4% |
| Unprogrammed Related (different employer, same worksite) | 9% | 9% | 9% | 11% | 9% | 8% |
| Programmed | 22% | 23% | 22% | 22% | 20% | 18% |

Source: DOSH

According to Figure 108, the number of inspections without violations decreased by 30 percent from 2012 to 2016 and then increased by 4 percent from 2016 to 2017. The number of inspections with violations cited more than doubled from 2012 to 2016 and then decreased by 27 percent from 2016 to 2017. The share of DOSH inspections that resulted in violations cited increased from 55 percent of all inspections in 2012 to 79 percent in 2016. From 2016 to 2017, the share of DOSH inspections that resulted in violations cited decreased by 6 percentage points from 79 to 73 percent.

**Figure 108: DOSH Inspections (With and Without Violations Cited), CY 2012–CY 2017**



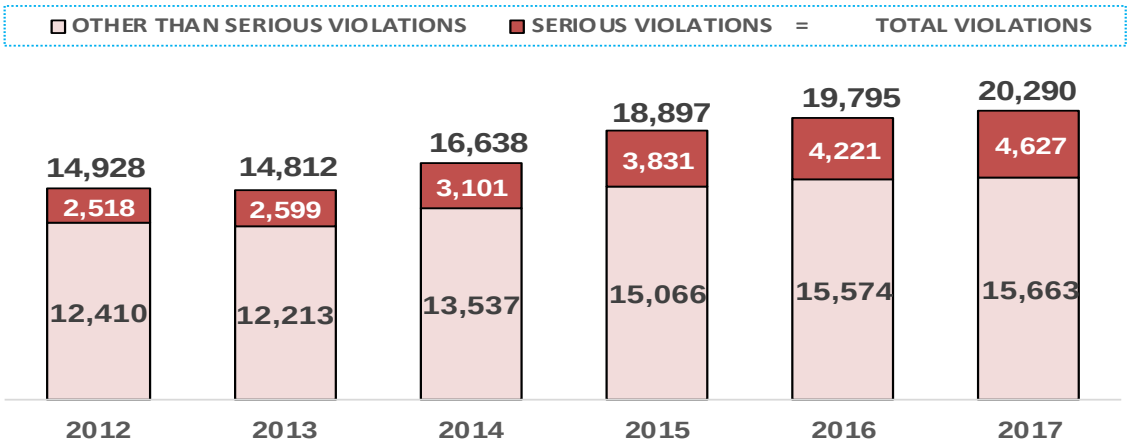

Data Source: DOSH

The number of violations exceeds that of inspections because most inspections of places where violations occur yield more than one violation. Violations are further broken down into serious and other-than-serious. The number of DOSH violations and their breakdown by type from 2012 to 2017 are shown in Figure 109.

The number of all violations increased by 36 percent from 2012 to 2017.

The number of serious violations increased by 84 percent from 2012 to 2017. (See Figures 116-118 for OSHAB statistics on the number of appeals of DOSH violations that were filed and resolved.)

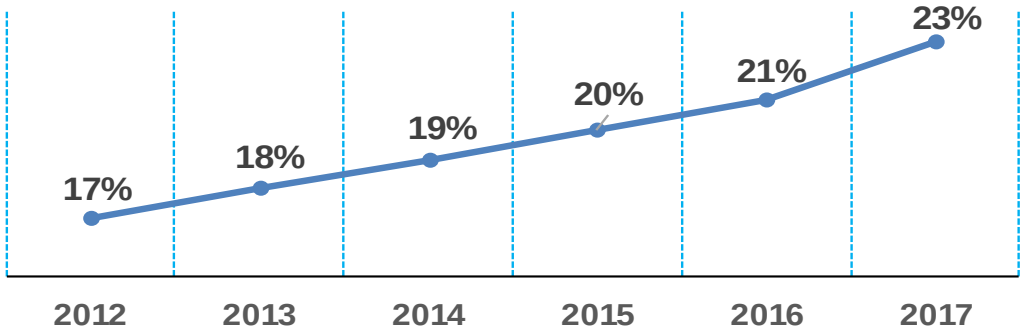
**Figure 109: DOSH Violations (Serious and Other Than Serious), CY 2012 - CY 2017**




Source: DOSH

Figure 110 shows the trend in serious DOSH violations as a share of all violations from 2012 to 2017. The share of serious DOSH violations gradually increased from 17 percent in 2012 to 23 percent in 2017.

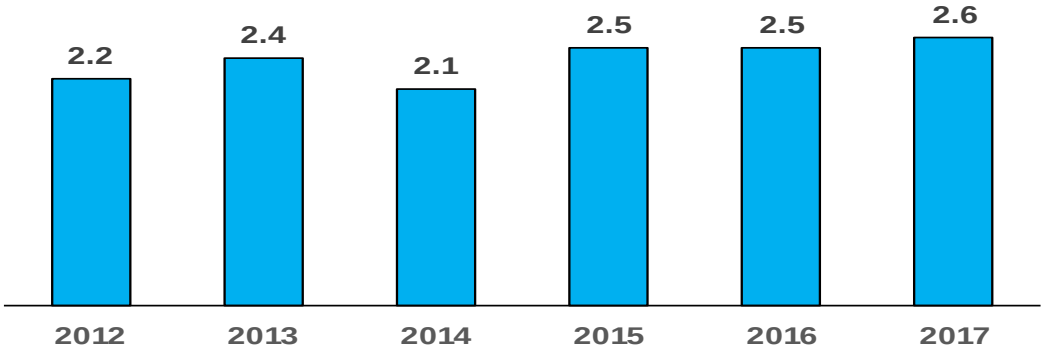
**Figure 110: Serious Violations as a Share of Total DOSH Violations, CY 2012–CY 2017**




Source: DOSH

The average number of DOSH violations per inspection averaged 2.2 from 2012 to 2015 and then increased to 2.6 in 2017.

**Figure 111: Average Number of DOSH Violations per Inspection, CY 2012–CY 2017**




Source: DOSH

**Table 35: Twenty-Five Most Frequently Cited CCR Title 8 Standards in CY 2017**

| Standard | Description | Total Violations | Serious Violations | Percent Serious |
|---|---|---|---|---|
| 3203 | Injury and Illness Prevention Program | 2,352 | 233 | 9.9% |
| 3395 | Heat Illness Prevention | 2,046 | 286 | 14.0% |
| 1509 | Construction Injury and Illness Prevention Program | 1,226 | 64 | 5.2% |
| 3314 | Clean, Repair, Service, Set-up and Adjust Prime Movers, Machinery and Equipment | 691 | 323 | 46.7% |
| 342 | Reporting Work-Connected Fatalities and Serious Injuries | 621 | 5 | 0.8% |
| 5194 | Hazard Communication | 602 | 14 | 2.3% |
| 5144 | Respiratory Protection | 484 | 36 | 7.4% |
| 6151 | Portable Fire Extinguishers | 419 | 3 | 0.7% |
| 1512 | Construction: Emergency Medical Services | 371 | 3 | 0.8% |
| 5162 | Emergency Eyewash and Shower Equipment | 367 | 180 | 49.0% |
| 461 | Permits to Operate Air Tanks | 364 | 4 | 1.1% |
| 3276 | Portable Ladders | 347 | 134 | 38.6% |
| 2340.16 | Work Space About Electric Equipment | 326 | 2 | 0.6% |
| 3650 | Industrial Trucks: General Requirements | 316 | 101 | 32.0% |
| 3328 | Safe Practices, Personal Protection: Machinery and Equipment | 284 | 109 | 38.4% |
| 3400 | Medical Services and First Aid | 212 | 12 | 5.7% |
| 3668 | Powered Industrial Truck Operator Training | 197 | 17 | 8.6% |

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| Standard | Description | Total Violations | Serious Violations | Percent Serious |
|---|---|---|---|---|
| 1670 | Personal Fall Arrest Systems, Personal Fall Restraint Systems and Positioning Devices | 195 | 130 | 66.7% |
| 5189 | Process Safety Management of Acutely Hazardous Materials | 189 | 23 | 12.2% |
| 3421 | Tree Work, Maintenance or Removal. General | 178 | 29 | 16.3% |
| 2500.8 | Flexible Electrical Cords and Cables: Uses not Permitted | 169 | 2 | 1.2% |
| 4650 | Compressed Gas and Air Cylinders: Storage, Handling, and Use | 169 | 55 | 32.5% |
| 3577 | Use, Care, and Protection of Abrasive Wheels: Protection Devices | 166 | 114 | 68.7% |
| 3380 | Personal Protective Devices | 165 | 27 | 16.4% |
| 1644 | Metal Scaffolds | 153 | 96 | 62.7% |

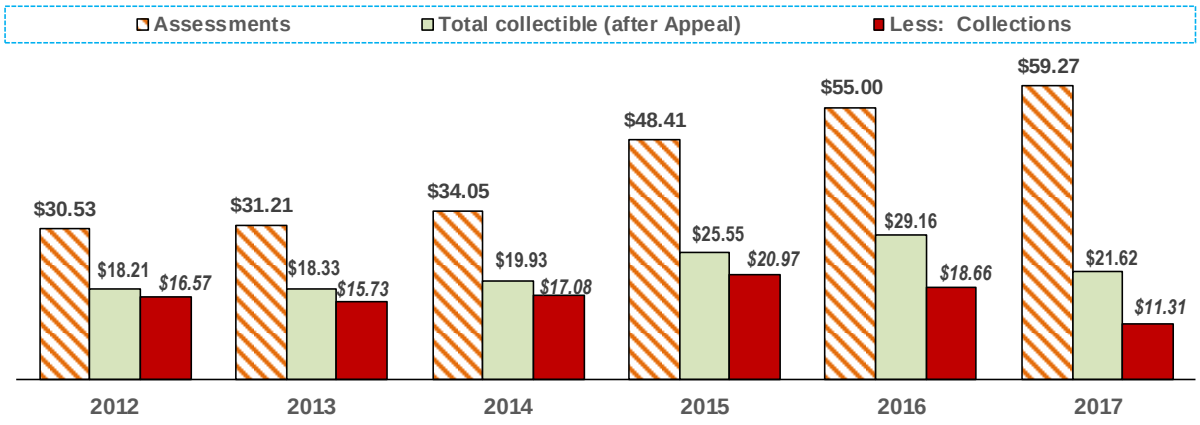
Source: DOSH Budget and Program Office.

Note: "Serious" includes Serious, Willful, and Repeat Violations.

Figure 112 demonstrates the trends in penalties and collections. Total penalties assessed were $59.3 million in 2017, almost doubling from 2012. 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 penalties eliminated due to procedural issues. Because of the appeals process, penalties collected are almost always less than the initial recommended penalties assessed. Total collections were $11.3 million in 2017.

Although Figure 112 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 give a sense of the general magnitude and accounting of penalties and collections, as well as provide a starting point for further analysis.

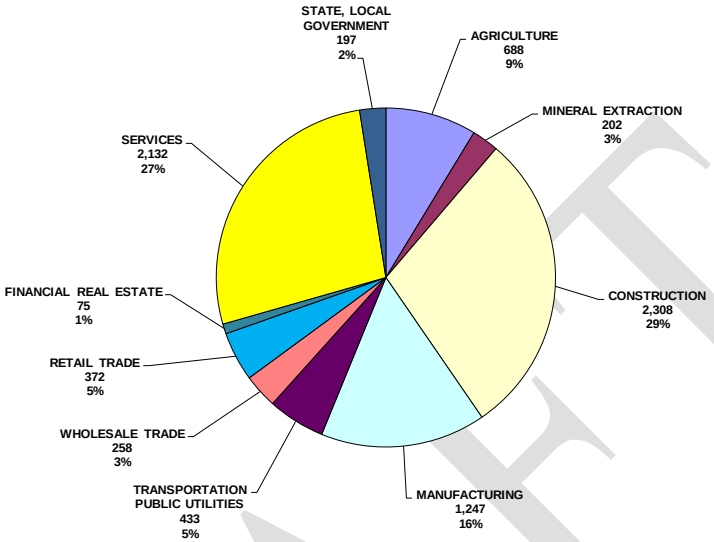
**Figure 112: Total DOSH Penalties Assessed and Collected, 2012–2017 (Million $)**




Source: DOSH

Figure 113 illustrates the proportion of inspections in major industrial groups. Of the 7,912 workplace health and safety inspections conducted in 2017, 2,308 (29 percent) were in construction and 5,604 (71 percent) were in non-construction.

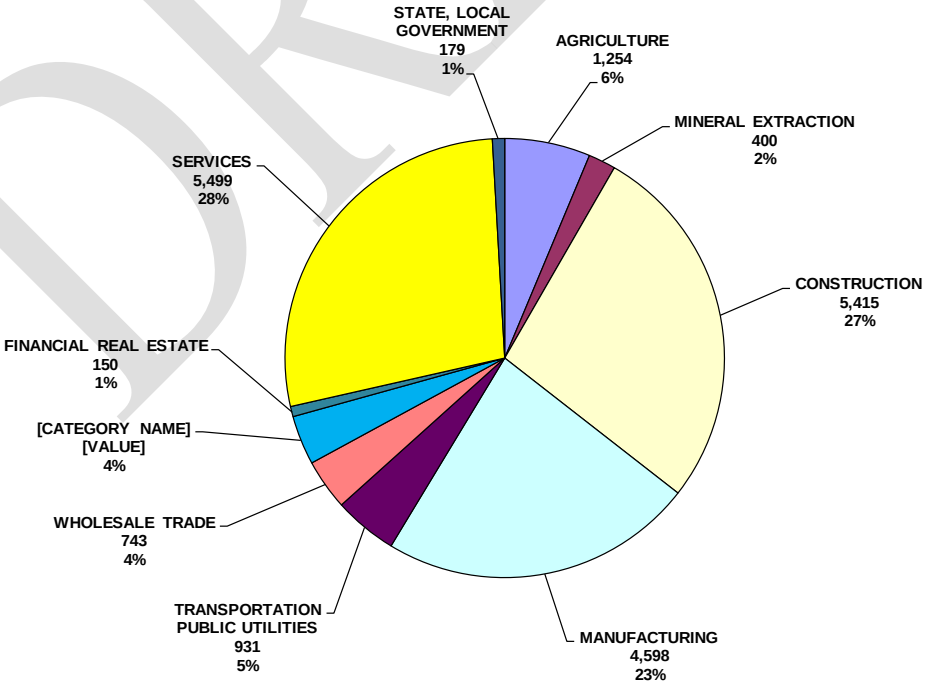
**Figure 113: Distribution of Inspections by Major Industry, CY 2017**
**(Total Inspections = 7,912)**




Source: DOSH

As shown in Figure 114, the highest percentage of violations was in service (28 percent) and, corresponding to the fact that the highest percentage of inspections was in construction, the next highest share (27 percent) of violations was also found in construction.

**Figure 114: Distribution of Violations by Major Industry, CY 2017**
**(Total Violations = 19,890)**




Source: DOSH

**High Hazard Identification, Consultation, and Compliance Programs**

Even though a statutory mandate no longer exists, the Division of Occupational Safety and Health (DOSH) reports annually on the activities of the constituent parts of the High Hazard Employer Program, specifically the High Hazard Consultation Program and the High Hazard Enforcement Program.

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. The collection of Targeted Inspection Consultation Fund ceased with the passage of Assembly Bill (AB) 1389.

In 2008, the passage of Assembly Bill (AB) 1389 gave DIR the statutory authority to levy and collect assessments from employers to fund DOSH's operations.

For FY 2015-2016, DOSH was granted additional funding for 40 new enforcement positions, 14 of which are dedicated to conducting programmed inspections of high hazard employers. Under the current structure, four of these positions are directly in the High Hazard North Unit office in Oakland and the remaining positions are in Regions 1-4. In 2017, two positions in the High Hazard Unit were abolished.

*High Hazard Consultation Program*

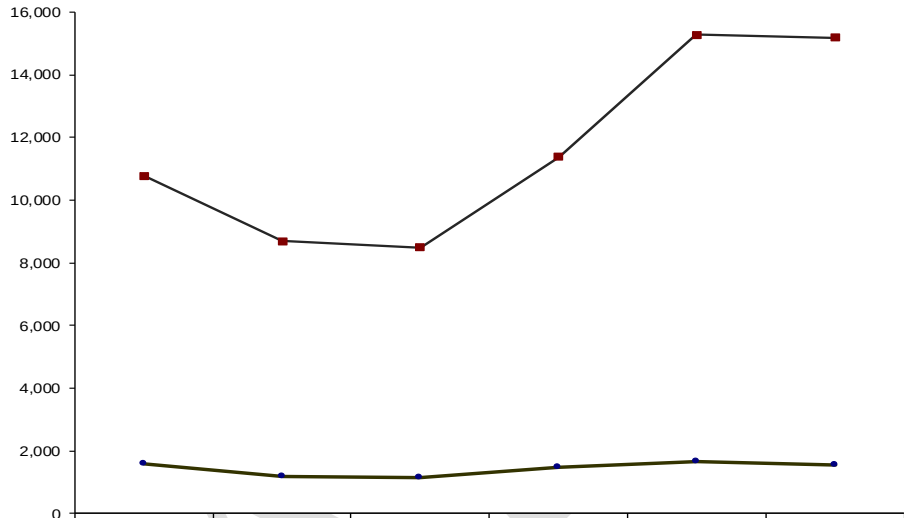
Using workers' compensation data, the Cal/OSHA Consultation Services Branch identifies employers in hazardous industries with the highest incidence of preventable occupational injuries and illnesses and workers' compensation losses. "Hazardous industries" are identified using published annual workers' compensation pure premium rates. Individual employers are identified using workers' compensation experience modification (ExMod) rate data.

The Cal/OSHA Consultation Services Branch reports that in 2017, it provided on-site high hazard consultative assistance to 1,561 employers. During consultation with these employers, 15,182 Title 8 violations were observed and corrected as a result of the provision of consultative assistance (see Figure 115).

Since 1994, 24,250 employers have been provided direct on-site consultative assistance, and 164,282 Title 8 violations have been observed and corrected. Of these violations, 33.4 percent were classified as "serious." It should be noted that for 2002 and 2003, all Consultative Safety and Health Inspection Projects (SHIPs) were included in the High Hazard Consultation Program figures. Effective 2004, only employers with ExMod rates of 125 percent and above are included in the High Hazard Consultation Program figures.

The Cal/OSHA Consultation Services Branch conducts annual surveys to measure the efficacy of the services provided. One of the efficacy measures is the comparison of employer lost-and-restricted-workday data (DART) before and after receiving on-site consultative assistance. The other efficacy measure compares individual employer's workers' compensation ExMod rate data again before and after receiving onsite consultative assistance.

**Figure 115: High Hazard Consultation Program Production by Year, 2012 - 2017**




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Number of Employers with High Hazard Consultative Assistance | 1,586 | 1,176 | 1,136 | 1,486 | 1,669 | 1,561 |
| Total Number of Title 8 Violations Observed and Corrected | 10,779 | 8,684 | 8,495 | 11,382 | 15,277 | 15,182 |

Source: DOSH

The efficacy of High Hazard Consultation is measured by comparing employer lost-and-restricted-workday data. In 2001, Log 300 replaced Log 200 as the source for lost-and-restricted-workday data. The use of the Lost Work Day Case Incidence (LWDI) rate was replaced with the Days Away, Restricted, or Transferred (DART) rate. Additionally, High Hazard Consultation uses ExMod rates to measure efficacy.

*High Hazard Enforcement Program*

It is the policy of DOSH to protect California's workers from serious injury and illness and to establish and implement a program for inspecting high hazard businesses operating in California. The High Hazard Unit, which consists of two offices (Northern and Southern) and a regional office, is dedicated to conducting targeted programmed inspections in "High Hazard Industries" throughout California.

In 2017, the High Hazard Unit opened 262 inspections and Regions 1-4 opened 183 inspections. The majority of inspections 460 (97 percent) were targeted programmed-planned. Other types of inspections opened by the High Hazard Unit were programmed-related, follow-up, accidents, complaints, and referrals. A total of 2,370 violations were identified and cited during inspections. Violations were identified in 73 percent of the inspections conducted. The violation per inspection ratio for targeted programmed-planned inspections in 2017 was 5.3.

The high hazard enforcement program activity measures are shown in Tables 35-38.

The distributions of high hazard targeted inspections by North American Industrial Classification System (NAICS) in 2015 and 2016 are shown in Table 36.

**Table 36: High Hazard Inspections by NAICS Code, 2016-2017**

| NAICS code and Description | 2016 | | 2017 | |
|---|---|---|---|---|
| | Number | % | Number | % |
| 11 Agriculture, Forestry, Fishing and Hunting | 52 | 15% | 33 | 8% |
| 21 Mining, Quarrying, and Oil and Gas Ext. | 0 | 0% | 0 | 0% |
| 22 Utilities | 1 | 0% | 0 | 0% |
| 23 Construction | 3 | 1% | 4 | 1% |
| 31-33 Manufacturing | 158 | 46% | 215 | 49% |
| 42 Wholesale Trade | 9 | 3% | 5 | 1% |
| 44-45 Retail Trade | 3 | 1% | 0 | 1% |
| 48-49 Transportation and Warehousing | 4 | 1% | 8 | 2% |
| 51 Information | 0 | 0% | 0 | 0% |
| 52 Finance and Insurance | 0 | 0% | 0 | 0% |
| 53 Real Estate and Rental/Leasing | 0 | 0% | 0 | 0% |
| 54 Professional, Scientific, and Technical Services | 3 | 1% | 5 | 1% |
| 56 Admin and Support and Waste Management and Remediation | 104 | 30% | 132 | 30% |
| 61 Educational Services | 0 | 0% | 0 | 0% |
| 62 Health Care and Social Assistance | 0 | 0% | 11 | 3% |
| 71 Arts, Entertainment, and Recreation | 0 | 0% | 0 | 0% |
| 72 Accomodation and Food Services | na | | 2 | 0% |
| 81 Other Services | 6 | 2% | 24 | 5% |
| 92 Public Administration | 0 | 0% | 1 | 0% |
| Total | 343 | | 440 | |

Source: DOSH

Violations observed during high hazard targeted inspections are divided into two categories: “serious, willful, and repeat (SWR)” and “other than serious” violations.

**Table 37: Violations Observed During High Hazard Inspections, 2012-2017**

| Targeted Inspections | 2012 | | 2013 | | 2014 | | 2015 | | 2016 | | 2017 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Serious, Willful, & Repeat | 586 | 33% | 443 | 28% | 429 | 21% | 535 | 25% | 510 | 23% | 588 | 25% |
| Other Than Serious | 1,187 | 67% | 1,122 | 72% | 1,653 | 79% | 1,621 | 75% | 1,671 | 77% | 1,790 | 75% |
| **Total** | **1,773** | | **1,565** | | **2,082** | | **2,156** | | **2,181** | | **2,378** | |

Source: DOSH

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Table 38 shows the distribution of enforcement actions taken during high hazard inspections by type in 2012–2017.

**Table 38: Enforcement Actions Taken During High Hazard Targeted Inspections, 2012-2017**

| Types of enforcement actions | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Warrants | 0 | 0 | 0 | 0 | 0 | 0 |
| Order Prohibiting Use | 75 | 20 | 0 | 8 | 12 | 5 |
| Information Memorandums | 15 | 53 | 75 | 71 | 25 | 14 |
| Violations | 1,773 | 1,565 | 2,082 | 2,156 | 2,181 | 2,378 |

Source: DOSH

Table 39 shows the most frequently observed violations during high hazard inspections in 2017.

**Table 39: Most Frequently Observed Violations During High Hazard Targeted Inspections, 2017**

| Title 8 Section | Description |
|---|---|
| 3203 | Injury and Illness Prevention Program |
| 461 | Permits to Operate (Air Tanks) |
| 5144 | Respiratory Protection Program |
| 5194 | Hazard Communication |
| 6151 | Portable Fire Extinguishers |
| 3314 | The Control of Hazardous Energy (Lockout/Tagout) |
| 3395 | Heat Illness Prevention Program |
| 5162 | Eyewash and Shower |
| 2340.16 | Work Space About Electric Equipment |
| 2473.1 | Conductors Entering Boxes, Cabinets, or Fittings |
| 3578 | Permissible Wheel Exposures for Grinders |

Source: DOSH

**Safety Inspections**

DOSH has three major public safety programs devoted to conducting inspections to protect the public from safety hazards:

- The Amusement Ride and Tramway Unit conducts public safety inspections of amusement rides, both portable and permanent, and aerial passenger tramways and ski lifts.
- The Elevator Unit conducts public safety inspections of different conveyances, including power-cable driven passenger and freight elevators, manlifts, and escalators.[52]
- The Pressure Vessel Unit conducts public safety inspections of boilers and pressure vessels to ensure their safe operation in places of employment.

[52] For a list of conveyances, please see http://www.dir.ca.gov/Title8/sub6.html.

**Cal/OSHA's Highest Hazard Industries List**

Pursuant to Labor Code 6401.7(e)(3)(A), Cal/OSHA issues the Highest Hazard Industry List annually. The methodology for Cal/OSHA's High Hazard Industry threshold is based on >200 percent of the annual private sector average DART (Days Away, Restricted, and Transferred) rate. The DART rate in 2015, serving as as a basis for FY 2017-2018 High Hazard Industry threshold, was 2.1. Accordingly, the high hazard industry threshold for that fiscal year is 4.2.

*For further information …*

Cal/OSHA's Highest Hazard Industry List for FY 2017–2018.
http://www.dir.ca.gov/dosh/documents/hhu-list-2017-2018.pdf

**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 to ensure 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 …*

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

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**Occupational Health and Safety Appeals Board (OSHAB)**

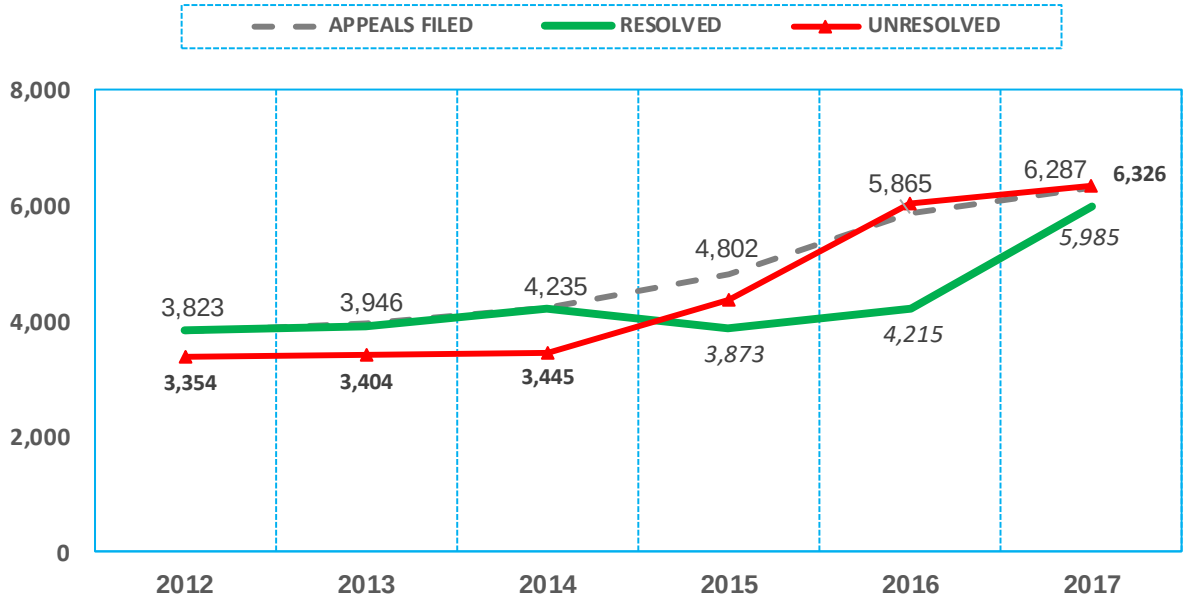
The Occupational Safety and Health Appeals Board (OSHAB) consists of three members appointed by the governor for four-year terms. By statute, the members are selected from among management, labor, and the general public. The chairman is selected by the governor.

The mission of OSHAB is to resolve appeals and to provide clear, consistent guidance to the public, thereby promoting workplace health and safety fairly, efficiently, and in a timely manner. OSHAB handles appeals from private and public sector employers regarding citations issued by DOSH for alleged violations of workplace health and safety laws and regulations.

Figure 116 shows the OSHAB workload: appeals filed, resolved, and unresolved. The number of appeals filed yearly increased by 64 percent from 2012 to 2017.

From 2012 to 2014, almost 100 percent of filed appeals were resolved each year; therefore, the average number of unresolved appeals per year reached its minimum of 3,400 cases on average from 2012 to 2014. In 2015 and 2016, the processing of appeals slowed down to 81 and then to 72 percent of filed appeals correspondingly, increasing the number of unresolved cases from 2015 to 2017. Resolved appeals as a share of yearly filed appeals increased to 95 percent in 2017.

**Figure 116: Occupational Safety and Health Appeals Board (OSHAB) Workload, 2012-2017**

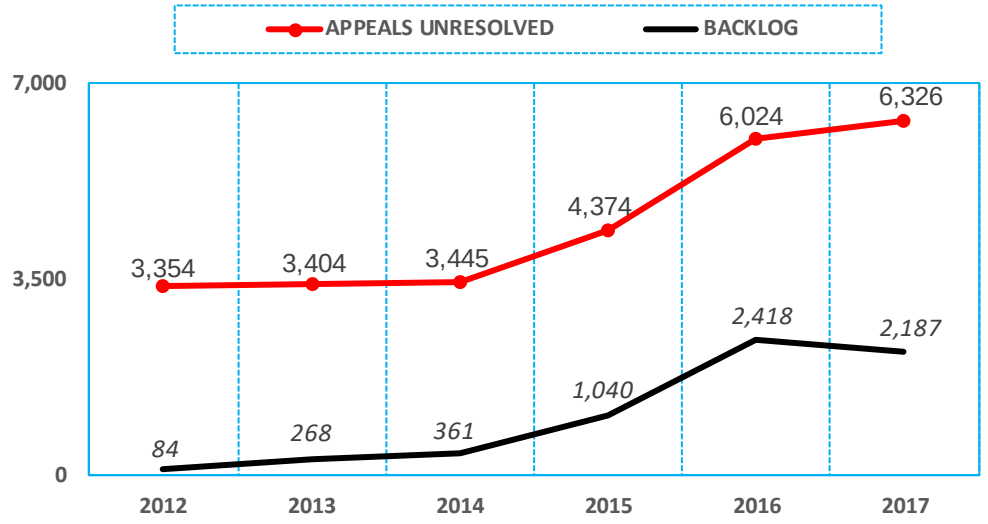



Data Source: OSHAB

The trend and level of backlogged citation appeals reflect changes in unresolved cases as they accumulate from previous years.

Figure 117 shows that the number of backlogged appeals increased from 84 in 2012 to 2,418 cases in 2016. This growth in the backlog was the result of the filed appeals outpacing the level of resolved cases in 2016 (see Figure 118), and an increase in the number of unresolved cases from 2012 to 2016. As the number of resolved cases increased by 42 percent from 2016 to 2017, the backlog decreased by about 10 percent.

**Figure 117: Occupational Safety and Health Appeals Board Backlogs, 2012-2017**




Data Source: OSHAB

**Educational and Outreach Programs**

In conjunction and in cooperation with the 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 6434, CHSWC is to assist inner-city schools or any school or district in implementing 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 worker injuries and illnesses. These partnership programs include the Voluntary Protection Program (VPP), Golden State, SHARP, Golden Gate, and special alliances formed among industry, labor, and OSHA.

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# UPDATE: THE CALIFORNIA WORKERS' COMPENSATION INSURANCE INDUSTRY

## Background

In California, approximately two-thirds of the total State payroll is covered for workers' compensation through insurance policies, while the remainder is through self-insurance. There are more than 200 private for-profit insurers and one public nonprofit insurer, the State Compensation Insurance Fund (SCIF).

The California Department of Insurance (CDI) oversees these insurers. To accomplish its principal objective to protect insurance policyholders in the State, CDI examines insurance companies to ensure that operations are consistent with Insurance Code requirements.

*Minimum Rate Law and Open Rating*

In 1993, workers' compensation reform legislation repealed California's 80-year-old minimum rate law and in 1995 replaced it 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 intended to cover other costs and expenses, including unallocated loss-adjustment expenses, as well as an operating profit.

## Workers' Compensation Advisory Premium Rates

As a result of the 2003 legislative reforms, WCIRB recommended changes and the Insurance Commissioner (IC) either approved them or declared no changes in the pure premium advisory rates. When decisions have been issued, the IC approved increases for all periods from July 1, 2012, to January 1, 2015, filings. The IC approved decreases in the pure premium advisory rates in six consecutive periods beginning from July 1, 2015 to January 1, 2018. The WCIRB did not submit its January 1, 2013, July 1, 2013, and July 1, 2014, pure premium rate filings, and the IC did not issue the interim advisory rates for these periods. (A history of pure premium rates since 2012 appears later in this section.)

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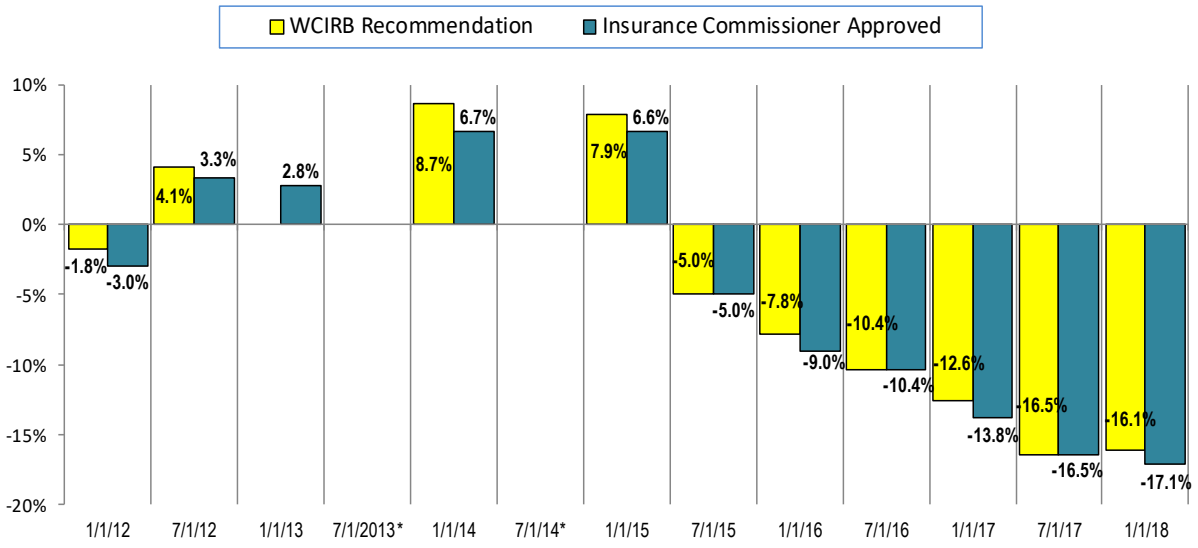
**Figure 118: Percentage Changes in Workers' Compensation Advisory Premium Rates, WCIRB Recommendation and Insurance Commissioner's Decision Compared to Corresponding Industry Average Filed Pure Premium Rate**




* WCIRB and/or Insurance Commissioner did not take actions.

Source: WCIRB

### California Workers' Compensation Rate Changes

Workers' compensation legislative reforms enacted in 2003 and subsequent decisions by the IC on advisory claims cost benchmarks and pure premium rates led insurers to file a series of significant manual rate reductions from 2004 through 2008. Despite recent manual rate increases filed by insurers, which helped lead to additional legislative reforms passed in 2012 (SB 863), the top ten California workers' compensation insurers still maintain greatly reduced filed manual rates from those in 2003 (see Table 39).

WCIRB reports that the projected industry average charged rate per $100 of payroll for policies incepting in the first three months of 2018 is $2.38. This is 6 percent below the average rate charged in 2017 and 15 percent below the average rate charged in 2016. The approved January 1, 2018 advisory pure premium rates are on average approximately 37 percent below the January 1, 2015 advisory pure premium rates.[53]

Since the first reform package was chaptered in 2003, 98 new insurers have filed to enter the California market and existing private insurers have increased their underwritings. The significant rate reductions, totaling 28 percent since the first reforms were enacted, and SCIF's declining market share from its peak of 53 percent in 2003 to 13 percent in 2015 point to the dramatic initial success of the 2003 cost containment reforms and a stabilizing market with increased capacity and greater rate competition.

The impact or savings from the latest reform, SB 863 passed in 2012 and effective January 1, 2013 are being realized as the advisory pure premium rates effective July 1, 2017 averaged $2.02 per $100 of payroll and were 7.8 percent less than the average of the approved January 1, 2017 advisory pure premium rates of $2.19. Approved pure premium rates effective January 1, 2018 averaged $1.94 per $100 of payroll and were 4.0 percent lower than the approved July 1, 2017 pure premium rate of $2.02 per $100 of payroll.

[53] WCIRB Report on March 31, 2018, Insurer Experience, released April, 2018, Chart 2.

**Table 40: California Workers' Compensation Top 10 Insurers Rate Filing Changes**

| COMPANY NAME | GROUP NAME | Market Share 2017 | *Cumulative Rate Change 1-04 to 4-18* | 1Q 2018 % Filed Rate Change* | 4-1-2017 % Filed Rate Change* | 4-1-2016 % Filed Rate Change* | 4-1-2015 % Filed Rate Change* |
|---|---|---|---|---|---|---|---|
| State Compensation Insurance Fund | | *10.65%* | *-46.77%* | *-8.00%* | *-9.50%* | *0.02%* | *9.00%* |
| Insurance Company of the West | American Assets Group | *5.99%* | *-45.17%* | *-10.60%* | *-10.32%* | *-5.60%* | *0.00%* |
| Travelers Property Casualty Company of America | Travelers Group | *5.36%* | *-39.83%* | *-6.40%* | *-5.20%* | *-4.00%* | *1.03%* |
| Security National Insurance Company** | AmTrust NGH Group | *3.47%* | *40.63%* | *-0.30%* | *-0.80%* | *-2.30%* | *3.00%* |
| Cypress Insurance Company | Berkshire Hathaway Grp | *3.19%* | *-52.25%* | *-7.00%* | *-5.00%* | *0.00%* | *2.60%* |
| Zurich American Insurance Company | Zurich Ins Group | *3.15%* | *-47.08%* | *-9.10%* | *-8.73%* | *0.00%* | *4.20%* |
| Zenith Insurance Company | Fairfax Financial Grp | *2.90%* | *-11.71%* | *-2.50%* | *-0.40%* | *-1.30%* | *4.50%* |
| Everest National Insurance Company | Everest Reins Holdings Grp | *2.76%* | *-41.88%* | *-12.60%* | *-12.40%* | *-4.80%* | *1.30%* |
| Ace American Insurance Company | ACE Ltd Grp | *2.48%* | *-79.37%* | *-7.70%* | *-9.08%* | *-10.80%* | *1.50%* |
| Redwood Fire & Casualty Insurance Co | Berkshire Grp | *2.01%* | *-69.17%* | *-6.90%* | *-9.60%* | *0.00%* | *3.40%* |

* Indicated % filed rate change reflects cumulative rate change(s) in effect as of that date from the rates in effect on the preceding date.
** Security National Insurance Company entered the California market in 2008.

### 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 1990s.

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 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 almost 63 percent from $23.5 billion to $8.8 billion between 2004 and 2009 due to rate decreases. From 2009 to 2016, the written premium more than doubled.

Figure 121 shows the California workers' compensation written premium before and after the application of deductible credits. Note that these amounts exclude dividends.

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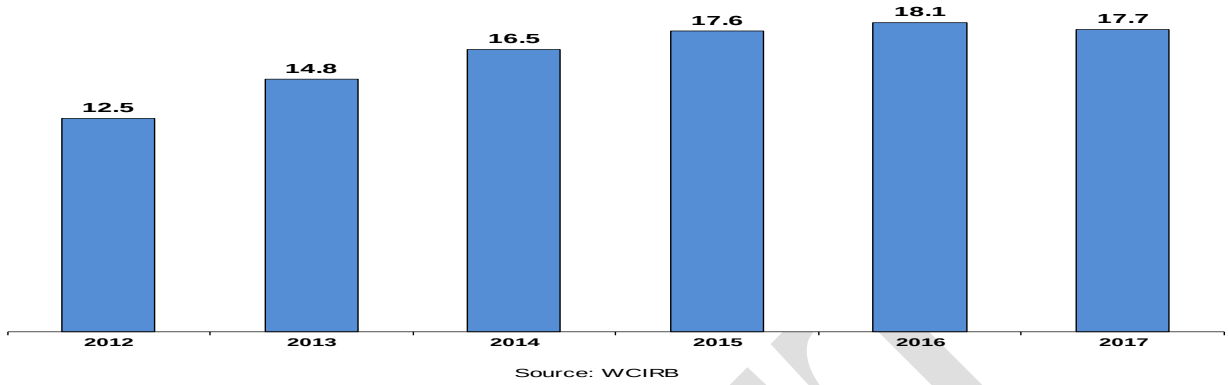
**Figure 119: Workers' Compensation Written Premium as of March 31, 2018 (Billion $)[54]**

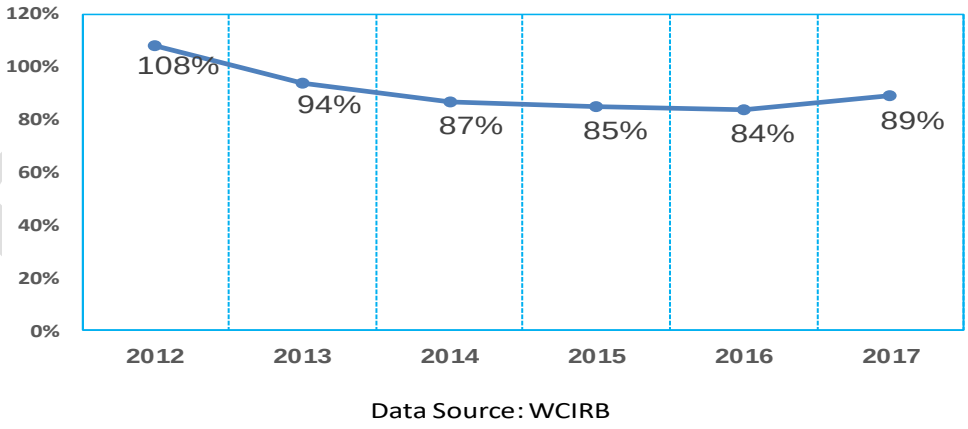



### Combined Loss and Expense Ratio

The accident year combined loss and expense ratio measures workers' compensation claims payments and administrative expenses against the earned premium.

In accident year 2018, insurers' claim costs and expenses amounted to $0.89 for every dollar of premium collected. The projected combined ratio for 2017 is 5 points higher than 2016 as premium levels have lowered while average claim severities increased moderately. Despite the recent increase, combined ratios for 2014 to 2017 remain the lowest since 2004.

**Figure 120: California Workers' Compensation Combined Loss and Expense Ratios***
**(Projected accident year, as of March 31, 2018)**

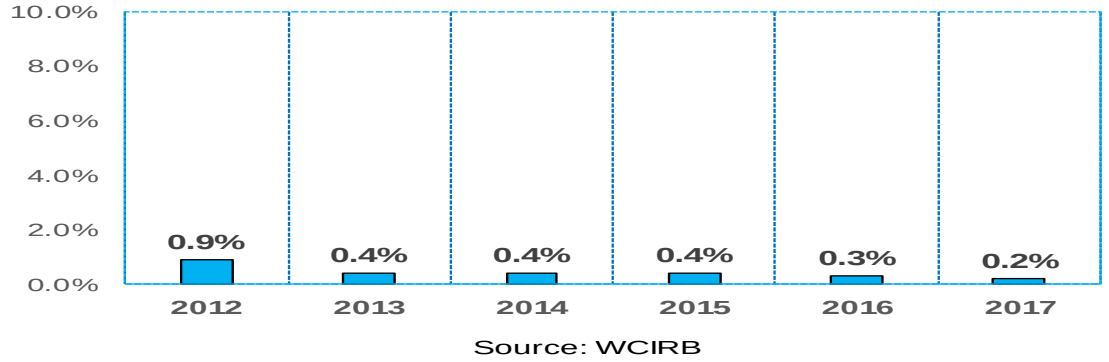



### Policy Holder Dividends

Dividends to policyholders were not paid in 2004, and then reinstated from 2005 through 2011 at a very low rate. Dividends paid to policyholders increased up to 0.9 percent in 2012 and then decreased to 0.4 percent and stabilized at that level from 2013 to 2016 with a slight decrease in 2016.

[54] WCIRB Report on March 31, 2018, Insurer Experience, released April, 2018, Chart 2.

**Figure 121: Insurer Policy Holder Dividends as a Percentage of Earned Premium (by Calendar Year)**



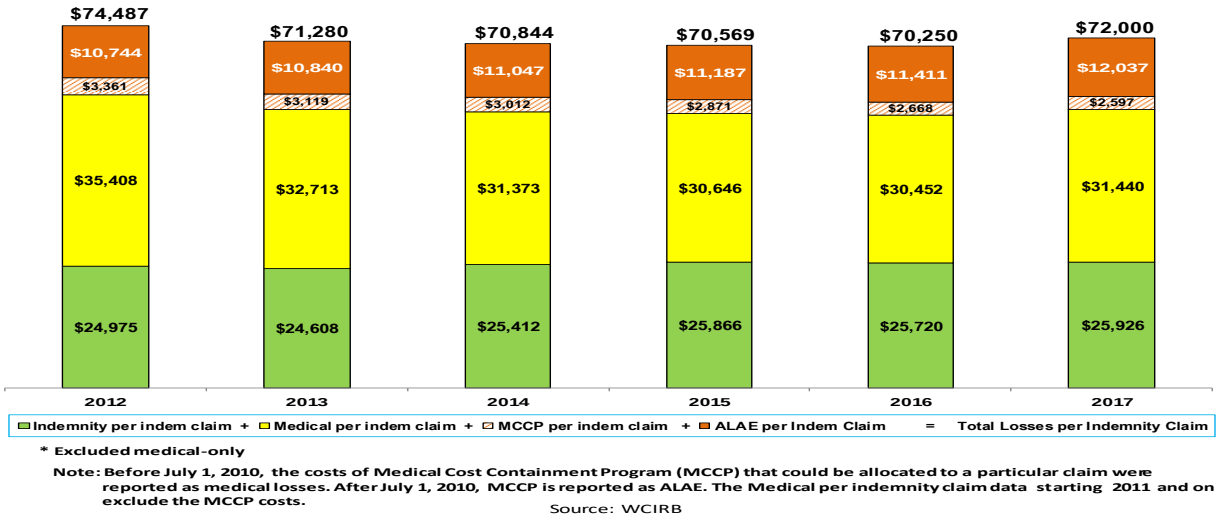

## Average Ultimate Total Loss

Figure 123 shows changes in indemnity and medical components of the projected ultimate total loss per workers' compensation indemnity claim.

Beginning with claims incurred on policies incepting on or after July 1, 2010, the cost of medical cost containment programs (MCCP) is reported to WCIRB as allocated loss adjustment expenses (ALAE) rather than as medical loss.

The total average cost of indemnity claims decreased by 6 percent from 2012 to 2016 and then increased by 2.5 percent from 2016 to 2017. The projected average indemnity cost showed relatively modest increase in 2017, primarily a result of SB 863 increases to permanent disability benefits effective in 2013 and 2014. The projected average medical cost of a 2017 indemnity claim is 3 percent above that for 2016, which follows decreases in medical severities from 2011 to 2015 driven by medical cost savings arising from SB 863. It is unclear whether this increase will develop downward like in recent years or it represents a return of more typical rates as in post-reform medical inflation.[55] The projected average ALAE cost of a 2017 indemnity claim is 5 percent above that of 2016 and 11 percent higher than the average ALAE severity for 2013. Average ALAE costs tend to rise shortly after the implementation of reforms, even during periods where medical costs have declined.[56]

**Figure 122: Estimated Ultimate Total Loss* and ALAE per Indemnity Claim as of March 31, 2018**

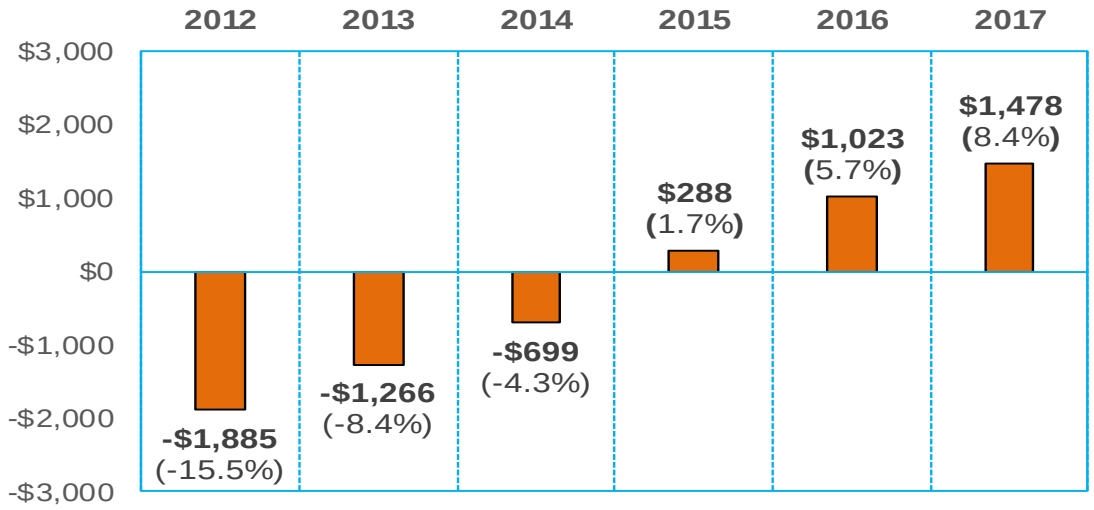



[56] WCIRB Report on March 31, 2018, Insurer Experience, released April, 2018, Charts 8 – 11.

### 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. From the implementation of the reforms of 2004 until 2008, insurer underwriting profits were uncharacteristically high. Investment income typically was the main source of insurer profits, but underwriting profits from policies was a new development. In 2008, workers' compensation insurers experienced losses for the first time since 2004. The pre-tax underwriting losses increased to 17 percent in both 2009 and 2010, reached 22.3 percent of earned premium in 2011, and then declined steadily from 2011 to 2014. In 2015, insurers experienced the underwriting profits of 1.7 percent after 7 years of losses. In 2016, the underwriting profits increased 4 percentage points from 1.7 percent.

**Figure 123: Insurer Pre-Tax Underwriting Profit/Loss, 2004-2016 (Million $ and as a Percentage of Earned Premium)**




Source: WCIRB

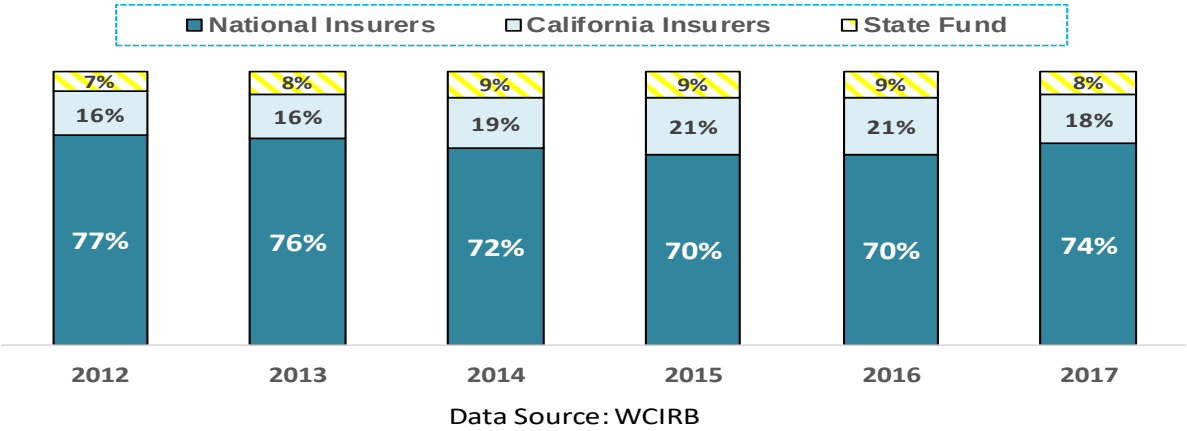
## Current State of the Insurance Industry

### Market Share

A number of California insurers left the market or reduced their underwritings as a result of the decrease in profitability, contributing to a major redistribution of market share among insurers since 1993. Figure 126 shows changes in the workers' compensation insurance market share from 1995 to 2015.

According to WCIRB, from 2012 through 2017, SCIF attained between 7 to 9 percent of the California workers' compensation insurance market. The market share of California domestic insurers, excluding SCIF, increased from 16 percent in 2012 to 21 percent in 2016 and then, in 2017 decreased to 18 percent.

**Figure 124: Workers' Compensation Insurance Market Share in California by Type of Insurer Based on Written Premium Prior to Deductible Credits**




California Insurers" are difined as private insurers who write at least 80 percent of their workers' compensation business in California.

**Impact of September 11, 2001, on Insurance Industry**

The problems in the reinsurance market caused by the tragic 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. Now known as TRIPRA, the Terrorism Risk Insurance Program Reauthorization Act of 2015 amends the expiration date of the Terrorism Risk Insurance Program (TRIP) to December 31, 2020.

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**Advisory Workers' Compensation Pure Premium Rates**
**A History Since the 2012 Reform Legislation**

**January 1, 2012**

***WCIRB recommendations:***

On August 22, 2011, the WCIRB submitted its January 1, 2012, pure premium rate filing to the California Insurance Commissioner. The pure premium rates proposed in this filing are benchmarked to the average insurer filed pure premium rate. The average of 494 classification pure premium rates is $2.33 per $100 of payroll and 1.8 percent less than the corresponding average of insurer filed pure premium rates for July 1, 2011.

***Insurance Commissioner action:***

On November 4, 2011, the Commissioner issued a decision approving new advisory pure premium rates effective January 1, 2012, which average $2.30 per $100 of payroll.

**July 1, 2012**

***WCIRB recommendations:***

On April 12, 2012, the WCIRB submitted its July 1, 2012, pure premium rate filing to the California Insurance Commissioner recommending an increase in advisory pure premium rates effective July 1, 2012. The advisory pure premium rates proposed for the 494 standard classifications currently in effect average $2.51, which is 4.1 percent more than the corresponding industry average filed pure premium rate of $2.41 as of January 1, 2012.

***Insurance Commissioner action:***

On May 29, 2012, the Commissioner issued a decision approving new advisory pure premium rates effective July 1, 2012, which average $2.49 per $100 of payroll.

**January 1, 2013**

***WCIRB recommendations:***

On October 1, 2012, the WCIRB submitted its January 1, 2013, pure premium rate filing to the California Insurance Commissioner. The WCIRB did not recommend a January 1, 2013, increase in the advisory pure premium rate level. Instead, the WCIRB proposed January 1, 2013, pure premium rates that average $2.38 per $100 of payroll, which is the industry average filed pure premium rate as of July 1, 2012. The amended January 1, 2013, Pure Premium Rate Filing incorporated new proposed advisory pure premium rates as well as proposed changes to the reporting requirements of the *California Workers' Compensation Uniform Statistical Reporting Plan*—1995 and to the eligibility threshold of the *California Workers' Compensation Experience Rating Plan*—1995.

***Insurance Commissioner action:***

On November 30, 2012, the Commissioner issued a decision approving new advisory pure premium rates effective January 1, 2013, that average $2.56 per $100 of payroll which is 2.8 percent higher than the industry average filed pure premium rate of $2.49 per $100 of payroll as of November 9, 2012.

**July 1, 2013**

***WCIRB recommendations:***

On April 3, 2013, after some discussion, the WCIRB Governing Committee unanimously agreed not to submit a July 1, 2013, Pure Premium Rate Filing. Instead, the Actuarial Committee agreed to continue reviewing insurer experience in preparation for the regular January 1, 2014, Pure Premium Rate Filing to be submitted in August.

***Insurance Commissioner action:***

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

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**January 1, 2014**

***WCIRB recommendations:***

On October 23, 2013, the WCIRB and public members voted unanimously to amend the WCIRB's January 1, 2014, Pure Premium Rate Filing to propose an additional 1.8 percent increase in pure premium rates to reflect the increased costs of the new physician fee schedule recently adopted by the Division of Workers' Compensation (DWC). With this amendment, the WCIRB proposed January 1, 2014, advisory pure premium rates that average $2.75 per $100 of payroll which is 8.7 percent greater than the industry average pure premium rate of $2.53 as of July 1, 2013. (The original Filing submitted on September 13, 2013, proposed an industry average pure premium rate of $2.70, which is 6.9 percent higher than the July 1, 2013, industry average pure premium rate.) ***Insurance Commissioner action:***

On November 22, 2013, the California Department of Insurance (CDI) issued a decision regarding the WCIRB's January 1, 2014, Pure Premium Rate Filing approving advisory pure premium rates effective January 1, 2014, that average $2.70 per $100 of payroll, which is 6.7 percent higher than the average filed pure premium rate as of July 1, 2013.

**July 1, 2014**

***WCIRB recommendations:***

On April 3, 2014, after some discussion, the WCIRB Governing Committee unanimously agreed not to submit a July 1, 2014, Pure Premium Rate Filing.

***Insurance Commissioner action:***

The Insurance Commissioner did not issue a decision with respect to the pure premium rate for this period.

**January 1, 2015**

***WCIRB recommendations:***

On September 4, 2014, the WCIRB voted to amend the WCIRB's January 1, 2015, Pure Premium Rate Filing to propose advisory pure premium rates that average $2.77 per $100 payroll in lieu of the advisory pure premium rates averaging $2.86 per $100 of payroll that were proposed in the WCIRB's initial August 19, 2014, Filing. The new proposed average pure premium rate of $2.77 is 7.9 percent higher than the corresponding industry average filed pure premium rate of $2.57 as of July 1, 2014.

***Insurance Commissioner action:***

On November 14, 2014, the Insurance Commissioner issued a decision regarding the WCIRB's January 1, 2015, Pure Premium Rate Filing approving advisory pure premium rates effective January 1, 2015, that average $2.74 per $100 of payroll, which is 6.6 percent higher than the average filed pure premium rate as of July 1, 2014, of $2.57 per $100 of payroll and 2.2 percent above the average approved January 1, 2014, pure premium rate of $2,68 per $100 of payroll.

**July 1, 2015**

***WCIRB recommendations:***

On April 6, 2015, the WCIRB submitted a July 1, 2015, Pure Premium Rate Filing to the California Department of Insurance (CDI) proposing advisory pure premium rates effective July 1, 2015, that average $2.46 per $100 of payroll. The average proposed advisory pure premium rate is 5.0 percent lower than the corresponding industry average filed pure premium rate of $2.59 as of January 1, 2015, and 10.2 percent less than the approved average January 1, 2015, advisory pure premium rate of $2.74.

***Insurance Commissioner action:***

On May 7, 2015, the Commissioner approved the WCIRB's proposed advisory pure premium rates that average $2.46 per $100 of payroll. The approved pure premium rates are, on average, 5.0 percent less than the industry average filed pure premium rate as of January 1, 2015, of $2.59 and 10.2 percent less than the average of the approved January 1, 2015, advisory pure premium rates of $2.74. The approved advisory pure premium rates are effective July 1, 2015, for new and renewal policies.

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**January 1, 2016**

***WCIRB recommendations:***

On August 19, 2015, the WCIRB submitted its January 1, 2016, Pure Premium Rate Filing to the California Insurance Commissioner. The pure premium rates for the 491 standard classifications proposed to be effective January 1, 2016, average $2.45 per $100 of payroll, which is $0.21, or 7.8 percent, less than the corresponding industry average filed pure premium rate of $2.66 as of July 1, 2015, and $0.02 or 0.8 percent less than the average approved July 1, 2015, advisory pure premium rate of $2.47.

***Insurance Commissioner action:***

On October 20, 2015, the Insurance Commissioner issued a decision regarding the WCIRB's January 1, 2016, Pure Premium Rate Filing, approving advisory pure premium rates that averaged $2.42 per $100 of payroll. The approved pure premium rates were, on average, 9.0 percent less than the industry average filed pure premium rate as of July 1, 2015, of $2.66 and 2.0 percent less than the average of the approved July 1, 2015, advisory pure premium rates of $2.47.

**July 1, 2016**

***WCIRB recommendations:***

On April 11, 2016, the WCIRB submitted its July 1, 2016, Pure Premium Rate Filing to the California Insurance Commissioner. The pure premium rates proposed to be effective July 1, 2016, average $2.30 per $100 of payroll, which is 10.4 percent lower than the corresponding industry average filed pure premium rate of $2.57 as of January 1, 2016, and 5.0 percent less than the average approved January 1, 2016, advisory pure premium rate of $2.42.

***Insurance Commissioner action:***

On May 31, 2016, the Insurance Commissioner issued a decision regarding the WCIRB's July 1, 2016, Pure Premium Rate Filing, approving advisory pure premium rates that averaged $2.30 per $100 of payroll. The approved pure premium rates were, on average, 10.4 percent less than the industry average filed pure premium rate as of January 1, 2016, of $2.57 and 5.0 percent less than the average of the approved January 1, 2016, advisory pure premium rates of $2.42.

**January 1, 2017**

***WCIRB recommendations:***

On August 19, 2016, the WCIRB submitted its January 1, 2017, Pure Premium Rate Filing to the California Insurance Commissioner. The pure premium rates proposed to be effective January 1, 2017, averaged $2.26 per $100 of payroll. On October 3, 2016, after completing evaluations of June 30, 2016 experience, the WCIRB submitted an amended advisory pure premium rate averaging $2.22 per $100 of payroll. The proposed rate is 12.6 percent less than the corresponding industry average filed pure premium rate of $2.54 as of July 1, 2016 and 4.3 percent less than the average approved July 1, 2016 advisory pure premium rate of $2.32.

***Insurance Commissioner action:***

On October 27, 2016, the Insurance Commissioner issued a decision regarding the WCIRB's January 1, 2017, Pure Premium Rate Filing, approving advisory pure premium rates that averaged $2.19 per $100 of payroll. The approved pure premium rates were, on average, 13.8 percent less than the industry average filed pure premium rate as of July 1, 2016, of $2.54 and 5.6 percent less than the average of the approved July 1, 2016, advisory pure premium rates of $2.32 per $100 of payroll.

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**July 1, 2017**

***WCIRB recommendations:***

On April 11, 2017, the WCIRB submitted its July 1, 2017, Pure Premium Rate Filing to the California Insurance Commissioner. The pure premium rates proposed to be effective July 1, 2017, averaged $2.02 per $100 of payroll. The average proposed rate is 16.5 percent less than the corresponding industry average filed pure premium rate of $2.42 as of January 1, 2017 and 7.8 percent less than the average approved January 1, 2017 advisory pure premium rate of $2.19.

***Insurance Commissioner action:***

On May 22, 2017, the Insurance Commissioner issued a decision regarding the WCIRB's July 1, 2017, Pure Premium Rate Filing, approving advisory pure premium rates that averaged $2.02 per $100 of payroll. The approved advisory pure premium rates were, on average, 16.5 percent less than the corresponding industry average filed pure premium rate as of January 1, 2017, of $2.42 and 7.8 percent less than the average of the approved January 1, 2017, advisory pure premium rates of $2.19 per $100 of payroll.

**January 1, 2018**

***WCIRB recommendations:***

On August 18, 2017, the WCIRB submitted its January 1, 2018, Pure Premium Rate Filing to the California Insurance Commissioner. The pure premium rates proposed to be effective January 1, 2018, averaged $2.01 per $100 of payroll. On September 8, 2017, the WCIRB submitted an amended January 1, 2018 Pure Premium Rate Filing. The proposed amended rate average $1.96 and is 16.1 percent less than the corresponding industry average filed pure premium rate of $2.00 as of July 1, 2017 and 2 percent less than the average approved July 1, 2017 advisory pure premium rate of $2.00.

***Insurance Commissioner action:***

On October 26, 2017, the Insurance Commissioner issued a decision regarding the WCIRB's January 1, 2018, Pure Premium Rate Filing, approving advisory pure premium rates that averaged $1.94 per $100 of payroll. The approved pure premium rate was, on average, 17.1 percent less than the industry average filed pure premium rate as of July 1, 2017, of $2.34 and 3 percent less than the average of the approved July 1, 2017, advisory pure premium rates of $2.00 per $100 of payroll.

**July 1, 2018**

***WCIRB recommendations:***

On April 9, 2018, the WCIRB submitted its July 1, 2018, Pure Premium Rate Filing to the California Insurance Commissioner. The pure premium rates proposed to be effective July 1, 2018, averaged $1.80 per $100 of payroll.The proposed advisory pure premium rate was 7.2 percent less than the average approved January 1, 2018 advisory pure premium rates.

***Insurance Commissioner action:***

On May 29, 2018, the Insurance Commissioner issued a decision regarding the WCIRB's July 1, 2018, Pure Premium Rate Filing, approving advisory pure premium rates that averaged $1.74 per $100 of payroll. The approved pure premium rate was, on average, 21.6 percent less than the industry average filed pure premium rate as of January 1, 2018, of $2.22 and 10.3 percent less than the average of the approved January 1, 2018, advisory pure premium rates of $1.94 per $100 of payroll.

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**January 1, 2019**

***WCIRB recommendations:***

On August 20, 2018, the WCIRB submitted its January 1, 2019, Pure Premium Rate Filing to the California Insurance Commissioner. The pure premium rates proposed to be effective January 1, 2019, averaged $1.70 per $100 of payroll.The proposed advisory pure premium rate was 4.5 percent less than the average approved July 1, 2018 advisory pure premium rates.

***Insurance Commissioner action:***

On November 7, 2018, the Insurance Commissioner issued a decision regarding the WCIRB's January 1, 2019, Pure Premium Rate Filing, approving advisory pure premium rates that averaged $1.63 per $100 of payroll. The approved pure premium rate was, on average, 23.5 percent less than the industry average filed pure premium rate as of July 1, 2018, of $2.13 and 8.4 percent less than the average of the approved July 1, 2018, advisory pure premium rates of $1.78 per $100 of payroll.

Source: WCIRB.

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# SPECIAL REPORT: EVALUATION OF SB 863 MEDICAL CARE REFORMS

## Introduction

California's workers' compensation (WC) program provides medical care and wage-replacement benefits to workers who suffer on-the-job injuries and illnesses. Injured workers are entitled to receive all medical care reasonably required to cure or relieve the effects of their injury with no deductibles or copayments. Over the years, WC medical care expenses have fluctuated. Total medical expenses increased by 24 percent from 2007 to 2011, with particularly significant increases in medical cost containment expenses and medical-legal costs. The latest WC medical care reforms were enacted by Senate Bill (SB) 863 in 2012.

The intention of SB 863 provisions was to constrain the rate of increase in medical expenses through a combination of measures designed to improve the quality, efficiency, and timeliness of medical care given to injured workers through improvements in the fee schedules and dispute resolution processes and increased accountability and oversight.

Key SB 863 provisions include:

- *Fee Schedule Changes*. Changes in the Official Medical Fee Schedule (OMFS) were designed to promote the efficient delivery of medical care. These changes include modifications to the inpatient hospital and ambulatory surgery facility fee schedules effective January 1, 2013, replacement of the existing OMFS for physician services with a Resource-Based Relative Value System (RBRVS) fee schedule effective January 1, 2014, and development of new fee schedules for home health care, copying services, and interpreter fees.

- *Medical Provider Networks (MPN).* SB 863 aimed to improve the operation and oversight of medical provider networks (MPNs). Since January 1, 2004, injured workers of employers with MPNs have been required to use network providers throughout the course of the treatment. The SB 863 provisions, including medical access assistants for injured workers, written contracts between MPNs and providers including language that providers will follow Medical Treatment Utilization Schedule (MTUS) guidelines, and additional oversight by the Division of Workers' Compensation (DWC) over MPN lists of providers, took effect January 1, 2014.

- *Medical-Legal Evaluations*. Improving the process of medical-legal evaluation included addressing deficiencies in the composition of qualified medical evaluator (QME) panels, streamlining the process and timelines for evaluations by agreed medical evaluators (AME) and QMEs, and increasing DWC oversight of the evaluators and their decisions; these regulatory changes took effect September 16, 2013. With respect to medical necessity disputes, the Independent Medical Review (IMR) process replaced the AME/QME process. Effective July 1, 2103, an evaluator no longer provides an opinion on any disputed medical treatment issue; evaluators continue to be needed to provide an opinion about whether the injured worker will require future medical care to mitigate the effects of an industrial injury.

- *Independent Medical Review (IMR).* Replacing the existing dispute resolution process with IMR was intended to improve the quality and timeliness of the process for resolving medical necessity determinations. The IMR process took effect January 1, 2013, for injuries that occurred in 2013 and


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on July 1, 2013, for any adverse utilization review (UR) decisions communicated on or after that date, regardless of the year in which the injury took place.

- *Independent Bill Review (IBR).* SB 863 provisions established requirements for bill submissions and processing to improve the timeliness of payment for medical treatment and implemented the IBR process to resolve payment disputes. The IBR process was effective for services furnished on or after January 1, 2013.

**Study Objectives**

The report used two types of analyses. The first type includes analyses of specific SB 863 provisions, for example, specific fee schedule changes, with the goal of describing how the provision in question is related to changes in WC-paid medical care utilization and spending. The second type includes analyses of SB 863 as a whole. These "consolidated" analyses rely on pre-post comparisons with control groups to identify changes in medical care utilization, medical care spending, and work-related outcomes.

**Research Questions**

The report addresses the following main research questions:

1. How has medical care utilization and spending changed over the SB 863 implementation period in terms of both overall levels (i.e., utilization and spending per injury) and the mix of services?

2. How have utilization and spending changed for specific medical care services affected by the implementation of RBRVS? What are the overall impacts of the transition to RBRVS?

3. Did other specific fee schedule changes introduced in SB 863—including changes to inpatient hospital and ambulatory surgery center services and the medical-legal fee schedule—change utilization and spending on these and related services?

4. How did changes in the IMR process affect IMR and UR frequency and other outcomes?

5. Was SB 863 associated with changes in earnings and return to work for injured workers, after unrelated trends through comparison to control workers are controlled for?

6. Was SB 863 associated with changes in medical care utilization and spending for injured workers, after unrelated trends through comparison to control patients are controlled for?

**Data Source**

The primary data source for the study come from the Workers' Compensation Information System (WCIS) database maintained by the DWC for services provided from 2007 to 2015.

**Summary of Findings**

*Medical care utilization and spending.* RAND found significant changes in utilization and spending medical services affected by SB863.

Spending on evaluation and management (E&M) office visits (per injured worker within 12 months of injury) increased by 37 percent from 2013 to 2014, as higher payment rates under RBRVS for these services went into effect and as providers started billing for consultation visits using these codes. Utilization for the same E&M services measured in the same way increased by 11 percent. When all E&M services are combined, however, the increases from 2013 to 2014 were smaller: spending increased 24 percent, and volume rose 3 percent.

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*RBRVS implementation and transition.* After the RBRVS is fully implemented in 2017, payments under RBRVS will be set at 120% of Medicare payment rates in July 1, 2012, before application of an inflation factor and a relative value scale adjustment factor.

The transition to RBRVS increased payments for E&M services, which are commonly delivered by general practitioners, and lowered payments for specialists. From the perspective of an individual provider, the net impact of the transition to RBRVS depends on the provider's mix of services before the transition and the change in rates for these services. The transition to RBRVS from 2013 to 2014 shifted the distribution of payments and volume of WC services in California. E&M visits accounted for a larger share of total payments and spending in 2013 and 2014.

The change in volume and payment for medical services varied significantly from 2013 to 2014 across different types of services. Payments for E&M services accounted for a larger share of total payments in 2014 than in 2013 (36.2 percent versus 29.5 percent). The volume for E&M services increased much more modestly (by less than one percentage point), which suggests that the increase in payment was driven by higher prices under RBRVS.

***Other Specific Fee Schedule Changes***

*Inpatient hospital schedule.* RAND found a reduction in inpatient hospital stays per claim beginning in 2011. Spending per claim peaked in 2011 at $269.44 and fell each successive year. In 2014, spending per claim for inpatient hospital services was $196.62, or 73 percent of the level in 2011. Across all inpatient stays in acute care hospitals subject to the OMFS for inpatient hospital services, from 2012 to 2014 total discharges decreased 12.6 percent, whereas total allowances decreased 5.0 percent.

*Ambulatory Surgery Center (ASC) schedule.* The fee schedule comparison also highlights the generosity of the OMFS ASC facility allowances relative to other Medicare-based fee schedules. In addition to the overall finding that estimated payments are 138 percent of the Medicare ASC allowances, the differences across types of procedures are of concern. SB 863 reduced the aggregate allowance for ASC facility services to 80 percent of the Medicare's hospital outpatient prospective payment system (OPPS) rate.

The Medicare ASC fee schedule is designed to create neutral incentives regarding where services are rendered. In contrast, the current OMFS provides incentives that are inconsistent with the efficient delivery of medically appropriate services in the least costly setting. These incentives drive device-intensive procedures to take place in the hospital and shift services commonly performed in an office setting to ASCs. Both incentives potentially increase WC expenditures for ambulatory surgery.

RAND analyzed the potential alternatives to current policies on OMFS facility fees for ASC surgical services. It considered the following options for refining the OMFS:

- Continue to pay using the OPPS framework, including the Comprehensive Ambulatory Payment Classifications (C-APC) bundling policies. This represents no change in OMFS policies for ASC facility fees.
- Continue to pay using the OPPS framework but determine allowances for procedures without the C-APC bundling policies. This would continue to use the current OMFS policies to determine the other factors that affect the allowances and represents the smallest change from pre-C-APC policies.
- Determine the allowances for ASC services based on 120 percent of the Medicare fee schedule for ASC facility services. This would conform the OMFS allowances for ASC facility services to the Medicare ASC fee schedule.

*Medical-Legal Fee Schedule.* The medical-legal (ML) fee schedule has not been updated since 2007, whereas estimated payments for E&M services were projected to increase when the RBRVS was fully implemented, before further adjustments for inflation. Instead, RAND found that the cost of $250 per hour used to determine the ML allowances is significantly higher than the allowances for E&M services that consist of similar activities after the full transition to RBRVS in 2017. Although this might lead to the

conclusion that no changes are needed in the ML fee schedules until the RBRVS fee schedule levels catch up to the ML fee schedule, RAND concluded that doing so would not be appropriate in light of the increase in the number of ML 104 evaluations and the number of units per evaluation. Despite these increases, the number of subsequent follow-up evaluations has also increased significantly. Together, the trends suggest that the allowances for extraordinarily complex evaluations should be restructured.

RAND discusses several considerations that might motivate the efficient completion of high-quality evaluations, including flat rates for complex ML 104 evaluations, limitation of supplemental reports, performing all diagnostic testing before an evaluation, and orderly control over medical documentation.

*Medical Necessity Dispute Resolution Process and IMR and UR frequency*. The medical necessity dispute resolution process begins with UR of medical care provided to an injured worker. Only a physician can issue an adverse UR decision to modify or deny the requested treatment. SB 863 streamlined the medical necessity dispute resolution process and shifted responsibility for resolving the disputes from WC administrative law judges to medical experts. The DWC contracted with Maximus to perform the independent medical review organization functions.

The issues that occurred when the IMR process was implemented have largely been addressed. Maximus has eliminated the initial backlog of IMR reviews and is issuing IMR decisions in a timely fashion after the supporting documentation is submitted by the claims administrator. Effective January 1, 2018, SB 1160 revises the Labor Code to require that the employer electronically submit the required medical documentation within 10 days of being notified that a request for IMR has been approved and has been assigned to the independent medical review organization, with copies to the employee and the requesting physician. The penalties for not complying with the IMR notice and reporting requirements were also strengthened.

Most claims administrators are processing UR requests in a timely way, but some claims administrators are not doing so or issuing UR decisions for a significant percentage of their UR requests, and the same is true for some UROs. Claims administrator practices vary widely in terms of the proportion of requests for authorization approved at the claims adjuster level, and prior authorization policies are fairly limited. Both policies have implications for administrative costs and medical cost containment expenses.

The SB 1160 provision requiring the electronic submission of UR documents to the DWC offers an opportunity to introduce more performance accountability to the system and more transparency about how the UR process actually functions.

*Earnings Losses and Return to Work after Medical Delivery Reforms in SB 863.* SB 863 included several modifications to the system for assigning disability ratings to injured workers and the law governing the level of benefits paid to a worker with a given disability rating. Some adjustment factors were increased substantially, meaning that most workers would receive higher permanent disability (PD) ratings for a given impairment rating. Also, the minimum and maximum weekly permanent partial disability (PPD) benefits were increased for the first time since 2006. RAND also points out that the Return to Work benefit avoids creating a work disincentive for employees (as might be the case if eligibility were simply tied to the worker's post-injury earnings).

RAND modeled several methods to examine employment and earnings. It found that economic outcomes for injured workers trended downward between 2010 and 2012. For injuries that occurred in 2013 and 2014, a clear trend break is apparent, with better outcomes for injuries in 2013 and a flatter trajectory for earnings and employment, compared to a downward trend prior to the enactment of SB 863.

**Recommendations**

(To be updated when available)

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# SPECIAL REPORT: EVALUATION OF THE RETURN-TO-WORK FUND IN CALIFORNIA'S WORKERS' COMPENSATION SYSTEM

## Introduction

In September 2012, California enacted Senate Bill 863, a major workers' compensation reform bill. The Return-to-Work (RTW) Fund was created under Labor Code Section 139.48 as one of the components of SB 863. This section requires that the Department of Industrial Relations (DIR)'s Return-to-Work Supplemental Program (RTWSP) administer a $120 million fund for the purpose of making supplemental payments to workers whose permanent disability benefits are disproportionately low in comparison to their earnings losses. Injured workers may be eligible for a one-time $5,000 Return-to-Work supplement if they have a date of injury on or after January 1, 2013, and have received a Supplemental Job Displacement Voucher (SJDB) because of that injury. The benefit is administered by DIR's RTWSP in accordance with the regulations implemented on April 13, 2015, and amendment effective March 20, 2017[57].

A prior CHSWC study[58] pointed out that the RTW Fund is a highly progressive benefit that greatly assists low wage workers. However, stakeholders have raised concern that not all workers who are eligible for supplemental payments from this fund are applying for these payments, and the appropriate level of the benefit is also under discussion.


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In 2016, Senator Tony Mendoza requested that CHSWC conduct a review of the RTW Fund. CHSWC commissioned RAND to conduct the study to assist with assessment of the fund's payments to injured workers.

## Study Objectives

The main objectives of the study are to:

A. Evaluate the adequacy and equity of the RTW Fund benefit.
B. Identify any practices and policies that would improve the adequacy, equity and efficiency of administration of the RTW Fund.

## Research Questions

The study addresses these study objectives through the following main research questions:

- How many workers are eligible for, apply for, and receive the RTW Supplement?
- Does the RTWSP accurately target workers whose permanent disability benefits are disproportionately low in comparison to their earnings loss?
- Are the RTWSP and its related processes vulnerable to fraud and abuse?
- Are barriers to access preventing eligible workers from receiving the RTW Supplement?
- What modifications should DIR consider to help the RTWSP more fully meet its goals?

[57] http://www.dir.ca.gov/ODRegulations/ReturnToWorkRegulations/ReturnToWork.html; http://www.dir.ca.gov/ODRegulations/ReturnToWork/ReturnToWork.html.
[58] http://www.dir.ca.gov/chswc/Reports/2016/WageLossReport_2016.pdf

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**Data Sources**

The quantitative part of the study conducted by RAND uses data from a variety of sources, including the Workers' Compensation Information System (WCIS), program records from the RTWSP, the Electronic Adjudication Management System (EAMS), the Disability Evaluation Unit (DEU), data on use of SJDB vouchers from a convenience sample of claims administrators, and several auxiliary data sets from public sources.

In addition to the quantitative analysis, RAND also conducted a thorough analysis of the program's operations since its inception, which included a review of regulations and practices governing the RTWSP, and held a Technical Advisory Group meeting on January 23, 2018, to obtain input on interim findings and potential modifications.

**Summary of Key Findings**

- The RTWSP is targeting the intended population: workers with more severe disabilities, who are less likely to return to work and thus may face disproportionate earnings losses.
- Program administration is efficient and rapid, with little evidence of fraud or abuse.
- Although the take-up by eligible workers has increased significantly over the life of the program, just over half of eligible workers apply for the RTWSP.
- The population eligible for the program is larger than was expected when the program was established, and increasing receipt of the SJDB voucher may contribute to continued eligibility growth.
- Language and geography were not as important as legal representation in determining which eligible workers applied for the RTWSP.

**Summary of Key Recommendations:**

- Make RTW Supplement payment automatic upon SJDB voucher issuance to ensure that the RTWSP reaches the full population of eligible workers.
- Improve notification and awareness of the program to increase take-up among eligible workers under current law.
- Improve monitoring of the SJDB voucher issuance to track emerging changes in the RTWSP-eligible population.
- Better empirical evidence on effectiveness of the SJDB is needed to assess whether the RTWSP promotes better employment outcomes by encouraging greater SJDB utilization.

*For further information.....*

"Evaluation of the Return-to-Work Fund in the California's Workers' Compensation System: Performance to Date and Options for Modification," RAND, 2018.
https://www.dir.ca.gov/chswc/meetings/2018/Eval-RTW-Fund-Report-2018.pdf

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# SPECIAL REPORT: BENEFITS AND EARNINGS LOSSES FOR PERMANENTLY DISABLED WORKERS IN CALIFORNIA: TRENDS THROUGH THE GREAT RECESSION AND IMPACTS OF RECENT REFORMS

## Introduction

CHSWC asked RAND to study the impact of Senate Bill (SB) 863. SB 863 raised the minimum and maximum weekly wage used for calculating benefits. The reforms also effectively eliminated the future earning capacity (FEC) adjustment, used to adjust the disability ratings for certain types of injuries. Finally, SB 863 created the Return-to-Work (RTW) Fund, which offers a supplemental payment to workers who do not receive a qualified RTW offer from their employer. Although these changes would clearly increase benefits, the provisions had the potential to affect groups differently and to interact in complex ways. The ultimate effect of SB 863 on the generosity of benefits was impossible to predict without detailed analysis.


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## Summary


According to the report "Benefits and Earnings Losses for Permanently Disabled Workers in California: Trends through the Great Recession and Impacts of Recent Reforms," by RAND researchers, California workers' compensation law, which is intended to help permanently disabled workers replace lost earnings, is likely succeeding in providing additional benefits. The RAND team also determined that the Great Recession had a severe impact on the earnings of permanently disabled workers, making the higher benefits provided under the recent reforms particularly important for maintaining adequate levels of wage replacement.

The study sought to:

- Pose three questions: How large were earnings losses for permanently disabled workers under SB 899? How did Permanent Partial Disability (PPD) benefits under SB 899 compare with earnings losses? Finally, would the increase in benefits under SB 863 lead to adequate wage replacement?
- Answer these questions, by estimating earnings losses for permanently disabled workers injured during the eight years leading up to SB 863 (2005 – 2012), when benefits were determined according to SB 899 and other prior laws.
- Analyze SB 899's impact on wage replacement by simulating what those same workers would have received if SB 863 had been in place. Comparing these simulated benefit levels with actual data on earnings losses allowed the research team to describe how SB 863 is likely to change the wage replacement rate (the most commonly used measure for evaluating benefit adequacy).


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## SPECIAL REPORT: BENEFITS AND EARNINGS LOSSES FOR PERMANENTLY DISABLED WORKERS IN CALIFORNIA: TRENDS THROUGH THE GREAT RECESSION AND IMPACTS OF RECENT REFORMS

Key Findings and Recommendations:

- Permanently disabled workers have large and persistent earnings losses.
- Earnings losses grew much more rapidly than PPD benefits during the Great Recession, and, as a result, wage replacement rates fell.
- SB 863 raised wage replacement rates by more than 21 percentage points from 58.8 percent under SB 899 to 80.2 percent under SB 863. The researchers' analysis suggests that SB 863 is likely to meet its primary objective of restoring adequate wage replacement rates
- The Return-to-Work (RTW) Fund is especially important for low-wage workers, for whom the RTW benefit had the largest benefit. RAND researchers found that the RTW Fund is highly progressive, both because the value of the benefit is fixed regardless of the workers' income level and because low-wage workers experience worse RTW outcomes than higher-wage workers do. From a policy perspective, the effect of the business cycle on earnings losses may provide an additional rationale for targeting benefits toward more vulnerable groups.
- Permanently disabled workers experienced much more severe earnings losses if they were injured after the beginning of the Great Recession than before it, which suggests that the economic downturn affected injured workers more than uninjured workers.

*For further information …*

"Benefits and Earnings Losses for Permanently Disabled Workers in California: Trends through the Great Recession and Impacts of Recent Reforms," RAND, 2016.
http://www.dir.ca.gov/chswc/Reports/2016/WageLossReport_2016.pdf

The link to the Research Brief is as follows:
http://www.dir.ca.gov/chswc/Reports/2016/Wage_Loss_Research_Brief.pdf

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# SPECIAL REPORT: JANITORIAL TRAINING PROJECT

## Introduction

On September 15, 2016, California Governor Jerry Brown signed into law AB 1978, a bill that established protection against harassment and sexual violence in the workplace for custodial staff. The law focuses on addressing sexual assault and harassment of workers, mainly undocumented female janitors, at night in empty buildings who often do not report the incidents out of fear of deportation or losing their job. AB 1978 protects janitorial workers by requiring employers to register annually with the Labor Commissioner to ensure employer compliance with this bill, starting July 1, 2018, and mandating that the Division of Labor Standards Enforcement (DLSE) establish a biennial in-person sexual violence and harassment prevention training program requirement for employees and employers.

The DIR, in collaboration with the Commission on Health and Safety and Workers' Compensation (CHSWC), has contracted with the Labor Occupational Health Program (LOHP) at UC Berkeley to develop the janitorial training program for janitors and supervisors on sexual harassment. To develop the training programs LOHP will use written materials developed by DIR, which may include a factsheet for workers and a factsheet for supervisors on sexual harassment and AB 1978 requirements. LOHP will provide suggestions on the content of the written materials developed by DIR, based on its work with janitors on this issue. The training program, which will use interactive methods, is aimed at helping workers play an active role in preventing and addressing workplace issues. The training format and delivery methods will be designed with an eye toward feasibility and practicality.

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## Project Objectives

The main objectives of this project are to:

- Develop a training program and short video for janitors on sexual harassment and assault, based on the requirements of the new regulations in AB 1978, and provide four "Training-of-Trainers" (TOT) sessions for worker leaders, worker representatives, and others so that they are prepared to train workers.
- Develop two training activities that can be included in the supervisor training program.
- Develop a lesson plan for a supervisor training program on sexual harassment.

**Status:** In Process

*For further information…*
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1978/.

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# SPECIAL REPORT: QUALIFIED MEDICAL EVALUATORS: UPDATING TRENDS IN EVALUATIONS, AVAILABILITY, AND EQUITY

## Executive Summary


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The Qualified Medical Examiner (QME) process is at the heart of the California workers' compensation dispute resolution process. The current process is the result of a series of reforms over the past 15 years that were meant to improve the delivery of medical-legal evaluations expeditiously and equitably for both parties.

This QME report updates the original 2010 review of the QME process for the Commission. The update was requested by Senate Committee on Labor and Industrial Relations Chair Tony Mendoza on October 17, 2016, and was approved by the Commission on December 9, 2016. The report examines how the QME process has changed over the past decade (2007-2017), with special attention on the issues raised in the previous report.

UC-Berkeley used extensive electronic administrative data made available by the Division of Workers' Compensation (DWC) Medical Unit and Disability Evaluation Unit (DEU), supplemented with summary data from several sources. The study covers the period from 2007 through 2017, during which much of the evolution occurred after the 2004 reforms, which introduced utilization and treatment guidelines, a new permanent disability rating schedule based on the AMA Guides, and changes in how parties in represented cases can select QMEs. Subsequently, SB 863 made additional important changes, including the Independent Medical Review (IMR) process, which was anticipated to replace the need for medical-legal exams to decide treatment issues. SB 863 also imposed restrictions on the number of locations at which QMEs could schedule exams.

*Key Findings in This Study*

- The number of providers registered as QMEs continues to decline (17% since 2007), but less rapidly than it did prior to 2007.
- The number of requests for QME panels has increased rapidly, 87 percent since 2007.
- The decline in QMEs and increase in panel requests means that the number of requests per QME has doubled (+101%).
- Coupled with a continuing increase in the average paid amount for QME reports, the average QME earns 240 percent more from panel reports now than in 2007.
- All the increase in panel requests is from represented track cases, up 400 percent despite the elimination of panels for most medical treatment issues (replaced by the IMR process). This increase was equally driven by requests from both applicants and defendants.
- Panel requests for unrepresented cases declined 55 percent, driven entirely by a decline in requests by injured workers. The number of requests by claims administrators in unrepresented cases changed little.
- The DWC began collecting the reasons for panel requests on represented cases in 2015. Those data show that the primary reasons for panels are: compensability (42.5%), permanent disability (21.4%), and Permanent & Stationary (P&S) status (11.4%).

In response to the earlier study, SB 863 placed limits on the number of locations (10) at which QMEs can be registered. This has had the effect of distributing QME panels more evenly and widely among registered providers.

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- Very-high-volume QMEs (with 11-100+ registered locations) have been eliminated.
- However, a high proportion of panel assignments (55%-60%) are still assigned to the busiest 10 percent of QMEs, nearly all of whom have exactly 10 offices and are in orthopedic specialties.
- Unlike the very-high-volume QMEs studied earlier, the top 10 percent and 5 percent of QMEs by the number of panels in the current system produce reports that show less bias. Even the top 5 percent of QMEs by volume give ratings that are only slightly more conservatively than average.

Access to QMEs does not appear to be an important current problem, but some signs indicate that delays in getting an evaluation may be developing.

- Orthopedic specialties are under-represented among registered QMEs relative to requests.
- The number of panels for which a subsequent panel is requested because the QME was not available within 60 days (a measure of access), while still low, has increased from 1 percent to 2.8 percent for unrepresented cases and 0.7 percent to 4.7 percent for represented cases. Almost all of this increase took place from 2013 to 2016.

The DWC has made an effort to eliminate providers who are accused or convicted of fraudulent activity or violations of professional standards from the workers' compensation system. This study examined the activity of these doctors in the QME process and how their suspension may affect QME evaluations. This study found:

- Of providers suspended or restricted under Labor Code sections 139.21 and 4615, 41 were registered as QMEs at least one year between 2007 and 2016.
- They represented a small minority of all QMEs (1.6%) and were assigned to a minority of the three-doctor panels (4.6%).
- Although these percentages are low overall, in some areas problem providers appear to be concentrated and present a special problem. The pain specialties (PAP, MAA, & MPP) stood out, and 40-50 percent of QME panels include at least one restricted or suspended provider.
- The more general pain category (MPA), which is more commonly used now, as well as Physical Medicine and Rehabilitation (PM&R) and Internal Medicine-Hematology (MMH) had 15-17 percent of panels with a restricted or suspended provider.
- Overall, the restricted and suspended doctors gave much more generous evaluations to injured workers than the average QME: higher ratings, less frequent use of apportionment, and more frequent Almaraz ratings.

**Recommendations for Possible Modifications in the QME Process and Future Monitoring**

- The DWC could use QME registration data linked with WCIS medical-legal payment data to examine whether the increases observed in average cost of medical-legal reports is driven primarily by providers acting through aggregators.
- The very high concentration of restricted and suspended doctors in the pain specialties suggests that the DWC could examine the costs and benefits of maintaining separate pain specialties in the QME system. If the specialties are retained, the DWC could concentrate special monitoring and outreach to this community of providers and related professional associations. This could involve additional testing and/or other restrictions on registering for these specialties
- The number of QMEs who are unavailable in the 60-day period is still small, but the recent increase suggests the need for continued close monitoring by the DWC, with special attention on the orthopedic specialties.

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The DWC should consider eliminating the requirement that unrepresented workers serve the claims administrator with notice and confirm the proof of service under penalty of perjury. This may be intimidating workers and reducing their use of the QME process when challenging the primary treating physician's (PTP's) findings. The DWC could supply notice to the claims administrator and eliminate the need for workers to do so.

***Advancing the Division of Workers' Compensation's Research Efforts***

The Division is hampered in evaluating how efficient and equitable the QME system is in evaluating issues of compensability, permanent disability (PD), and future medical because of substantial gaps in the data on which claimants are evaluated by QMEs and which of those evaluations are rated by the DEU.

- The DWC should consider drawing a random sample of initial workers' compensation first reports of injury and examine how they are resolved, including issues of compensability and permanent disability. Key questions could include:
    - What are the characteristics of claims and claimants using the QME process vs. resolving disputes based on the PTP's report?
    - What are the characteristics of PD claims and claimants who are rated by the DEU vs. other sources such as the claims administrator in unrepresented cases and private raters or the parties in represented cases?
- The DWC should consider identifying more information about the operation of aggregators managing the QME location and appointment process. The consolidation of QMEs under a small number of aggregators with a substantial share of the market may be having an impact on the system.
- The DWC should collect electronically the reason for panel requests in unrepresented cases, similar to the data collected on represented cases. The main reasons for requesting a QME panel are already included on the documentation submitted by workers and claims administrators.

*For further information…*
"Qualified Medical Evaluators: Updating Trends in Evaluations, Availability, and Equity."
University of California, Berkeley, 2017.
http://www.dir.ca.gov/chswc/reports/2017/QME_2017_Trends.pdf

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# SPECIAL REPORT: AGING IN THE WORKPLACE: PROMOTING SAFE AND HEALTHY WORKPLACES FOR EVERYONE

## Introduction

The Commission on Health and Safety and Workers' Compensation (CHSWC) convened a roundtable discussion on Health and Safety and the Aging Workforce on November 13, 2015, facilitated by the Labor Occupational Health Program (LOHP) at the University of California, Berkeley.

The purpose of the roundtable was to promote model programs, best practices, and messages that promote the health and safety of the aging workforce, use the experiences of older workers to promote workplaces that are healthy and safe for everyone, promote return-to-work policies that bring injured older workers back into the workforce, and develop recommendations and policies that help achieve age-friendly workplaces. Participants included representatives from unions, community organizations, private businesses, employer associations, insurance agencies, universities, and state agencies.

## Research and Statistics on Older Workers

A review of research found that older workers represent a significant and increasing percentage of the workforce. As the older worker population continues to grow, ensuring the health and safety of older workers will be increasingly important. In order to promote the well-being of the aging workforce, the health and safety issues facing older workers need to be addressed.

Although older workers in general are not at a higher risk of occupational injury, the relationship between age and nonfatal occupational injury and illness is complex, and the average trends may not apply to a particular occupational class, industry, or injury type. For example, farming is more risky for older workers, and older female workers experience a higher rate of injury than their male counterparts. Older workers tend to incur bruises and contusions, fractures, and multiple traumatic injuries at higher rates than younger workers and workers overall.

Although older workers may have lower overall rates of nonfatal occupational injuries, injuries among older workers are much more likely to be fatal. The workplace fatality rate among workers age 65 and over is nearly three times that of workers under 65. The majority of fatalities among older workers are the result of primarily of transportation incidents (43 percent) and secondarily by falls, slips, and trips (21percent). Recovery time following a nonfatal workplace injury also tends to increase with age.

Because the frequency of nonfatal injuries among older workers is relatively low and older workers do not dominate the workforce, the increase in workers' compensation costs resulting from an older workforce is expected to be modest.

## Age-Friendly Workplace

An age-friendly workplace is one that promotes and preserves the ability to work safely among all workers as they age. This is done though workplace practices and policies that match the work to the worker and that create a culture of health throughout the workplace. Age-friendly workplaces employ strategies that take advantage of older workers' strengths, such as their experience and institutional knowledge, while finding workable solutions to their challenges, such as diminished physical capacity. Employers that establish age-friendly workplaces stand to benefit from the increased safety, productivity, and competitiveness of their workforce.

According to the report authors, the most comprehensive framework for designing an age-friendly workplace comes from a curriculum developed by the University of Washington (www.agefriendlyworkplace.org). To develop an age-friendly workplace that preserves the capacity of workers to work safely and effectively as they age, the University of Washington recommends employers

focus on enhancing four workplace variables: work environment, health promotion and disease prevention, work arrangements, and community social support.

An age-friendly work environment is an environment in which the jobs, equipment, tools, and workstations are designed to match the physical and psychological needs of workers. Age-friendly enhancements to workplace health promotion and disease prevention focus on integrating health and safety programs with workplace wellness programs and promoting a culture of health that incorporates strategies across homes, communities, and the workplace. Establishing age-friendly work arrangements involves developing human resource policy options that adapt a worksite to the interwoven demands of family, life, and work that change as people age. Age-friendly community social support refers to strategies for influencing the larger community environment through public policies and programs that support older workers in the workplace. The curriculum includes examples from BMW, Scripps Health, a Dutch construction company, Accenture, BP, GE, IBM, and Procter & Gamble.

**Recommendations That Support the Occupational Safety and Health Needs of Older Workers**

Companies can voluntarily choose to design age-friendly workplaces, but the promotion of age-friendly workplaces on a broader scale will likely require legislative or regulatory action.

During the roundtable discussion, small groups met to brainstorm policy, education, and research recommendations for initiatives the state could take to promote safe and healthful, age-friendly workplaces. Policy recommendations included universal design, workload standards, training programs, family and sick leave, age privacy/blindness in workers' compensation underwriting, and integration with health-care programs. Among the education/outreach recommendations were a needs assessment, communications strategy and campaign, and an information clearinghouse on the aging workforce. Research recommendations comprised improved data sharing among state agencies, addressing underreporting of injuries and illnesses, and evaluating production standards for health impacts on the aging worker.

**Conclusion**

These recommendations in the areas of policy, education, and research not only promote the health and safety of older workers but help protect the health and safety of all workers. The authors write that, because CHSWC is charged with examining health and safety and workers' compensation systems in California and recommending administrative or legislative modifications to improve their operation, the Commission is in a unique position to play a leadership role in bringing about the recommended initiatives.

*For further information…*

> "Aging in the Workplace: Promoting Safe and Healthy Workplaces for Everyone: A Report from a Roundtable Discussion Convened by the Commission on Health and Safety and Workers' Compensation," prepared and submitted by the Labor Occupational Health Program at the University of California at Berkeley, November, 13, 2015.
> http://www.dir.ca.gov/chswc/Reports/2016/AgingWorkforce.pdf

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# SPECIAL REPORT: HEALTH AND SAFETY TRAINING FOR CHILD-CARE WORKERS

## Background

According to the Labor Occupational Health Program (LOHP), in 2015-2016 the Service Employees International Union (SEIU), with funding from the California Community College Chancellor's Office and the California Workforce Development Board, developed a curriculum for teaching child-care workers in family day-care settings about workplace health and safety.[59]

In 2017, Assemblyperson Monique Limon sponsored Assembly Bill (AB) 676 which proposed an Early Educators' Occupational Safety and Health Training Program. She also requested that CHSWC develop a model-training curriculum for occupational safety and health training for early care and education workers and employers, with the goal of prevention and reduced costs for employers and employees.

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## Training Curriculum

In 2018, CHSWC funded a study for LOHP to assess the effectiveness of the SEIU-created curriculum and training and to develop and pilot a proposed expanded curriculum for center-based and school-based child-care centers in California, adopting some training elements from AB 676 and acknowledging the work of the California Childcare Health Program at the University of California, San Francisco.[60]

That study is currently in progress with the following objectives:

- Review and assess the effectiveness of existing health and safety curriculum for family day-care providers developed by SEIU.
- Adapt that curriculum for child-care workers in center- and school-based settings.
- Provide two training of trainer (TOT) programs in English and Spanish to prepare trainers to conduct the health and safety training.
- Develop a dissemination plan and begin a limited rollout.
- Assess effectiveness of TOT and of initial dissemination/outreach plan.

The curriculum developed is expected to be posted on the CHSWC website in English and in Spanish in 2019.

Status: In Process

[59] http://seiuearlyeducatortraining.org/
[60] https://cchp.ucsf.edu/sites/cchp.ucsf.edu/files/PHT-curriculum-2018-FINAL.pdf

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# SPECIAL REPORT: CALIFORNIA OCCUPATIONAL RESEARCH AGENDA

## Background

Despite the gains California has made in occupational safety and health over the years, according to recent data 376 workers died from injuries sustained on the job, over 650,000 filed workers' compensation claims for non-fatal injuries, and workers' compensation system costs exceeded $24 billion. Occupational injuries and illnesses in California take a substantial toll on workers, who lose worktime and wages and may suffer permanent disability or even death. Employers are also negatively affected by lost productivity and higher workers' compensation insurance premiums.

To help address these issues, the Department of Industrial Relations (DIR)/Commission on Health and Safety and Workers' Compensation (CHSWC) and its partners, the California Department of Public Health's Occupational Health Branch (CDPH OHB) and the University of California's Centers for Occupational and Environmental Health (COEH), are collaborating to identify a set of research priorities specific to the needs of California's workforce.

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## Objectives

The objectives of this project include:

- Reviewing and summarizing current illness and injury data and National Occupational Research Agenda (NORA) topic areas relevant to California
- Identifying and recruiting stakeholders to assist in determining the regional workplace and workforce issues and research needs specific to California
- Developing, conducting, and summarizing an online survey of identified stakeholders in California
- Convening a roundtable of key stakeholders to review survey results and data summary and provide input on key themes that should be included in a California Occupational Health Research Agenda
- Developing a final report that describes the selected research priorities and suggested next steps in developing and implementing a statewide California Occupational Research Agenda (CORA) program to identify key research needs and fund occupational health research.

**Status**: In process.

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# SPECIAL REPORT: OVERVIEW OF THE BEHAVIORAL HEALTH OF FIRST RESPONDERS IN CALIFORNIA USING PTSD-RELATED WORKERS' COMPENSATION CLAIMS DATA

## Background

In May 2017, Assemblymember Tim Grayson (District 14 and author of AB 1116) requested that the Commission on Health and Safety and Workers' Compensation (CHSWC) gather data and conduct a study on occupational behavioral health for emergency response personnel (first responders).


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The issue brief summarized the current peer-reviewed literature, detailed the current medical guidance for treatment, analyzed workers' compensation claims data, examined existing treatment models for consideration, and discussed trends in legislation on the topic in other states and differences between California's laws and legislation in those states.

The brief began with the definition of post-traumatic stress disorder (PTSD) according to the American Psychiatric Association and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). After citing figures for diagnoses in the U.S. population, the brief suggests that a cultural shift ("it's okay not to be okay") is widely acknowledged as necessary before emergency responders will take advantage of peer counseling services.

The Medical Treatment Utilization Schedule (MTUS) offers guidance for workers' compensation (WC) doctors to ensure the streamlined delivery of medical treatment for behavioral health disorders, such as PTSD. Through a combination of MTUS guidelines and the MTUS medical evidence and search sequence, appropriate guidance is available to address any condition.

For the analysis, staff used data from the Workers' Compensation Information System (WCIS) for claims and bills reported with a date of injury between January 1, 2012, and December 31, 2016. To isolate PTSD-related claims, staff relied on diagnosis code PTSD (ICD-9 diagnosis code 309.81; ICD-10 diagnosis codes F431 [F43.1], F4310 [F43.10], F4311 [F43.11], F4312 [F43.12]). To isolate the first-responder cohort, claims were identified using NAICS codes 922120, 922160, 922190, and 621910. The resulting small sample size ($N$ = 133) of eligible cases reported for first-responder PTSD WC claims suggests that findings should be interpreted with caution.

## Findings

Nearly half (47%) of first-responder PTSD claimants were 40-49 years old when the injury occurred. In the United States, the median age of firefighters is 38.6 years, and the median age of police officers is 39.7 years. Gender differences among first responders differ from those in all industries, and it follows that the PTSD claims by gender also differed. Although women represent a very small percentage of the first-responder workforce, they represent a higher proportion of PTSD claims. Although men have a higher risk of exposure, women have a higher risk of developing PTSD. For all PTSD claims, other injuries were typically also associated and treated. Medical services for first-responder PTSD WC claims averaged $15,659 per claim. IMR data was also examined and found a higher overturn rate than average for pharmacy (specific drugs not mentioned) and diagnostic testing, but a lower overturn rate than average for psych services.

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**Treatment Programs**

The brief reviewed two treatment programs specifically designed for first responders to attend in California, as well as one other program for veterans and a new diagnostic technology.

**Legislation**

Legislation from other states was reviewed and provided in an appendix.

**Conclusions**

California's MTUS treatment guidelines and medical evidence search sequence offer appropriate guidance for behavioral health disorders, including PTSD. Pursuant to Labor Code section 3208.3, all workers, including first responders, are covered by workers' compensation insurance. The evidence shows that cases are underreported and associated stigma prevents care-seeking behavior in general (including first responders and veterans). The brief concluded that considering the variety of legislative efforts underway across the country, California may benefit from drawing on the examples and the experiences of others.

*For further information …*

Issue Brief on First Responder Behavioral Health (September 2018)

- Assemblymember Timothy Grayson Letter Response about First Responder Behavioral Health - September 2018

Issue Brief on First Responder Behavioral Health (October 2017)

- Assemblymember Timothy Grayson Letter Response about First Responder Behavioral Health (July 2017)
- Assemblymember Timothy Grayson Letter about First Responder Behavioral Health (May 2017)

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# SPECIAL REPORT: ASSESSMENT OF THE SUPPLEMENTAL JOB DISPLACEMENT BENEFIT (SJDB) VOUCHER PROGRAM

## Introduction


***Project Team***

Eduardo Enz
*Executive Officer, CHSWC*

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Senator Lara issued a legislative directive to study the efficacy of the Supplemental Job Displacement Benefit (SJDB) program. Since its creation in 2004, various stakeholders have reported challenges and concerns with the structure of the SJDB. Most recently, in an attempt to ensure that SJDB training providers offer appropriate levels of training, Senate Bill 863 (Statutes of 2012, Chapter 363) modified the SJDB to be a flat benefit with more flexibility in how it could be spent and required that training providers be certified and listed on the California Workforce Investment Board's Eligible Training Provider List. In modifying the SJDB, the Legislature believed that it would streamline benefit administration, improve the ability of injured workers to receive high-quality training, and ensure that some of California's most vulnerable injured workers are able to return to work. Subsequently, some reports from stakeholders suggested the California Legislature's goal had not been fully reached. Therefore, Senator Lara asked the Commission on Health and Safety and Workers' Compensation (CHSWC) to conduct the SJDB study

## Key Findings

- Return-to-Work Supplement Program (RTWSP) $5,000 benefit participation:
  - 47 percent participated in the RTWSP $5,000 benefit
  - 7 percent paid someone to help them apply
- The main reason workers did not apply despite being eligible for RTWSP:
  - 81 percent did not know about the benefit

## Summary

- Characteristics of beneficiaries:
  - SJDB eligibility and payments are increasing.
  - Most (58 percent) beneficiaries are male and the average worker is 43.5 years old and earned around $635 in weekly wages
  - 50 percent lived in southern California (mostly Los Angeles)
  - Manufacturing, retail, and administrative support industries had the greatest share of SJDB recipients
  - 1 in 3 beneficiaries worked in labor and maintenance occupations
- Claims data revealed that strains and lifting injuries, followed by cumulative trauma, were the leading causes of injury and accounted for a greater share of SJDB claimant injuries than workers' compensation claims in general.

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- Program effectiveness:
  - Because these workers were not offered a job with their at-injury employer, securing a new job is critical
  - Less than 50 percent respondents were employed at the time of the survey
  - 50 percent lived in southern California (mostly Los Angeles)
  - Of those eligible for the SJDB who participated in the injured worker survey, only 6 percent indicated they got a new job using the skills they gained
  - In current form, the benefit may not be producing intended results for permanently disabled workers, namely workforce re-entry
- Matching intent with need:
  - Although SJDB payments for Vocational Education and Training (VET) services are issued, anecdotal evidence and survey responses suggest workers are not receiving education or training that leads to employment
  - Given current low unemployment rates, these workers are among a few not succeeding when searching for a job
  - For workers no longer actively seeking employment, perhaps this is because they are unable to work as reported by 28 percent of survey respondents, VET delivered through the SJDB may be ineffective
  - It may be timely to consider alternative benefit options that may better serve these workers

**Status:** Completed.

*For further information …*

A brief titled "Findings of Supplemental Job Displacement Benefits (SJDB) Voucher Program Assessment" dated September 27, 2018, was posted on the CHSWC website.

CHSWC Brief:
https://www.dir.ca.gov/chswc/Meetings/2018/SJDB_assessment.pdf.

Senator Lara's Letter:
https://www.dir.ca.gov/chswc/meetings/2018/Letter-Sen-Lara-RE-SJDB-2-5-18.pdf.

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## *LIST OF PROJECTS AND STUDIES*

CHSWC Projects and Studies are numerous and often build on the previous work initiated in prior years. As CHSWC refined its approach to the study of the workers' compensation and health and safety systems, the projects incorporate that knowledge to develop ever more sophisticated lines of inquiry and research. Further, when changes and additions are made to the systems new lines of inquiry and analysis are warranted. Lastly, when stakeholders or constituents express a compelling concern there are opportunities for detailed investigation. CHSWC readily accesses the expertise of partners and collaborators to challenge and innovate in individual aspects of very complex systems where humans and procedures exchange and interact to achieve the goal of safety and health, return to work, and cost effective risk management.

A complete historical list of projects and studies is provided in the 2017 Annual Report. In this 2018 Annual Report and future Annual Reports, only the current year's projects and studies are described. All Annual Reports can be found at: https://www.dir.ca.gov/chswc/AnnualReportpage1.html

The below categories do not explain how intricate some of the systems and sub-systems can be, but review of the actual reports and studies will demonstrate the on-going need to examine and monitor the efficiency of the administrative function. For reference, we will continue to list the categories of projects and studies and any changes to the categories in future Annual Reports, as follows:

**I. PERMANENT DISABILITY AND TEMPORARY DISABILITY STUDIES**

**II. RETURN TO WORK**

**III. WORKERS' COMPENSATION REFORMS**

**IV. OCCUPATIONAL SAFETY AND HEALTH**

**V. WORKERS' COMPENSATION ADMINISTRATION**

**VI. INFORMATION FOR WORKERS AND EMPLOYERS**

**VII. MEDICAL CARE**

**VIII. COMMUNITY CONCERNS**

**IX. DISASTER PREPAREDNESS AND TERRORISM**

**X. CHSWC ISSUE PAPERS**

**XI. OTHER**

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# 2018 List of Projects and Studies :

### II. RETURN TO WORK

Report on Evaluation of the Return-to-Work Fund in California's Workers' Compensation System: Performance to Date and Options for Modification - Michael S. Dworsky, Denise D. Quigley, Stephanie L. Rennane, Madeline B. Doyle, RAND, 2018
*Status:* Completed
https://www.dir.ca.gov/chswc/meetings/2018/Eval-RTW-Fund-Report-2018.pdf

### III. WORKERS' COMPENSATION REFORMS

Evaluation of SB 863 Medical Care Reforms, RAND
*Status:* Ongoing

### IV. OCCUPATIONAL HEALTH AND SAFETY

Health and Safety Training for Childcare Workers – UC Berkeley (LOHP)
*Status:* Ongoing

### VII. MEDICAL CARE

Medical Care Provided to California's Injured Workers: Monitoring System Performance Using Administrative Data - by Barbara O. Wynn, Andrew W. Mulcahy, Harry H. Liu, Rosalie Malsberger, Edward N. Okeke, RAND, 2018
*Status:* Completed
https://www.dir.ca.gov/chswc/Reports/2018/MedicalCare_IW.pdf

Issue Brief on First Responder Behavioral Health - September 2018
*Status:* Completed
https://www.dir.ca.gov/chswc/Reports/2018/PTSD_September_2018.pdf

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# CHSWC AND THE COMMUNITY

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Oakland, CA 94612

| ***Phone***: | ***FAX***: | ***Email***: |
|---|---|---|
| 510-622-3959 | 510-286-0499 | chswc@dir.ca.gov |


***Internet***:

In 2012, most government departments and agencies were asked by Governor Brown's Office to redesign their public website so that information can be located more efficiently. CHSWC participated in the redesign process and, according to its mandate, continues to post useful information for the public and related stakeholders.

Check out www.dir.ca.gov/chswc for:

- What's New
- Research Studies and Reports by Topic and by Year
- Information Bulletins
- Commission Members
- Meeting Schedules and Minutes
- DIR/CHSWC Young Workers' Program
- Information for Workers and Employers
- Worker Occupational Safety and Health Training and Education Program (WOSHTEP)
- Past Conferences
- Public Comments and Feedback
- Injury and Illness Prevention Program (IIPP) Resources
- School Action for Safety and Health (SASH) Program
- Other Resources

**CHSWC Publications**

In addition to the many reports listed in the CHSWC List of Projects and Studies section of this report, CHSWC has published:

CHSWC Annual Reports, 1994–2015

CHSWC Strategic Plan, 2002

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CHSWC is pleased to acknowledge and thank the following individuals and organizations from the California health, safety and workers' compensation communities.

Their willingness to share the insights and knowledge derived from their years of experience has assisted CHSWC immeasurably in its mission to examine and recommend improvements in the health and safety and workers' compensation systems in California.

**American Medical Association (AMA)**

**American Insurance Association**
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Participants in CHSWC project advisory committees

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