Oversight Hearing on Workers' Compensation Fraud
Assembly Insurance Committee
Assemblymember Tom Daly, Chair
Wednesday February 28, 2018
9:00 a.m. – 11 a.m.
State Capitol, Room 437
Sacramento, California

BACKGROUND

The best estimates among the most reliable researchers and regulators are that workers' compensation fraud costs the system between $1 billion and $3 billion per year. $1 billion wasted in this program that is extremely important to every employer and every person who works as an employee in this state is a serious problem; $3 billion would be scandalous! But this is the backdrop on the scope of the fraud problem that characterizes today's workers' compensation system. And this unacceptable scope of the problem exists despite years of efforts (explained in more detail below) specifically targeted at addressing the fraud problem. This history, and these uncertainties, prompted Assemblymember Tom Daly, Chair of the Assembly Insurance Committee, to seek a qualified, independent evaluation of the problem. As a result of a two-year effort by Assemblymember Daly, the State Auditor was authorized in 2017 to conduct an audit of the state's workers' compensation program's anti-fraud efforts. The report on that audit will be presented to the Assembly Insurance Committee at an informational hearing on February 28.

Past efforts.

It was long considered fraudulent activity to lie or make false claims in order to obtain insurance proceeds. However, in the late 1980's and early 1990's the Legislature began to take specific steps to address insurance fraud generally, and workers' compensation fraud specifically, in a more comprehensive manner.

In 1989 the Legislature adopted a specific, comprehensive anti-insurance fraud statute, and fine-tuned that statute several times over the next few years.

In 1991, the Legislature enacted a comprehensive anti-insurance fraud program, and established what was then the Fraud Bureau in the Department of Insurance, staffed by peace officers dedicated to fighting insurance fraud generally, and workers' compensation fraud specifically. That Bureau has grown into the Fraud Division within Department of Insurance with well over 100 peace officers dedicated to fighting workers' compensation fraud.

Funding for the Fraud Divisions workers' compensation activities – both peace officers within Department of Insurance and prosecutors employed by local District Attorneys – was normalized by the creation of the Fraud Assessment Commission (FAC). The FAC is empowered to determine an annual assessment on employers (either directly for self-insured employers, or via the insurance company for employers that purchase workers' compensation insurance) to fund these activities. Assessments in recent years have been nearly $60 million annually. These funds are divided by a statutory formula, with 40% going to Department of Insurance, 40% going to local prosecutors, and 20% within the FAC's discretion. For the past several years, the FAC has provided this 20% discretionary funding to local prosecutors.

Each major workers' compensation reform measure since the early 1990's and in numerous stand-alone bills in between the major reform measures, the Legislature has attempted to tackle the fraud issues *du jour*. It has proven remarkably difficult to keep up with the creativity of those who would seek to defraud the workers' compensation system, and as recently as 2016 SB 1160 (Mendoza) and AB 1244 (Gray and Daly) addressed medical providers who are suspected of committing fraud by placing limits on medical liens and empowering the Administrative Director of the Division of Workers' Compensation to suspend providers from participating in the workers' compensation system. While these efforts have shown positive results, it remains the case that a substantial amount of organized fraudulent activity avoids detection.

Fraud vs. Abuse. The anti-"fraud" efforts of the Department of Insurance and local prosecutors are focused on actual fraudulent claims – that is, billing for things that weren't provided, lying about the facts supporting a claim, providing treatments when it is known that they are not needed, lying about payroll to reduce insurance premiums, and the like. There are also a range of behaviors that are commonly referred to as fraud, but that are not specifically the target of criminal prosecution. These abusive practices – such as inflated billing for medical devices, prescribing expensive name brand medications (and then directly dispensing them) rather than cheaper, equally efficacious products, and numerous other schemes that do not contribute to healing or returning injured workers to their jobs – also cause waste in the system.

With all of these problems, and the seemingly endless "whack-a-mole" approach to reducing these unproductive costs in the system, Assemblymember Daly asked for a fresh, independent review of the system with the hope that "new eyes" might identify approaches to better combat workers' compensation fraud. The Audit authorized by the Joint Legislative Audit Committee has now been completed, and the Auditor's Report issued. The upcoming hearing of the Assembly Insurance Committee on February 28 will offer the Auditor and key stakeholders the opportunity to comment on the Audit itself, and offer perspectives and ideas about the fight against workers' compensation fraud.

The State Auditor's Report can be found at www.auditor.ca.gov. The Auditor's reference number for this audit is 2017-103. Below are the highlights from the Report and summary of results:

"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.

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 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. 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."