WORKERS' COMPENSATION FRAUD

Detection and Prevention Efforts Are Poorly Planned and Lack Accountability

Audit Highlights . . .

Our review of the State's program to reduce workers' compensation fraud revealed that:

- ☑ *Although employers are assessed annually to pay for efforts to reduce fraud in the workers' compensation system—an amount that has averaged about $30 million per year for the past five years—the Fraud Assessment Commission (fraud commission) and the insurance commissioner have not taken steps to measure fraud in the system or develop a statewide strategy to reduce it.*
- ☑ *Neither the fraud commission nor the insurance commissioner has acted to ensure that the assessments employers pay are necessary or are put to the best use for reducing the overall cost that fraud adds to the workers' compensation system.*
- ☑ *Shortcomings also exist in the process used to distribute fraud assessment funds to county district attorneys in a way that maximizes their effectiveness in fighting fraud.*

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REPORT NUMBER 2002-018, APRIL 2004

Department of Insurance, Department of Industrial Relations, and Fraud Assessment Commission responses as of October 2004

Section 1872.83 of the Insurance Code (Chapter 6, Statutes of 2002), requires the Bureau of State Audits (bureau) to evaluate the effectiveness of the efforts of the Fraud Assessment Commission (fraud commission), the Department of Insurance Fraud Division (fraud division), the Department of Insurance (Insurance), and the Department of Industrial Relations (Industrial Relations), as well as local law enforcement agencies, including district attorneys, in identifying, investigating, and prosecuting workers' compensation fraud and employers willful failure to secure workers' compensation benefits for their employees.

Finding #1: The fraud commission and the insurance commissioner cannot be certain that fraud assessment funds are effectively used to reduce fraud.

The California Constitution authorizes the Legislature to create and enforce a workers' compensation system that requires employers to compensate workers for job-related injuries and illnesses. Employers must pay for these benefits to injured workers either by purchasing workers' compensation insurance from an insurer or directly through self-insurance. The total cost of California's workers' compensation system has more than doubled recently—growing from about $9.5 billion in 1995 to about $25 billion in 2002—giving rise to sharp increases in employers' workers' compensation insurance premiums and prompting several efforts to reform various aspects of the system. Some of these reform efforts have been targeted at combating the fraud alleged to exist in the workers' compensation system, including fraud perpetrated by workers, medical and legal providers, insurers, and employers.

- ☑ *Industrial Relations has not implemented three statutory programs intended to identify and prevent workers' compensation fraud.*
- ☑ *The formulas the Department of Industrial Relations (Industrial Relations) uses to calculate and collect the workers' compensation fraud assessment surcharges have, in recent years, consistently resulted in insured employers being overcharged.*
- ☑ *Although Industrial Relations suspects that some insurers do not report and remit all of the fraud assessments they collect from employers, it states it does not have the authority, nor has it established a process, to verify that insurers remit all of the fraud assessments they collect from employers.*
- ☑ *Because the fraud division has not conducted adequate strategic planning, it has not met all its noninvestigative responsibilities and spends a significant portion of its workers' compensation antifraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by county district attorneys.*
- ☑ *The fraud division does not facilitate an effective system to obtain referrals of suspected fraud from insurers and other state entities involved in employment related activities.*

One of the reform efforts, Senate Bill 1218 passed in 1991, created an annual assessment collected from employers and paid into a fund dedicated to increasing the investigation and prosecution of fraud in the workers' compensation system. This legislation also established the fraud commission, which is responsible for determining the annual assessment after considering the advice and recommendations of the fraud division and the insurance commissioner.

However, neither the fraud commission nor the insurance commissioner has acted to ensure that the assessments employers pay are necessary or are put to the best use for reducing the overall cost that fraud adds to the workers' compensation system. Specifically, no meaningful steps have been taken to measure the extent and nature of fraud in the system. Instead, the fraud commission, the insurance commissioner, and the fraud division rely primarily on anecdotal testimony from stakeholders in the workers' compensation community, unscientific estimates, and descriptions of local cases involving fraud included in county district attorneys' applications for antifraud program grants. According to the fraud division chief, lacking the necessary resources and expertise, the fraud division cannot measure the extent and nature of fraud in the workers' compensation system or determine the effectiveness of activities to deter it.

Additionally, neither the fraud commission nor the insurance commissioner has made a meaningful effort to establish baselines for measuring the current level of fraud and gauging future changes in that level. If baselines were available, it would be possible to systematically and periodically measure the level of fraud, using available data, to determine the effectiveness of programwide strategies in reducing fraud in the workers' compensation system. Instead, the fraud division collects and publishes discrete statistics showing the number of investigations, arrests, convictions, and restitutions; revealing only that some sources of fraud may have been removed, not whether antifraud efforts are cost-effective—that is, whether they have reduced the overall cost that fraud adds to the system by as much or more than what is spent annually to fight it.

We recommended that to better determine the assessment to levy against employers each year for use in reducing fraud in the workers' compensation system, the fraud commission and the insurance commissioner should direct the fraud division to measure the nature and extent of fraud in the workers' compensation system. To establish benchmarks to gauge the

- ☑ *The fraud division's special investigative audit unit lacks a program that effectively targets insurers to achieve maximum compliance with suspected fraud reporting requirements, a standardized approach to conducting audits, timely reports and follow-up, and effective penalties to promote compliance.*
- ☑ *Improvement is needed in sharing information between the Industrial Relations and the fraud division to identify potential workers' compensation fraud.*

effectiveness of future antifraud activities, these measures should include analyses of available data from insurers and state departments engaged in employment-related activities, such as Industrial Relations and the Employment Development Department. In addition, the insurance commissioner should consider reactivating an advisory committee comprising stakeholders focused on reducing fraud in the workers' compensation system to contribute to the data analyses, provide input about the effects of fraud, and suggest priorities for reducing it. This advisory committee should meet regularly and in an open forum to increase public awareness and the accountability of the process.

Insurance Action: Pending.

Insurance reports that it is preparing a research plan to determine the nature of fraud within the workers' compensation insurance system. This plan will address emerging trends in fraud schemes and the return-on-investment of the anti-fraud program in California.

Fraud Commission Action: None.

The fraud commission did not submit the six-month response to our report that was due on October 29, 2004.

Finding #2: The fraud commission and the insurance commissioner have no overall strategy for using funds assessed against employers to most effectively and efficiently reduce fraud in the workers' compensation system.

Such a strategy could be translated into the goals and objectives, priorities, and measurable targets that state and local entities involved in fraud reduction efforts need to work effectively. These systemwide goals and priorities could be broken down into regional elements to accommodate any unique regional fraud problems. Having a measured level of fraud and a strategy for combating it could provide the fraud commission with criteria to use in arriving at the appropriate assessment to be paid by employers each year and in allocating the fraud assessment funds to state and local entities that are considered most effective in the efforts to reduce fraud. As a result, the fraud commission has limited authority to hold the fraud division or local district attorneys accountable for their antifraud efforts.

To assure California's employers that their fraud assessment has been used effectively to reduce the amount of fraud and thereby reduce the overall cost of the workers' compensation

system, the fraud commission and the insurance commissioner need (1) a systematic effort to measure the extent of workers' compensation fraud in the system and the types of fraudulent activities most responsible for driving up premiums, (2) an overall strategy to combat them, and (3) a means to periodically evaluate the effectiveness of the efforts (at both the State and local level) to reduce the occurrence of those types of fraud. Neither the fraud commission nor the insurance commissioner has met these three requirements. Simply put, they cannot justify the amount employers are assessed each year to combat fraud. According to some members of the fraud commission, one of the motivations behind the chosen funding level is to levy an assessment that allows both the fraud division and county district attorneys to maintain their current effort in pursuing workers' compensation fraud. However, at the December 2003 meeting to determine the fiscal year 2004–05 aggregate fraud assessment, one member of the fraud commission voiced her concern that the commission was voting without enough information to make an informed decision.

We recommended that once the nature and extent of fraud in the system has been identified, the fraud commission and the insurance commissioner and his staff should design and implement a strategy to reduce workers' compensation fraud. The strategy should be systemwide in scope and include objectives, priorities, and measurable targets that can be effectively communicated to the fraud division and the county district attorneys participating in the antifraud program. Efforts to achieve the strategy targets should be both a condition for receiving awards of fraud assessment funds and a measure of how well the fraud division and the county district attorneys pursue the systemwide objectives. The strategy should clearly define the roles and responsibilities of the participants in antifraud activities.

In addition, we recommended that the fraud commission take the following steps to gather the information it needs to determine the annual amount to assess employers to fight fraud in the workers' compensation system:

- Revamp its decision-making process so that it includes the best information available, including (1) the results of Insurance's analyses of the nature and extent of fraud in the workers' compensation system, once they are completed; (2) analysis of the effectiveness of efforts by the fraud division and district attorneys in the prior year to reduce fraud in accordance with their respective antifraud program objectives; and (3) any newly emerging trends in fraud schemes that should receive more attention.

- Request an annual report from the fraud division that outlines (1) its objectives from the prior year that are linked to measurable outcomes and (2) its objectives for the ensuing year, together with estimates of the expenditures the fraud division needs to make to accomplish those objectives.

- Request, in addition to the information currently required of each county district attorney planning to participate in the antifraud program, a report listing the district attorney's accomplishments in achieving the goals and objectives outlined in the prior year's application and the goals and objectives for the ensuing year. The report should also include the estimated cost of the grant year's activities to achieve the district attorney's goals and objectives and a description of how those goals and objectives align with the program goals described by the fraud commission and the insurance commissioner.

If the fraud commission believes that altering the funding formula from the statutorily required levels—under which 40 percent of fraud assessment funds are automatically awarded to both the fraud division and the district attorneys—would increase accountability over the use of antifraud program funds, we recommended that the fraud commission encourage legislation that would allow it more discretion in how these funds are distributed.

Insurance Action: Pending.

Insurance reports that it has been working to develop a strategy to improve the efficiency, consistency, and accountability in the decision-making process. Together with the fraud commission and district attorneys it will work to provide the best information available on reported fraud and trends, continue with round-table discussions pertaining to anti-fraud efforts, and make adjustments to program objectives focused on reducing fraud.

In addition, Insurance reports that it has formed a Performance Measurement Committee (committee) with representatives from the department, county district attorneys, and the fraud commission. The committee met four times during 2004 and reviewed the current request for grant fund application, district attorney program reports, and the workers' compensation grant review score sheet. The committee's recommendations to change these forms will be forwarded to the insurance commissioner. Insurance also reported that it planned to meet in November 2004 to discuss topics that included performance

measurements for the workers' compensation antifraud program, legal issues and opinions, suspected fraud referral standards, proposed regulations for special investigative units, and other regulatory changes.

Insurance reports that it will work closely with the fraud commission so that its vision, objectives, and priorities align with the insurance commissioners' strategic initiatives. To provide information to the fraud commission, the division commenced an analysis of its anti-fraud program for fiscal year 2003–04 to review its achievements and establish a benchmark for future comparisons. The division will outline its planned objectives and expenditures for fiscal year 2004–05 and present them to the fraud commission to be used in funding allocation decisions.

Insurance reports that it intends to amend the regulations relevant to grants of anti-fraud funds and will be presenting future guidelines to the fraud commission that focus on district attorney performance, past and future. The majority of counties that applied for fiscal year 2004–05 funding identified goals, objectives, anticipated expenses, and program accomplishments for fiscal year 2003–04.

Fraud Commission Action: None.

The fraud commission did not provide a six-month response to our report.

Finding #3: Shortcomings exist in the process used to distribute fraud assessment funds to county district attorneys in a way that maximizes their effectiveness in fighting fraud.

A review panel comprising fraud commission members, representatives of the fraud division and Industrial Relations, and an independent criminal expert makes recommendations to the insurance commissioner regarding how to allocate fraud assessment funds to district attorneys who have applied for grants. In making its recommendations, the review panel evaluates grant applications and uses the recommendations it receives from fraud division staff who also conduct a review of the grant applications. However, both the fraud division and the review panel fail to consistently apply criteria or document the rationale they use in making funding recommendations. Rather, each review panel member uses a personal, subjective set of criteria when developing recommendations for grant awards, without retaining any evidence of the basis of any decision.

Further, the panel members do not share their decision-making criteria or rationale with the district attorneys or with other review panel members. Nor does the fraud division retain documentation showing the reasoning it used to arrive at its funding recommendations to the review panel. As a result, neither the review panel nor the fraud division staff can provide evidence justifying their decisions to recommend specific grant awards, leaving the process open to the perception that it may not be equitable. Finally, the review panel did not always comply with open-meeting requirements when developing funding recommendations.

To better ensure that fraud assessment funds are distributed to district attorneys so as to most effectively investigate and prosecute workers' compensation fraud and increase their accountability in using the funds, we recommended that the fraud commission and the insurance commissioner take the following steps:

- Develop and implement a process for awarding fraud assessment grants that provides for consistency among those making funding recommendations by incorporating standard decision-making criteria and a rating system that supports funding recommendations.

- Include in the decision-making criteria how well county district attorneys' proposals for using fraud assessment funds align with the strategy and priorities developed by the fraud commission and the insurance commissioner, as well as the district attorneys' effectiveness in meeting the prior year's objectives.

- Document the rationale for making decisions on recommendations for grant awards.

- Change the past policy of awarding the base portion of fraud assessment grants to county district attorneys exclusively on whether they submit a completed application by required deadlines and instead, make recommendations for total grant awards, including the base allocations, on evaluations of county district attorneys' plans that include how they will use the funds, as required by Insurance regulations.

- Continue current efforts to establish performance measures to use in evaluating the effectiveness of the fraud division and participating district attorneys in reducing workers' compensation fraud. The measures can also assist in determining recommendations for grant awards to the county district attorneys and the fraud division.

- Determine whether the Bagley-Keene provisions apply to the review panel's meetings to recommend fraud assessment grants to county district attorneys and, if they do, seek a specific exemption for discussions of portions of the county district attorneys' applications for grant awards that include confidential criminal investigation information. All other parts of these meetings should remain open to the public.

Insurance Action: Partial corrective action taken.

Insurance reports that it will adopt amended regulations that base grant awards on measurable performance criteria.
Insurance reports that during the July 2004 Workers' Compensation Review Panel (review panel) hearing, the panel strived for a greater level of consistency and clarity. The panel required applicants to explain and justify the data forming the basis for their grant requests and to state their strategic objectives relative to those articulated by the insurance commissioner. Insurance and the review panel could make only limited criteria modifications during this funding cycle to ensure alignment of district attorney proposals for the use of grant funds with the insurance commissioner priorities because regulations need to be amended to make significant changes.
During an August 2004 hearing, the insurance commissioner articulated his priorities for the anti-fraud program as high impact cases involving providers and employer failures to appropriately secure workers' compensation coverage, allocating funds based on performance, building effective partnerships with state and local agencies, and addressing bureau recommendations.
However, although three fraud commissioners articulated their priorities, as of October 29, 2004, the fraud commission as a whole has not articulated its official strategies and priorities for the program.
Insurance reports that it is evaluating comments and recommendations regarding the funds allocation process from the review panel and its committee to incorporate them into the appropriate standardized criteria for allocating funds to be included in amended regulations.

Insurance Action: Pending.

Insurance reports that the division is working to develop a business plan that will align with Insurance's vision, goals, and strategic initiatives, and acknowledges it needs to address performance measures for both investigations and prosecutions within its business plan and will be working with the fraud commission, district attorneys, and other stakeholders to accomplish this result.

Insurance Action: Corrective action taken.

Insurance reports that it has changed the policy of awarding grant funds to county district attorneys based exclusively on whether they submitted a completed application by the required deadline. Rather, these grants are awarded based on whether the applying county met criteria based on the evaluation of the county district attorney's plans and past performance.
Legal counsel for Insurance has determined that the open public meeting requirements of the Bagley-Keene Act apply. Counsel's opinion encourages communication between program participants and individual review panel members and that district attorneys designate information that is confidential so it can be redacted for public disclosure

Fraud Commission Action: None.

The fraud commission did not provide a six-month response to our audit report.

Finding #4: Controls intended to restrict how county district attorneys use their grants of fraud assessment funds to pay for indirect costs are not always effective.

Insurance regulations allow county district attorneys three options for charging counties' indirect costs to fraud assessment grants; each option is intended to place a limit on these charges. However, one option is based on cost rate proposals approved under requirements of the United States Office of Management and Budget, without any input from the fraud commission or insurance commissioner, and does not provide the control of charges of indirect costs provided by the other two options. As a result, one county district attorney charges county administrative costs to the grant at a rate equal to 43 percent of the total salaries and wages charged to the grant.

We recommended that Insurance reevaluate its regulations pertaining to how indirect costs are charged to fraud assessment grants to determine whether the regulations provide the desired amount of control. The fraud commission and the insurance commissioner should also seek changes in the regulations if required and ensure that all county district attorneys that apply for fraud assessment grants disclose their methods of charging indirect costs.

Insurance Action: Pending.

Insurance reports that it is in the process of developing amended regulations to require one standardized methodology for all counties to use when charging indirect costs to program funds.

Fraud Commission Action: None.

The fraud commission did not provide a six-month response to our report.

Finding #5: The fraud division has not conducted adequate strategic planning to ensure it has met all its noninvestigative responsibilities.

Because the fraud division has not conducted adequate strategic planning, it has not met all its noninvestigative responsibilities and spends a significant portion of its workers' compensation antifraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by county district attorneys. The fraud division pays for its workers' compensation antifraud activities using its share of the fraud assessment funds—averaging more than $13 million per year over the five years ending with fiscal year 2002–03—that are levied on California employers.

Lacking a sound strategic plan, the fraud division dedicates too few of its workers' compensation fraud resources to the noninvestigative activities that its statutory responsibilities demand. For example, the fraud division has put little effort into conducting the research necessary to measure the magnitude of the various types of workers' compensation fraud, a yardstick that could help the fraud division guide its antifraud approach and measure its actions and effectiveness in reducing the fraud problem. Further, the fraud division has not developed the information on fraud needed to prepare reports for individuals and entities overseeing the antifraud program, such as the insurance commissioner, the Legislature, and the fraud commission. However, the fraud division's ability to successfully identify goals and objectives is somewhat limited because, as

previously discussed, the fraud commission and the insurance commissioner have not established a statewide strategy for the antifraud program.

In addition, our review of workers' compensation fraud cases in its case management database reveals that the fraud division could manage its investigative efforts more effectively. For example, 87 percent of the referrals of suspected workers' compensation fraud the division receives do not end up in the hands of district attorneys for prosecution. Between September 2001 and December 2003, the fraud division spent more than 16 percent of its investigative hours on cases that it closed and did not submit for prosecution. Moreover, based on past trends, one-third of the hours charged to open cases as of December 2003 will probably be spent on cases not submitted to district attorneys for prosecution. Similarly, during the same time period, the division closed 83 percent of the high-impact, high-priority cases referred to it without submitting the cases to district attorneys, frequently citing insufficient evidence as the reason.

To ensure that it fulfills all aspects of its role in the workers' compensation antifraud program, the fraud division should take the following steps:

- Recognize its responsibilities beyond investigating fraud by: (1) conducting the research needed to advise the fraud commission and the insurance commissioner on the optimum aggregate assessment needed by the program annually to fight workers' compensation fraud, (2) using documented past performance and future projections to advise on the most effective distribution of the funds assessed to investigate and prosecute workers' compensation fraud, and (3) reporting on the economic value of insurance fraud and making recommendations to reduce it.

- Modify its business plan to meet noninvestigative responsibilities, including establishing appropriate goals and objectives, activities, and priorities.

- Establish benchmarks to measure its and the district attorneys' performance in meeting goals and objectives and to determine whether the antifraud program is operating as intended and resources are appropriately allocated.

- Reevaluate the process it has established for insurers and other state entities involved in employment-related activities to report suspected fraud. The fraud division should identify the

type of referrals and level of evidence it requires to reduce the number of hours it spends on referrals that it ultimately does not pass on to county district attorneys for prosecution.

To justify the use of fraud assessment funds, we recommended that the fraud commission and the insurance commissioner require the fraud division to conduct a return-on-investment analysis for the workers' compensation antifraud program as a whole and to annually report the results to the fraud commission and the insurance commissioner.

Insurance Action: Partial corrective action taken.

Insurance reports that it will allocate resources to address fraud research, trend analysis, and effective funding disbursement methods, and improved oversight of county grants. Pending research will result in a plan that Insurance stated would address the return-on-investment of the anti-fraud program.

Insurance Action: Pending.

In addition, Insurance reports it is taking steps to meet its noninvestigative responsibilities, including revising its business plan and realigning its resources as an advisor regarding the level of funding and the direction of fraud reduction efforts.

Finding #6: Independent audit reports submitted by county district attorneys participating in the antifraud program do not assure the fraud division that the district attorneys use grants of fraud assessment funds appropriately.

Although an audit unit within Insurance conducts reviews of district attorneys' use of workers' compensation fraud assessment funds that are effective and have resulted in the detection and recovery of questionable expenditures, the audit unit's limited resources hinder its ability to audit all district attorneys, including those receiving the largest grants. As a result, the fraud division cannot verify that county district attorneys receiving grants use the funds in accordance with state law, Insurance regulations, and the terms of the grant agreements.

To improve the level of assurance contained in the independent audit reports submitted by county district attorneys regarding fraud assessment funds being spent for program purposes, we recommended that the fraud division do the following:

- Clarify its expectations for the independent audits by seeking a change in Insurance regulations that require audit reports to provide an opinion on county district attorneys' level of compliance with key provisions of the applicable laws, regulations, and terms of the fraud assessment grants.

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

Insurance Action: Partial corrective action taken.

Insurance reports that it is developing amendments to its regulations to clarify the independent audit requirements and ensure that county district attorneys comply with those requirements.

Finding #7: The fraud division does not offer insurers an effective system for referring suspected workers' compensation fraud to the fraud division.

An effective fraud referral system is important to the fraud division because its ability to investigate is dependent on the number and quality of referrals it receives. Despite a legal requirement to investigate suspected fraud and to report cases that show reasonable evidence of fraud, insurers' frequency of reporting varies significantly. In fact, some of the larger insurers in the workers' compensation system reported no suspected fraud referrals in 2001 and 2002. The chief of the fraud division stated that past regulations poorly defined when insurers should refer suspected fraud to the fraud division. Insurance and the fraud division have recently adopted emergency regulations in an attempt to better define when reporting is required. Additionally, the fraud division is currently working to increase and improve its monitoring of insurers' special investigative units, which are responsible for reporting fraud. Included in the fraud division's planned improvements is developing a new method for auditing the special investigative units.

Nonetheless, the fraud division's efforts to ensure that it receives referrals of suspected fraud from insurers still have many internal weaknesses. A lack of strategic planning has left the fraud division's special investigative audit unit without a program that effectively targets insurers to achieve maximum

compliance with reporting requirements, a standardized approach to its audits that will ensure an adequate review, timely reports and follow-up on audit findings, and effective penalties to promote compliance.

To ensure that it receives the suspected fraud referrals it needs from insurers to efficiently investigate suspected fraud, we recommended that the fraud division continue its efforts to remove the barriers that prevent insurers from providing the desired level of referrals. Additionally, Insurance should seek the necessary legal and regulatory changes in the fraud-reporting process. Barriers to adequate referrals include the following:

- Lack of a uniform methodology and standards for assessing and reporting suspected fraud.
- Regulations that poorly define when insurers should report suspected fraud to the fraud division.
- Perceived exposure to civil actions when criminal prosecutions of referrals are not successful.

Given the number of referrals of suspected fraud cases by insurers that the fraud division has decided not to investigate because of a perceived lack of sufficient evidence, the fraud division should work with insurers to reduce the number of referrals that are not likely to result in a successful investigation or prosecution, thereby preserving limited resources. It should also work to ensure that the referrals that insurers do make contain the level of evidence necessary for the fraud division to assess the probability of a successful investigation and prosecution.

Once the fraud division has determined the level of evidence included with the suspected fraud referrals it needs from insurers, it should implement a strategy for its special investigative audit unit to focus the unit's limited resources on determining whether insurers are following the law in providing the referrals the fraud division needs.

Insurance Action: Pending.

Insurance points out that it has certain responsibilities under existing statutes to investigate reported suspected fraud and reports that it will evaluate its suspected fraud referral process and evidence standards within the context of those existing statutes.
Insurance reports that its special investigative unit management has analyzed staff duties and classified positions within this unit to better complete reviews in compliance with government auditing standards. In addition, special investigative unit staff now use a policy manual to conduct reviews of insurers, providing for more consistent, accurate, and timely reviews, and periodic follow-up on audit findings.

Insurance Action: Partial corrective action taken.

Finally, Insurance reports that it has developed a pilot audit plan utilizing risk factors such as line of business and market share to develop a more comprehensive audit plan for future fiscal years.

Legislative Action: Corrective action taken.

Assembly Bill 1227 was chaptered on September 20, 2004, to provide authority and an appropriate penalty structure to increase insurance company compliance with special investigative unit statutes.

Finding #8: The fraud division's ability to gather identifying information of potential workers' compensation fraud is hampered by other departments' failure to share it.

The Division of Labor Standards Enforcement (DLSE) within Industrial Relations investigates violations of certain labor laws, including the failure to provide workers' compensation insurance and benefits to employees. However, the DLSE does not routinely refer its findings to the fraud division for consideration of possible criminal prosecution. During 2003, the DLSE cited nearly 1,300 employers for failing to provide workers' compensation insurance and benefits for their employees. Having information on some of these cases, particularly those involving repeat offenders, might have alerted the fraud division of noncompliance with the law and helped it detect potentially fraudulent activities. The fraud division chief told us he has sought to improve information sharing between the fraud division and divisions within Industrial Relations.

Also, recent legislation required the DLSE, in conjunction with the Employment Development Department and the Workers' Compensation Insurance Rating Bureau, to establish a program to identify employers that fail to secure workers' compensation insurance for their employees. This requirement is similar to a pilot project that demonstrated that such a program provides an effective and efficient method for discovering illegally uninsured employers. Industrial Relations' Division of Workers' Compensation (DWC) is also required by recent legislation to implement a protocol for reporting suspected medical provider fraud and a program to annually warn employers, claims adjusters and administrators, medical providers, and attorneys who participate in the workers' compensation system against committing workers' compensation fraud. Notification of the legal risks is regarded as an important step in deterring fraud.

To help the fraud division investigate employers that fail to secure payment for workers' compensation insurance for their employees, the DLSE should track employers that do not provide workers' compensation insurance for their employees and report to the fraud division any employer that repeatedly fails to provide workers' compensation insurance.

To ensure that it effectively targets employers in industries with the highest incidence of unlawfully uninsured employers, we recommended that the DLSE establish a process that uses data from the Uninsured Employers Fund, the Employment Development Department, and the Workers' Compensation Insurance Rating Bureau, as required by law.

To provide a mechanism to allow reporting of suspected medical provider fraud, the DWC should implement the fraud-reporting protocols required by law.

To help deter workers' compensation fraud, the DWC should warn participants in the workers' compensation system of the penalties of fraud, as required by law.

Industrial Relations Action: Partial corrective action taken.

Industrial Relations stated that it has entered into a memorandum of understanding with Insurance to exchange information concerning uninsured employers. Industrial Relations reports that it is in the process of implementing a mechanism to allow reporting of suspected medical provider fraud. The mechanism will include a reporting protocol and report form, an internal process for receiving and screening reports of suspected provider fraud and routing them to the appropriate licensing and disciplinary entities or law enforcement agencies, and efficient and cost effective ways to broadly disseminate the protocol to the public upon its completion.
Industrial Relations reports that it is also in the process of implementing the statutory requirement to warn participants in the workers' compensation system of the penalties of fraud.

Industrial Relations Action: None.

Industrial Relations reports that it has not secured funding to implement a program where data obtained from the Uninsured Employers' Fund, Employment Development Department, and the Workers' Compensation Insurance Rating Bureau can be compared to determine employers potentially operating without workers' compensation insurance coverage.

Finding #9: Improvement is needed in the process used to collect the fraud assessment funds that finance increased antifraud activities.

The formulas Industrial Relations uses to calculate the workers' compensation fraud assessment surcharge rates have, in recent years, consistently resulted in insured employers being overcharged. In addition, Industrial Relations suspects that not all insurers correctly report and remit all the workers' compensation fraud assessment surcharges they collect from employers. Industrial Relations estimates that a range of roughly $8 million to more than $13 million has been unreported and unremitted during 1999 through 2001. However, Industrial Relations stated it does not have the authority, nor has it established a process, to verify that insurers remit all of the fraud assessment surcharges collected from employers.

To avoid overcharging the State's insured employers for the workers' compensation fraud assessment, we recommended that Industrial Relations work with the Workers' Compensation Insurance Rating Bureau to improve the accuracy of the projected premiums for the current year, which it uses to calculate the fraud assessment surcharge to be collected from insured employers.

To make certain that insurers do not withhold any portion of the fraud assessment surcharge, we recommended that Industrial Relations seek the authority and establish a method to verify that insurers report and submit the fraud assessment surcharges they collect from employers.

Industrial Relations Action: None.

➲ Industrial Relations did not address these recommendations in its six-month response to our report.