

Workers' Compensation Fraud:

*Detection and Prevention Efforts Are Poorly
Planned and Lack Accountability*

Presentation by

California State Auditor

Labor and Industrial Relations

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This presentation document is only intended to outline selected portions of Report 2002-018, *Workers' Compensation Fraud: Detection and Prevention Efforts Are Poorly Planned and Lack Accountability* (April 2004). For a more complete explanation of the points outlined in this document, refer to the report.

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AUDIT SCOPE

BACKGROUND INFORMATION

Section 1872.83 of the Insurance Code requires the Bureau of State Audits to evaluate the effectiveness of the efforts of the fraud commission, the fraud division, the Department of Insurance, and the Department of Industrial Relations as well as local law enforcement agencies, including district attorneys, in identifying, investigating, and prosecuting workers' compensation fraud and employers' willful failure to secure workers' compensation benefits for their employees.

AUDIT HIGHLIGHTS

FRAUD COMMISSION AND INSURANCE COMMISSIONER

The Fraud Assessment Commission (fraud commission) and the insurance commissioner have not adequately implemented a strategy to ensure that funds assessed against employers—averaging approximately \$30 million for each of the past five years—are required and are used in the most effective manner to reduce the costs that fraud adds to the workers' compensation system.

The fraud commission and the insurance commission have not taken the steps necessary to measure the type and extent of fraud in the system or develop a statewide strategy to reduce it.

Shortcomings also exist in the process used to distribute fraud assessment funds to county district attorneys in a way that maximizes their effectiveness in fighting fraud.

DEPARTMENT OF INSURANCE FRAUD DIVISION

Both the fraud division and the review panel (comprising fraud commission members, representatives of the fraud division, the Department of Industrial Relations, and an independent criminal expert) fail to consistently apply criteria or document the rationale they use in making funding recommendations for grant awards.

Controls intended to restrict how county district attorneys use their grants of fraud assessment funds to pay for indirect costs are not always effective.

Because the fraud division has not conducted adequate strategic planning, it has not met all its noninvestigative responsibilities and spends a significant portion of its workers' compensation antifraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by county district attorneys.

Lacking a sound strategic plan, the fraud division dedicates too few of its workers' compensation fraud resources to the noninvestigative activities that its statutory responsibilities demand.

The fraud division could manage its investigative efforts more effectively. For example, during the period we reviewed, 87 percent of the referrals of suspected workers' compensation fraud the division received did not end up in the hands of district attorneys for prosecution.

Because the reporting requirements established by the Department of Insurance are ambiguous, independent audit reports submitted by county district attorneys participating in the antifraud program do not assure the fraud division that the district attorneys use grants of fraud assessment funds appropriately.

The fraud division does not offer insurers an effective system for referring suspected workers' compensation fraud to the fraud division. In fact, some of the larger insurers in the workers' compensation system reported no suspected fraud referrals in 2001 and 2002.

The fraud division's special investigative audit unit does not have a program that effectively targets insurers to achieve maximum compliance with suspected fraud reporting requirements. The unit also lacks a standardized approach to conducting audits, issuing timely reports and conducting follow-up, and providing effective penalties to promote compliance.

DEPARTMENT OF INDUSTRIAL RELATIONS

The Division of Labor Standards Enforcement (DLSE) does not routinely refer its findings of employers failing to provide workers' compensation insurance and benefits to employees to the fraud division for consideration of possible criminal prosecution. During 2003, the DLSE cited nearly 1,300 employers for failing to provide workers' compensation insurance and benefits for their employees. Sharing this information could help the fraud division identify potential workers' compensation fraud.

The Department of Industrial Relations has not implemented three mandated programs that would enhance efforts to identify and prevent workers' compensation fraud. State law requires the Department of Industrial Relations to:

- Establish a program to identify employers that fail to secure workers' compensation insurance for their employees.
- Implement a protocol for reporting suspected medical provider fraud.
- Implement a program to annually warn employers, claims adjusters, administrators, medical providers, and attorneys who participate in the workers' compensation system against committing workers' compensation fraud.

The formulas the Department of Industrial Relations uses to calculate the workers' compensation fraud assessment surcharge rates have, in recent years, consistently resulted in insured employers being overcharged. In addition, the Department of Industrial Relations suspects that not all insurers correctly report and remit all the workers' compensation fraud assessment surcharges they collect from employers.

Workers' Compensation Antifraud Efforts Lack Adequate Planning and Coordination, and Funding Is Not Determined Using Established Priorities

THE FRAUD COMMISSION AND THE INSURANCE COMMISSIONER CANNOT BE CERTAIN THAT FRAUD ASSESSMENT FUNDS ARE EFFECTIVELY USED TO REDUCE FRAUD

The Extent and Nature of Fraud Within the Workers' Compensation System Is Not Adequately Measured or Monitored.

Neither the fraud commission nor the insurance commissioner has made a meaningful attempt to measure how much and what types of fraud exist in the workers' compensation system.

Professionals who study fraud maintain that a systematic measurement of fraud is paramount to identifying the appropriate approach to controlling a fraud problem.

Other Entities Have Devised Ways to Measure Fraud and Noncompliance

The Internal Revenue Service (IRS) has used audits of statistically selected tax returns to gain insight about the level of taxpayers' overall compliance with tax laws, and to design a strategy for enforcement audits that target the returns most likely to be noncompliant, thereby, putting the IRS's limited resources to their best use.

Likewise, Medicare fraud experts cite a review of medical payment transactions as an effective tool in identifying the extent and nature of fraud.

The Fraud Division Has Access to Data That Could Help It Assess the Extent of Workers' Compensation Fraud

The fraud division and the insurance commissioner believe fraud committed by medical care providers and employers is more costly to the workers' compensation system and thus have assigned these types of fraud a higher priority in antifraud efforts.

However, without a systematic measurement of the types of fraud and their magnitude, it is difficult to justify not only current activities but also any shift in focus.

The fraud division could perform a statistically valid analysis to detect potential provider and claimant fraud in the form of indicators of actual or potential fraud for a large percentage of the State's workers' compensation insurance market using the data from as few as 37 insurers.

In 2002, 37 insurers accounted for more than 84 percent of the California workers' compensation insurance market.

No Overall Strategy Exists to Direct Statewide Workers' Compensation Antifraud Efforts

The fraud commission and the insurance commissioner have not collaborated to develop a statewide strategy for reducing fraud in the workers' compensation system.

An expert on fraud and fraud control has identified a fraud control model that includes certain components:

- Commitment to routine, systematic measurement.
- Resource allocation for controls based on an assessment of the seriousness of the problem.
- Clear designation of responsibility for fraud control.
- Deliberate focus on early detection of new types of fraud.
- Fraud-specific controls that intervene before payments are made.

The insurance commissioner's priorities for the fraud program are influenced by stakeholder input and are established with the intent of dedicating resources to high-impact cases, because these cases typically result in higher amounts of fraudulent activity, affect more people, and serve as a larger deterrent to future fraud when successfully prosecuted.

The fraud division's practice of collecting and publishing discrete statistics of investigations and arrests, convictions, and restitution as measures of success of the program's efforts show only that some source of fraud may have been removed from the system, but does not reveal whether the antifraud efforts have actually reduced the overall cost that fraud adds to the system.

The fraud commission and the insurance commissioner have thus far not collaborated in developing a statewide strategy in the form of a plan containing their consensus of the goals, objectives, actions, and performance targets necessary to reduce fraud in the workers' compensation system.

The Fraud Commission and the Insurance Commissioner Conduct Activities to Obtain Input From the Workers' Compensation Community

On several occasions, the fraud commission and the insurance commissioner, sometimes working with the fraud division, have held forums that allowed for stakeholder input on fraud in the workers' compensation system.

In November 2003, the California District Attorneys Association and the Department of Insurance held a roundtable discussion at which they met with members of the fraud commission to inform and educate them on issues related to workers' compensation fraud.

A Workers' Compensation Fraud Advisory Committee exists; however, it has not met since October 2002 because of low attendance at committee hearings, budget limitations, and management changes at the Department of Insurance.

Once elected, the insurance commissioner did assemble one advisory panel and one task force on a temporary basis to provide input on the status of various issues surrounding the workers' compensation system, including fraud. However, the advisory panel's report to the insurance commissioner, issued in February 2003, did not address fraud.

In his February 2004 plan for workers' compensation reform, the insurance commissioner stated that the Department of Insurance is restructuring its fraud and investigative units to improve coordination efforts and prioritize cases of fraud in the workers' compensation system.

ANNUAL FUNDING LEVELS FOR ANTIFRAUD EFFORTS ARE NOT BASED ON DOCUMENTED NEEDS

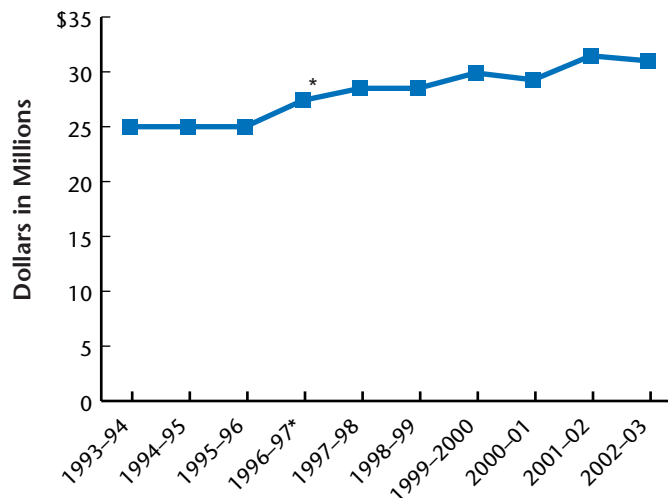
The fraud commission reaches its funding decisions without adequate knowledge of the extent and nature of the problems caused by fraud in the workers' compensation system or the effects of prior years' efforts to reduce fraud.

There is little assurance that the funds it assesses against California's employers—averaging approximately \$30 million for each of the past five years—have been used effectively to reduce the amount of fraud and thereby the overall cost that fraud adds to the system.

The Fraud Assessment Commission Bases the Annual Assessment on Previous Funding Levels to Ensure Continuity of the Program

FIGURE 5

Annual Aggregate Assessment Amount Levied by the Fraud Commission



Source: Fraud division's Annual Program Reports.

* Amount includes \$2.4 million in restitution funds directed to district attorneys.

The Fraud Assessment Commission Has Limited Information When Determining the Annual Aggregate Assessment

The fraud commission determines the aggregate assessment amount without reviewing any detailed information about the district attorneys' past performance in reducing fraud and without obtaining a specific proposal from the fraud division as to how it plans to spend the grant award during the upcoming year.

The district attorneys' reports outlining activities they completed with the prior year's funding are not required until January, nearly one month after the fraud commission has made its determination.

The fraud commission also does not receive adequate information from the fraud division regarding its activities before making a decision regarding what the aggregate fraud assessment should be.

The Fraud Assessment Commission Has Limited Authority to Hold the Fraud Division or District Attorneys Accountable for Their Antifraud Efforts

According to state law, after certain incidental and administrative costs are deducted, at least 40 percent of the annual aggregate assessment must be set aside for grants to district attorneys and 40 percent must be provided to the fraud division.

The fraud commission has discretion over how the remaining 20 percent is divided for the two purposes. Therefore, the fraud commission has little ability to hold the fraud division or district attorneys accountable for how they spend the funds.

PROCEDURES TO DETERMINE THE MOST EFFECTIVE DISTRIBUTION OF FRAUD ASSESSMENT FUNDS LACK ACCOUNTABILITY

Fraud division staff and members of the review panel that are involved in awarding grant funds do not use standard criteria to evaluate applications or document the rationale they use in reaching their respective recommendations for distributing the funds.

None of the criteria used includes measures of performance that would allow the fraud division staff, the review panel, the insurance commissioner, and the fraud commission to make a more informed decision on the most effective distribution of fraud assessment funds, as the law requires.

The fraud division and the review panel do not base their recommendations for the distributions of fraud assessment funds to participating district attorneys exclusively on an evaluation of the district attorneys' applications for the funds, as called for in Department of Insurance regulations.

Apparently, based on legal advice received in the early days of the program, the fraud division believes that the review panel must recommend base allocations as long as the county sends in a completed application within the time limit prescribed.

Controls intended to restrict the use of grant funds for county administrative costs are not always effective.

The programs' regulations do not appear to provide the restrictions on charges of indirect costs that the fraud commission expects.

The district attorney's office in Los Angeles indicated in its fiscal year 2003-04 grant application that it planned to charge its county indirect costs to its grant at a rate of 43 percent of the cost of salaries and wages charged to the program.

Our comparison revealed that the ratio of Los Angeles County's proposed operating expenses to its costs for salaries and wages was roughly twice that of two other high-cost counties—Santa Clara and San Diego.

The Fraud Division Is Developing Performance Measures to Help It Evaluate Its Own Effectiveness and That of the County District Attorneys in Reducing Fraud

The chief of the fraud division stated that the division is working to establish a set of performance metrics to better evaluate the effectiveness of the fraud division and participating district attorneys in reducing the overall cost of workers' compensation fraud.

Lacking Adequate Strategic Planning the Fraud Division Has not Met All Its Responsibilities for the Workers' Compensation Antifraud Program

THE FRAUD DIVISION'S BUSINESS PLAN DOES NOT ADEQUATELY DEFINE ITS RESPONSIBILITIES

Instead of a strategic plan, the fraud division has developed a business plan.

Fraud Division's Mission Statement

To protect the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud and to reduce the overall incidence of insurance fraud through antifraud outreach to the public, private, and governmental sectors.

Source: Fraud Division Business Plan (revised January 2004).

The fraud division's mission speaks only to investigations, arrests, and outreach and does not include its noninvestigative functions, which are meant to ensure that investigations are carried out effectively and efficiently.

The Fraud Division Has Not Established the Goals and Objectives Necessary to Meet All Its Responsibilities

Neither its goal nor its objectives are specific enough to provide sufficient direction for the fraud division's antifraud efforts.

Goal and Objectives Defined in the Fraud Division's Business Plan

Goal:

- To be the best consumer protection agency in the nation and to enforce workers' compensation fraud laws vigorously, effectively, and fairly.

Objectives directly related to workers' compensation fraud or to fraud in general:

- To reduce overall workers' compensation costs to employers by increasing the investigations of high-impact cases by 10 percent over the prior year.
- To decrease the cost of workers' compensation insurance in California by working with insurance companies to increase the number of insurance fraud referrals to the fraud division by 10 percent.
- To implement a pilot project to improve outreach efforts in the workers' compensation insurance industry by educating the roofing and construction industry on detecting workers' compensation fraud schemes, including premium fraud.
- To ensure that quality cases are assigned and to preclude the creation of a case backlog, the fraud division will increase by 10 percent the number of suspected fraudulent claims reviewed by supervisors for investigation or disposition.

The fraud division acknowledges that some of the external criticisms of the division include that it is not investigating all cases, that case investigations take too long, and that the fraud division does not provide a return on investment.

The business plan is silent regarding how the fraud division can use its special investigative audit unit to improve insurers' compliance with requirements for reporting suspected fraud.

Some of the objectives that the fraud division has included in its business plan for the workers' compensation antifraud program will not necessarily accomplish their stated outcomes even if the objectives are achieved.

The Fraud Division Does Not Allocate Its Resources to Meet Its Responsibilities or Establish Adequate Performance Measures

The fraud division's local assistance unit—the unit responsible for administering various fraud assessment grants to county district attorneys—has such limited resources allocated to it that it uses the fraud division's research specialist to assist in gathering and compiling information.

As a result, the research specialist is not available to conduct the type of research needed to identify the nature and extent of workers' compensation fraud and develop ways to establish baselines that can be used to measure the effectiveness of antifraud efforts.

The fraud division does not adequately measure its effectiveness in reducing fraud or its performance in meeting its goal and objectives.

THE FRAUD DIVISION DOES NOT MEET ALL ITS NONINVESTIGATIVE RESPONSIBILITIES

Not only does the fraud division substantially ignore noninvestigative functions in its business plan, but it also fails to allocate enough resources to these activities to ensure that it at least minimally meets its responsibilities.

The fraud division does not always use its research specialist to study workers' compensation issues and has not gained the capability to conduct the research necessary to measure the extent and nature of workers' compensation fraud, and evaluate the effectiveness of the fraud division's and district attorneys' efforts to deter fraud, and develop the information mandated by law.

Rather than draw on the skills listed in his job description, such as developing databases containing suspected fraud claims, identifying trends in insurance fraud, and designing statistical and survey techniques and training staff in their use, the fraud division's research specialist spends the majority of his time working in a unit that administers local assistance grants.

In March 2004, the fraud division initiated the process of amending an existing consultant contract to begin working on a set of metrics to measure the effect of its antifraud efforts and refine its business plan.

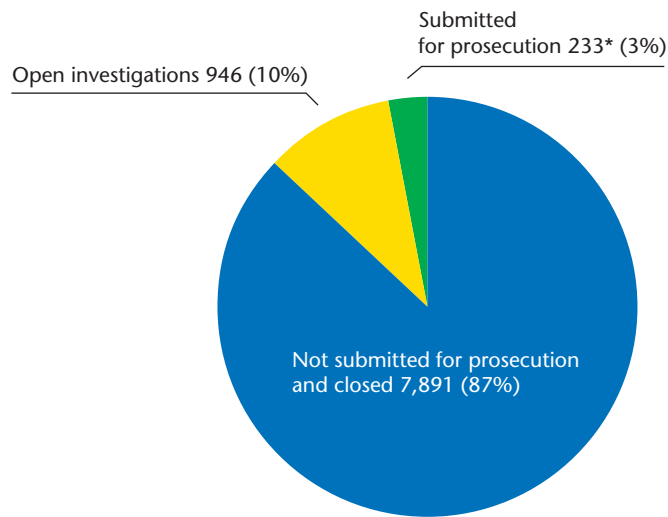
Although by law the annual program reports must contain the funding the fraud division received and a detailed breakdown of how it used the funds, the fraud division ignores these and other requirements and largely limits its reports to the allocations made to the district attorneys, the number of arrests and prosecutions, and the number of convictions and the names of those convicted.

A LARGE PERCENTAGE OF THE FRAUD DIVISION’S REFERRALS DO NOT RESULT IN PROSECUTIONS

Of the workers’ compensation referrals the fraud division received between September 2001 and December 2003, 87 percent were not submitted to district attorneys for prosecution, 3 percent were submitted, and 10 percent are open investigations.

FIGURE 7

Outcome of Referrals the Fraud Division Received From September 2001 Through December 2003



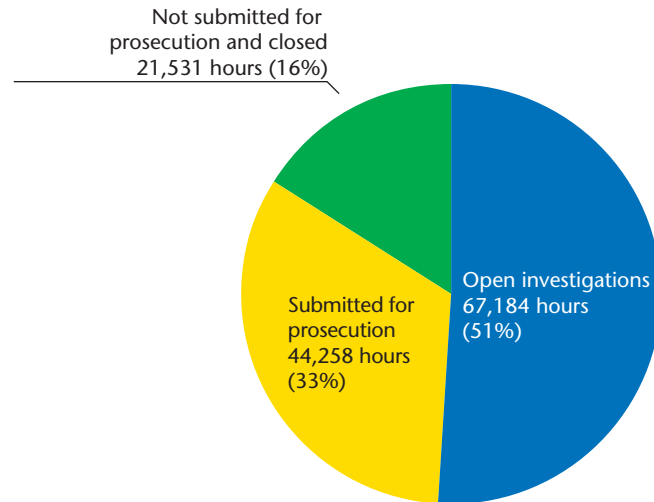
Source: Fraud division’s case management database.

* Of the 233 referrals submitted for prosecution as of December 22, 2003, 28 were rejected by district attorneys.

During the same time period, fraud division investigators spent more than 16 percent of their investigative hours on 1,362 cases it closed and did not submit to the district attorneys.

FIGURE 8

**Outcome of Hours Fraud Division
Investigators Spent on All Referrals
From September 2001 Through December 2003**



Source: Fraud division's case management database.

Based on the large portion of referrals that the fraud division reports are closed because of insufficient evidence, it appears that the quality of suspected fraud referrals the fraud division receives from insurers is not high enough to allow for successful investigations.

The fraud division's business plan does not address improving the quantity and quality of the evidence the fraud division receives supporting the referrals.

The fraud division has not adequately monitored and managed its referral and investigation caseloads to determine its success in focusing on the stated priorities of the insurance commissioner and fraud division.

The fraud division indicates that it emphasizes the insurance commissioner's initiative of focusing on high-impact referrals—those suspected fraud cases that include multiple suspects, involve a medical provider or attorney, or result in large losses—through its referral prioritization system.

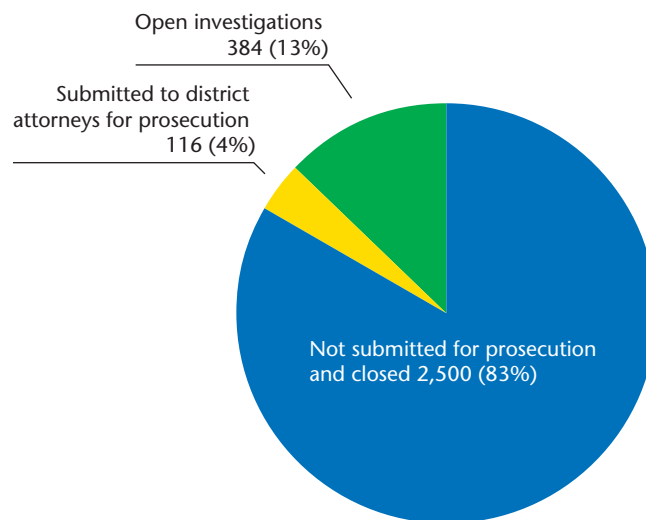
Our review of the case management database shows that between September 2001 and December 2003 half of the cases it submitted to district attorneys were considered high impact. Of the 233 referrals the fraud division submitted to district attorneys, 116 were high impact and 117 were not.

However, because the fraud division did not establish baselines for these types of fraud and set targets for the number of high-impact cases it would submit for prosecution, it cannot know whether these statistics align with the insurance commissioner’s initiatives or not.

As shown in Figure 9, of the 3,000 high-impact referrals entered into the database, 2,500 (83 percent) were closed without being submitted to district attorneys for prosecution as opposed to the 116 that were submitted.

FIGURE 9

**Outcome of High-Impact Referrals the Fraud Division Received
From September 2001 Through December 2003**



Source: Fraud division’s case management database.

The fraud division closes the majority of the high-impact referrals it receives without investigating them.

Of the 3,000 high-impact referrals received from September 2001 through December 2003, investigators charged hours to only 872, leaving 2,128 with no hours charged. Of those 2,128, 86 are still open and 2,042 were closed without assigning them to an investigator. The reason listed for closing most of these referrals (1,427 or 70 percent) was insufficient evidence.

More than half of the high-impact referrals for which fraud division investigators charged time were closed without being submitted to district attorneys for prosecution.

The Fraud Division Has Not Defined Benchmarks or Targets for Each Appropriate Activity and Used Them to Measure Performance

The fraud division has not come up with a way to measure the return on investment regarding its investigative activities and its success in fighting fraud.

The fraud division has yet to establish a target for how many investigations it plans to submit to the county district attorneys per year and how many of those investigations it expects district attorneys to successfully prosecute each year so that it can measure the success or failure of its investigative efforts funded by the fraud assessment.

The division could measure its return on investment by setting a targeted return on the fraud assessment funds invested in the program compared to the amount of chargeable fraud taken out of the system based on successfully prosecuted cases.

THE DIVISION DOES NOT ADEQUATELY MONITOR THE USE OF FRAUD ASSESSMENT FUNDS AWARDED TO DISTRICT ATTORNEYS

Department of Insurance regulations require that each county submit an annual independent audit certifying that the county district attorney's expenditures complied with the laws, regulations, request for application guidelines, and the county plan.

Although the request for application guidelines include audit procedures that must be followed, all but one of the audits we reviewed failed to adhere to these procedures.

In fact, 26 of the 27 audits we reviewed did not include the required certification, nor did they comment on the internal control system as it applied to the workers' compensation antifraud program.

These audit reports did not provide an opinion on the district attorneys' compliance with laws, regulations, contracts, and grant provisions. Rather, they performed certain tests to assure that the financial statements were free of material misstatement.

Department of Insurance Audits Provide Limited Assurance That District Attorneys Properly Use Fraud Assessment Funds

Department of Insurance audits of county district attorneys' use of workers' compensation fraud assessment grants give a thorough and documented indication of their compliance with the requirements of the grants. However, the audit unit has only completed a limited number of these audits.

During the last two years, the audit unit has reviewed 13 of the more than 30 county district attorneys that receive workers' compensation fraud assessment grants, reported 38 findings, and recommended that these district attorneys return \$103,400 in grant funds because of questionable expenditures.

The audit unit has not recently reviewed 22 of the 34 county district attorneys that received fraud assessment funds in fiscal year 2002-03, and reviews of the five county district attorneys receiving the largest amounts of grant funds have not been conducted since 1998.

The chief of the audit unit told us that he places county district attorneys who receive only workers' compensation grant funds at the bottom of the audit plan, as he receives no funding to conduct these audits. However, if the fraud division required the county district attorneys to submit audit reports that met the requirements in the Department of Insurance regulations and fraud grant application guidelines and contained an opinion on compliance, the audits performed by the audit unit would not be necessary.

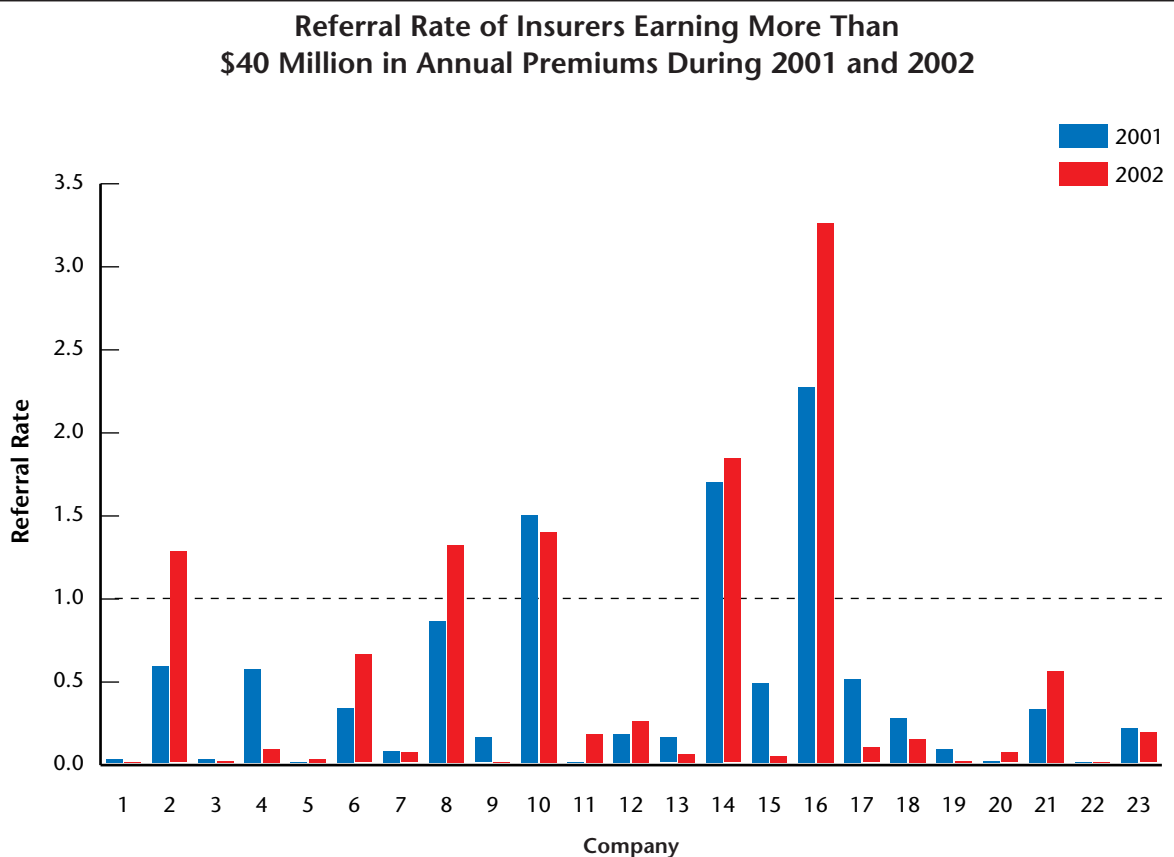
Efforts to Detect and Prevent Workers' Compensation Fraud Are Inadequate and Lack Cooperation Between Agencies

Insurer Compliance With Requirements to Detect and Report Suspected Workers' Compensation Fraud Varies

Despite a requirement that insurers investigate suspected fraud and refer to the fraud division claims that show reasonable evidence of fraud, insurers vary significantly in the number of fraud referrals they submit.

As shown in Figure 13, among insurers earning workers' compensation premiums exceeding \$40 million per year, some appear to be underreporting suspected fraud while others appear to be regularly referring suspected fraudulent claims.

FIGURE 13

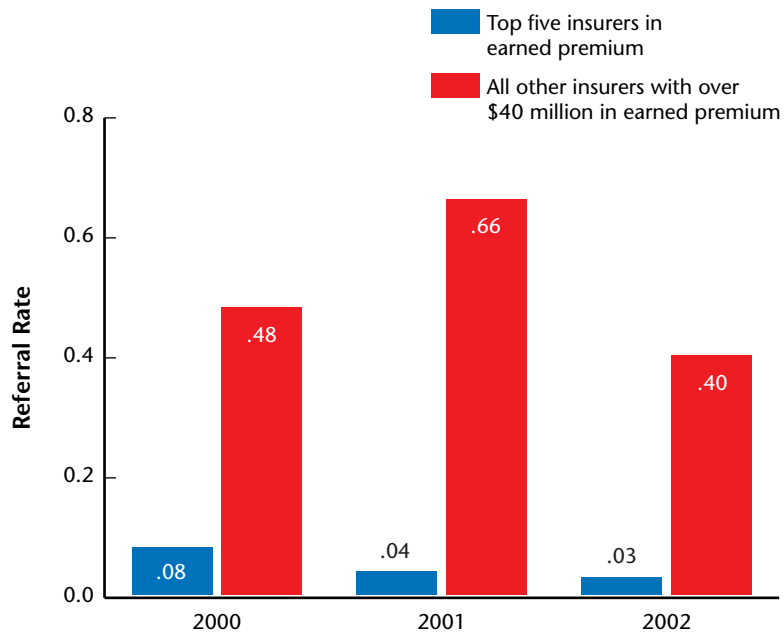


Sources: Department of Insurance Web site and the fraud division's case management database.

Five insurers reporting the highest earned premiums for 2000 through 2002 referred suspected claims at a much lower rate than those reporting lower levels of earned premiums. The referral rate for the top five insurers in 2002 was .03, or less than one suspected fraudulent claim per \$20 million in earned premiums.

FIGURE 14

Referral Rates for Workers' Compensation Insurers by Earned Premium for 2000 Through 2002



Sources: Department of Insurance Web site and the fraud division's case management database.

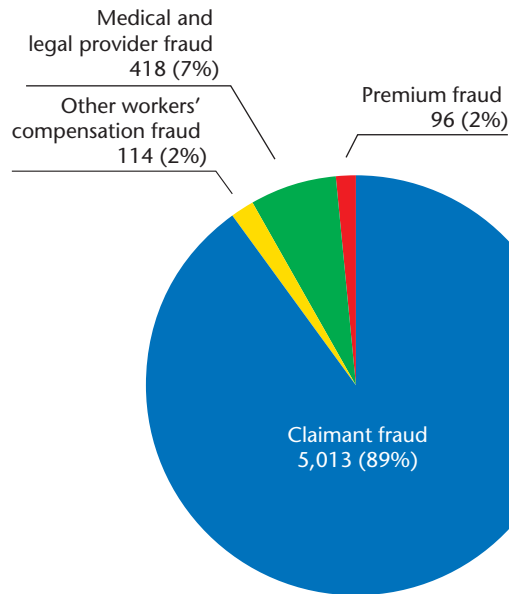
Barriers Exist That Prevent Insurers From Consistently Referring Suspected Fraud

- The lack of a uniform methodology and standards for assessing and reporting suspected fraud is one reason that some insurers may be derelict in their responsibility to fight fraud.
- Past regulations poorly defined when insurers should refer suspected fraud to the fraud division.
- Perceived exposure to civil actions when criminal prosecutions of referrals are not successful.

Insurers are not reporting the types of suspected fraud the insurance commissioner has designated as high-impact. According to our review of its database of fraud referrals, the division received almost two-thirds of its referrals from insurers, and 89 percent of these were for claimant fraud.

FIGURE 15

**Types of Suspected Fraud Referrals Insurers Reported
From September 2001 Through December 2003**



Source: Fraud division's case management database.

Audit Efforts Have Not Provided Adequate Coverage of Insurers

The fraud division's special investigative audit unit has not achieved the most effective audit coverage of the community of workers' compensation insurers.

- The fraud division focused 59 percent of its audits on insurers that represent less than 0.5 percent of the market.
- The special investigative audit unit chose not to review 43 percent of the insurers selling workers' compensation in the State because they do not have offices in California.
- The special investigative audit unit reviews an average of only 14.5 (8 percent) of the 175 insurers in the fraud division's workers' compensation database each year.

The special investigative audit unit has not performed more audits of workers' compensation insurers during the past two years because of inadequate staffing levels and travel restrictions.

The insurance commissioner stated that because the special investigative audit unit is also responsible for auditing insurers selling other lines of insurance it could not focus its resources exclusively on workers' compensation audits.

The Special Investigative Audit Unit Lacks Standards in Its Approach to Auditing Insurers

Without standards for audit objectives, audit procedures, and supervision of the audits, the fraud division cannot be certain that the special investigative audit unit is helping insurers provide referrals of the quality that the fraud division needs to effectively and efficiently investigate workers' compensation fraud.

Not surprisingly, the reviews we examined reflect disparate approaches.

Of the 10 reviews we examined, we found only four in which the reviewers sampled claims and in two of those cases the reviewer allowed the insurer to select the claims for review.

The fraud division is preparing a manual of procedures for conducting reviews, and it has already implemented a policy to use a standard random sampling methodology with a minimum sample of 30 claims per audit.

The Special Investigative Audit Does Not Promptly Finalize Its Reports or Track and Enforce Audit Findings

For five of the seven audits of insurers with findings that we reviewed, the special investigative audit unit had not sent letters to the insurers outlining the findings, even though between one and three months had passed since the review was completed.

The special investigative audit unit also does not adequately track its audit findings to follow up on corrective action by insurers.

The fraud division has not established effective penalties to promote compliance with the requirement that insurers maintain a special investigative unit.

The law states that any insurer failing to comply with fraud-reporting provisions will be subject to a maximum fine of \$55,000 and/or suspension of the insurer's certificate of authority to conduct business in the State.

Insurers are not complying with the requirements in law related to special investigative units.

Out of our sample of 10 audit reviews, one insurer did not meet the statutory standards of maintaining a fraud-reporting function, and four had failed to make any referrals of suspected fraud to the fraud division as called for by the law.

IMPROVEMENT IS NEEDED IN SHARING INFORMATION BETWEEN STATE DEPARTMENTS TO IDENTIFY POTENTIAL WORKERS' COMPENSATION FRAUD

The Department of Industrial Relations' DLSE does not share the results of its field reviews of employers with the fraud division.

Without greater sharing of information, the fraud division is denied information that Industrial Relations possesses on employers that fail to provide workers' compensation insurance for their employees.

During 2003, the DLSE conducted 6,816 field reviews and cited nearly 1,300 employers for failing to secure workers' compensation insurance.

The DLSE does not track repeat offenders. As a result, the DLSE denies the fraud division a tool it could use for identifying employers that repeatedly fail to carry workers' compensation insurance, thereby indicating a willful intent that warrants investigation.

INDUSTRIAL RELATIONS HAS YET TO IMPLEMENT REQUIRED PROGRAMS DESIGNED TO DETER WORKERS' COMPENSATION FRAUD

Recent legislation mandates that Industrial Relations implement three antifraud programs:

- A program to detect employers that willfully fail to secure workers' compensation insurance for their employees. (Law required the program to be operational by January 1, 2003.)
- A program establishing a protocol for reporting suspected fraud by medical providers. (Law required the protocols to be operational by January 1, 2004.)
- A program requiring Industrial Relations to issue annual warnings against committing workers' compensation fraud to employers, claims adjusters and administrators, medical providers, and attorneys who participate in the workers' compensation system, and to notify them of the relevant penalties. (Law required the program to be operational by January 1, 2003.)

INDUSTRIAL RELATIONS COLLECTS EXCESS FRAUD ASSESSMENTS FROM INSURED EMPLOYERS

Industrial Relations often collects much more than it intended because the formula it uses to calculate the surcharge rate usually results in overcharges to insured employers.

Industrial Relations' formula for calculating the fraud assessment to be collected from insured employers results in very large variations between the estimated and actual collections.

Each year Industrial Relations estimates and requests an advance payment of the fraud assessment surcharge from insurers that write workers' compensation policies in California, based on the projected policy premiums for the current year.

Insurers collect the surcharge through the premiums they charge employers.

Industrial Relations' regulations require that it use the rating bureau's projection of total current year premiums to determine the fraud surcharge factor. However, information provided by Industrial Relations suggests that the rating bureau does not always provide accurate estimates of current year premiums.

Industrial Relations does not determine that insurers correctly report all fraud assessment surcharges. Industrial Relations staff noted that in prior years, some insurers reported they did not bill their insured employers for fraud surcharges even though the insurers showed premium income in those years.

Some insurers have reported that the amount paid in advance exactly equaled the amount of fraud assessment surcharges they billed to insured employers, a circumstance that is very unlikely.

KEY RECOMMENDATIONS

The fraud commission and the insurance commissioner should direct the fraud division to measure the nature and extent of fraud in the workers' compensation system.

The insurance commissioner should consider reactivating an advisory committee comprising stakeholders focused on reducing fraud in the workers' compensation system to contribute to the data analyses, provide input about the effects of fraud, and suggest priorities for reducing fraud.

The fraud commission and the insurance commissioner and his staff should design and implement a strategy to reduce workers' compensation fraud. The strategy should be systemwide in scope and include goals, objectives, priorities, and the measurable targets that can be effectively communicated to the fraud division and the county district attorneys participating in the antifraud program.

To gather the information it needs to determine the annual amount to assess employers to fight fraud, the fraud commission should:

- Revamp its decision-making process so that it includes the best information available including (1) the results of the Department of Insurance's analyses of the nature and extent of fraud in the system, (2) analysis of the effectiveness of efforts by the fraud division and district attorneys, and (3) any newly emerging trends in fraud schemes that should receive more attention.
- Request an annual report from the fraud division that outlines objectives from the prior year that are linked to measurable outcomes, and its objectives for the ensuing year together with estimates of the expenditures that the fraud division needs to accomplish those objectives.
- Request each county district attorney to submit a report listing the district attorneys' accomplishments in achieving the goals and objectives outlined in the prior year's application and the goals and objectives for the ensuing year.

To better ensure that fraud assessment funds are distributed to district attorneys so as to most effectively investigate and prosecute workers' compensation fraud, the fraud commission and the insurance commissioner should:

- Develop and implement a process for awarding fraud assessment grants that provides for consistency.
- Include in the decision-making criteria how well county district attorneys' proposals for using fraud assessment funds align with the strategy and priorities developed by the fraud commission and the insurance commissioner.

- Document the rationale for making grant award decisions.
- Make recommendations for total grant awards, including the base allocations, on evaluations of county district attorneys' plans that include how they will use the funds, as required by the Department of Insurance regulations.
- Continue current efforts to establish performance measures to use in evaluating the effectiveness of the fraud division and participating district attorneys in reducing workers' compensation fraud.

The fraud division should:

- Conduct the research needed to advise the fraud commission and the insurance commissioner on the optimum aggregate assessment needed annually to fight workers' compensation fraud.
- Modify its business plan to meet noninvestigative responsibilities.
- Establish benchmarks to measure its and the district attorneys' performance in meeting goals and objectives.
- Reevaluate the process it has established for insurers and other state entities involved in employment-related activities to report suspected fraud.

The fraud commission and the insurance commissioner should require the fraud division to conduct a return-on-investment analysis for the workers' compensation antifraud program as a whole and to annually report the results.

To improve the level of assurance contained in the independent audit reports submitted by county district attorneys, the fraud division should:

- Clarify its expectations for the independent audits.
- Ensure that county district attorneys comply with the independent audit requirements and submit their audit reports in a timely manner.

To ensure that it receives the suspected fraud referrals it needs from insurers to efficiently investigate suspected fraud, the fraud division should continue its efforts to remove the barriers that prevent insurers from providing the desired level of referrals.

The fraud division should work with insurers to reduce the number of referrals that are not likely to result in a successful investigation or prosecution, thereby preserving limited resources.

To help the fraud division investigate employers that fail to secure payment for workers' compensation insurance for their employees, the Division of Labor Standards Enforcement

should track employers that do not provide workers' compensation insurance for their employees and report to the fraud division any employer that repeatedly fails to provide workers' compensation insurance.

To ensure that it targets employers in industries with the highest incidence of unlawfully uninsured employers, the Division of Labor Standards Enforcement should establish a program that uses data from the Uninsured Employers Fund, the Employment Development Department, and the rating bureau to target unlawfully uninsured employers, as required by law.

The Division of Workers' Compensation should implement the fraud-reporting protocols required by law.

The Division of Workers' Compensation should warn participants in the workers' compensation system of the penalties of fraud, as required by law.

The Department of Industrial Relations should work with the Workers' Compensation Insurance Rating Bureau to improve the accuracy of the projected premiums for the current year, which it uses to calculate the fraud assessment surcharge to be collected from insured employers.

The Department of Industrial Relations should seek the authority and establish a method to verify that insurers report and submit the fraud assessment surcharges they collect from employers.