

Workers' Compensation Insurance

The State Needs to Strengthen Its Efforts to Reduce Fraud

Report 2017-103

COMMITMENT
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December 12, 2017

2017-103

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning public agencies' processes for preventing, detecting, and prosecuting fraud occurring in the State's workers' compensation insurance (workers' compensation) system. This report concludes the State needs to strengthen its efforts to reduce workers' compensation fraud. The Department of Industrial Relations (Industrial Relations) estimates that workers' compensation cost the State's employers—who pay for the system by either purchasing insurance policies or self-insuring—\$25.1 billion in 2015. Furthermore, the California Department of Insurance (CDI) states that the amount of workers' compensation fraud in the State ranges from an estimated \$1 billion to \$3 billion annually. Public agencies involved in preventing, detecting, and prosecuting workers' compensation fraud include CDI, Industrial Relations, and county district attorneys' offices.

We identified certain weaknesses in the State's processes for detecting workers' compensation fraud. For example, although state law requires insurers to refer to CDI and district attorneys' offices any claims that show reasonable evidence of fraud, some insurers are significantly less likely than others to report suspected fraud. For the 21 insurers that we examined, the number of referrals ranged from zero to more than 350 for the two years we reviewed; eight insurers had rates of one or fewer referrals per \$10 million in earned premiums (the high was 11 referrals per \$10 million). These eight insurers collectively had \$3.9 billion in earned premiums in 2016, which represented 31 percent of earned premiums in California. We also observed that Industrial Relations has not yet fully documented its procedures for using predictive data analytics, a tool that should enable it to detect potential provider fraud more quickly, and that California could improve its efforts to detect potential workers' compensation fraud by requiring insurers to periodically issue explanation of benefits statements to injured employees.

We also identified concerns regarding the investigation and prosecution of workers' compensation fraud. Specifically, CDI's 27 percent vacancy rate for its fraud investigator positions—calculated based on data as of February 2017—likely limits its ability to investigate suspected fraudulent workers' compensation claims. Although the State has reduced the pay gap between fraud investigators and other similar law enforcement positions, CDI lacks a retention plan and its recruitment plan omits activities to recruit retired law enforcement officers. Finally, rather than redirecting \$2.4 million from fiscal year 2015–16 in unspent CDI funds to district attorney's offices to bolster their investigation and prosecution efforts to fight workers' compensation fraud, the insurance commissioner and the Fraud Assessment Commission opted to reduce the amount of funds employers would have otherwise had to pay in a subsequent year.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

Selected Abbreviations Used in This Report

CDI	California Department of Insurance
DAR	District Attorney Program Reports
EOB statements	explanation of benefits statements
Fraud Commission	Fraud Assessment Commission
Industrial Relations	Department of Industrial Relations

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Summary

Results in Brief

The system for workers' compensation insurance (workers' compensation) in California requires employers to provide benefits to employees who are injured or disabled in the course of employment. These benefits include covering the costs associated with health care and other services necessary for injured employees to return to work, providing disability payments, and compensating injured employees who cannot fully return to work. In exchange, employers generally have protection against law suits filed by employees related to workplace injuries. The Department of Industrial Relations (Industrial Relations) is responsible for monitoring the administration of claims filed through the workers' compensation system, which California has had in place for over 100 years. A 2016 report by Industrial Relations indicates that the workers' compensation system cost the State's employers—who pay for the system by either purchasing workers' compensation policies or self-insuring—\$25.1 billion in 2015.

In part because of its size and complexity, the workers' compensation system creates ample opportunity for fraud. This fraud can take many forms, including employees who claim to be injured when they are not or health care providers who bill insurers for services or treatments they did not provide. A number of state and local entities are involved in preventing, detecting, and prosecuting such fraud. In particular, the California Department of Insurance (CDI) is the lead state agency for the criminal investigation of workers' compensation fraud. It receives case referrals from insurers, law enforcement agencies, third parties, employers, and employees. Depending on the circumstances, CDI, the county district attorneys' offices, or both will investigate these referrals. The county district attorneys' offices also have responsibility for prosecuting workers' compensation fraud cases when appropriate. Their prosecutions can result in convictions, financial penalties, and court-ordered restitution. In order to help pay for these antifraud efforts, the State created the Fraud Assessment Commission (Fraud Commission), which sets an annual total assessment amount to be collected from employers. The insurance commissioner—who is in charge of CDI—and the Fraud Commission then allocate the assessment funds to CDI and the district attorneys' offices.

Despite the State's efforts, we identified certain weaknesses in its processes for detecting workers' compensation fraud. For example, although state law requires insurers to refer to CDI and district attorneys' offices any claims that show reasonable evidence of fraud, insurers vary significantly in the number of fraud referrals

Audit Highlights . . .

Our review of processes for preventing, detecting, and prosecuting fraud in California's workers' compensation system revealed the following:

- » *Although state law requires insurers to refer to CDI and district attorneys' offices any claims that show reasonable evidence of fraud, insurers vary significantly in the number of fraud referrals they submit.*
- » *Industrial Relations has not fully documented its procedures for implementing a critical tool—data analytics—for combatting workers' compensation fraud by providers.*
- » *The State does not currently require insurers to issue explanation of benefits statements to injured employees to provide them an opportunity to review the services that providers bill.*
- » *CDI's high vacancy rate in fraud investigator positions limits its ability to investigate suspected fraudulent claims.*
 - *CDI closes about 40 percent of the referrals it receives without investigation due to insufficient resources.*
- » *CDI lacks a retention plan and its recruitment plan omits activities to recruit retired law enforcement officers.*
- » *CDI's vacancy rate has resulted in it underspending the workers' compensation fraud assessment funds it has budgeted for personnel to investigate fraud.*
- » *Instead of redirecting \$2.4 million from fiscal year 2015–16 in unspent CDI funds to district attorneys' offices, the funds were used to reduce a subsequent year's collection from employers.*

they submit. We calculated the referral rates for 21 insurers that each had more than \$150 million in earned workers' compensation premiums for 2015 and 2016.¹ We found that eight of these 21 insurers submitted one or fewer referrals per \$10 million in earned premiums in at least one of the two years we examined. In fact, two insurers submitted no referrals for one of the years. These low referral rates could indicate that the insurers are not referring suspected workers' compensation fraud to CDI and the district attorneys' offices, leaving this potential fraud uninvestigated. Nonetheless, CDI does not include referral rates as a criterion when selecting insurers whose special investigative units it will audit.

In addition, Industrial Relations has not yet fully documented its procedures for using a tool that may enable it to detect provider fraud more quickly. Provider fraud cases can continue unnoticed for years and a single case can cost insurers millions of dollars. To address this, Industrial Relations is in the early stages of implementing data analytics, which should help it to predict which providers may be committing such fraud. According to a consultant Industrial Relations commissioned, data analytics is a rapidly developing field of information science that involves intensive examination of large volumes of data to develop deeper insights, make predictions, and generate recommendations. Because data analytics may provide high rates of return, Industrial Relations should fully document its plan for using data analytics to uncover provider fraud as soon as possible.

In addition, California could further improve its efforts to detect workers' compensation fraud by requiring insurers to periodically issue explanation of benefits statements (EOB statements) to injured employees. These statements list the types of services providers rendered to injured employees, the dates the providers rendered the services, and the fees they received for the services. Consequently, EOB statements provide injured employees with the opportunity to review the services for which providers have billed insurers and potentially identify fraudulent charges. Nonetheless, the State does not currently require insurers to issue EOB statements to injured employees.

The State could also do more to improve its investigation of workers' compensation fraud. Specifically, CDI's high vacancy rate for its fraud investigator positions limits its ability to investigate suspected fraudulent workers' compensation claims. According to calculations based on data as of February 2017, CDI had a statewide vacancy rate for fraud investigators of 27 percent.

¹ The term *earned premiums* refers to the amount of premiums an insurer recognizes as revenue for a certain period of time, such as a year.

Further, in a recent budget change proposal, CDI asserted it had the available resources to investigate only 5 percent of the suspected fraudulent claims it receives annually across all types of insurance. In fact, our analysis of data from its case management system indicates that CDI closes about 40 percent of the workers' compensation referrals it receives without investigation due to insufficient resources. In these instances, CDI may be allowing fraudulent activities to continue without investigation. In addition, vacant fraud investigator positions place a burden on the district attorneys' offices that depend on CDI's investigators as part of the investigative and prosecutorial process. Nonetheless, we observed that CDI omitted from its recruitment plan activities to recruit experienced and retired law enforcement officers and lacked a retention plan for addressing its high vacancy rate.

Further, the State has made certain funding decisions that may also negatively affect its effort to fight workers' compensation fraud. State law mandates that the insurance commissioner and the Fraud Commission must allocate to both CDI and the district attorneys' offices a minimum of 40 percent each of the total workers' compensation fraud assessment funds the State collects from employers each fiscal year. The insurance commissioner and the Fraud Commission can allocate the remaining 20 percent of the funds at their discretion. In recent years, CDI has received only its minimum 40 percent allotment—\$24 million per year in fiscal years 2015–16 and 2016–17—but was unable to spend \$2.4 million (10 percent) of that amount in fiscal year 2015–16, in large part because of its vacant positions. However, instead of redirecting CDI's unspent funds to the district attorneys' offices, the insurance commissioner and the Fraud Commission used the funding to offset—or reduce—a subsequent year's collection from employers. If they had chosen to redirect the funds, the insurance commissioner and the Fraud Commission could have avoided reducing the amount of money available for investigating and prosecuting workers' compensation fraud.

Selected Recommendations

Legislature

To better ensure that the payments insurers issue to providers for workers' compensation claims are based on valid services, the Legislature should require workers' compensation insurers to periodically provide EOB statements to injured employees.

CDI

To reduce insurers' potential underreporting of workers' compensation fraud, CDI should, by June 30, 2018, add a requirement that it consider rates of fraud claim referrals when selecting insurers to audit and that it give priority to those insurers with high volumes of premiums and very low numbers of referrals.

To better address vacancies in its fraud investigator positions, CDI should take the following actions by June 30, 2018:

- Develop and implement a retention plan.
- Revise its recruiting plan to include the recruitment and hiring of retired local law enforcement officers.

To better ensure the timely and effective use of fraud assessment funds to fight workers' compensation fraud in California, CDI should, by June 30, 2018, develop and implement a process to use its unspent funds to augment funding to district attorneys' offices rather than to offset collections from employers for subsequent years.

Industrial Relations

To ensure the growth and effectiveness of its data analytics efforts to identify provider fraud, Industrial Relations should better document its data analytics effort within its protocol manual by June 30, 2018.

Agency Comments

Industrial Relations disagrees with both our recommendation to the Legislature and the recommendation we directed to it. CDI agrees with the recommendations we made to it.

Introduction

Background

California established its workers' compensation insurance (workers' compensation) system more than 100 years ago to protect both injured employees and their employers. Before implementation of the workers' compensation system, the only legal remedy for work-related injuries was to bring suit against employers and prove their liability. However, in 1911 and 1918, the public voted to amend the California Constitution to authorize the Legislature to create and enforce a workers' compensation system that requires employers to cover the costs of specific benefits when employees are injured or disabled in the course of employment. At the same time, the system generally protected employers from employee lawsuits except when, among other things, the employers failed to carry insurance.

Currently, California's workers' compensation system provides several benefits that help injured employees. These benefits include health care, temporary and permanent disability payments, death benefit payments, and vouchers to help pay for retraining or skill enhancements. Employees are eligible for some or all of these benefits when they suffer injuries that arise out of their employment and occur in the course of their employment. In other words, a causal relationship must exist between their employment and their injuries, and their injuries must occur when they are working and doing reasonable activities that their employers permit. The text box describes the four key types of participants involved in workers' compensation.

Administration of the Workers' Compensation System

California's workers' compensation system is funded by employers rather than by taxes. Specifically, state law generally requires employers either to purchase insurance or to self-insure. A 2016 report by the Department of Industrial Relations (Industrial Relations) estimated that the total systemwide cost for workers' compensation was \$25.1 billion for 2015. Figure 1 shows the distribution of the \$25.1 billion among various cost categories.

Key Workers' Compensation System Participants

Employees suffering workplace injuries or illnesses are entitled to employer-paid medical and other related services necessary to help them recover and return to work. They can also receive disability benefits, and their dependents can receive death benefits.

Employers are responsible for funding the workers' compensation system by acquiring insurance or meeting certain state requirements to self-insure and pay benefits directly.

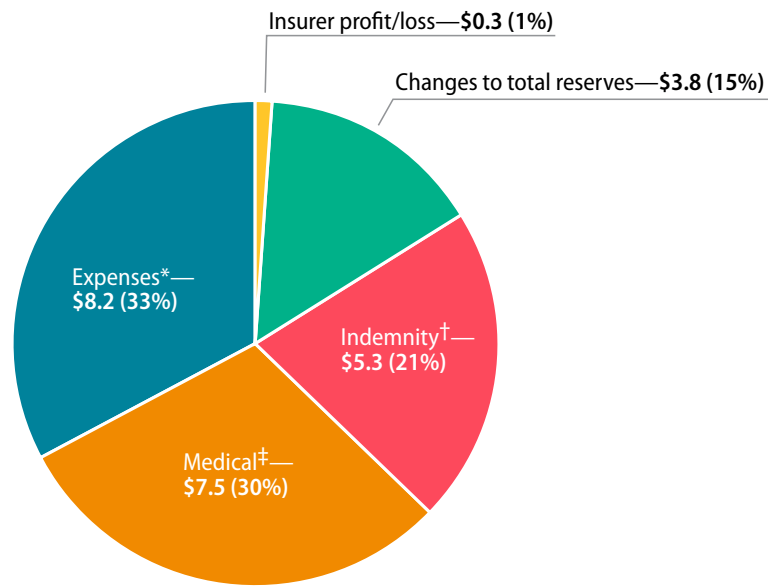
Service providers render services to help injured employees recover. Service providers include medical personnel, attorneys, interpreters, and copy services. To obtain payment for services, providers bill workers' compensation claims administrators for insurance companies, self-insured employers, and third-party administrators. State law allows providers to file liens with the Workers' Compensation Appeals Board to obtain payment.

Insurance companies, including claims adjusters, claims administrators, and third-party administrators, manage worker's compensation claims for employers by making benefit payments, collecting medical records, reimbursing for medical expenses and, in some cases, paying penalties. They can approve or deny claims for payment or hold them while acquiring additional information.

Sources: State laws and documents obtained from Industrial Relations and the Workers' Compensation Rating Bureau of California (Rating Bureau).

Industrial Relations' report also stated that California's workers' compensation system covered 15.6 million employees working for about 936,000 employers in 2015 and that employees had nearly 607,000 occupational injuries and illnesses that year, ranging from minor medical treatment cases to catastrophic injuries and deaths.

Figure 1
Distribution of the 2015 Estimated Costs for the Workers' Compensation System
(Dollars in Billions)



Source: Unaudited data from the 2016 *Annual Report* issued by the Commission on Health and Safety and Workers' Compensation.

* *Expenses* consists of loss adjustments, commission and brokerage fees, other acquisition expenses, general expenses, and premium and other taxes.

† *Indemnity* consists of disability and death payments, life pensions, and vouchers for rehabilitation and education.

‡ *Medical* consists of payments for medical benefits, including physicians, hospitals, pharmacies, and interpreters.

Although employers fund the workers' compensation system, a number of state agencies play roles in its administration. In particular, Industrial Relations has several units involved in the administration of the workers' compensation system. For example, its Division of Workers' Compensation is responsible for monitoring the administration of workers' compensation claims and for providing administrative and judicial services to assist in resolving disputes. Furthermore, this division staffs 22 district

offices and two satellite offices located around the State, called Workers' Compensation Appeals Boards, that assist employers, injured employees, and others in the resolution of disputes that can arise from workers' compensation claims. In addition, Industrial Relations' Office of Self-Insurance Plans is responsible for overseeing and regulating employers' workers' compensation self-insurance within California. Finally, Industrial Relations' Commission on Health and Safety and Workers' Compensation is responsible for examining the workers' compensation system and recommending administrative or legislative modifications to improve its operation.

In addition, the California Department of Insurance (CDI) is involved in the administration of the workers' compensation system. Specifically, it is responsible for regulating the business of insurance in California, including workers' compensation, under the direction of the insurance commissioner. CDI's regulatory responsibilities include overseeing insurer solvency, licensing agents and brokers, and resolving consumer complaints. Further, it is responsible for investigating allegations of workers' compensation fraud, as we discuss in a later section.

Finally, a private entity also plays a role in the administration of the workers' compensation system. The Rating Bureau is an unincorporated, nonprofit association composed of all companies licensed to transact workers' compensation insurance in the State. The Rating Bureau establishes what it refers to as *pure premium rates* for workers' compensation insurance. It recommends these rates to the insurance commissioner. Insurers may use pure premium rates as benchmarks to develop their own premium rates to charge. To pay for its operations, the Rating Bureau uses insurer membership fees and assessments, rather than state funds.

Workers' Compensation Fraud

CDI's website mentions that workers' compensation fraud costs employers—who fund the workers' compensation system—amounts estimated to range from \$1 billion to \$3 billion annually. This equates to 4 percent to 12 percent of the system's 2015 cost estimate, and the employers likely pass on these costs to their consumers. Furthermore, CDI's data show that the total estimated chargeable fraud in workers' compensation for fiscal year 2015–16 approached \$970 million. CDI defines *chargeable fraud* as the total amount of suspects' workers' compensation fraud that district attorneys' offices believe can be proven and can result

in convictions.² Table 1 identifies the numbers of cases in court and the amounts of chargeable fraud by type from fiscal years 2013–14 through 2015–16.

Table 1
Number of Workers' Compensation Fraud Cases in Court and Estimated Chargeable Fraud by Case Type
Fiscal Years 2013–14 Through 2015–16

CASE TYPE	FISCAL YEAR			PERCENT OF 2015–16 TOTAL
	2013–14	2014–15	2015–16	
Number of Cases in Court				
Claimant (Employee)	371	440	444	32.2%
Employer–Premium	178	160	192	13.9
Employer–Uninsured Employer	718	713	607	44.0
Provider	23	25	41	3.0
Insider (Insurer)	13	10	20	1.5
Other types	68	61	75	5.4
Total number of cases in court	1,371	1,409	1,379	100.0%
Estimated Chargeable Fraud (in Thousands)*				
Claimant (Employee)	\$18,958	\$16,985	\$19,505	2.0%
Employer–Premium	128,772	115,929	133,741	13.8
Provider	129,808	509,049	812,339	83.8
Insider (Insurer)	1,723	1,692	1,154	0.1
Other types	2,810	2,532	2,748	0.3
Total estimated chargeable fraud	\$282,071	\$646,187	\$969,487	100.0%

Source: District Attorney Program Reports (DAR) system provided by CDI.

Note: The DAR system does not separate medical fraud from other types of provider fraud—such as legal services, billing services, and translation services. Therefore, we attempted to quantify the estimated chargeable fraud for medical provider fraud using CDI's Fraud Integrated Database, which separates provider fraud case referrals between medical and legal. For fiscal years 2013–14 through 2016–17, approximately 97 percent to 100 percent of the potential loss amount recorded for provider fraud case referrals were for medical providers.





* The DAR system did not include amounts of chargeable fraud for the fraud type *Employer–Uninsured Employer*.

As Figure 2 illustrates, fraud can occur in many ways within the workers' compensation system. For example, employees can commit workers' compensation fraud by falsely claiming injuries were work-related, faking injuries, or continuing on disability when they are capable of returning to work. Employers can commit fraud by being uninsured or underinsured, preventing employees from reporting workplace injuries, misrepresenting facts to avoid liability, underreporting their payroll amounts, or misclassifying the work

² CDI's data include different estimates of workers' compensation fraud amounts, including *potential loss* and *suspected fraud loss-to-date*. Because *chargeable fraud* is the amount that district attorneys' offices believe they can prove, we opted to report this estimate.

performed by their employees.³ Insurance companies can commit fraud by issuing fraudulent policies that they have no intention of honoring. Finally, service providers can commit fraud either by billing for services not provided or needed or by overbilling for services actually provided. Providers can also commit fraud by improperly referring injured employees to other service providers in exchange for illegal payments, often referred to as *kickbacks*.

Figure 2
Key Participants in California’s Workers’ Compensation System and Examples of How They May Commit Fraud

	 INJURED EMPLOYEE	 EMPLOYER	 INSURANCE COMPANY, CLAIMS ADJUSTER OR ADMINISTRATOR, OR THIRD PARTY ADMINISTRATOR	 SERVICE PROVIDER <i>Such as medical personnel, attorneys, interpreters, and copy services</i>
Involved Party				
Activity	<p><i>Sustains injury or illness arising out of, and occurring in the course of, employment.</i></p>	<p><i>Provides workers’ compensation coverage for workplace injuries or illnesses.</i></p>	<p><i>Provides full or partial payments to providers for services rendered to or on behalf of injured workers, or denies claims.</i></p>	<p><i>Provides treatment to injured or ill workers, or other services related to the injuries or illnesses.</i></p>
Potentially Fraudulent Activities	<p>The employee could be...</p> <ul style="list-style-type: none"> • Not injured at work • Not injured or ill • No longer injured or ill 	<p>The employer could be...</p> <ul style="list-style-type: none"> • Illegally uninsured • Underinsured • Not reporting the correct level of risk 	<p>These entities could...</p> <ul style="list-style-type: none"> • Issue phony policies • Collude with employers to commit premium fraud 	<p>The provider could...</p> <ul style="list-style-type: none"> • Claim payment for services not rendered or needed • Overbill for costs • Accept kickbacks for illegally referring injured workers

Sources: California State Auditor’s analysis of state law, publications from and websites for CDI and Industrial Relations, Rating Bureau reports, and information from district attorneys’ offices.

³ Insurers use factors such as employers’ payroll amounts, types of work performed, and safety histories to calculate workers’ compensation premiums. For instance, if an employer reports it has seven administrative staff (for which insurers charge lower premiums) when in fact those employees are roofers (for which insurers charge higher premiums), the employer has engaged in fraud.

We also use the term *employer fraud* to include willfully uninsured employers. Although an employer that is willfully uninsured can be charged with a crime separate from fraud, the insurance commissioner and the Fraud Assessment Commission (Fraud Commission) both mention willfully uninsured employers in their annual messages regarding objectives for the investigation and prosecution of workers’ compensation fraud.

Key Public Entities Involved in Workers' Compensation and the Fight Against Fraud

Industrial Relations

- Oversees the workers' compensation claims process and assists in resolving claim disputes.
- Oversees workers' compensation self-insurance.
- Helps prevent workers' compensation fraud by automatically staying liens filed by medical providers that are facing criminal charges for fraud and suspending providers from participating in the workers' compensation system if they are convicted of certain crimes.

CDI

- Receives and investigates referrals of possible workers' compensation fraud.
- Refers fraud cases to district attorneys' offices for prosecution.
- Audits special investigative units that insurers use to monitor claims for fraud.
- Helps prevent workers' compensation fraud through outreach efforts, including providing training to industry groups.

County District Attorneys' Offices

- Investigate and prosecute cases involving workers' compensation fraud.
- Help prevent workers' compensation fraud through outreach efforts, including providing training sessions to stakeholder groups; meeting with business groups and self-insured companies; and broadcasting the antifraud message across various mediums, including social media, radio, and television.

Fraud Commission

- Determines an annual aggregate assessment amount to fund workers' compensation antifraud efforts.
- Provides advice and consent to the insurance commissioner regarding the determination of the assessment's funding split between CDI and the district attorneys' offices.

Sources: State law and regulation, CDI's and Industrial Relations' websites, CDI's 2015 and 2016 *Annual Report of the Commissioner*, CDI's fiscal year 2016–17 *Report to the Fraud Assessment Commission*, district attorneys' offices' grant funding applications, and the *Governor's Budget* for fiscal year 2016–17.

Although uninsured employer fraud and employee fraud—as Table 1 on page 8 indicates—are the most frequent types of workers' compensation fraud cases, the largest monetary losses result from provider fraud and, to a lesser extent, employer premium fraud. A recent example highlights the scale of provider fraud. In 2017 two defendants who were associated with a single provider fraud case were charged with perpetrating workers' compensation fraud, engaging in conspiracy, and paying kickbacks. In this case, three medical billing and medical management companies provided the means by which the two defendants were able to bill a total of \$40 million in fraudulent claims. Of this amount, the two defendants received about \$23.2 million.

The State's Antifraud Efforts

To protect consumers, state and local entities play critical roles in fighting workers' compensation fraud, as noted in the text box. These efforts generally fit into one of four categories: prevention, detection, investigation, and prosecution. Prevention consists of efforts to dissuade individuals and businesses from committing workers' compensation fraud. These efforts can include outreach and education campaigns that inform employers and employees about how fraud can occur and explain its criminal consequences. Detection includes the work that the special investigative units of insurers perform to identify and refer possible instances of workers' compensation fraud to the attention of authorities. Depending on the circumstances, investigations of fraud cases may be conducted by federal, state, or local authorities, or combinations of the three. Finally, county district attorneys' offices prosecute workers' compensation fraud cases. These prosecutions can result in convictions, imprisonment, fines, and restitution orders. Workers' compensation fraud in California can be either a felony or a misdemeanor, depending on the facts and circumstances of a case.

Although Industrial Relations is responsible for monitoring the administration of California's workers' compensation claims, CDI is the lead state agency for the criminal investigation of workers' compensation fraud. The mission statement for

CDI's Enforcement Branch charges it with protecting the public from economic loss and distress by actively investigating, arresting, and referring for prosecution or other adjudication those who commit insurance fraud. Although CDI can receive allegations of workers' compensation fraud—called suspected fraudulent claim referrals (referrals)—from anyone, state law requires every insurance company to have or hire a special investigative unit that submits referrals to both CDI and district attorneys' offices. When CDI receives a referral, it reviews it for accuracy and completeness, directs the referral to the appropriate regional office, performs preliminary intelligence gathering, and makes a decision about whether to initiate a formal investigation. Factors CDI considers when making a decision include public safety, evidence quality, the insurance commissioner's strategic initiatives, and the availability of investigative resources. Figure 3 on the following page depicts the referral process.

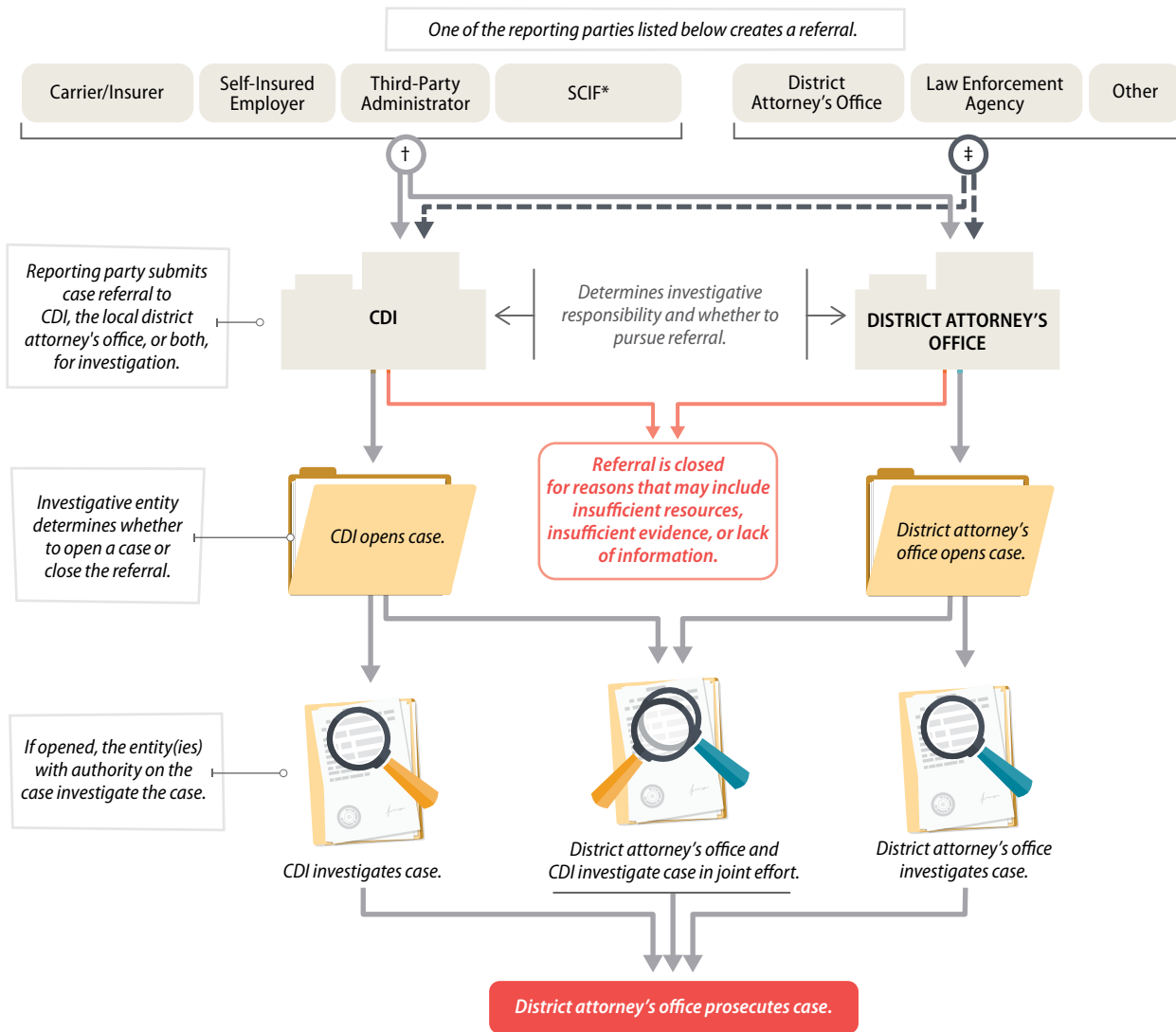
Based on the available information, CDI may open a case for investigation by its staff; agree to have a district attorney investigate the referral; jointly investigate the referral with a district attorney's office; or close the referral due to insufficient evidence, insufficient resources, or other reasons. CDI's investigators conduct fraud investigations at its nine regional offices, as Figure 4 on page 13 depicts. Each regional office is assigned specific counties and works with the district attorneys' offices in those counties.⁴ If CDI chooses to investigate a case itself, it can subsequently refer that case to a district attorney's office for prosecution. Although CDI's investigators fight several types of insurance fraud—including health care and automobile—its data indicate that from fiscal years 2013–14 through 2016–17, nearly 44 percent of the fraud investigation hours its staff charged involved workers' compensation. Additionally, district attorneys' offices may initiate their own cases based on referrals and complete both the investigative and prosecutorial efforts.

The State funds efforts to combat workers' compensation fraud using an assessment that employers pay rather than the State's General Fund. Specifically, in 1991 the State enacted legislation to establish the Fraud Commission to allocate funding to enhance state and local efforts to combat workers' compensation fraud. The Fraud Commission consists of seven members, six of whom the Governor appoints as representatives of workers' compensation stakeholder groups; the seventh is the president of the State Compensation Insurance Fund (SCIF) or a designee. The Fraud Commission annually establishes an aggregate assessment amount that employers must pay to support the Workers' Compensation Insurance

⁴ CDI divides Los Angeles County between two different regional offices.

Fraud Program. The State uses the funds resulting from this assessment to help pay for CDI's and the district attorneys' offices' efforts to fight workers' compensation fraud.

Figure 3
Process to Initiate, Investigate, and Prosecute a Fraud Case in the Workers' Compensation System



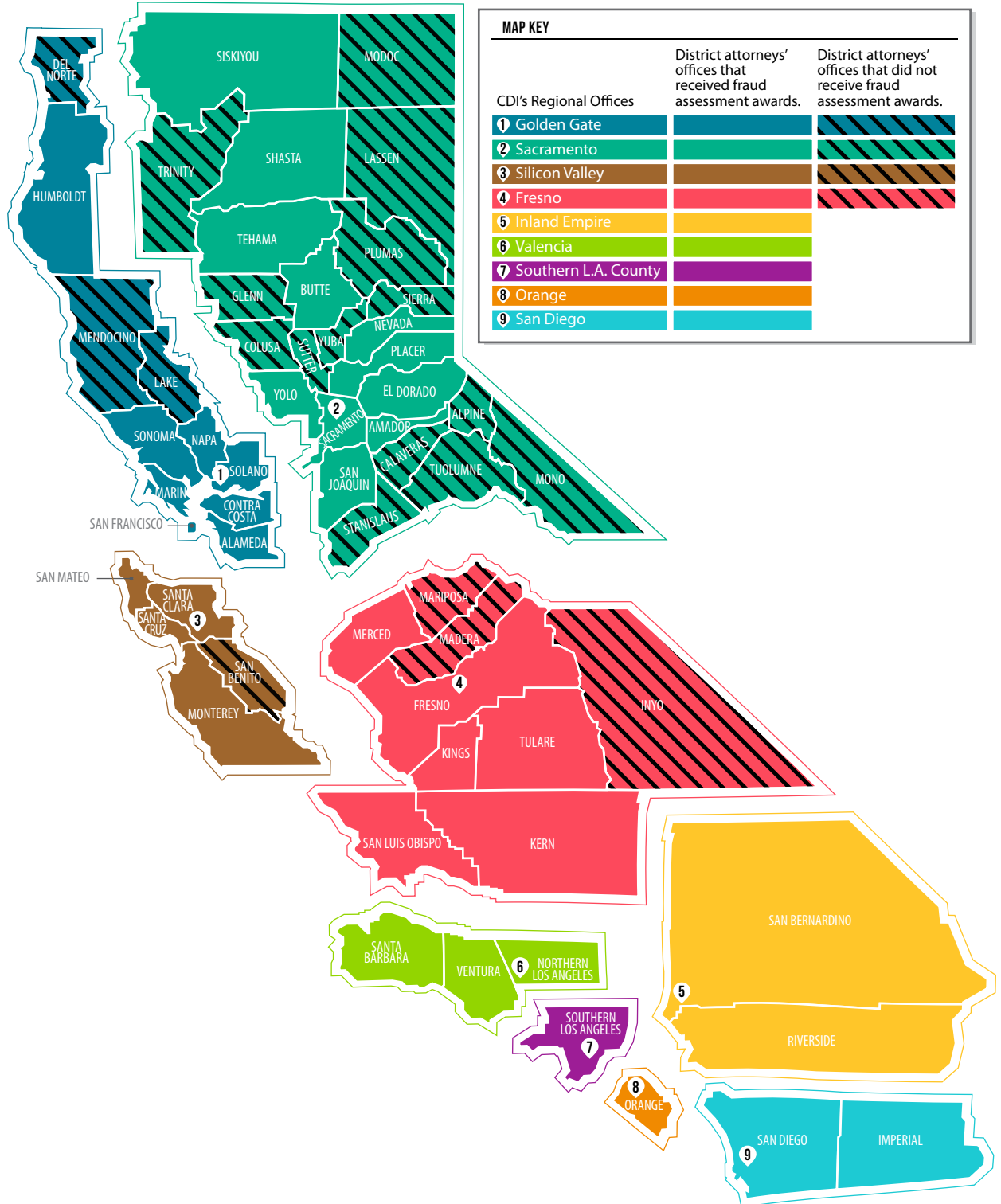
Sources: CDI's instructions for reporting suspected fraudulent insurance claims, CDI's internal documents, district attorneys' offices' grant applications, the Insurance Code, and documents regarding SCIF.

* SCIF is a quasi-public entity that competes with other insurers to provide workers' compensation insurance. It is the largest workers' compensation insurer in California. It is also a third-party administrator for public employers in the State who opt to self-insure or who are legally uninsured.

† State law requires that insurers, including self-insured employers, third-party administrators, and SCIF, report suspected fraudulent claims to both the CDI and their local district attorneys' offices.

‡ All other entities reporting suspected fraudulent claims send the referrals to CDI, their local district attorneys' office, or both.

Figure 4
Map of CDI’s Regional Offices and of the District Attorneys’ Offices That Were Awarded Fraud Assessment Funds for Fiscal Year 2016–17

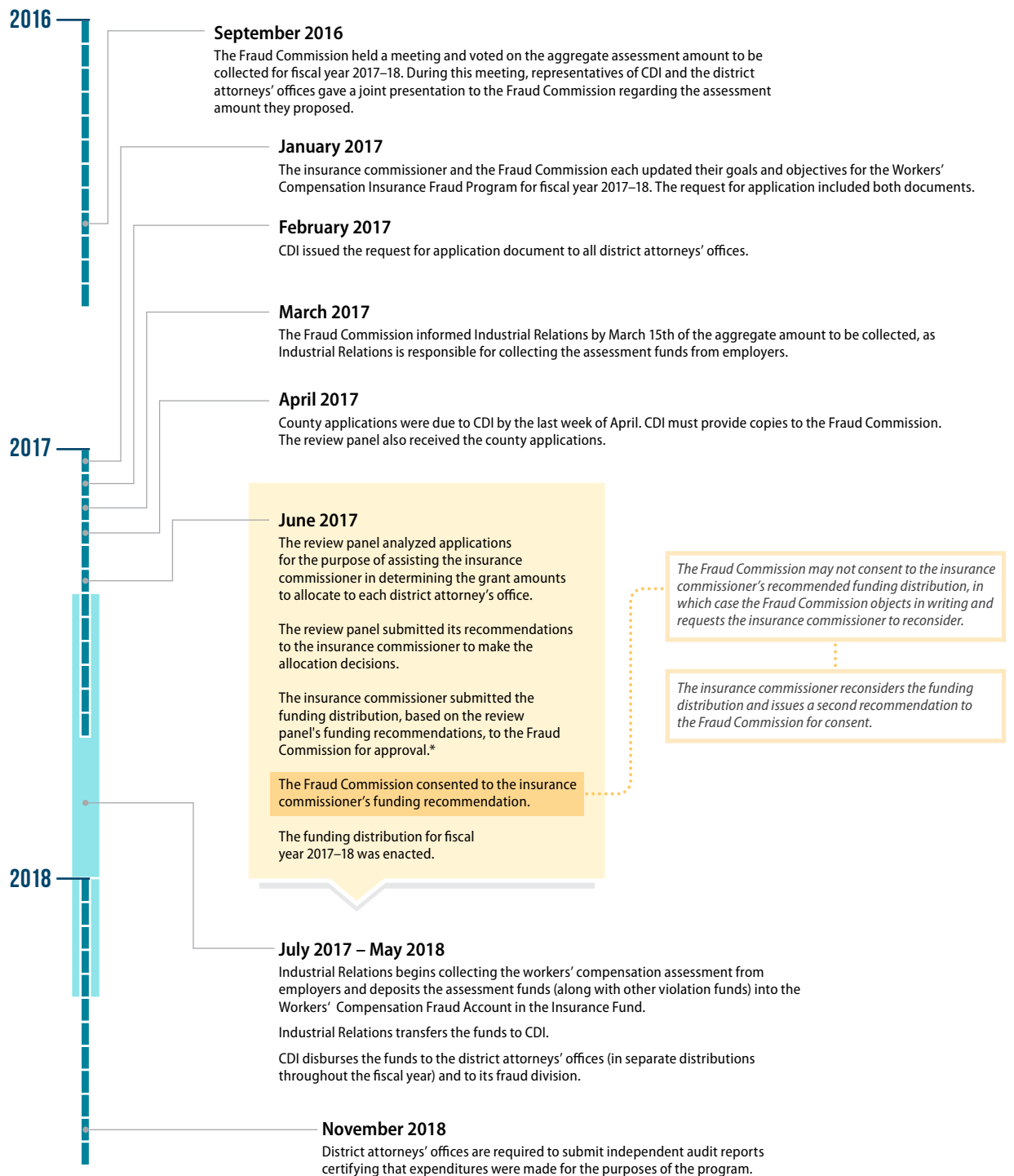


Sources: CDI’s Fraud Division’s *Report to the Fraud Assessment Commission* for fiscal year 2016–17 and CDI’s grant distribution documents.
Notes: The Santa Cruz County District Attorney’s Office declined its \$49,000 award without explanation.
Amador, Humboldt, and Yolo counties submitted applications representing their own counties plus seven others.

State law requires that, after incidental expenses, CDI and the district attorneys' offices each receive a minimum 40 percent of the fraud assessment funding. State law is largely silent on the allocation of the remaining 20 percent, giving the insurance commissioner and the Fraud Commission the discretion to allocate it however they deem appropriate between CDI and the district attorneys' offices. For fiscal years 2013–14 through 2016–17, they allocated the discretionary 20 percent almost entirely to district attorneys' offices, leaving CDI with the minimum 40 percent funding state law requires it to receive. For fiscal year 2016–17, the total fraud assessment amount was about \$58.9 million. Figure 4 identifies the district attorneys' offices that received awards for fraud assessment funding for fiscal year 2016–17, while Figure 5 shows a timeline of the Fraud Commission's grant program.

Once the insurance commissioner and the Fraud Commission determine the assessment amount they will allocate to the district attorneys' offices, a five-person review panel develops recommendations for the distribution of these funds among the offices that applied for funding. The review panel consists of two members of the Fraud Commission, the chief of CDI's Fraud Division or a designee, Industrial Relations' director or a designee, and an expert in consumer crime investigation and prosecution whom the insurance commissioner designates. The insurance commissioner then considers the review panel's recommendations and may make adjustments, which the Fraud Commission considers for approval. In the distribution decision for fiscal year 2017–18 allocations, the insurance commissioner adjusted the recommended allocations for five counties. However, none of the adjustments exceeded \$11,500. Table 2 on page 16 shows the funding awards to district attorneys' offices and CDI for fiscal years 2013–14 through 2016–17.

Figure 5
Process for the Collection and Distribution of Fiscal Year 2017–18 Workers’ Compensation Assessment Funds



Sources: Insurance Code, California Code of Regulations, review of CDI’s internal documents, interviews with CDI staff, the fiscal year 2017–18 request for application, and Fraud Commission meeting minutes.

* According to the assistant chief of CDI, the insurance commissioner also decides, with the advice and consent of the Fraud Commission, how much of the discretionary 20 percent should be allocated to CDI or the district attorneys’ offices. She stated that, for at least the last decade, the 20 percent has been included within the proportion allocated to the district attorneys’ offices, without an annual redetermination.

Table 2
Workers' Compensation Insurance Fraud Program Funding for County District Attorneys' Offices and CDI
Fiscal Years 2013–14 Through 2016–17

COUNTY	FISCAL YEAR			
	2013–14	2014–15	2015–16	2016–17
Alameda	\$1,425,916	\$1,435,733	\$1,511,933	\$1,511,933
Amador	410,333	386,479	386,479	393,896
Butte	75,421	65,514	76,000	76,378
Contra Costa	619,000	644,405	850,000	864,000
El Dorado	251,615	248,088	271,428	292,828
Fresno	1,152,108	1,114,206	1,236,000	1,116,000
Humboldt	179,016	168,480	200,000	200,000
Imperial	163,495	163,495	163,495	125,450
Kern	827,500	886,522	1,058,000	752,904
Kings	263,875	263,875	263,875	263,875
Los Angeles	5,805,244	5,869,952	6,458,643	6,729,177
Marin	233,585	233,868	245,648	245,000
Madera		15,000*		
Merced	94,012	95,210	174,000	175,209
Monterey	607,200	605,320	660,000	660,000
Napa	130,153	130,741	135,500	123,609
Nevada	66,190	66,315	73,525	75,049
Orange	3,620,608	3,629,627	3,966,000	4,152,802
Placer			175,000	175,000
Riverside	1,529,658	1,588,669	2,020,000	2,084,970
Sacramento	880,794	880,635	910,000	952,027
San Bernardino	2,244,246	2,101,458	2,113,943	1,968,662
San Diego	4,477,303	4,567,000	4,990,459	5,028,198
San Francisco	702,366	679,946	713,943	758,121
San Joaquin	484,647	469,859	472,972	472,972
San Luis Obispo	62,254	55,803	54,419	54,419
San Mateo	680,286	689,314	691,588	677,353
Santa Barbara	272,800	272,800	340,420	331,499
Santa Clara	2,446,586	2,432,404	2,626,811	2,626,811
Santa Cruz	149,332	131,425	118,223	49,000 [†]
Shasta	157,739	144,342	154,955	137,307
Siskiyou	34,606	43,384	52,992	46,832
Solano	169,710	169,710	175,742	169,476
Sonoma	56,804	35,388	66,800	82,120
Tehama	84,017	84,214	110,248	112,127
Tulare	504,211	499,033	499,258	501,165
Ventura	686,997	678,109	683,465	708,652
Yolo	224,765	228,069	250,067	257,010
Total County funding	\$31,774,392	\$31,774,392	\$34,951,831	\$34,951,831
CDI funding	21,395,608	21,395,608	23,535,169	23,535,169
Incidental expenses[‡]	275,000	275,000	375,000	375,000
Total assessment	\$53,445,000	\$53,445,000	\$58,862,000	\$58,862,000

Sources: CDI's aggregate assessment and distribution tracking documents.

* Madera County declined its \$15,000 funding award for fiscal year 2014–15.

† Santa Cruz County declined its \$49,000 funding award for fiscal year 2016–17.

‡ *Incidental expenses* are those costs incurred by CDI and Industrial Relations to administer the program and may include the Fraud Commission's expenses, Industrial Relations' costs of collection of assessments, administrative support of CDI's Fraud Division program component, and CDI's management of the distribution and oversight of funds allocated to the district attorneys' offices.

In addition to CDI and the Fraud Commission, Industrial Relations also takes steps to reduce workers' compensation fraud. Specifically, to ensure employees receive appropriate workers' compensation benefits in a timely manner, Industrial Relations audits insurers, self-insured employers, and third-party administrators for compliance with their obligations under the Labor Code and Industrial Relations' regulations. Further, in 2016 the enactment of two bills gave Industrial Relations new tools to help combat workers' compensation fraud. For example, one law allows it to automatically stay any liens providers of medical services file if those providers are charged with certain fraud-related crimes.⁵ The other law requires the administrative director of Industrial Relations' Division of Workers' Compensation to promptly suspend providers from participating in the workers' compensation system if they are convicted of certain crimes, including worker's compensation fraud. Furthermore, Industrial Relations is the lead agency for the Labor Enforcement Task Force, a multiagency organization aimed at fighting the underground economy. This task force visits employers to ensure they are paying required taxes, fees, and penalties. The task force identifies workers' compensation insurance violations as part of its efforts.

Scope and Methodology

The Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor to audit public agencies' processes for preventing, detecting, and prosecuting fraud in California's workers' compensation system. Table 3 beginning on the following page lists the Audit Committee's objectives and the methods we used to address them.

⁵ California law allows providers of services to injured workers to file liens in the workers' compensation system to secure payment for those services.

Table 3
Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.	<ul style="list-style-type: none"> Reviewed relevant laws, rules, and other background materials related to the State's antifraud efforts associated with workers' compensation. Interviewed key staff at CDI, Industrial Relations, the Fraud Commission, and the district attorneys' offices for Los Angeles, Orange, and San Diego counties.
2 Identify the state, local, and other agencies that are responsible for workers' compensation system antifraud efforts and describe the relationships, roles, and responsibilities of these agencies in preventing, detecting, and prosecuting workers' compensation fraud.	<ul style="list-style-type: none"> Interviewed key individuals at CDI, Industrial Relations, the Fraud Commission, and the district attorneys' offices for Los Angeles, Orange, and San Diego counties. Reviewed laws, regulations, policies, annual reports, and websites related to workers' compensation insurance.
3 Determine how and to what extent, if any, the various governmental agencies—including CDI and Industrial Relations—coordinate their efforts with insurers and self-insured employers to prevent and detect workers' compensation fraud. Identify any gaps or weaknesses in their coordination efforts and areas for improvement.	<ul style="list-style-type: none"> Examined the rates at which relatively larger insurers submitted referrals of possible workers' compensation insurance fraud to CDI to assess their detection efforts. Attended the June 2017 meeting at which the five-person review panel received budget proposals and heard presentations from representatives of county district attorneys' offices regarding fraud assessment funds to identify how counties planned to use these funds to prevent, investigate, and prosecute workers' compensation fraud. We also examined the proposals submitted by the three counties we visited to obtain more detailed information regarding their efforts. Examined reports and other documents regarding CDI's and Industrial Relations' participation in the Joint Enforcement Strike Force and the Labor Enforcement Task Force, both tasked to fight California's underground economy, including ensuring employer compliance with workers' compensation laws. Examined Industrial Relations' audits of insurers, self-insured employers, and third-party administrators to ensure compliance with state workers' compensation regulations regarding the provision of benefits. Examined the memorandum of understanding between Industrial Relations and CDI regarding the sharing of data for the purpose of identifying possible workers' compensation fraud, examined examples of the information shared, and interviewed CDI staff to assess the effectiveness of the agreement's results.
4 Evaluate whether the State's existing system of distributing fraud assessment funds to local district attorneys' offices has been effective in increasing the frequency with which workers' compensation fraud cases have been accepted and successfully prosecuted.	<ul style="list-style-type: none"> Reviewed the State's criteria and process for collecting and disbursing fraud assessment funds. Interviewed members of the Fraud Commission and the Review Panel, and relevant staff at CDI and three district attorneys' offices. We also reviewed the Fraud Commission's meeting minutes. To determine the local agencies to include as part of this audit, we examined information from CDI applicable to district attorneys' offices, including the number of investigations opened, number of suspected fraudulent claims received, amount of fines and restitution ordered, and the average amount of grant funding received. Based on this information, we selected the district attorneys' offices of Los Angeles, Orange, and San Diego counties.
5 Review the methods used and rationale for allocating fraud assessment funds between investigative and prosecutorial functions.	<ul style="list-style-type: none"> Reviewed and analyzed applications for fraud assessment funding submitted by the three district attorneys' offices we selected, audit reports for the three district attorneys' offices, and the budget and expenditure information for both CDI and the three district attorneys' offices. Obtained and analyzed DAR system information for all county participants from fiscal years 2013–14 through 2015–16.
6 Evaluate the efficiency of CDI, Industrial Relations, and a selection of three local agencies in deploying their investigative and prosecutorial resources. Determine the extent to which resources are appropriately balanced between the investigative and prosecutorial functions.	<ul style="list-style-type: none"> Obtained and reviewed the Fraud Integrated Database, which contains referral information, and analyzed outcomes for both CDI and the participating district attorneys' offices. Interviewed relevant staff and reviewed county applications for our selected district attorneys' offices to determine how each office addressed investigation and prosecution, its performance measures, and its caseload for different fraud types.

AUDIT OBJECTIVE	METHOD
7 Review and evaluate the effectiveness of CDI's efforts to recruit and retain peace officer fraud investigators.	<ul style="list-style-type: none"> Reviewed documents obtained from CDI pertaining to its recruiting and retention efforts for fraud investigators, analyzed the number of CDI's investigator positions authorized and filled, and interviewed key personnel. Analyzed personnel data from the State Controller's Office for fiscal years 2013–14 through 2016–17 to determine the number of new hires and separations for fraud investigators at CDI.
8 Determine how antifraud resources pertaining to workers' compensation are organized and directed in other large states. Assess whether there are alternative structures that would be more effective in identifying, prosecuting, and preventing fraud.	<ul style="list-style-type: none"> Based on state population statistics obtained from the U.S. Census Bureau's website, we selected Florida, New York, and Texas as the other states to include as part of our audit. For the three selected states, we examined antifraud information from their websites, reviewed publicly available annual reports, and interviewed individuals involved with the antifraud efforts. Because our review of these three states failed to disclose alternative structures that would be more effective for California, we also interviewed the executive director of the Coalition Against Insurance Fraud (Coalition) to obtain perspective on nationwide antifraud efforts related to workers' compensation. The Coalition's executive director stated that California had the most robust system of antifraud for workers' compensation and that not all states incorporate workers' compensation into their fraud-fighting efforts.
9 To the extent possible, identify for the most recent three fiscal years the amount of discovered fraud perpetrated by insurers, employers, employees, medical providers, and attorneys.	Analyzed data from CDI's DAR system and present this information in Table 1 on page 8 in the Introduction.
10 Review and assess any other issues that are significant to the audit.	No additional reportable issues significant to the audit came to our attention.

Sources: California State Auditor's analysis of the Audit Committee's audit request number 2017-103 as well as state law, regulations, and information and documentation identified in the column titled *Method*.

Assessment of Data Reliability

In performing this audit, we obtained electronic data files extracted from the data sources listed in Table 4 beginning on the following page. The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support findings, conclusions, or recommendations. Table 4 describes the analyses we conducted using data from these sources, our methods for testing, and the results of our assessments. Although these determinations may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

Table 4
Methods Used to Assess Data Reliability

DATA SOURCE	PURPOSE	METHOD AND RESULT	CONCLUSION
State Controller's Office Uniform State Payroll System Fiscal years 2013–14 through 2016–17	Identify CDI fraud investigators that were hired or separated during the audit period and the subsequent employing agencies for separated fraud investigators.	<ul style="list-style-type: none"> We performed dataset verification procedures and electronic testing of key data elements and did not identify any issues. To gain assurance of the completeness of the data, we verified it included payroll information for all CDI fraud investigators contained in the Fraud Integrated Database System and found no exceptions. To gain assurance over the accuracy of the data, we traced key data elements to source documentation for a selection of 29 fraud investigators and found no exceptions. 	Sufficiently reliable for the purposes of the audit.
California Public Employees' Retirement System (CalPERS) Actuarial Valuation System As of fiscal year 2015–16	Identify the age of CDI fraud investigators who separated from state service during the audit period.	<ul style="list-style-type: none"> We performed dataset verification procedures and electronic testing of key data elements and did not identify any issues. To gain assurance of the completeness of the data, we compared it to a listing of fraud investigators that separated from state service and found that the data did not contain birth-date information for three of the 41 fraud investigators. To gain assurance of the accuracy of the data, we traced key data elements to source documentation for a selection of 29 fraud investigators. We verified the birth-date information for 24 of the fraud investigators. However, we were unable to test the remaining five because CDI lacked source documentation for the birth dates. 	<p>Undetermined reliability for the purposes of this audit.</p> <p>Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.</p>
CDI Fraud Integrated Database System Fiscal years 2013–14 through 2016–17	Identify suspected fraudulent claims, associated dollar amounts, and related information, and calculate a referral rate per \$10 million in earned workers' compensation premiums.	<ul style="list-style-type: none"> We performed dataset verification procedures and electronic testing of key data elements and did not identify any issues. We did not perform accuracy and completeness testing on these data because the source documents required for this testing are stored at various locations throughout the State, making such testing cost-prohibitive. To gain some assurance, we compared the data to published totals for the years that the information was available and found that the totals materially agreed with our data. 	<p>Undetermined reliability for the purposes of this audit.</p> <p>Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.</p>
CDI District Attorney Program Reports (DAR) system Fiscal years 2013–14 through 2016–17	Determine the number of cases and the amount of chargeable fraud by fraud type, and select district attorneys' offices to visit.	<ul style="list-style-type: none"> We performed dataset verification procedures and electronic testing of key data elements and did not identify any issues. We did not perform accuracy and completeness testing on these data because the source information required for this testing is stored at various locations throughout the State, making such testing cost-prohibitive. To gain some assurance of the data's reliability, we reviewed the results found in CDI audit reports covering fiscal year 2014–15 for two of the three district attorneys' offices we visited. Our review included steps to examine the case and chargeable fraud information the offices submitted to the DAR system. We found no reported findings. 	<p>Undetermined reliability for the purposes of this audit.</p> <p>Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.</p>

DATA SOURCE	PURPOSE	METHOD AND RESULT	CONCLUSION
<p>CDI</p> <p>Lists of the amounts of earned workers' compensation premiums for California insurers for which CDI cites the National Association of Insurance Commissioners (NAIC) as the source</p> <p>2015 and 2016</p>	<p>Identify California insurers with more than \$150 million in earned workers' compensation premiums and calculate a referral rate per \$10 million in earned premiums.</p>	<p>We did not perform accuracy and completeness testing on these data because NAIC does not fall within our audit authority. To gain some assurance that CDI accurately reported the NAIC information, we compared earned premium totals obtained from CDI's lists for a selection of insurers to comparable information shown on NAIC's website and did not identify any issues.</p>	<p>Undetermined reliability for the purposes of this audit.</p> <p>Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.</p>

Sources: California State Auditor's analysis of various documents, interviews, and data obtained from the entities listed in this table.

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Chapter 1

CALIFORNIA COULD IMPROVE ITS DETECTION OF WORKERS' COMPENSATION FRAUD

Chapter Summary

As we indicate in the Introduction, a key step in combatting workers' compensation fraud is its detection. Nonetheless, we identified weaknesses in the processes CDI, Industrial Relations, and insurers use to detect fraud. For example, CDI does not currently take advantage of a key indicator that could help it identify and audit insurers that may not be adequately reporting potential fraud. Specifically, although state law requires insurers to investigate suspected fraud and refer to CDI and district attorneys' offices those claims that show reasonable evidence of fraud, insurers vary significantly in the number of referrals they submit. Of the 21 insurers that we examined, eight submitted one or fewer referrals per \$10 million in earned premiums for at least one of the two years we examined.⁶ Low referral rates could indicate that insurers are not referring suspected workers' compensation fraud, leaving this potential fraud uninvestigated. However, CDI does not use the rate of insurers' submissions of referrals as a tool to assess risk when identifying those insurers it will audit.

In addition, Industrial Relations has not fully documented its procedures for implementing a critical tool for combatting workers' compensation fraud by providers. Provider fraud cases can continue unnoticed for years, and a single case can cost an insurer millions of dollars. To more quickly uncover such fraud, Industrial Relations is in the process of implementing data analytics, which will allow it to examine large volumes of data. However, Industrial Relations is still in the beginning stages of its implementation and has not yet fully documented how it will identify potential fraud and use the results of such examinations. Because data analytics has the potential for high rates of return, Industrial Relations should fully document its data analytics efforts as soon as possible.

Finally, California can further improve its fraud detection efforts related to workers' compensation by requiring insurers to periodically issue explanation of benefits statements (EOB statements) to injured employees. These statements itemize the types of services rendered, the dates employees received the services, and service fees paid on their behalf. EOB statements

⁶ The term *earned premiums* refers to the amount of premiums an insurer recognizes as revenue for a certain period of time, such as a year.

State law requires that within 60 days of having a reasonable belief that a claim may be fraudulent, an insurer must submit a referral to both CDI and the district attorney's office where the loss occurred.

provide injured employees with the opportunity to review the services for which providers bill and to identify potentially fraudulent charges.

Some Insurers Are Significantly Less Likely Than Others to Report Suspected Workers' Compensation Fraud

Despite a requirement that insurers refer to CDI and district attorneys' offices those claims that show reasonable evidence of fraud, the number of referrals insurers submit varies significantly, leading us to question whether some insurers are reporting all suspected fraud. By law, every insurer must have or use a special investigative unit to pursue instances of suspected fraud. State law further requires that within 60 days of having a reasonable belief that a claim may be fraudulent, an insurer must submit a referral to both CDI and the district attorney's office where the loss occurred. We expected that those insurers with relatively higher amounts of earned premiums—indicating that they likely process more workers' compensation claims—would also have generally higher frequencies of referring suspected fraudulent claims to CDI and the district attorneys' offices. However, our review found that referral rates varied significantly.

According to the *2016 Annual Report of the Commissioner*, referrals are CDI's primary source of leads for workers' compensation fraud investigations. CDI can receive referrals from anyone: insurers, employers, employees, medical providers, and the general public. Referrals can be for any type of workers' compensation fraud: employee, employer, medical provider, and others. Referrals most often involve employee fraud; the numbers of employer and provider fraud referrals are also considerable. Table 5 provides more information regarding referrals for fiscal years 2013–14 through 2016–17.

In our April 2004 audit report *Workers' Compensation Fraud: Detection and Prevention Efforts Are Poorly Planned and Lack Accountability*, Report 2002-018, we concluded that some insurers appeared to underreport suspected workers' compensation fraud while others appeared to regularly refer suspected fraudulent claims. We found that although five of the 23 insurers we reviewed during that audit referred more than one claim per \$1 million in earned premiums, some of the remaining 18 insurers might have been failing to fulfill their responsibilities to refer suspected fraud, including some that did not submit a single referral during one or more of the years in our audit period. We also identified barriers that might prevent insurers from consistently referring suspected fraud and recommended that CDI take steps to address these barriers.

Table 5
CDI Receives Thousands of Fraud Referrals Each Year
Fiscal Years 2013–14 Through 2016–17

FRAUD TYPE	FISCAL YEAR							
	2013–14		2014–15		2015–16		2016–17	
	REFERRALS	PERCENT OF TOTAL	REFERRALS	PERCENT OF TOTAL	REFERRALS	PERCENT OF TOTAL	REFERRALS	PERCENT OF TOTAL
Employee	4,802	84.2%	4,933	83.1%	4,405	82.1%	3,266	78.3%
Employer	435	7.6	475	8.0	459	8.6	445	10.7
Medical provider*	236	4.1	240	4.0	253	4.7	228	5.5
Legal provider	55	1.0	48	0.8	83	1.5	47	1.1
Other	177	3.1	238	4.0	166	3.1	187	4.5
Totals	5,705	100.0%	5,934	100.0%	5,366	100.0%	4,173	100.0%

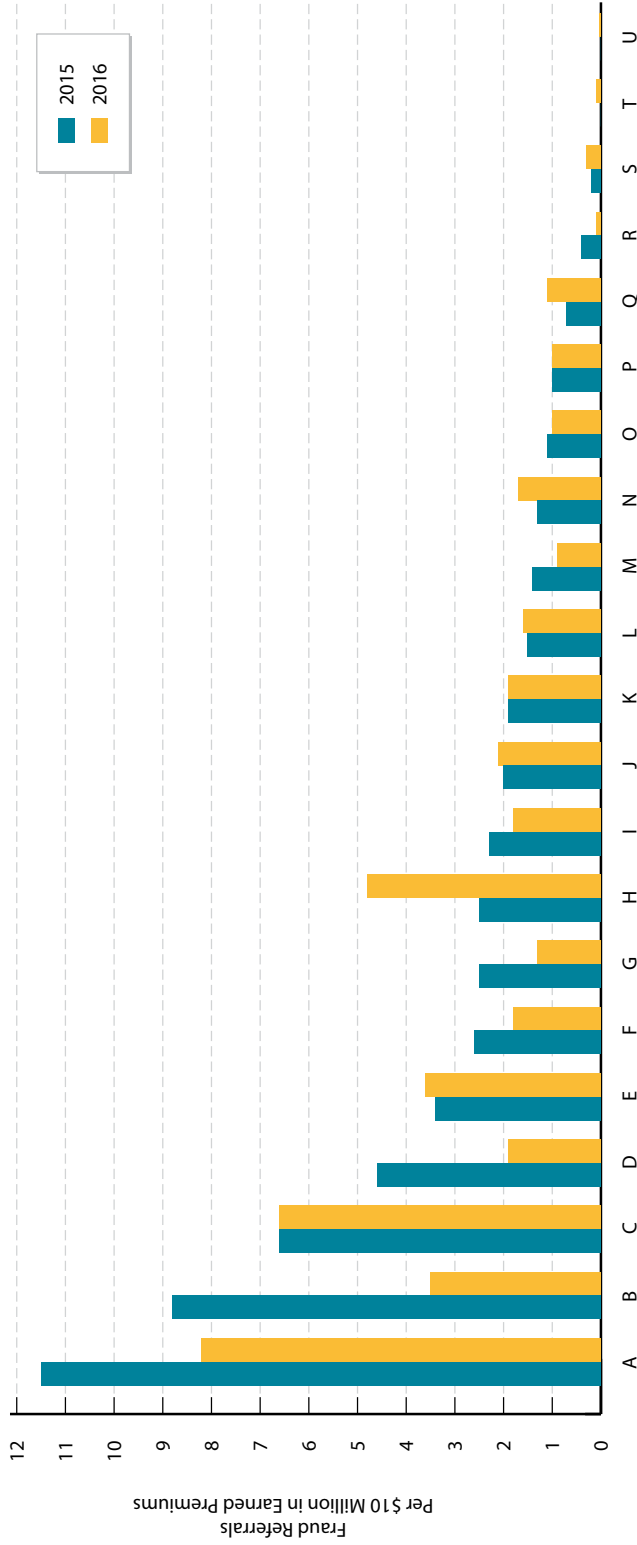
Source: California State Auditor’s analysis of data obtained from CDI’s Fraud Integrated Database System.

Note: Due to rounding, the percent columns may not equal exactly 100 percent when added.

* *Medical Provider* also includes referrals related to pharmacies.

During our current audit, we continued to see significant variation in the rates at which insurers submitted referrals, leading us to believe that some insurers may be underreporting fraud. As Figure 6 on the following page shows, we calculated the referral rates for 21 insurers that each had more than \$150 million in earned premiums for 2015 and 2016. In 2016 these insurers collectively earned almost \$8 billion in premiums and represented 62 percent of workers’ compensation earned premiums in California. For the two years we reviewed, the insurers’ referral rates ranged from a high of 11 referrals per \$10 million in earned premiums to a low of no referrals, while the actual number of referrals ranged from more than 350 to zero. Of the 21 insurers, eight submitted one or fewer referrals per \$10 million in earned premiums in at least one of the two years we examined. Because of the high amount of estimated fraud in the workers’ compensation system, the rates we observed for these eight insurers seemed low and could indicate that they are not referring suspected workers’ compensation fraud. These eight insurers collectively had \$3.9 billion in earned premiums in 2016, which represented 31 percent of workers’ compensation premiums in California.

Figure 6
Fraud Referral Rates by Large Insurers Vary Significantly



The 21 Insurance Companies With Greater Than \$150 Million in Earned Premiums

Sources: California State Auditor's analysis of referral data from CDI's case management system and of premium data from CDI's market share reports.

We believe that when an insurer with over \$150 million in annual earned workers' compensation premiums submits few or no referrals during a year, it should at least prompt CDI to make an inquiry. Because insurer referrals are the primary method the State uses to initiate investigations into suspected fraudulent workers' compensation claims, we asked CDI whether it was aware of the relatively low referral rates by these eight insurers, whether it knew why the referral rates were so low, and whether it was reasonable for the referral rates to be so low. The manager who oversees CDI's compliance office (compliance manager) indicated that a low number of referrals by itself does not mean that the insurer is not detecting, investigating, and then referring suspected fraud to CDI. Instead, a low number of referrals may be attributable to other factors, such as the insurer having few California claims. The compliance manager further stated that the reasons for low referral rates may vary based on lines of business and specialized insurance products. However, when we interviewed a senior executive with an insurer, he stated that the cost of the special investigative units is a factor affecting the quantity of referrals and that certain insurers invest only enough to comply with regulations, while others are vigorous in fighting fraud. The compliance manager agreed that insurers' attitudes toward fraud may play a role, stating that some are committed to combatting it while others accept it as a cost of doing business.

Other entities have called attention to certain insurers' actions by publishing reports on the insurers' performances. For example, Texas law requires that the Texas Department of Insurance publish a periodic report card that evaluates specified workers' compensation health care provider networks on the cost and the quality of medical care provided to injured workers. Similarly, California law requires Industrial Relations to publish the result of its Profile Audit Review in an annual report that lists the insurers it audited in that year, identifies how each scored, and ranks how each performed based on the audit. We believe a comparable public report that rates insurers' antifraud efforts could motivate insurers with minimal compliance to improve and could also better inform consumers about insurers' fraud-fighting efforts—or lack thereof.

Although California regulations require insurers to submit annual reports to CDI regarding the performance of their special investigative units, CDI does not currently screen these reports for low referral rates relative to other insurers. The regulations require these reports to include the number of claims the insurers processed, the number of claims they referred to their special investigative units, and the number of incidents of suspected insurance fraud they reported to CDI and district attorneys' offices for the past calendar year. The annual reports also provide overviews of the special investigative units' organizational

Although California regulations require insurers to submit annual reports to CDI regarding the performance of their special investigative units, CDI does not currently screen these reports for low referral rates relative to other insurers.

CDI periodically examines insurers' special investigations units; however, it does not ensure that it selects large insurers with low referral numbers when planning its audits.

arrangements of antifraud personnel; descriptions of the units' staff expertise and how that expertise meets CDI's requirements; descriptions of the units' methods of investigation and written procedures for detecting, investigating, and reporting suspected fraud; and the units' plan for initial and ongoing training for integral antifraud personnel. CDI's compliance office's procedures indicate that staff analyze these reports for discrepancies and noncompliance issues. However, the compliance manager stated that CDI does not evaluate the reports for low referral rates relative to other insurers.

In addition, CDI periodically examines insurers' special investigations units; however, it does not ensure that it selects large insurers with low referral numbers when planning its audits. According to CDI's compliance review program, the compliance office is responsible for reviewing over 1,100 insurers and their special investigative units. CDI has staffed its compliance office with four to six auditors for the last 10 years. According to the compliance manager, CDI's management decides which insurers to audit. He also indicated that because of limited staff, CDI uses a risk-based approach when selecting insurers for review. Some of the risk factors CDI considers are the length of time since an insurer's last audit, the insurer's market size, any complaints CDI has received, and information in the insurer's annual report for its special investigative unit. The compliance manager supplied a schedule showing that the compliance office has averaged roughly 12 audits per year for the last four years. Because of the large number of special investigative units and the small number of CDI audit staff, the compliance office could benefit from using an audit selection criterion that compares large insurers' referral rates with those of their peers. Since fiscal year 2013–14, CDI's compliance office has examined four of the eight insurers we selected that had a rate of one or fewer referrals in either 2015 or 2016. Following CDI's disclosure of the results of these examinations, two of the insurers increased the number of referrals they made, while the other two did not meaningfully change the numbers of their referrals.

Industrial Relations Has Not Yet Fully Documented the Procedures for Its Provider Fraud Data Analytics Efforts

Provider fraud cases can continue unnoticed for years, and a single case can cost insurers millions of dollars. To better fight this type of fraud, the State is in the process of implementing data analytics to predict which providers may be committing workers' compensation fraud. Two consultants, which CDI and Industrial Relations commissioned, specifically recommended in 2008 and again in 2017 that Industrial Relations explore and implement data analytics. According to one of the consultants, data analytics is a rapidly

developing field of information science that involves intensive examination of large volumes of data to discover deeper insights, make predictions, and generate recommendations.

Industrial Relations' Anti-Fraud Unit recently began using data analytics both to support new laws enacted in 2016 that related to workers' compensation liens and to uncover previously unidentified provider fraud. Its efforts related to uncovering new provider fraud are still in the nascent stages. According to Industrial Relations' documentation, the Anti-Fraud Unit has a team responsible for implementing data analytics. The Anti-Fraud Unit performs both descriptive and predictive analytics. Descriptive analytics is a tool that can help identify patterns of past behavior among providers—in other words, what happened—while predictive analytics is a tool that can help identify possible patterns that indicate provider fraud—in other words, what could happen. Industrial Relations told us that as of October 2017, it had provided two lists of potentially fraudulent providers that its data analytics effort had identified to CDI. CDI is then responsible for matching these potentially fraudulent providers to its current investigations. The assistant chief of CDI's Fraud Division told us that CDI already had investigations underway for most providers on the first list and that CDI had forwarded this list to its regional offices for their review. She also stated that although CDI was still checking the second list against its internal information, it was confident that the second list would uncover previously unknown provider fraud.

Despite the potential value of the lists it has already produced, we believe that Industrial Relations could do more to ensure the success of its data analytics efforts. Specifically, it has not yet fully documented the procedures for these efforts, resulting in a lack of specificity about how it intends to move forward. For example, when we requested a plan for its data analytics efforts, Industrial Relations provided only draft processes for the Anti-Fraud Unit that did not include any specifics related to data analytics; an undated, one-page draft schematic of the feedback loop for when data analytics identify suspicious activity; and a list of seven indicators that other providers convicted of fraud exhibited. Industrial Relations later provided a final protocol manual for its Anti-Fraud Unit and its activities. However, this protocol manual included only limited information about data analytics and did not explain how Industrial Relations intends to refine its data analytics through discussions with CDI or include timelines for that refinement.

Data analytics is a promising tool with a potentially high rate of return. Moreover, Industrial Relations' effective implementation of data analytics is critical because provider fraud imposes serious financial costs on consumers, businesses, and government. Thus, Industrial Relations should better document its procedures for its

Industrial Relations' effective implementation of data analytics is critical because provider fraud imposes serious financial costs on consumers, businesses, and government.

EOB statements would provide injured employees with the opportunity to review the services for which providers have billed insurers and identify potentially fraudulent charges.

data analytics efforts as soon as possible to better ensure the success of those efforts. Its procedures should include a description of how it will adjust its protocols as necessary, depending on the results of its efforts.

By Issuing EOB Statements, Insurers Could Increase Detection of Workers' Compensation Fraud

California can further improve its fraud detection efforts by requiring insurers to periodically issue EOB statements to injured employees after the employees receive workers' compensation-related services. By failing to provide such statements, insurers are missing opportunities to involve injured employees in their antifraud efforts. EOB statements itemize the types of services providers rendered, the dates the patients received the services, and service fees the insurers paid on the patients' behalf. Thus, EOB statements would provide injured employees with the opportunity to review the services for which providers have billed insurers and identify potentially fraudulent charges. Nonetheless, as of October 2017, California did not require insurers that cover workers' compensation to send or otherwise make EOB statements available to injured employees.

By requiring insurers to periodically provide EOB statements to injured employees, California could enlist those employees in its battle against workers' compensation fraud. As the Los Angeles County District Attorney's Office (LA District Attorney) stated, a number of vulnerabilities in the workers' compensation system are readily identifiable, including the lack of review by the patients who purportedly received the services, equipment, or medications for which providers submit claims. This lack of review creates the potential for serial billing, in which providers bill multiple insurance carriers for the same services. The LA District Attorney concluded that instances of serial billing are likely to continue unless red flags are identified that might lead to greater scrutiny of or even denial of the billed charges. The periodic provision of EOB statements would allow injured employees to provide this type of red flag.

Certain government agencies and some insurers outside of the workers' compensation program already use EOB statements to help fight fraud. For instance, the U.S. Centers for Medicare and Medicaid Services provides quarterly EOB statements to beneficiaries under its Original Medicare programs at least in part to fight health care fraud.⁷ According to health care antifraud

⁷ Original Medicare is the traditional fee-for-service program the federal government offers and includes Medicare Part A (hospital insurance) and Part B (medical insurance).

literature, Medicare beneficiaries have discovered fraud through reviewing their EOB statements. The concerns that the beneficiaries raised have resulted in prosecutions, convictions, and the recovery of funds. Similarly, California law requires insurers providing disability insurance, including those providing health insurance, to provide EOB statements to people submitting insurance claims (claimants).

In addition, some California employers that self-insure see the value of providing EOB statements to their injured employees. Disneyland Resort (Disney) stated in a presentation on workers' compensation that EOB statements can help uncover provider billing mistakes, billing mischief, or fraud. The manager of workers' compensation for Disney (Disney manager) stated that although some people believe that no one reads or understands EOB statements and that they cost too much, these are misconceptions. The Disney manager asserted that the expense of EOB statements is worthwhile because they promote transparency, awareness, communication, and goodwill. Further, Disney spends only 50 cents per EOB statement, and the Disney manager stated that, to ensure costs remain low, it sends an EOB statement only when there was a billing payment in the prior month.

According to key players within the health care system, not providing EOB statements to patients gives providers who want to commit fraud an easy means of doing so. According to the Ponemon Institute's 2015 *Fifth Annual Study on Medical Identity Theft*, in 2014 the third most common method through which victims discovered medical identity theft—the use of an individual's identity either to fraudulently receive medical services or drugs or to commit fraudulent billing—was through detecting errors in their EOB statements.⁸ Further, the LA District Attorney stated within its grant application for the Workers' Compensation Insurance Fraud Program that it actively advocates the value that quarterly EOB statements provide to injured employees. The LA District Attorney also stated that outreach and training to inform the public about the workers' compensation system and the information available through EOB statements are essential.

Although the Legislature can require insurers to provide EOB statements, both CDI and Industrial Relations have expressed concerns about the statements' usefulness and cost-effectiveness. Specifically, CDI stated that while providing EOB statements

Although the Legislature can require insurers to provide EOB statements, both CDI and Industrial Relations have expressed concerns about the statements' usefulness and cost-effectiveness.

⁸ According to its website, the Ponemon Institute conducts independent research on privacy, data protection, and information security policy to enable public and private organizations to have a clear understanding of the trends in practices, perceptions, and potential threats that will affect the collection, management, and safeguarding of personal and confidential information about individuals and organizations.

to injured employees could help reduce billing for services that were not provided, the impact would depend on the injured employees' interest in reviewing the EOB statements. It believes that this interest might be limited by the fact that employees are not liable for any of the costs related to services they receive through workers' compensation. However, CDI would support further consideration of whether EOB statements would be a cost-effective means of identifying workers' compensation fraud and whether they would be duplicative of existing disclosures. Further, CDI's website states that it encourages consumers to review their EOB statements for other lines of insurance and to report billing for the following: treatment that was not provided, medical tests or evaluations that were not conducted, medical supplies that were not provided, office visits that never occurred, cancellation charges for office visits that were not scheduled, and pharmaceuticals that were never received.

In contrast, Industrial Relations' director (director) stated that her department examined the viability of requiring insurers to send EOB statements and concluded that it would be more effective to impose notice requirements, such as EOB statements, on those medical providers who may treat injured employees without the employers' or insurers' knowledge. She explained that this type of medical care may be more vulnerable to fraud and abuse and that it would help the workers' compensation system to require providers rendering treatment in this manner to promptly issue notices to all parties (including employees, employers, insurers, and Industrial Relations). The director further stated that existing controls—including fee schedules, independent medical and bill reviews, and utilization reviews—provide effective controls for care provided within the system under accepted claims, and that such care would not be improved by the issuance of EOB statements. The director also stated that the cost of EOB statements would place a burden on those operating in compliance with the system and might lead to an increase in premiums. Industrial Relations, however, did not provide evidence sufficient to support the director's statements. Further, we question whether providers that are more apt to commit fraud would issue accurate and complete EOB statements to all parties.

We believe that EOB statements could be an effective tool to help fight provider fraud in the workers' compensation system and that the benefits of these statements would likely outweigh any perceived drawbacks.

Despite CDI's and Industrial Relations' concerns, we believe that EOB statements could be an effective tool to help fight provider fraud in the workers' compensation system and that the benefits of these statements would likely outweigh any perceived drawbacks. For instance, insurers may believe that EOB statements are prohibitively expensive. However, fraud already harms employers by contributing to the increasingly high cost of workers' compensation, and the amount of chargeable provider fraud—as we show in Table 1 on page 8 in the Introduction—has grown from about \$130 million in fiscal year 2013–14 to over \$812 million in fiscal year 2015–16, an increase of 525 percent. Further, insurers could keep their costs down by

providing EOB statements only periodically, such as once a quarter, and by consolidating all claims in that period. Insurers may also argue that EOB statements are confusing and that injured employees will consequently ignore them. To address this, the literature we examined suggested that insurers could format EOB statements in ways that make them easier for employees to understand. For example, the EOB statements should clearly state that they are not bills, should include simple language, should explain medical codes, and should offer question-and-answer formats. The EOB statements should also state that the insurers use them to combat fraud and should identify whom to call if the injured employees suspect fraud.

Our research suggests that many injured employees may prove eager to assist in the fight against fraud. For example, a 1998 report by the Office of the Inspector General cited a Medicare survey that revealed that 74 percent of Medicare beneficiaries said they always read their EOB statements. The same survey found that if beneficiaries knew more about Medicare fraud, 89 percent of them would report it when they saw it. Similarly, a senior deputy district attorney for Orange County stated that she often finds that injured employees have no idea that they have been involved in workers' compensation fraud schemes. She indicated that even though the insurers incur the fraudulent charges, the injured employees are still concerned and object to the use of their identities for others' fraudulent gain. According to the senior deputy district attorney, many of these individuals stated that had they been aware of the fraudulent charges, they would have reported them.

Recommendations

Legislature

To better ensure that the payments insurers issue to providers for workers' compensation claims are based on valid services, the Legislature should require workers' compensation insurers to periodically provide EOB statements to injured employees.

CDI

To reduce insurers' potential underreporting of workers' compensation fraud, CDI should do the following by June 30, 2018:

- Create a public report that ranks workers' compensation insurers based on the effectiveness of their antifraud efforts, including the rate at which they submit fraud referrals.

- Add a requirement that it consider rates of fraud claim referrals when selecting insurers to audit and that it give priority to those insurers with high volumes of premiums and very low numbers of referrals.

Industrial Relations

To ensure the growth and effectiveness of its data analytics efforts to identify provider fraud, Industrial Relations should better document its data analytics effort within its protocol manual by June 30, 2018.

Chapter 2

CALIFORNIA COULD IMPROVE ITS INVESTIGATION AND PROSECUTION OF WORKERS' COMPENSATION FRAUD

Chapter Summary

As the Introduction discusses, CDI is the lead state agency for criminal investigations of insurance fraud. However, vacant fraud investigator positions limit CDI's capacity to investigate suspected fraudulent workers' compensation claims. CDI has a high number of vacancies for its fraud investigators partly because its salaries for these investigators have historically been lower than those for similar investigative positions at other state agencies, contributing to its inability to retain investigators and to hire new investigators quickly enough to outpace attrition. It also lacks a retention plan. Furthermore, because district attorneys' offices depend on CDI's investigators to bolster their investigative and prosecutorial efforts, CDI's vacancy rate directly impacts district attorneys' offices' ability to investigate and prosecute cases.

Further, CDI's vacancy rate has resulted in it underspending the workers' compensation fraud assessment funds it has budgeted for personnel to investigate workers' compensation fraud. State law mandates that CDI must receive a minimum of 40 percent of the total workers' compensation fraud assessment each year. Although CDI could have received a higher proportion, in recent years the insurance commissioner and the Fraud Assessment Commission (Fraud Commission) have awarded CDI only this minimum allotment—\$24 million per year in fiscal years 2015–16 and 2016–17. Nonetheless, CDI was unable to spend \$2.4 million (10 percent) of that amount in fiscal year 2015–16. Instead of redirecting CDI's unspent funds to district attorneys' offices that could use it to investigate and prosecute more cases of workers' compensation fraud, the insurance commissioner and the Fraud Commission used the unspent funds to reduce the assessment amounts the State collected from employers in a subsequent year. In effect, the insurance commissioner and the Fraud Commission chose to reduce the total amount of funds available to fight fraud rather than to redirect the funds to the district attorneys' offices, which could have used it.

Ongoing Vacancies in Fraud Investigator Positions Have Reduced CDI's Antifraud Efforts

CDI's capacity to investigate workers' compensation fraud in California has been limited by ongoing vacancies in its fraud investigator positions. As a result of these vacancies, CDI has closed a

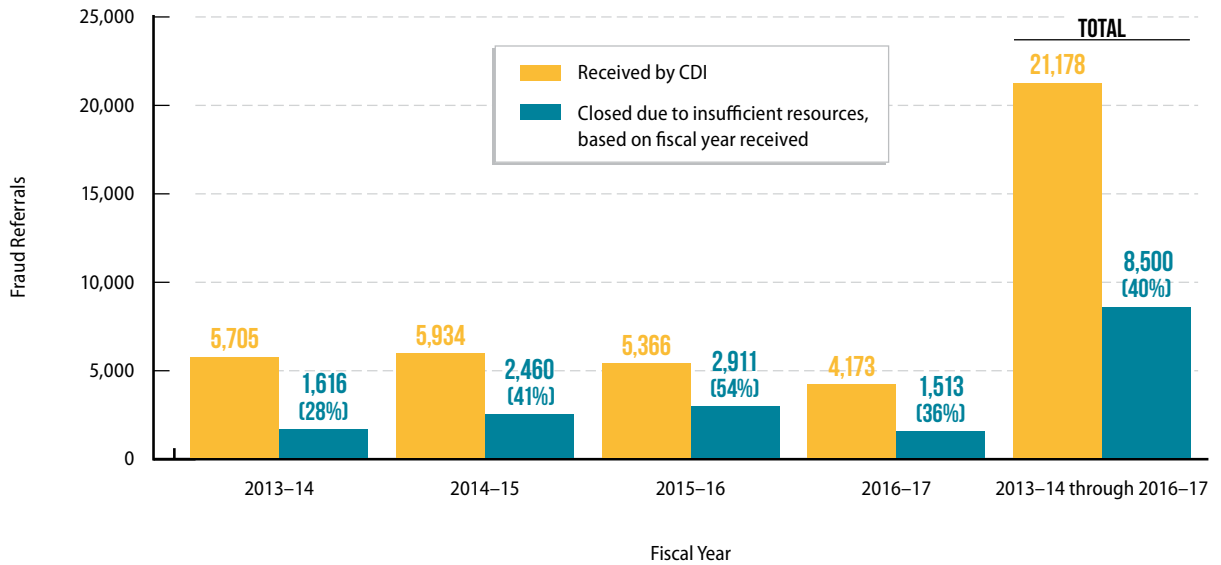
For fiscal year 2016–17, CDI was authorized for 232 fraud investigators; however, it had 63 vacant fraud investigator positions as of February 2017, resulting in a vacancy rate of 27 percent.

substantial number of referrals without investigation and potentially jeopardized the effectiveness of district attorneys' offices' efforts to investigate and prosecute workers' compensation fraud. For example, for fiscal year 2016–17, the state budget authorized a total of 232 fraud investigators for CDI's Enforcement Branch, which is responsible for five insurance fraud programs, including workers' compensation. These positions are a combination of investigators and supervising fraud investigators we collectively refer to as *fraud investigators*. However, according to the *Strategic Vacancy Report* we received from CDI, it had 63 vacant fraud investigator positions as of February 2017, resulting in a vacancy rate of 27 percent.

Although fraud investigator vacancies caused CDI to spend less money than it budgeted for personnel costs, they also contributed to a decrease in the number of referrals CDI assigned for investigation and an increase in the number of referrals it closed due to insufficient resources. According to its July 2014 criminal activity report, CDI assigned 654 referrals for investigation by fraud investigators during fiscal year 2013–14. However, our analysis of its case management system indicates that it closed more than 1,600 (28 percent) of the roughly 5,700 referrals it had received during this period because of insufficient resources. In addition, CDI's July 2016 report showed that the number of new referrals CDI assigned for investigation in fiscal year 2015–16 fell to 488, while the percentage of referrals it closed due to insufficient resources increased to 54 percent—2,911 out of 5,366. Although the percentage of referrals it closed due to insufficient resources decreased to 36 percent in fiscal year 2016–17, it only assigned 551 referrals for investigation that year, a 16 percent decrease compared to fiscal year 2013–14 levels. In total, CDI received 21,178 referrals from fiscal years 2013–14 through 2016–17. As Figure 7 shows, CDI closed 8,500 (40.1 percent) of these referrals due to insufficient resources. The total losses insurers reported paying related to these 8,500 referrals was about \$160.8 million, or an average of about \$18,900 per referral.

Our analysis found that 80.4 percent of the referrals closed due to insufficient resources involved employee fraud and that the total losses insurers reported paying related to these referrals were about \$66.8 million, or an average of about \$9,800 per referral. Although only about 7.9 percent of the referrals CDI closed due to insufficient resources involved provider fraud, the total losses insurers reported paying related to these referrals totaled about \$48.2 million, or an average of about \$71,800 per referral. This average illustrates how costly provider fraud can be to the system. As we mention in the Introduction, employers bear the cost of the workers' compensation system. Because fraud-related losses can result in insurers raising the premiums employers pay, businesses may in turn increase the prices they charge consumers.

Figure 7
CDI Closed 40 Percent of the Fraud Referrals It Received Due to Insufficient Resources



Source: California State Auditor’s analysis of data obtained from CDI’s Fraud Integrated Database System.

In addition, CDI’s high number of vacant fraud investigator positions can affect the ability of district attorneys’ offices to prosecute workers’ compensation fraud cases. For example, in its fiscal year 2016–17 application to the Fraud Commission for funding to fight workers’ compensation fraud, the LA District Attorney asserted it could not adequately process its caseload unless CDI had a sufficient number of fraud investigators to handle the cases. From fiscal years 2013–14 through 2016–17, Los Angeles County experienced the highest number of suspected fraudulent workers’ compensation claims of any county in the State. However, CDI’s South Los Angeles County regional office had a 47 percent vacancy rate for fiscal year 2015–16. In its funding application, the LA District Attorney stated that because it could not compensate for CDI’s resource limitations, it might have to decline new referrals, establish a minimum-loss qualifying criterion, or close cases due to a lack of investigative resources. The LA District Attorney added that none of these options serve the public interest and explained that failing to investigate referrals, extending the time it takes to investigate cases and risking evidence spoilage and destruction, or permitting those engaged in fraud to continue to steal for longer periods of time are all unacceptable outcomes that can and should be avoided.

We estimate that if CDI were fully staffed, it could potentially investigate an additional 200 to 300 workers' compensation referrals per year.

Finally, the vacancies in its fraud investigator positions have had ramifications beyond limiting CDI's ability to combat workers' compensation fraud. In a budget change proposal for fiscal year 2017–18, CDI stated it had the resources available to investigate just 5 percent of the annual referrals it received across all types of insurance, including automobile; disability and health care; property, life, and casualty; and workers' compensation. We estimate that if CDI were fully staffed, it could potentially investigate an additional 200 to 300 workers' compensation referrals per year.

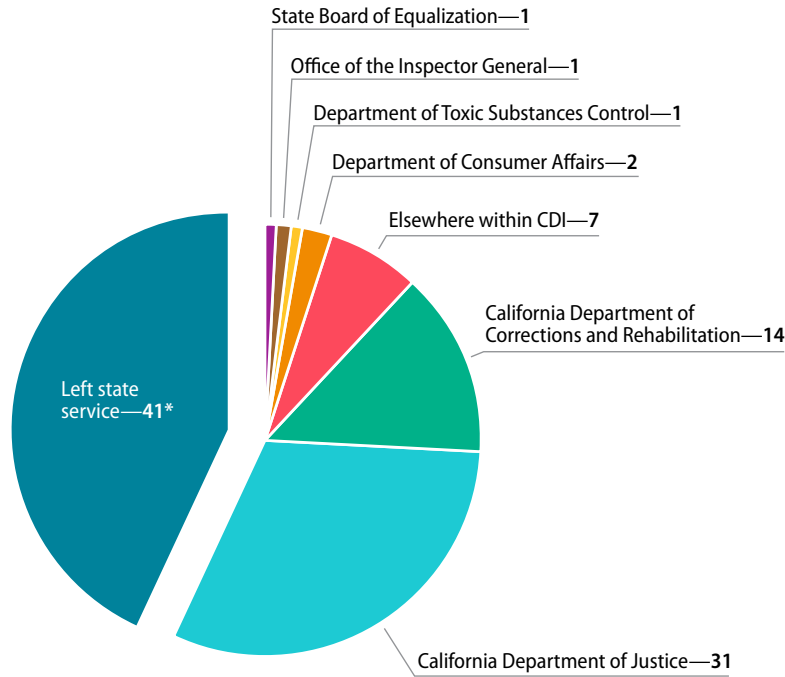
Although CDI Has Taken Certain Steps to Address Fraud Investigator Vacancies, It Has Yet to Develop a Retention Plan

CDI has acknowledged its continuing high vacancy rate is a problem and has attempted to resolve it. For instance, CDI recognized that the salaries the State authorized it to pay its fraud investigators were less than those some other state agencies paid for their investigative positions. In response, it sought and received increases that have reduced these pay gaps as of July 2017. In addition, CDI has taken steps to create a specific team responsible for recruiting activities, it authored both a recruitment plan and strategic vacancy report, and it established a goal of achieving a vacancy rate of 5 percent or less. However, because many of CDI's recruiting efforts are either in the planning stage or are just now being implemented, we do not feel that enough time has passed to evaluate their effectiveness. Further, we have concerns regarding CDI's lack of a retention plan and a departmentwide process for performing exit interviews and surveys.

CDI acknowledges that the salaries the State authorized it to pay its fraud investigators were lower than those offered by other state agencies with similar investigative positions, which may have contributed to difficulties in both keeping staff and attracting candidates to fill vacant positions. In fact, CDI attributes its high vacancy rate primarily to the fact that many fraud investigators chose to leave CDI because the pay it could offer was significantly lower than that offered for similar sworn investigative positions at the California Department of Justice and the California Department of Corrections and Rehabilitation. As Figure 8 shows, our analysis of the State Controller's Office's payroll data indicates that CDI lost 98 fraud investigators from fiscal years 2013–14 through 2016–17. Of that number, 31 joined the California Department of Justice, 14 joined the California Department of Corrections and Rehabilitation, and 41 left state service.⁹ Of the fraud investigators that left state service, 27 were age 50 or older and potentially eligible for retirement.

⁹ The remaining 12 went to a variety of other state agencies or elsewhere in CDI. Of the 41 who left state service, several took positions with district attorneys' offices or other local law enforcement entities, some of which also offered higher pay.

Figure 8
From Fiscal Years 2013–14 Through 2016–17, CDI Lost 98 Fraud Investigators, 57 of Whom Accepted Other State Positions



Source: California State Auditor’s analysis of payroll data maintained in the State Controller’s Office’s Uniform State Payroll System.

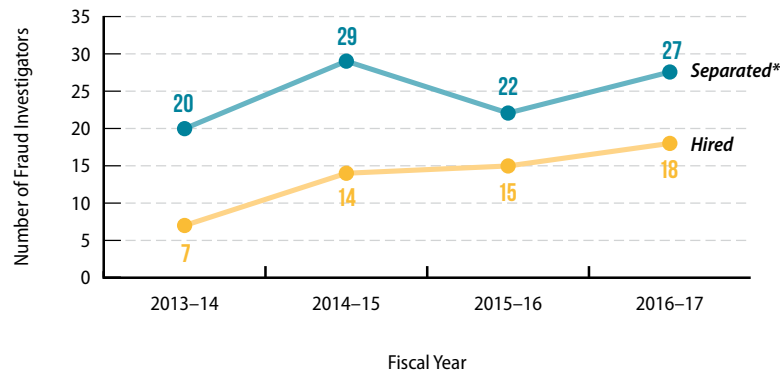
* Although our analysis of payroll data indicates that these employees stopped receiving regular paychecks from the State, we did not assess whether these employees were merely inactive during that time and later returned to duty.

To help address this issue, the California Department of Human Resources (CalHR) established a pay differential that reduced the pay gap between CDI’s fraud investigators and those at other state law enforcement agencies, effective July 1, 2017. In fiscal year 2016–17, before the salary increase, the high end of the salary range for CDI’s investigators was about \$7,100 per month, excluding overtime. As of August 2017, the high end of the salary range for CDI’s fraud investigators was about \$7,800 per month, which narrowed the gap with other agencies. The top of the ranges for comparable positions at the California Department of Justice and California Department of Corrections and Rehabilitation were about \$8,200 per month and \$9,800 per month, respectively.

Further, in fiscal year 2016–17, CDI recognized the need to dedicate resources to recruiting in order to attract qualified applicants and reduce its vacancy rate to its goal of 5 percent or less. From fiscal years 2013–14 through 2016–17, CDI’s ability to hire new fraud investigators did not keep up with the rate at which its fraud

investigators left. As Figure 9 demonstrates, we found that although CDI lost 98 fraud investigators during this period, it hired only 54 to replace them. According to a human resources analyst with CDI, the background investigation process for hiring a fraud investigator can take several months for some applicants. It includes both an internal component at CDI and an external component within CalHR, and CDI stated each process currently takes about three to six months.

Figure 9
CDI Lost More Fraud Investigators Than It Hired
Fiscal Years 2013–14 Through 2016–17



Source: California State Auditor's analysis of payroll data maintained in the State Controller's Office's Uniform State Payroll System.

* Although our analysis of payroll data indicates that some of these employees stopped receiving regular paychecks from the State, we did not assess whether they were merely inactive during that time and later returned to duty.

To be more effective in addressing its vacancy problem, CDI created a Recruitment and Background Investigations Team in August 2016 to be responsible for its recruiting efforts. This team created both a recruitment strategic plan and strategic vacancy report. The recruitment strategic plan focuses on building new recruiting efforts by developing personalized relationships with applicants before they are hired and on structuring CDI's internal organization and growing its budget to support more streamlined processes for background investigations and hiring. Because CDI has yet to fully implement the strategies it identified in its recruitment plan, we cannot yet tell whether they will have their intended effect: the reduction of vacancies.

We believe CDI could potentially increase its candidate pool by amending its recruitment plan so that it focuses in part on retired law enforcement officers. Although CDI hires candidates

with this type of experience, its plan focuses on recruiting recent college graduates, attending career fairs, and developing recruiting opportunities at peace officer academies. However, we found that other states and two of the three district attorneys' offices we visited hire retired or experienced law enforcement officers as investigators. The captain of CDI's Recruitment and Background Investigations Team stated that the plan's lack of recruiting activities for experienced and retired law enforcement officers was an oversight and that in practice, CDI strives to hire from a diverse applicant pool. Further, he stated that CDI values the qualities that retired and experienced law enforcement officers can bring, including having less need for training and being able to serve as mentors for less experienced investigators. The captain indicated, however, that CDI investigator positions may be more attractive to law enforcement officers who have retired from systems other than CalPERS, the State's retirement system. He stated that law enforcement officers who have retired from CalPERS would have to be reinstated into the system, which would affect their retirement.

Despite CDI's recent progress toward improving its recruiting efforts, we are unsure whether other factors exist that may affect its retention of fraud investigators because CDI has not created a retention plan to address fraud investigator separations and alleviate causes that are not related to pay. CDI could develop a retention plan based on the results of routine interviews of separating employees as well as surveys of its current employees to assess their job satisfaction. According to a human resources management textbook published by the University of Minnesota, the first step an entity should consider in developing a retention plan is a formal method to assess the satisfaction level of employees through exit interviews or surveys. From these types of data, CDI could begin to create its retention plan, making sure it is tied to organizational objectives. The plan should include analyses of the exit interview and survey results, the strengths and weaknesses of any prior retention efforts, the goal of the retention plan, and the specific strategies CDI plans to implement.

The chief of CDI's human resources management division (human resources) stated that although human resources sent exit surveys to recently separated staff to voluntarily complete, it did not complete written analyses of the survey results. The chief asserted that she reviewed all exit surveys and followed up with program management and executive staff as warranted. Nevertheless, the captain of the Recruitment and Background Investigations Team stated his branch did not have access to the results due to confidentiality. In fact, although employees returned fewer than 15 surveys between 2015 and 2017, CDI could have used the results of the surveys to create a retention strategy to address common causes for separation that were unrelated to pay. Our analysis of

We are unsure whether other factors exist that may affect CDI's retention of fraud investigators because it has not created a retention plan to address fraud investigator separations and alleviate causes that are not related to pay.

the exit surveys found that six fraud investigators who separated from CDI highlighted dissatisfaction not only with pay, but with investigative training, growth opportunities, policies and procedures, and promotion potential.

District Attorneys' Offices Could Have Used CDI's Unspent Antifraud Funds

As the Introduction explains, state law requires that CDI receive at least 40 percent of the total fraud assessment amount each year, after incidental expenses. The assessment amounts for fiscal years 2015–16 and 2016–17 were each about \$59 million, of which CDI received about \$24 million. As Table 6 shows, CDI spent about \$112,000 more than its allotment in fiscal year 2016–17, but it failed to spend roughly \$2.4 million (10 percent) of its allocation in fiscal year 2015–16. In the proposed budget CDI presented to the Fraud Commission in September 2017 to determine the total assessment amount for fiscal year 2018–19, CDI divided its costs into three categories: salaries and benefits, operating expenses and equipment, and administrative support (that is, indirect costs). In the three most recent fiscal years, CDI has expended less for salaries and benefits than it proposed to the Fraud Commission and spent more than it proposed in one or both of the remaining categories. However, because CDI did not present this information side-by-side to the Fraud Commission, the Fraud Commission may be unaware of these trends. Additionally, information CDI presented to the Fraud Commission was not always consistent. For instance, CDI excluded encumbrances from a spending total for one year while including them in other totals for the same year.¹⁰

In the three most recent fiscal years, CDI has expended less for salaries and benefits than it proposed to the Fraud Commission.

¹⁰ An encumbrance represents a commitment of all or part of an appropriation through a contract, purchase order, or other means.

Table 6
CDI Spent Less on Personnel Costs Than It Proposed to the Fraud Commission When Requesting Funding
Fiscal Years 2014–15 Through 2016–17

STATE OPERATIONS EXPENDITURES	FISCAL YEAR					
	2014–15		2015–16		2016–17	
	PROPOSED	ACTUAL	DIFFERENCE	PROPOSED	ACTUAL	DIFFERENCE
Positions*	123	113	10	143	105	38
Salaries and benefits	\$13,802,061	\$12,645,347	\$1,156,714	\$15,295,506	\$12,332,180	\$2,963,326
Operating expenses and equipment	3,864,787	4,593,990	(729,203)	4,238,685	5,115,983	(877,298)
CDI administrative support	3,728,760	3,952,521	(223,761)	4,000,978	3,929,328	71,650
Total expenditures	\$21,395,608	\$21,191,858	\$203,750	\$23,535,169	\$21,377,491	\$2,157,678
CDI's funding level		\$21,570,608			\$23,760,169	
Difference between funding level and total expenditures		\$378,750			\$2,382,678	
Percent underspent		2%			10%	
					\$24,021,708	\$(486,539)
					\$23,910,169	
					\$(111,539)	
						(0.5%)

Sources: The Fraud Division's Report to the Fraud Assessment Commission for fiscal years 2014–15 through 2016–17 and CDI's internal expenditure documents.

Note: CDI presents proposed expenditures to the Fraud Commission at its September meeting when the Fraud Commission determines funding levels for the following fiscal year. In other words, proposed expenditures for fiscal year 2016–17 were presented at the September 2015 meeting.

* We used the positions calculated in the Fraud Division's Report to the Fraud Assessment Commission because CDI uses a different methodology to calculate these figures than the data we used elsewhere in the text to report vacancy rates. Also, CDI based the calculated number of positions here on staffing levels for fraud investigators and support staff at its headquarters and regional offices.

CDI should be held to stricter reporting standards in order to increase transparency and help the Fraud Commission make more informed funding decisions.

CDI should be held to stricter reporting standards in order to increase transparency and help the Fraud Commission make more informed funding decisions. For example, when the district attorneys' offices initially apply for grant funds, they have to provide expansive grant applications, detailed statistical reports on program activities, financial audit reports prepared by independent auditors, and carry-over utilization requests for unexpended funds. However, because the State does not require CDI to apply for funds to investigate fraud, it is not subject to the same rigorous application requirements as district attorneys' offices. In addition, district attorneys' offices must provide detailed proposed budgets to the Fraud Commission, whereas CDI—as we previously mention—only provides its three major spending categories. In fact, at the Fraud Commission's most recent meeting in September 2017, a commission member requested additional detailed budgetary information related to CDI's staffing and personnel costs. CDI's presentation to the Fraud Commission included an overview of the program successes and a request for additional funding. It did not, however, describe whether the additional funds were needed to maintain current staffing levels or to fully staff the program.

Finally, if district attorneys' offices wish, for example, to spend more money on personnel and less on equipment than they originally presented, they must submit budget modification requests to CDI for approval. No similar requirement applies to CDI, as it asserts it is not technically a grantee, and thus it may underspend or overspend in categories without the Fraud Commission's approval or knowledge. As a result of this lack of reporting requirements, the Fraud Commission may not have the information necessary to understand how CDI spends its assessment funds and what funding CDI needs, which is critical information for determining the appropriate total assessment the State needs to collect.

In addition, the insurance commissioner and the Fraud Commission missed an opportunity to increase the amount of money available to district attorneys' offices when they decided to use CDI's unspent funds to offset—or reduce—a subsequent year's collections from employers. Although we found no direct evidence of a specific decision by the insurance commissioner and the Fraud Commission regarding the use of CDI's unspent funds, a March 2017 letter from the Fraud Commission to Industrial Relations reduced the total assessment for fiscal year 2017–18 by an offset amount that appears to include CDI's unspent funds from fiscal year 2015–16. State law gives the insurance commissioner and the Fraud Commission the option of using unspent CDI funds to offset or augment future program funding. The Fraud Commission's chair stated that he suggested years ago that the Fraud Commission consider redirecting any unused CDI funds to district attorneys' offices rather than offsetting future assessments;

however, the Fraud Commission encountered issues that prevented it from redirecting the funds at that time, and it has not reconsidered this approach in subsequent years.

Had the insurance commissioner and the Fraud Commission redirected CDI's unspent fiscal year 2015–16 allocation, district attorneys' offices could have used the funds to further support their antifraud efforts. State law in effect caps the allotment that district attorneys' offices can collectively receive at 60 percent of the assessment funds, after incidental expenses. From fiscal years 2013–14 through 2016–17, the insurance commissioner and the Fraud Commission awarded participating district attorneys' offices—37 representing 44 counties for fiscal year 2016–17—the maximum funding allowable under the law. Although two of the three district attorneys' offices that we visited underspent grant funds at least once from fiscal years 2013–14 through 2015–16, both offices received the required approvals from the insurance commissioner to carry over money to the subsequent year. Table 7 on the following page summarizes the three offices' spending. During this time period, the district attorneys' offices that applied for funding collectively requested more grant funding than was available for distribution, often citing the need for more investigative staff. The amounts the district attorneys' offices requested suggest they could have used the unspent funds. Had the insurance commissioner and the Fraud Commission decided to redirect CDI's unspent funds, they could have partially covered the deficit in requested funding for district attorneys' offices. Table 8 on page 47 summarizes the budget funding requested and approved for the three counties we visited.

The LA District Attorney provides an example of how the district attorneys' offices might have used the additional funding. In its fiscal year 2016–17 grant application, the LA District Attorney—which consistently received the highest number of referrals in the State for the years we examined—requested additional funding for more personnel. It asserted that it would use the additional funds to add four workers' compensation investigators and explained that it had the staffing resources available to fill these positions internally. However, the Fraud Commission approved only \$6.7 million for the LA District Attorney—more than \$1 million less than the amount it requested. Given that CDI has struggled to fill its fraud investigator positions, distributing its unspent funds to district attorneys' offices to use for their fraud-fighting efforts seems logical, particularly when doing so will likely enable the offices to increase the number of cases they investigate.

Distributing CDI's unspent funds to district attorneys' offices to use for their fraud-fighting efforts seems logical, particularly when doing so will likely enable the offices to increase the number of cases they investigate.

Table 7
District Attorneys' Offices We Visited Spent Most of the Fraud Assessment Funding They Received
Fiscal Years 2013–14 Through 2015–16

	DISTRICT ATTORNEY'S OFFICE											
	LOS ANGELES COUNTY			ORANGE COUNTY			SAN DIEGO COUNTY					
	2013–14	2014–15	2015–16	2013–14	2014–15	2015–16	2013–14	2014–15	2015–16	2013–14	2014–15	2015–16
Filled positions*	31.9	32.9	31.7	19.4	19.0	22.6	25.2	29.4	28.2			
Salaries and benefits	\$5,239,923	\$5,407,534	\$5,786,223	\$3,149,065	\$3,202,016	\$3,725,393	\$3,890,686	\$3,665,581	\$4,152,150			
Operating expenses and equipment	335,213	243,642	127,174	333,152	283,254	327,315	461,152	671,764	437,881			
Indirect costs†	351,043	347,785	373,560	189,176	188,544	226,989	259,809	248,515	281,720			
Total expenditures	\$5,926,179	\$5,998,960	\$6,286,958	\$3,671,393	\$3,673,814	\$4,279,696	\$4,611,647	\$4,585,860	\$4,871,751			
Annual funding level	\$5,805,244	\$5,869,952	\$6,458,643	\$3,620,608	\$3,629,627	\$3,966,000	\$4,477,303	\$4,567,000	\$4,990,459			
Funds available from prior year and interest earned	—	—	—	—	—	—	\$229,567	\$99,100	\$93,398			
Funds remaining/(overspent)	\$(120,935)	\$(129,008)	\$171,685	\$(50,785)	\$(44,187)	\$(313,696)	\$95,223	\$80,240	\$212,106			

Sources: The district attorneys' offices' grant applications, audit reports, expenditure reports, and requests for use of unexpended funds; CDI's Fraud Division's reports to the Fraud Commission; CDI's internal documents; and interviews with staff of the Orange County District Attorney's Office.

Note: Due to rounding, totals may differ slightly.

* This row includes both filled investigative and prosecutorial positions and was calculated using the number of positions and percentage of time devoted to the workers' compensation program.

† The district attorneys' offices' indirect costs, including those not readily itemized but necessary to local program operations, may not exceed 10 percent of their personnel salaries (excluding benefits and overtime) or 5 percent of total direct program costs (excluding equipment).

Table 8
District Attorneys’ Offices We Visited Rarely Received the Full Amount of Fraud Assessment Funding They Requested
Fiscal Years 2014–15 Through 2016–17

COUNTY	FISCAL YEAR								
	2014–15			2015–16			2016–17		
	REQUESTED	AWARDED	PERCENT AWARDED	REQUESTED	AWARDED	PERCENT AWARDED	REQUESTED	AWARDED	PERCENT AWARDED
Los Angeles	\$6,075,734	\$5,869,952	97%	\$6,458,643	\$6,458,643	100%	\$7,867,136	\$6,729,177	86%
Orange	3,794,911	3,629,627	96	4,159,371	3,966,000	95	4,784,359	4,152,802	87
San Diego	5,500,000	4,567,000	83	5,500,000	4,990,459	91	6,000,000	5,028,198	84

Sources: District attorneys’ offices’ grant applications and CDI’s disbursement documents.

Note: A district attorney’s office’s requested grant amount may not be indicative of the total amount required to operate its program; that is, a district attorney’s office cannot request funding above a certain amount for indirect costs, even though its actual indirect costs may be greater than that amount.

If the insurance commissioner and the Fraud Commission decide to use unspent CDI funds to augment funding to district attorneys’ offices, CDI will need to establish processes for doing so. CDI’s deputy general counsel indicated that before deciding to reallocate unspent funds, CDI must first address policy considerations and practical hurdles. He stated that deciding whether unspent assessment funds should be returned to employers as offsets against subsequent years’ collections or be used to augment the existing budget awards for district attorneys’ offices is a significant policy consideration. He added that employers might object if the State does not reduce the assessment even though it failed to spend the prior-year’s funding. The deputy general counsel also asserted that CDI would need processes for deciding how much to reallocate to individual district attorneys’ offices and for transferring the funds from CDI to the offices. Currently, CDI does not have a process for either. Finally, CDI’s deputy general counsel stated that it might be preferable to allocate unspent funds to district attorneys’ offices that had not received their full allocations but had spent their awards. Given that state law requires district attorneys’ offices to submit to CDI independent audit reports—which would expose any historical pattern of underspending—and that CDI has information showing which district attorneys’ offices have consistently received less funding than requested, we find it reasonable that CDI develop a process to award and distribute any unspent CDI funds.

Although the District Attorneys' Offices We Reviewed Have Their Own Approaches to Fighting Workers' Compensation Fraud, All Three Coordinate Their Efforts With CDI

Our review of three district attorneys' offices found that each had its own approach to fighting workers' compensation fraud because each structures its investigative and prosecutorial efforts to reflect the individual characteristics of fraud in its county. Although each county fights all types of workers' compensation fraud, we reviewed each of the three county district attorney office's applications for assessment funds to gain an understanding of the elements that influence its approach. For example, the San Diego County District Attorney's Office asserted in its fiscal year 2017-18 application that premium fraud associated with the underground economy especially plagues the county and that the size of its population and its physical proximity to an international border lead to a high volume of workers' compensation fraud cases. The LA District Attorney's application, on the other hand, stated that it focused primarily on both provider and employer fraud but had opted to forego pursuing misdemeanor employer fraud cases due to the lack of investigative resources at CDI's Southern Los Angeles County Regional Office. Lastly, the Orange County District Attorney's Office stated in its application that it prioritizes provider fraud in particular because it has determined that, among other factors, the mix of a large workforce coupled with the skyrocketing growth of the health care industry in the county creates the essential demographics to make it prone to provider fraud. In general, we found that the district attorneys' offices made choices depending on the type and magnitude of fraud affecting the counties and the available resources. This approach appears reasonable.

In their applications for assessment funds, all three of the district attorneys' offices we visited submitted joint plans with CDI that described their efficient use of joint resources.

In their applications for assessment funds, all three of the district attorneys' offices we visited submitted joint plans with CDI that described their efficient use of joint resources. The request for applications requires that all applicants submit joint plans that create the framework for effective communication and resources management in the investigation and prosecution of fraud. Both the county prosecutor and the captain of each CDI regional office that is responsible for that county must agree upon the plan. For example, we found that joint plans for all three district attorneys' offices we visited included processes for assessing whether cases merit opening before the offices use their investigative and prosecutorial resources. The LA District Attorney's joint plan indicates that the office conducts a preliminary review to determine the feasibility of asking the referring party to make a case presentation for any suspected fraudulent claim that it believes is based on sufficient evidence. Subsequently, it will determine

whether the case merits opening. The Orange County District Attorney's Office and the San Diego County District Attorney's Office both conduct similar preliminary reviews.

In addition, the three district attorneys' offices we visited use a process generally referred to as *vertical prosecution*, which aids in balancing their efforts between investigation and prosecution. As we discuss in the Introduction, a CDI fraud investigator, an investigator at a district attorney's office, or both may investigate a case before it is prosecuted by the district attorney's office. To balance these efforts, the vertical prosecution process requires a case investigator to communicate with the assigned prosecutor at the beginning of the investigation so that they can work together to build the case from inception through final adjudication. For example, according to the San Diego County District Attorney's Office's most recent assessment application, it assigns a prosecutor to a case when CDI opens an investigation, thereby providing CDI's investigator with a legal resource should any issues arise. For some cases, the investigator and prosecutor will hold regularly scheduled meetings and share case updates throughout the investigation. This enables the prosecutor to know the facts of the case, and it also ensures that CDI uses its investigative resources for work that is necessary to the case's prosecution. The LA District Attorney asserts that vertical prosecution is an essential component of developing and implementing an effective and efficient investigative prosecution plan.

Recommendations

To better address vacancies in its fraud investigator positions, CDI should take the following actions by June 30, 2018:

- Develop and implement a retention plan. This plan should be based on the results of in-person exit interviews with separating staff or similar tools, such as satisfaction surveys, to identify and address potential causes for separation other than pay. CDI should share the results of any trends arising from its exit interviews as well as its analyses of survey responses with the appropriate units as it deems necessary.
- Revise its recruiting plan to include the recruitment and hiring of retired local law enforcement officers.

To better enable the Fraud Commission to determine an appropriate amount for the total annual fraud assessment, CDI should, within 60 days and periodically thereafter, meet with the Fraud Commission and agree upon specific information to include in the Fraud Division's report to the Fraud Commission.

Additional information could, for example, include a comparison of proposed, projected, and actual expenditures by category for a specific fiscal year, calculated using a consistent methodology.

To better ensure the timely and effective use of fraud assessment funds to fight workers' compensation fraud in California, CDI should, by June 30, 2018, develop and implement a process to use its unspent funds to augment funding to district attorneys' offices rather than to offset collections from employers for subsequent years.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

Date: December 12, 2017

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

STATE OF CALIFORNIA

EDMUND G. BROWN JR., *Governor*

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Christine Baker, Director
Office of the Director
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November 15, 2017

Elaine M. Howle, State Auditor^{*}
California State Auditor's Office
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Re: Response to the State Auditor's Draft Report "Workers' Compensation Insurance: The State Needs to Strengthen Its Efforts to Reduce Fraud."

Dear Ms. Howle:

On behalf of the Labor and Workforce Development Agency, as Director of the Department of Industrial Relations (DIR), I appreciate the opportunity to respond to the State Auditor's draft report on workers' compensation insurance and the DIR's role in reducing fraud in the workers' comp system.

With respect to the DIR's portion of the audit, the State Auditor identified one area for improvement and recommended that the DIR formalize its efforts surrounding its use of data analytics. The State Auditor also recommends that the Legislature require workers' compensation insurers to send "evidence of benefit" (EOB) notices to hundreds of thousands of injured workers in California every year. Although we welcome the State Auditor's recommendations and take them very seriously, in the DIR's view, these recommendations are misplaced and would create costly burdens for the workers' comp system without providing sufficient benefits in reducing fraud.

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Auditor's Recommendation to the Legislature

To better ensure that the payments insurers issue to providers for workers' compensation claims are based on valid services, the Legislature should require workers' compensation insurers to periodically provide EOB statements to injured workers.

The DIR's Response:

The Auditor's recommendation to require insurers to send millions of EOB notices fails to advance the intended goal of preventing fraud, because it focuses solely on approved treatment, for which controls—such as utilization review, independent medical review, and independent bill review—are already in place. Requiring insurers to mail out notices for even a fraction of the annual 8 million approved treatments and services would create significant costs that would then be passed on to covered employers without any concrete evidence that doing so would curb fraud in the workers' comp system. This administrative burden would likely also lead to an increase in premium rates with no deterrent impacts on fraud.

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* California State Auditor's comments begin on page 55.

Letter to Elaine M. Howle
Re: Response to Auditor's Draft Report
Page 2

- ④ By contrast, the use of EOBs could provide some benefit if it were targeted at medical providers who treat injured workers independently on a lien basis, an area of the workers' comp system that has proven more susceptible to fraud and abuse because of the lack of oversight of treatment by employers and insurers. Unfortunately, a requirement for insurers to issue an EOB notification, as recommended by the Audit, may likely exempt this small share of providers for the simple reason that insurers may be unaware of the services rendered on a lien basis.

Auditor's Recommendation to the DIR

To ensure the growth and effectiveness of its data mining efforts to identify provider fraud, Industrial Relations should better document its data analytics effort within its protocol manual by June 30, 2018.

The DIR's Response:

- ⑤ The DIR's efforts to carry out the legislative mandates in SB 1160/AB 1244 to combat fraud in the workers' compensation system are documented and have proven successful, resulting in:
- Dismissals of 292,000 liens (with a total claim value of \$2.5 billion) for failure to file the required declarations under Labor Code section 4903.05. The time given back to injured workers and employers in workers' compensation court time is estimated to exceed 562 years.
 - The designation "4615" in the Electronic Adjudication Management System (EAMS) of more than 415,000 liens filed by or on behalf of criminally charged providers. Labor Code section 4615 refers to the stay of liens pending criminal charges for fraud against workers' compensation and medical billing, among other enumerated items.
 - Voluntary dismissals of 28,395 liens filed by or on behalf of suspended providers, with a total claim value of more than \$253 million.
 - Consolidations (and stays) of 22,433 liens filed by or on behalf of suspended providers, with a total claim value of more than \$319 million.
 - Suspension orders terminating the participation of 94 providers in the workers' compensation system and suspension notices served on an additional 63 providers.
 - Identification of an additional 458 providers who qualify for suspension under Labor Code section 139.21.
 - The successful defense of newly enacted anti-fraud laws, including legal challenges to the lien declaration requirement under Labor Code section 4903.05 and provider suspensions under Labor Code section 139.21.
- ⑤ The DIR will continue its efforts to combat fraud and correct any mistaken perception by the State Auditor that the department's efforts are insufficiently documented by updating the demonstrated results on the DIR website and responding to the Auditor, as required, by June 30, 2018.

Letter to Elaine M. Howle
Re: Response to Auditor's Draft Report
Page 3

If you need additional information regarding the DIR's responses, please do not hesitate to contact Christopher Jagard, Chief Counsel for the department.

Sincerely,

A handwritten signature in cursive script that reads "Christine Baker".

Christine Baker
Director of Industrial Relations

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF INDUSTRIAL RELATIONS

To provide clarity and perspective, we are commenting on Industrial Relations' response to our audit. The numbers below correspond to the numbers we have placed in the margin of Industrial Relations' response.

Contrary to the assertion by Industrial Relations' director, our recommendations regarding EOB statements and data analytics are not "misplaced". We made these two recommendations specifically to help the State to better identify possible instances of provider fraud in California's workers' compensation system. As Table 1 on page 8 shows, the amount of chargeable provider fraud increased from \$130 million in fiscal year 2013-14 to \$812 million in fiscal year 2015-16, a 525 percent increase over this time period. If provider fraud continues to be as costly to California's employers and ultimately its consumers, we believe the Legislature—to which the California Constitution gives "plenary power" to "...enforce a complete system of workers' compensation"—should take additional steps to better combat this type of fraud. Further, the director asserts that these two recommendations would "create costly burdens for the workers' compensation system without providing sufficient benefits," but she did not provide adequate support for her position during the audit. We address this point more specifically in the following comments.

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Industrial Relations' director mischaracterizes our recommendation; we did not recommend that the State "require insurers to send millions of EOB" statements nor did we make this recommendation with "the intended goal of preventing fraud." Our recommendation on page 33 of our report states, "To better ensure that the payments insurers issue to providers for workers' compensation claims are based on valid services, the Legislature should require workers' compensation insurers to periodically provide EOB statements to injured employees." Page 30 of our report clearly states that we intended this recommendation to better detect possible instances of provider fraud. Furthermore, we reported that participants involved in both the workers' compensation system and the fight against fraud see the added value that EOB statements provide. For example, we point out on page 31 that the Disney manager of workers' compensation stated that EOB statements can help uncover provider billing mistakes, billing mischief, and fraud. We also mention on page 32 that the benefits of EOB statements would likely outweigh any

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perceived drawbacks and cite the Disney manager, who indicated on page 31 that the belief that EOB statements cost too much is a misconception.

- ③ Despite the director's opinion regarding the absence of concrete evidence that EOB statements would help curb fraud, we state on page 30 of our report that certain government agencies and some insurers outside of the workers' compensation program already use EOB statements to help fight fraud.
- ④ Industrial Relations' director states that EOB statements "could provide some benefit" if they were targeted at providers who treat injured employees independently on a lien basis. Our viewpoint differs. Regardless of whether they pay workers' compensation claims submitted directly from service providers or in accordance with the liens process, insurers and employers can still use EOB statements to engage injured employees in the effort to better detect provider fraud in the workers' compensation system.
- ⑤ The director's statement notwithstanding, Industrial Relations' data analytics efforts are insufficiently documented. The director's comments in her response regarding Industrial Relations' recent efforts regarding liens are not relevant to our finding. We point out on page 29 that Industrial Relations' effort to identify previously unknown provider fraud is still in the nascent stages and that it has not yet fully documented its procedures for these predictive analytics. Furthermore, given the expense that California's employers and ultimately its consumers face from provider fraud as Table 1 on page 8 indicates, we believe it is important for Industrial Relations to properly document how it intends to guide its predictive data analytics efforts for unveiling previously unknown provider fraud. Finally, we are unsure how Industrial Relations' "updating the demonstrated results on the DIR website" will address our recommendation to better document its data analytics effort related to provider fraud. We anticipate that the status updates Industrial Relations provides us within 60 days, six months, and one year of our report's publication date will better describe how it intends to address this recommendation.

STATE OF CALIFORNIA

Dave Jones, *Insurance Commissioner*

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November 17, 2017

VIA EMAIL

The Honorable Elaine M. Howle, CPA
California State Auditor
621 Capital Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for the opportunity to comment upon the California State Auditor's draft report entitled *Workers' Compensation Insurance: The State Needs to Strengthen Its Efforts to Reduce Fraud*" (2017-103). We would like to thank you and your staff for your professional approach in conducting this audit. It is our understanding that your team likewise found the staff at the California Department of Insurance (CDI) to be accessible and cooperative, and knowledgeable about the matters related to your inquiry.

California consumers, employees, and businesses continue to face unparalleled economic challenges in uncertain times. This means that vigilance in the fight against workers' compensation insurance fraud is more important than ever. CDI continues to increase its efforts to combat workers' compensation insurance fraud and these efforts are enhanced through partnerships and cooperation with the Fraud Assessment Commission (FAC), district attorneys, allied law enforcement, state and local agencies, the insurance industry, employers and the public.

CDI's responses to the recommendations related to CDI in the draft report are as follows:

Chapter 1, Recommendation 1: CDI should...by June 30, 2018: Create a public report that ranks workers' compensation insurers based on the effectiveness of their antifraud efforts, including the rate at which they submit fraud referrals.

CDI agrees with the recommendation to create a public report that ranks workers' compensation insurers based on the effectiveness of their antifraud efforts, including the rate at which they submit fraud referrals. The public report would need to comply with confidentiality limitations associated with certain anti-fraud information related to the insurers' efforts.

Chapter 1, Recommendation 2: CDI should...by June 30, 2018: Add a requirement that it consider rates of fraud claims referrals when selecting insurers to audit and that it give priority to those insurers with high premiums and very low numbers of referrals.

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CDI already considers the relationship between the number of fraud-claims referrals to the number of reported claims and insurers' Special Investigations Unit (SIU) investigations when selecting insurers to audit. CDI agrees with this recommendation that it also consider rates of fraud claim referrals compared to total Workers' Compensation premium when selecting insurers to audit and, in addition to the audit selection fraud claim referral ratios currently being used by CDI, that it give priority consideration to those insurers with high premiums and low numbers of referrals. An insurer with a high earned premium and a low referral rate does not necessarily mean, however, that the insurer is not aggressive in its efforts to detect, investigate, and refer suspected fraud. If an insurer is primarily providing workers' compensation insurance to industries with a lower risk of worker injuries, the actual claims submitted to the insurer may not be proportional to the earned premium.

Chapter 2, Recommendations 1 and 2: To better address vacancies in its fraud investigator positions, CDI should take the following actions by June 30, 2018:

The primary reason for vacancies in the fraud investigator positions has been the large pay disparity that existed, and still exists significantly, between CDI fraud investigator positions and similar investigators who are paid much more at other state agencies. CDI has found it difficult to recruit and retain investigators when they can make much more at other agencies for the same work. Pay levels are set by the Legislature and the Governor after collective bargaining, and like every agency, CDI is limited by those pay levels. Prior to July of 2017, CDI was only authorized to pay its investigators roughly 17% less than investigators performing similar functions at other agencies, including the California Department of Justice (DOJ) and the California Department of Corrections and Rehabilitation (CDCR). Achieving pay parity with other law enforcement agencies has been one of CDI's top priorities. Since April 2011, CDI has asked CalHR to obtain a salary adjustment for CDI investigators so CDI can remain competitive with other state law enforcement agencies. In 2016, CalHR addressed a portion of the pay disparity through labor negotiations.

These efforts resulted in a 5% special salary adjustment for CDI investigators; however, that adjustment did not sufficiently reduce the pay disparity between CDI and DOJ. As a result of further requests by CDI, CalHR proposed and the Legislature acted to modify the collective bargaining agreement in February 2017 to provide a 7.44% salary increase for CDI investigators who have been at the maximum salary of Range C for twelve qualifying months. While these salary increases are welcome improvements, they only became effective July 1, 2017, and so it is too soon to see any improvement in recruitment and retention. It must also be noted, however, that despite these increases, until the state addresses the significant pay disparity that remains between CDI Investigators and comparable positions with DOJ and CDCR, that disparity will continue to negatively impact the ability of CDI to fill vacancies and to retain investigators.

Chapter 2, Recommendation 1: Develop and implement a retention plan. This plan should be based on the results of in-person exit interviews with separating staff or similar tools such as satisfaction surveys to identify and address potential causes for separation. CDI should share the results of any trends arising from its exit interviews as well as its analyses of survey responses with the appropriate units as it deems necessary.

The Honorable Elaine M. Howle
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CDI agrees with this recommendation.

Chapter 2, Recommendation 2: Revise its recruiting plan to include the recruitment and hiring of retired local law enforcement officers.

CDI agrees with this recommendation, and will amend its recruitment plan to expressly incorporate CDI's ongoing efforts to recruit and hire retired local law enforcement officers.

Chapter 2, Recommendation 3: CDI should within 60 days and periodically thereafter, meet with the Fraud Commission and agree upon specific information to include in the Fraud Division's report to the Fraud Commission.

CDI agrees with this recommendation. CDI currently provides the FAC an Annual Report regarding Fraud Division spending, outcomes, and other mandated information. Holding periodic meetings between CDI and the FAC regarding the content of the annual report will ensure that additional content can be added to ensure the FAC has all of the relevant information it believes it needs to make informed decisions.

Chapter 2, Recommendation 4: CDI should by June 30, 2018, develop and implement a process to augment funding to district attorneys should CDI have unspent funds, rather than using the unspent funds to offset collections in subsequent years.

CDI agrees with this recommendation and will commence efforts to develop and implement a process to augment funding to district attorneys should CDI have unspent funds.

Thank you again for the opportunity to provide these comments. In the event you have any questions or require any additional information, please feel free to contact me, or Deputy General Counsel Michael J. Levy.

Sincerely,



Joel Laucher
Chief Deputy Insurance Commissioner