



## *Workers' Compensation Insurance*

Some State Agencies Are Paying Millions of Dollars More Than Necessary to Provide Benefits to Their Employees

*November 2019*

**REPORT 2019-106**





**CALIFORNIA STATE AUDITOR**

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November 21, 2019  
**2019-106**

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 directed by the Joint Legislative Audit Committee, my office conducted an audit of workers' compensation insurance (insurance). Our assessment focused on insurance used by state agencies, and the following report details the audit's findings and conclusions. In general, we determined that some agencies are paying millions more than necessary to provide benefits to employees.

State law allows agencies to decide how to provide workers' compensation benefits to their employees. Almost 90 percent of them choose to do so using a master agreement that the California Department of Human Resources (CalHR) negotiated on their behalf with the State Compensation Insurance Fund (State Fund). Under the master agreement, State Fund administers, processes, and pays employee benefits for participating state agencies, and the agencies reimburse State Fund for the actual costs of services rendered. According to CalHR data, nearly 190 agencies provided benefits through the master agreement in fiscal year 2017–18, while 32 agencies—or portions of agencies—opted to purchase insurance directly from State Fund.

When we reviewed the costs of 10 of the 32 agencies that purchased insurance directly from State Fund in fiscal year 2017–18, we found that each of these agencies consistently paid more in insurance premiums than it would have if it had provided benefits by using the master agreement. We estimate that from fiscal years 2013–14 through 2017–18, these 10 agencies collectively paid an average of \$5.7 million per year in premiums but they could have saved the State more than \$20 million during the period we reviewed if they had used the negotiated master agreement.

Finally, we found that State Fund does not always provide state agencies with enough time to review settlement authorization requests (settlement requests) before the mandatory settlement conferences (settlement conferences) in which State Fund and injured employees attempt to come to agreement to avoid seeking a trial. State Fund should provide 30 days to review settlement requests before the settlement conferences. However, for eight of the 15 claims we reviewed, State Fund did not do so. When State Fund does not make settlement requests available for agencies to adequately review before settlement conferences, it may delay the settlement authorization process and may lead to agencies' having to pay additional expenses if the cases go to trial.

Respectfully submitted,

A handwritten signature in black ink that reads "Elaine M. Howle". The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA  
California State Auditor

## Selected Abbreviations Used in This Report

CAL FIRE	California Department of Forestry and Fire Protection
CalHR	California Department of Human Resources
Caltrans	California Department of Transportation
CHP	California Highway Patrol
DWC	Department of Industrial Relations' Division of Workers' Compensation
IDL	Industrial Disability Leave
Social Services	California Department of Social Services
State Fund	State Compensation Insurance Fund

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## Summary

### Results in Brief

State law requires state agencies—like other California employers—to provide workers' compensation benefits to state employees who are injured or disabled in the course of their employment. In addition to covering the costs of medical expenses, these benefits may provide injured employees with a portion of their wages while they recover, as well as payments for permanent disability. State law allows agencies to decide how to provide workers' compensation benefits to their employees. Almost 90 percent of them choose to do so using a master agreement that the California Department of Human Resources (CalHR) negotiated on their behalf with the State Compensation Insurance Fund (State Fund), a nonprofit entity that also provides workers' compensation insurance to private businesses. Under the master agreement, state agencies reimburse State Fund for the actual cost of workers' compensation claims, rather than paying for insurance or maintaining a workers' compensation reserve. According to CalHR data, nearly 190 agencies provided benefits through the master agreement in fiscal year 2017–18, while 32 agencies opted to purchase insurance from State Fund.

When we reviewed the costs of 10 of the 32 agencies that purchased insurance from State Fund in fiscal year 2017–18, we found that each of these agencies consistently paid more in insurance premiums than it would have paid had it provided benefits under the master agreement. We estimate that from fiscal years 2013–14 through 2017–18, these 10 agencies collectively paid an average of \$5.7 million per year in premiums but would have paid an average of less than \$1.6 million per year under the master agreement. For example, the California Department of Food and Agriculture paid an average of nearly \$1 million per year in premiums, even though we estimate that its average annual cost under the master agreement for claims would have been less than \$250,000. In fact, had the 10 agencies used the master agreement, they could have saved the State more than \$20 million during the period we reviewed. However, CalHR is not required to assist agencies in deciding whether purchasing workers' compensation insurance or using the master agreement is likely to be more cost-effective for them.

In addition, we reviewed four state agencies that provide workers' compensation benefits through the master agreement—the California Department of Forestry and Fire Protection, the California Department of Transportation, the California Highway Patrol, and the California Department of Social Services—to determine whether they met state-mandated timelines for processing claims and whether any delays affected the ability of injured employees

### Audit Highlights . . .

*Our audit of workers' compensation insurance used by state agencies revealed the following:*

- » *In fiscal year 2017–18, nearly 190 agencies provided workers' compensation benefits through the State's master agreement, while 32 agencies opted to purchase insurance directly from State Fund.*
- » *The 10 agencies we reviewed who purchased insurance from State Fund consistently paid more in premiums than they would have paid had they provided benefits under the master agreement.*
  - *These 10 agencies collectively paid an average of \$5.7 million per year in premiums to State Fund but would have paid an average of less than \$1.6 million per year under the master agreement, saving the State more than \$20 million.*
- » *A lack of qualified medical evaluators has delayed appointments for medical evaluations, resulting in State Fund automatically denying some claims and employees having to wait longer to receive benefits or return to work.*
- » *State Fund's failure in some cases to provide agencies with sufficient time to review and approve requests for settlement authority before settlement conferences has limited its ability to resolve claims efficiently.*

to receive care. We reviewed eight claims per agency—32 claims in total—and found that the four agencies missed some deadlines specified in state law. However, because state law requires agencies to provide each injured employee with up to \$10,000 in medical benefits until State Fund either accepts or denies a claim, none of the few delays we noted affected the injured employees' access to necessary medical treatments.

Although State Fund also met the majority of the mandated time frames for processing the claims we reviewed at the four agencies, a lack of qualified medical evaluators (medical evaluators) to produce timely medical evaluation reports resulted in it automatically denying some of these claims. If an employee and State Fund cannot agree on whether an injury is work-related, the employee may be required to see a medical evaluator. Upon receiving a request, the Department of Industrial Relations' Division of Workers' Compensation must generate a randomly selected list of three medical evaluators (panel). Generally, if the injured employee is represented by an attorney, the parties each choose one medical evaluator to remove from the panel, and the injured employee then schedules an appointment with the remaining medical evaluator. State regulation requires the selected medical evaluator to be available within 60 days to conduct an evaluation of the injured employee. If the medical evaluator is unavailable within this window, state regulation generally allows the requester to ask for a replacement panel, thereby restarting the process.

When medical evaluators are unavailable, injured employees may face delays in receiving benefits. Specifically, State Fund automatically denied four of 32 claims we reviewed because the employees could not obtain timely appointments for medical evaluations within 90 days, the legal deadline to deny claims before they are presumed to be accepted. Although State Fund may subsequently accept a claim if a medical evaluator determines that the injury was work-related, until it is accepted the injured employee does not receive the appropriate type of workers' compensation benefit. State Fund did not accept these four claims until an average of four months later, after the employees finally obtained appointments with the medical evaluators.

A shortage of medical evaluators likely contributed to these delays in claim resolutions. Requests for replacement medical evaluators because the original evaluators were not available for appointments within the 60-day window more than quadrupled from fiscal years 2013–14 through 2017–18. Representatives of the four agencies we reviewed explained that when injured employees do not receive workers' compensation benefits because they are unable to obtain timely appointments for medical evaluations, it may force the employees to seek temporary benefits from other sources such as

Nonindustrial Disability Insurance. In addition, having medical evaluators available to conduct timely appointments for evaluations can help ensure that employees return to work as soon as they are medically able and prevent unnecessary disability payments. For example, we reviewed a claim in which an agency paid an employee more than twice the amount in disability payments than it might have if State Fund had received a timely medical evaluation report declaring that the employee's condition had reached maximum medical improvement.

Finally, State Fund does not always provide state agencies with enough time to review settlement authorization requests (settlement requests) before the mandatory settlement conferences (settlement conferences) in which State Fund and injured employees attempt to come to agreement to avoid seeking a trial. State Fund must obtain approval from agencies before entering into settlements, unless the agencies have authorized State Fund to settle cases without such preapproval. State Fund and several of the agencies we reviewed indicated that State Fund should provide agencies with 30 days to review settlement requests before the settlement conferences. However, State Fund did not provide agencies with 30 days to respond to the settlement requests for eight of the 15 claims we reviewed that involved settlement conferences. When settlement requests are not available for agencies to adequately review before settlement conferences, it may delay the settlement authorization process and lead to agencies' having to pay additional expenses if the cases go to trial.

## **Selected Recommendations**

### ***CalHR***

To ensure that all state agencies provide workers' compensation in the most cost-effective manner, CalHR should provide each agency that purchases workers' compensation insurance with a cost-benefit analysis every five years that compares the cost of purchasing this insurance through State Fund with the cost of obtaining coverage through the master agreement.

### ***State Fund***

To ensure that state agencies have adequate time to review settlement requests and provide settlement authority, State Fund should create and follow a policy by May 2020 to provide settlement authorization requests to agencies at least 30 days before settlement conferences.

**Agency Comments**

CalHR agreed to implement our recommendation. State Fund did not agree with our recommendation, asserting that it will strive to meet a guideline that State Fund will complete settlement requests at the earliest opportunity.

# Introduction

## Background

Before the creation of workers' compensation systems, civil courts were responsible for resolving disputes over responsibility for workplace injuries. The burden of proving that injuries were the result of employers' negligence generally fell on the injured employees. However, by the early 1900s, states began to enact workers' compensation laws. In the years that followed, California passed several workers' compensation laws, eventually establishing a no-fault workers' compensation system. Workers' compensation in California is considered no-fault because employees no longer have to prove that their employers caused their injuries through negligence.

California's workers' compensation system benefits both employees and their employers. State law requires all employers to provide workers' compensation benefits or workers' compensation insurance that generally guarantee compensation for injuries, illnesses, and deaths occurring at and caused by their work. Furthermore, state law also generally standardized how employees' permanent disability benefits are calculated. In exchange for these and other benefits, state law prohibits employees from suing their employers for most workplace injuries, illnesses, and deaths. For state employees, their respective agencies decide how to provide workers' compensation. In the pages that follow, we discuss the different options available to state agencies and explain in further detail how the workers' compensation system functions.

## Workers' Compensation System

A California employer can provide workers' compensation benefits through different methods, in part depending on whether it is a private entity or a public agency. As Table 1 shows, employers can be self-insured, insured through another entity, or for state agencies provide benefits through the state's master agreement, which we describe later in the Introduction. Each option involves a different method of processing and paying benefits to injured workers. Given the different types of coverage, several state agencies are jointly involved in various aspects of the oversight and provision of workers' compensation benefits, as Table 2 demonstrates.

Under certain conditions, employers can become self-insured by applying to the Office of Self-Insurance Plans (self-insurance office), which is within the Department of Industrial Relations (Industrial Relations). The director of Industrial Relations may approve applicants

**Table 1**  
California Employers Use Three Approaches to Provide Workers' Compensation Coverage

	TYPE OF WORKERS' COMPENSATION COVERAGE		
	SELF-INSURANCE	INSURANCE PROVIDERS	MASTER AGREEMENT
Who uses it	Some private companies, some local governments, and the University of California.	Private companies and a small number of state agencies.	Most state agencies, including CAL FIRE, Caltrans, CHP, and Social Services.
How claims are administered	Employers either manage claims internally or contract with a third-party administrator to manage claims.	An insurance provider, such as State Fund, administers and processes claims.	State Fund administers and processes claims.
How claims are paid	Employers pay benefits directly.	Employers make premium payments to an insurance provider that pays the cost of claims out of reserves the insurance provider manages.	Agencies reimburse State Fund from their operational budgets for medical and disability payments made to injured employees.

Source: Analysis of state law, regulations, the master agreement, State Fund data, Department of Industrial Relations' Office of Self-Insurance Plans' data, Workers' Compensation Insurance Rating Bureau of California reports, agency websites, and staff interviews.

**Table 2**  
Multiple Entities Are Responsible for Providing and Overseeing Workers' Compensation Programs for California Employees

STATE ORGANIZATION	WORKERS' COMPENSATION ROLE
<i>California Department of Human Resources*</i>	A state agency that administers the workers' compensation master agreement between State Fund and participating agencies.
<i>California Department of Insurance</i>	A state agency that issues licenses to various entities, ensures insurers are solvent, resolves consumer complaints, and investigates and prosecutes insurance fraud.
<i>Department of Industrial Relations</i>	A state agency that administers and enforces laws governing medical care and some workers' compensation benefits.
<i>Division of Workers' Compensation</i>	The division within the Department of Industrial Relations responsible for monitoring the administration of workers' compensation claims and for providing administrative and judicial services to assist state agencies in resolving disputes that arise in connection with claims for workers' compensation benefits.
<i>Office of Self-Insurance Plans</i>	A program within the Department of Industrial Relations responsible for the oversight and regulation of workers' compensation self-insurance plans within California.
<i>State Compensation Insurance Fund*</i>	A self-supporting, nonprofit enterprise fund created by the Legislature in 1913 that provides workers' compensation insurance to California employers and that administers claims for state agencies that participate in the master agreement.
<i>Workers' Compensation Insurance Rating Bureau</i>	An unincorporated, private, nonprofit association that comprises all workers' compensation insurance providers authorized to provide insurance in California. It gathers and compiles relevant statistics to develop state premium rates. It also collects information on payroll amounts, reserve amounts, and benefits amounts from insurance providers for the insurance commissioner to use in administering regulations.

Source: Analysis of state law, the master agreement, and agencies.

\* Agencies reviewed for this audit. We include the other agencies in this table to provide additional context on workers' compensation in California.

if they furnish satisfactory proof of their ability to self-insure and to pay any compensation that may become due to their employees. Generally, self-insured private employers must use a certified third-party administrator for their first three years of self-insurance. Thereafter, they can choose to administer their claims themselves. According to the self-insurance office, more than 7,100 employers were self-insured as of 2017. This total represents 3,500 private employers and 3,600 public employers, including cities, counties, school districts, and the University of California.

If employers are unwilling or unable to become self-insurers, they can obtain coverage for workers' compensation claims through insurance providers. Insurance providers manage and process claims. Insurance providers also pay for benefits out of funds, known as *reserves*, that they set aside for this purpose from employer premiums they receive. Alternatively, employers can purchase workers' compensation insurance from the State Compensation Insurance Fund (State Fund), a nonprofit public enterprise fund that the Legislature created in 1913 to provide workers' compensation insurance to California employers, including state agencies. State Fund is a quasipublic entity that competes with other insurers to provide workers' compensation insurance to California employers. Although the majority of State Fund's unresolved claims involve state agencies, it also provides insurance to private employers unable to obtain insurance from private insurers. According to the Workers' Compensation Insurance Rating Bureau—a nonprofit association that the State authorized to gather and compile relevant statistics for insurance providers to develop state premium rates—more than 400 private workers' compensation providers wrote 592,000 policies for private employers in 2018, while State Fund wrote another 121,000 policies.

Although state agencies are generally liable for their employees' on-the-job injuries, state law does not require them to provide benefits through an insurer or through self-insurance. Instead, nearly all state agencies pay their workers' compensation costs through a master agreement negotiated between State Fund and the California Department of Human Resources (CalHR).<sup>1</sup> Nearly 90 percent of state agencies—or almost 190 agencies—provided workers' compensation benefits through the master agreement during fiscal year 2017–18. Other agencies purchase insurance policies directly from State Fund, like many private employers. Specifically, as of June 2018, 32 agencies—21 of which employed fewer than 70 people—had such policies. Because State Fund does not separately account for these 32 agencies and the private

<sup>1</sup> State Fund and CalHR recently renewed this agreement for July 2019 through June 2024. The previous term of the agreement was from July 2014 through June 2019.

employers that purchase insurance from it, we refer to both the state agencies and private entities that purchase insurance from State Fund as *insured employers* throughout this report.

Under the master agreement, State Fund administers, processes, and pays employee benefits for participating state agencies, and the agencies reimburse State Fund for the expenditures and the actual costs of services rendered. Although state law requires insurance providers to set aside reserves to pay for the cost of claims, state agencies under the master agreement reimburse State Fund using funds from their operational budgets. For example, if a state employee is injured while at work, the agency submits the employee's claim to State Fund, which may pay for medical benefits or wage replacement. State Fund will then submit an invoice to the agency requesting reimbursement for any workers' compensation expenditures. We discuss this process in more detail in the pages that follow. Additionally, State Fund charges each agency an annual fee for the costs of providing specified services, including administering claims and providing legal representation, based on that agency's average number of open claims during the three most recently completed quarters.

At the Joint Legislative Audit Committee's request, we focused this audit on State Fund's management of workers' compensation claims for four entities covered by the master agreement. As Table 3 shows, these four agencies are the California Department of Forestry and Fire Protection (CAL FIRE), the California Department of Transportation (Caltrans), the California Highway Patrol (CHP), and the California Department of Social Services (Social Services). We also assessed 10 other state agencies' decisions to purchase workers' compensation insurance from State Fund rather than participate in the master agreement.

### **Workers' Compensation Benefits**

Under the workers' compensation system, injured state employees have access to certain benefits, regardless of whether their employing agencies provide those benefits under the master agreement or through insurance. For example, when a state employee submits a claim to an agency, state law requires that agency to cover specified medical costs up to \$10,000 while State Fund determines whether to accept liability for the claim. *Accepting liability* generally means that State Fund agrees that the injury occurred while the individual was working and that the agency is therefore financially responsible for the associated workers' compensation benefits. Throughout this report, we refer to this determination by State Fund as a *liability decision* and to instances in which State Fund accepts liability for work-related injuries as *accepted claims*.

**Table 3**  
From Fiscal Years 2015–16 Through 2017–18, State Fund Established Almost 14,000 Claims for the Four Agencies We Reviewed

AGENCY REVIEWED	AGENCY RESPONSIBILITIES	TOTALS FROM FISCAL YEARS 2015–16 THROUGH 2017–18		
		NUMBER OF EMPLOYEES	NUMBER OF CLAIMS	ESTIMATED COST OF CLAIMS
<i>CAL FIRE</i>	Responds to 5,600 wildfires and 350,000 emergency calls per year.	7,685	4,345	\$76.4 million
<i>Caltrans</i>	Manages more than 50,000 miles of highways and freeways, provides intercity rail, and oversees airports.	20,160	4,522	74.5 million
<i>CHP</i>	Provides uniform traffic law enforcement on highways statewide.	10,596	4,232	127.5 million
<i>Social Services</i>	Provides aid, services, and protection to needy and vulnerable children and adults.	4,308	569	7.9 million
<b>Totals for the Four Agencies We Reviewed</b>		<b>42,749</b>	<b>13,668</b>	<b>\$286.3 million</b>

Source: Analysis of claims established from fiscal years 2015–16 through 2017–18, CalHR’s workers’ compensation cost report for fiscal year 2017–18, and agency websites.

When injured state employees are unable to work but State Fund has not yet accepted their claims, they may be able to apply for California State Disability Insurance (disability insurance) through the Employment Development Department (EDD). Disability insurance provides partial wage replacement benefits for illnesses and injuries that are not work-related. It is funded by deductions from employees’ wages and state employers’ contributions. As the text box describes, state law provides at least two options for eligible state employees to receive disability insurance for injuries that are not work-related, depending on several factors. The disability insurance options are the California State Disability Insurance, which is also available to employees of private entities, or Nonindustrial Disability Insurance, which is available to certain state employees only. Because disability insurance is for injuries that are not work-related, employees are generally no longer eligible for it if State Fund accepts their claims. However, if State Fund rejects their claims, state employees may continue utilizing disability insurance until they can return to work, while paying for their medical care through their health insurance. If state employees are not eligible for or

**State Employees Have Access to Different Wage Replacement Programs Based on Their Employer and the Nature of Their Injury**

**Non-Work-Related Injury:**

- **California State Disability Insurance**—Wage replacement program that, among other things, replaces about 60 percent to 70 percent of an injured employee’s income, up to \$1,252 weekly, for a maximum of 52 weeks.
- **Nonindustrial Disability Insurance**—Wage replacement program that replaces up to \$250 per week for a maximum of 26 weeks.

**Work-Related Injury:**

- **Industrial Disability Leave**—Wage replacement program intended to replace an employee’s wages for a maximum of 52 weeks within a two-year period from the date of disability. The injured employee is entitled to receive full pay minus withholdings for the first 22 days and two-thirds pay thereafter.

Source: State law, CalHR, Industrial Relations, EDD, Nonindustrial Disability Insurance and California State Disability Insurance informational brochures from EDD.

choose not to apply for either type of disability insurance, they may be able to utilize vacation or sick days or to take unpaid leaves of absence.

Once State Fund accepts claims for work-related injuries, state law requires agencies to provide specific benefits to compensate workers based on the severity of their injuries, as Figure 1 describes. In addition to paying for the cost of authorized medical expenses, agencies must also provide Industrial Disability Leave (IDL) payments to eligible state employees who are temporarily disabled because of work-related injuries. Once State Fund has accepted their claims, employees can receive IDL payments for up to 52 weeks within two years from the first day of their disabilities.<sup>2</sup> If the employees' injuries become permanent, they can receive permanent disability payments according to their calculated level of disability. In addition, since at least 2004, agencies have been able to offer employees modified or alternative work assignments, depending on their disabilities and circumstances. Currently, if an agency does not offer regular, modified, or alternative work meeting specific criteria to employees whose injuries have resulted in permanent disabilities, the employees are eligible for vouchers to pay for education, retraining, or professional certification fees for use in another field. If injuries are fatal, agencies are responsible for reasonable burial expenses and paying to support surviving dependents for a specified time.

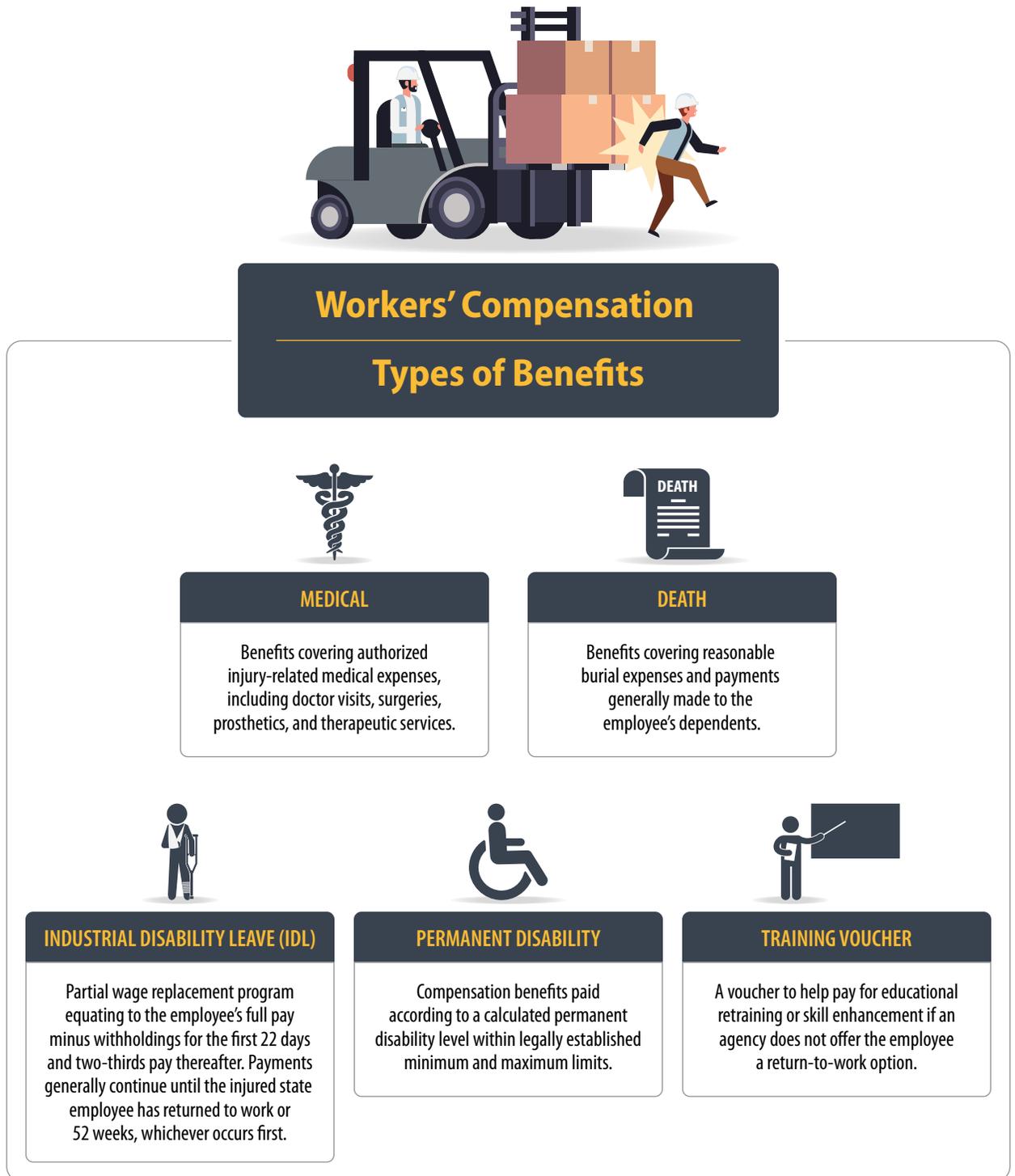
In total, State Fund paid more than \$600 million in costs associated with state agencies' workers' compensation claims under the master agreement during fiscal year 2017–18. According to State Fund, more than \$125 million of this amount related to 19,000 new state employee claims that agencies submitted during this time. State Fund's data indicate that 76 percent of state employees' claims that it closed from fiscal years 2015–16 through 2017–18 incurred less than \$10,000 each in total costs.

### Processing and Resolving Claims

In accordance with state law and the master agreement, all agencies have an obligation to promptly report workplace injuries to State Fund. Within one business day of receiving notice or knowledge that an employee has incurred an injury meeting specific conditions that may be work-related—generally defined as the *date of knowledge*—an agency must provide the injured employee or the employee's dependents an employee claim form (employee form).

<sup>2</sup> Generally, State Fund may also provide temporary disability benefits to injured employees once they have exhausted the 52 weeks of IDL benefits.

**Figure 1**  
Several Types of Benefits Are Available Through California’s Workers’ Compensation System



Source: Analysis of state law, regulations, and Industrial Relations' *Injured Workers Guidebook*.

The agency must then file within five days an employer's report of the injury (employer report) with State Fund.<sup>3</sup> After the employee or the employee's dependents return the employee form, the agency has one working day to authorize up to \$10,000 in approved medical treatment until State Fund accepts or rejects the claim.

State Fund plays a key role in processing claims, as Figure 2 shows. Generally, state regulations require State Fund to notify the employee regarding its decision to accept, reject, or delay its liability decision within 14 days of the date of knowledge. State Fund can delay a claim if the employee has not yet provided requested documentation or if it is waiting for the employee to receive a comprehensive medical evaluation. However, if State Fund does not accept or deny the claim within 90 days of the submission date of the employee form, the claim is presumed accepted.

If the injured employee and the agency do not agree on whether an injury is work-related or disagree about other issues, the employee may be required to see a qualified medical evaluator (medical evaluator) in an appropriate specialty.<sup>4</sup> Under the oversight of Industrial Relations' Division of Workers' Compensation (DWC), medical evaluators conduct evaluations and generate reports to help resolve disputes. These disputes may involve disagreement about whether injuries are work-related, the period of temporary disability, the degree of permanent disability, or the need for future medical treatment. To become medical evaluators, physicians must be licensed to practice in California, spend at least one-third of their total practice time providing direct medical treatment, not have specified conflicts of interest, and pass a medical evaluator competency exam. Certain types of medical providers must meet other requirements as well.

Within five working days of an employee or agency requesting a medical evaluator, DWC is responsible for providing a randomly selected list of three medical evaluators (panel) to both parties. Generally, if the injured employee is represented by an attorney (represented employee), the parties each choose one medical evaluator to remove from the panel, and the injured employee then schedules an appointment with the remaining medical evaluator. An employee without legal representation generally selects one of the three evaluators from the panel and schedules an appointment. In both cases, the medical evaluator usually has up to 60 calendar days

<sup>3</sup> The employee form documents the date and type of injury, along with other facts. The employer report documents additional information about the employee's injury and employment status. For example, the report specifically identifies the type of activity being performed at the time of the injury, the type of equipment involved, and the employee's work schedule.

<sup>4</sup> Medical evaluators in California may specialize in one or more of 30 areas, including internal medicine, neurology, pain medicine, psychiatry, and hand and spine issues. According to state law, a claim administrator and a represented employee can resolve a disputed case by using a medical evaluator whom they select by agreement.

to conduct the evaluation (60-day window), unless the scheduling requirement is waived. If the medical evaluator is unavailable within the 60-day window and the scheduling requirement has not been extended or waived, state regulations generally allow the parties to apply for a replacement medical evaluator or panel from DWC. Such a request restarts the process. After the in-person evaluation, the medical evaluator submits a report to the employee and State Fund for use in resolving the dispute.

In addition, State Fund reviews treatments and medication proposed by an employee’s workers’ compensation physician and approves those deemed medically necessary—a process known as a *utilization review*. Once the employee’s physician determines the employee’s condition has stabilized and, with or without medical treatment, is not expected to get any better or any worse within a year, the employee is considered to have reached maximum medical improvement (maximum improvement). Once the employee reaches maximum improvement, State Fund can decide how to resolve the employee’s claim, as Figure 3 indicates. If the employee no longer requires any medical treatment and does not receive permanent disability benefits, State Fund may close the claim administratively. However, if the employee has some degree of permanent disability, a treating physician or medical evaluator may determine the extent of the disability and any work restrictions resulting from the injury. We describe in the text box the ways in which an employee with a permanent disability may return to work. State Fund uses this information to determine future disability payments and a possible settlement authorization request (settlement request).

State Fund and injured employees can consider two types of settlements, either a compromise and release agreement or stipulations with request for award (stipulations). Under a compromise and release agreement, the employee and State Fund negotiate the value of the claim payout, considering factors such as disability payments and possible future disability medical costs. If the employee and State Fund reach an agreement, the employee agrees to forego future benefits in exchange for a lump sum payment, and the agency is not responsible for providing future medical care to the employee. Alternatively, the employee may agree to stipulations, the terms of which may include specified disability payments and the right to receive medical treatment in the future.

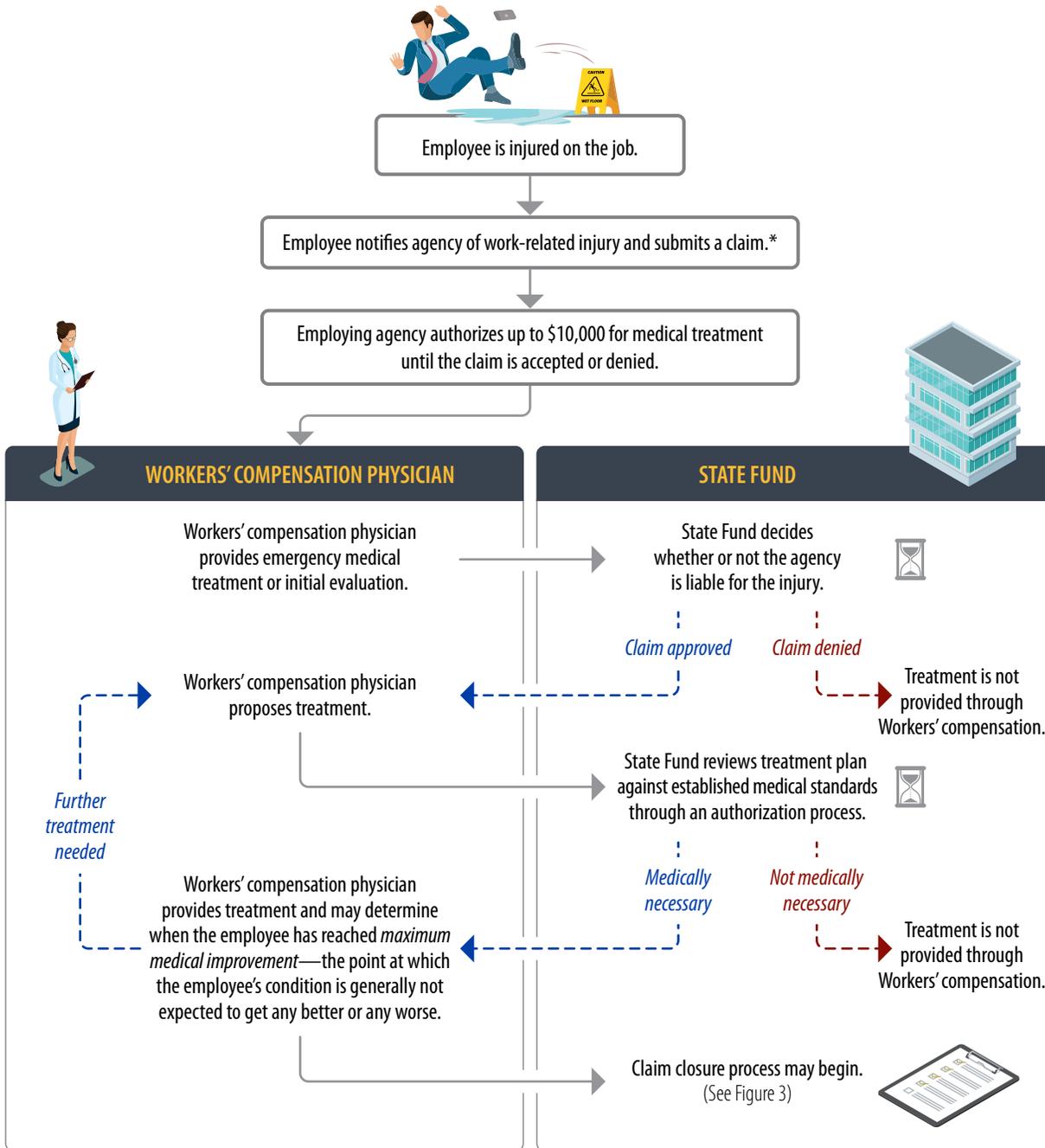
### The State Provides Injured Workers Multiple Ways to Return to Work

Generally, if an employee has some permanent disability and if a doctor has determined the employee can perform the physical requirements of a proposed job, the employer may provide the employee the following ways to return to work or may provide supplemental job displacement benefits.

- **Regular work**—The regular occupation or position at which the employee previously worked with wages and compensation equivalent to those paid at the time of injury.
- **Modified work**—Generally, a modified version of the employee’s regular occupation or position that enables the employee to perform all the functions of the job with wages and compensation that are at least 85 percent of those paid at the time of injury.
- **Alternative work**—Generally, work that the employee has the ability to perform that may be different from regular duties with wages and compensation that are at least 85 percent of those paid at the time of injury.
- **Supplemental job displacement benefit**—A voucher to help pay for an employee’s educational retraining or skill enhancement if the employer does not offer the employee a work assignment that falls into one of the above categories within 60 days of receipt of a report finding the employee has reached maximum medical improvement or if the work assignment the agency offers is for less than 12 months.

Source: Analysis of state law and regulation.

**Figure 2**  
State Fund Follows a Process for Handling the Medical Aspects of a Workers' Compensation Claim



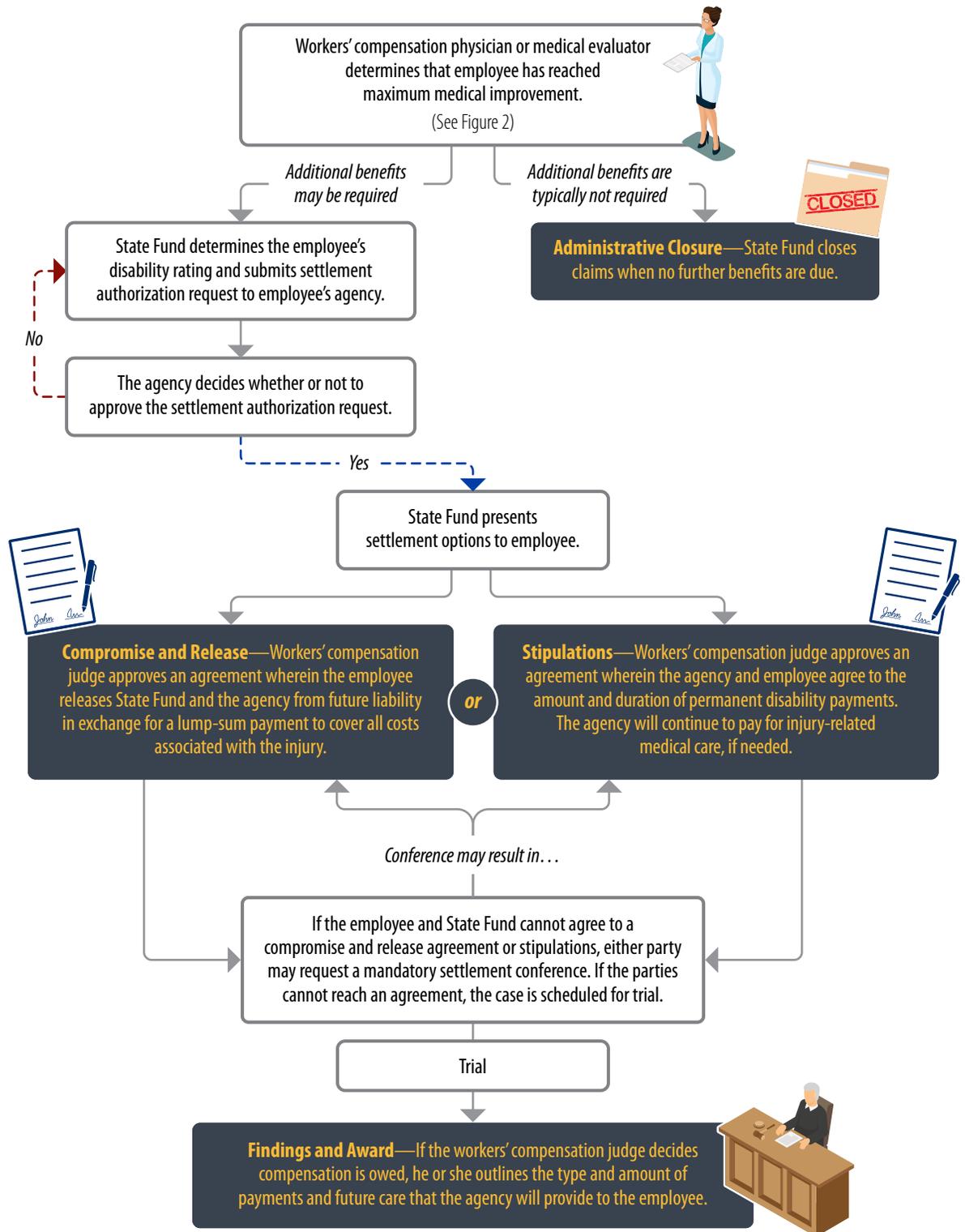
Source: Review of state laws, regulations, and State Fund's procedure manuals.

Note: A qualified medical examiner may be required when the employee and State Fund cannot agree on whether the injury was work-related or the level of permanent disability, among other things.

\* The date an agency learns that one of its employees has suffered from a work-related injury is defined as the *date of knowledge*.

⌚ = Step must be completed under time requirements, which vary under different circumstances.

**Figure 3**  
State Fund Has Established a Process for Closing Claims



Source: Review of state law and State Fund's procedure manuals.

Under the master agreement, State Fund must obtain approval from an agency before entering into a settlement, unless the agency has established prior settlement authority for State Fund to settle cases without preapproval.

After the injured employee or the employee's attorney has negotiated a settlement with State Fund, a workers' compensation judge or the appeals board must approve it. If the injured employee and State Fund are unable to reach an agreement, both parties may appear at a mandatory settlement conference (settlement conference). If the parties are unable to reach an agreement at the settlement conference, the judge will generally schedule the claim for trial. After a trial, a judge will determine the outcome of the case and issue a finding and award if the judge determines compensation is owed to the injured worker.

## Audit Results

### Some State Agencies Are Overpaying for Insurance Rather Than Providing Benefits Through the Master Agreement

As we describe in the Introduction, nearly 90 percent of state agencies and departments provide workers' compensation coverage through the master agreement. However, according to CalHR, 32 agencies or units within agencies opted to purchase insurance from State Fund rather than use the master agreement during fiscal year 2017–18. These agencies pay premiums to State Fund to cover the cost of potential claims, rather than reimbursing State Fund for administering their claims and for the actual costs associated with the claims. According to the program manager for CalHR's benefits division, agencies usually identify funding-related reasons for choosing to pay for insurance coverage. These include the predictability of premiums compared to the unpredictable costs of workers' compensation claims and the difficulty of funding a large workers' compensation claim.

Although agencies can purchase insurance to mitigate the risk of unpredictable costs, historical trends do not justify the cost of insurance premiums for some state agencies. We identified 10 state agencies that each had 90 or more employees and purchased insurance from State Fund in fiscal year 2017–18. When we analyzed these agencies' workers' compensation costs and premiums from fiscal years 2013–14 through 2017–18, we found that each consistently paid more in insurance premiums than it would have had it instead used State Fund to administer its claims under the master agreement. We estimate that under the master agreement, these 10 agencies would have collectively paid an average of less than \$1.6 million annually for the costs of the claims and State Fund's administrative fees during the five years we reviewed. Instead, they collectively paid an average of \$5.7 million per year in premiums.

As Table 4 shows, we estimate that the State could have saved more than \$20 million during the period we reviewed had these 10 agencies provided workers' compensation through the master agreement rather than purchasing insurance. For example, over the five-year period, the California Department of Food and Agriculture paid an average of nearly \$1 million per year in premiums, even though we estimate that its average annual cost under the master agreement would have been less than \$260,000. Similarly, the annual premiums for the Secretary of State's Office over the five-year period ranged from \$520,000 to \$970,000, whereas its annual master agreement costs would have never exceeded \$360,000 and would have averaged about \$250,000 based on its claim activity.

**Table 4**  
The State Overpaid for Workers' Compensation Coverage for 10 State Agencies

FISCAL YEAR	INSURANCE PREMIUMS PAID	ESTIMATED MASTER AGREEMENT COST	SAVINGS IF AGENCIES USED THE MASTER AGREEMENT
2013-14	\$5,280,000	\$2,190,000	\$3,090,000
2014-15	6,590,000	2,600,000	3,990,000
2015-16	9,520,000	1,030,000	8,490,000
2016-17	3,510,000	1,010,000	2,500,000
2017-18	3,630,000	910,000	2,720,000
<b>Totals</b>	<b>\$28,530,000</b>	<b>\$7,740,000</b>	<b>\$20,790,000</b>
<b>Annual average</b>	<b>\$5,706,000</b>	<b>\$1,548,000</b>	<b>\$4,158,000</b>

Source: Analysis of CalHR data and State Fund data for 10 insured state agencies for fiscal years 2013-14 through 2017-18.

Considering the amount that these agencies could have saved if they had used the master agreement, we believe that CalHR should advise agencies that do not participate in the master agreement if doing so might result in workers' compensation savings. Although CalHR and State Fund perform an assessment to determine an agency's ability to pay for its workers' compensation costs if that agency wants to participate in the master agreement, this assessment does not consider the cost-effectiveness of using the master agreement instead of an insurance policy. Moreover, the master agreement does not require either entity to assist agencies in deciding which workers' compensation option is more cost-effective. When we asked the 10 agencies why they provide workers' compensation coverage by purchasing insurance, eight indicated that they did so because they believed it would be the most cost-effective way to provide coverage.<sup>5</sup> However, as we describe above, our analysis indicates that this belief is erroneous.

The program manager for CalHR's Benefits Division stated that CalHR's ability to conduct this type of analysis may require additional legislative authority to compel agencies to share the claim data necessary to conduct the analyses. Given that part of the intent of the master agreement is to protect the public through the implementation of effective cost-containment programs, we believe that it is appropriate for CalHR to conduct cost-benefit analyses for each agency that intends to purchase insurance from State Fund and compare the costs of purchasing insurance and using the master agreement.

<sup>5</sup> The ninth agency indicated that it prefers insurance for its consistent costs because it relies on federal funding, which can be sporadic. The tenth stated that another state agency reimburses it for its workers' compensation insurance.

### **Injured Workers Received Timely Medical Care Even When Agencies Failed to Meet Deadlines for Submitting Claims**

Although the four agencies we reviewed missed some deadlines for providing forms to injured employees or submitting workers' compensation claims to State Fund, we found no evidence that these delays affected the timely delivery of medical care to the employees. As we discuss in the Introduction, state law generally requires agencies to provide an employee form to an injured employee within one business day of the date of knowledge of a claim and requires agencies to submit an employer report to State Fund within five days of the date of knowledge. According to a claims compliance director at State Fund, when an agency submits an employer report to State Fund in a timely manner, it provides State Fund with the maximum amount of time to determine whether to accept or deny that claim.

We reviewed eight workers' compensation claims at each of the four agencies we reviewed—a total of 32 claims—and found that all four agencies we audited failed to meet the required deadlines for providing either the employee form or employer report for one or more claims. For instance, Caltrans and CHP each submitted four of eight employer reports more than five calendar days after their dates of knowledge of work-related injuries. We also noted one instance in which CAL FIRE submitted an employer report late to State Fund and one in which Social Services did not provide an employee form to an injured employee within the one-day time frame. Managers in units handling workers' compensation claims at CAL FIRE, CHP, and Caltrans explained that supervisors did not always submit the employer reports on time because of limitations such as remote worksites and difficulties in contacting employees to obtain required information. In addition, they explained that some injured employees did not return employee forms in a timely manner because the employees initially believed that they did not need medical treatment or that they could self-treat rather than report the injuries to their supervisors.

However, because the agencies provide up to \$10,000 of specified medical benefits—as state law requires—until State Fund either accepts or denies a claim, none of the initial claim intake delays affected the injured employees' ability to obtain necessary medical treatment for the claims that we reviewed. For example, one of the employees involved had an injury that required more than \$1,000 in medical care during the nine days following his injury. Even though the agency did not send the employer report to State Fund until 26 days after the injury, the employee received medical care before State Fund accepted the claim. For each of the claims we reviewed

*Because the agencies provide up to \$10,000 of specified medical benefits—as state law requires—until State Fund either accepts or denies a claim, none of the initial claim intake delays affected the injured employees' ability to obtain necessary medical treatment for the claims that we reviewed.*

*State Fund met the majority of the mandated periods for processing the claims we reviewed at the four agencies, and in all cases, the injured employees received access to health care.*

that did not meet all required timelines, we found that employees still received medical treatment up until the point that State Fund either accepted or denied their claims.

State Fund met the majority of the mandated periods for processing the claims we reviewed at the four agencies, and in all cases, the injured employees received access to health care. State regulations generally require State Fund to notify an employee within 14 days of the date of knowledge if it delays its decision on a claim. If it does not deny a claim within 90 days from when the employee files the employee form, the claim is presumed accepted. Although we identified two instances in which State Fund missed deadlines for notifying employees that it was delaying their claims, it made all claim decisions within the 90-day time frame. Our testing showed that in both of these instances, the injured employees continued to receive medical treatment through the \$10,000 in medical benefits they are entitled to until State Fund accepted or denied their claims. According to a claims compliance specialist at State Fund, notification of a delay is important for informing an employee of a claim's status but has no significant impact on the delivery of benefits or the liability decision.

In addition, our testing showed that for six medical emergencies that were likely to exceed this \$10,000 threshold, State Fund approved the claims within an average of 11 days, significantly less than the 90 days allowed under state law. For example, one employee who was involved in an automobile accident had already incurred nearly \$10,000 in medical care as of the date State Fund established the claim. However, State Fund accepted this claim only six days later.

State Fund also approved medical treatments for injured employees within required time frames. State law requires State Fund to establish a process to review treatments and to approve them if it determines they are compensable. For example, state law generally requires that once State Fund is in receipt of the information it needs to make its determination, it must approve, modify, or deny a physician's request for treatment within 72 hours for urgent cases and five business days for nonurgent cases. Our testing showed that State Fund approved, modified, or denied all treatment requests in accordance with these time frames.

### **A Lack of Available Medical Evaluators Has Resulted in Delays and Automatic Denials of Claims**

Our review found that a lack of available medical evaluators has at times delayed appointments for medical evaluations, resulting in State Fund's automatically denying claims and some

injured employees' having to wait to receive benefits. State Fund automatically denied four of 32 claims we reviewed because the employees could not obtain timely appointments for medical evaluations. It did not accept these four claims until an average of four months later, after medical evaluators finally saw the injured employees and determined the injuries were work-related. The agencies for which these employees worked explained that in some cases, untimely appointments for medical evaluations can also delay an employee's return-to-work process and may unnecessarily increase a state agency's workers' compensation costs.

***Some Employees Are Unable to Receive Medical Evaluations Before State Fund Automatically Denies Their Claims***

A lack of available medical evaluators has delayed some injured employees' appointments for medical evaluations, resulting in the automatic denial of their claims and postponing the resolution of their benefit payments. As we explain in the Introduction, the workers' compensation process may rely on medical evaluators to resolve claim disputes. Upon receiving a request for a medical evaluator, DWC must generate a randomly selected panel according to the requested specialty. For represented employees the employee and State Fund can each remove one medical evaluator and the injured employee then schedules an appointment with the remaining medical evaluator.

The medical evaluator then has a 60-day window to conduct the evaluation, unless the party scheduling the appointment—generally the employee—waives this requirement and agrees to extend the window by 30 days. When a medical evaluator is unavailable within the extended 90-day window, state law generally allows either party to request a replacement panel or to waive the 90-day requirement altogether. Similarly, if the parties need to replace a medical evaluator or panel for other specified reasons—for instance, if the employee has moved to a new area—DWC issues a replacement panel. However, DWC is not legally required to issue a replacement panel within a specific time frame. Further, once it issues a replacement panel and a new evaluator is selected, the 60-day window restarts. Thus, each replacement panel may result in a further overall delay in claim resolution.

During fiscal year 2017–18, DWC generated about 145,000 medical evaluator panels to resolve medical disputes. In that same year, DWC received a total of nearly 19,000 requests for replacement panels because the medical evaluators on the initial panels were not available within the 60-day window. For example, one employee requested a replacement panel because of a conflict of interest

***A lack of available medical evaluators has delayed some injured employees' appointments for medical evaluations, resulting in the automatic denial of their claims and postponing the resolution of their benefit payments.***

with one medical evaluator and an availability issue with another. Ultimately, that employee did not see an evaluator until 195 days, or more than six months, after the initial panel request.

State law requires that regardless of the availability of a medical evaluator, State Fund must deny a claim within 90 days after an employee files it or it is presumed to be accepted. According to State Fund's claims compliance director, State Fund automatically denies a claim within 90 days if an unresolved dispute exists about whether the employer is responsible for the injury. State Fund cites in its decision a lack of medical evidence, even when the delay is the result of a lack of available medical evaluators. However, if it denies a claim because of pending medical evidence, State Fund may subsequently accept the claim if a medical evaluator determines that the injury was work-related. Once State Fund denies a claim, it no longer pays for the employee's medical care, and it does not pay benefits.

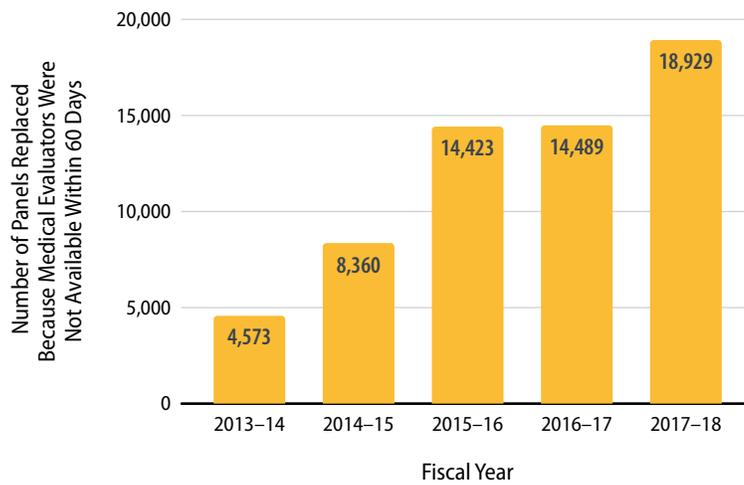
Our testing indicated that some employees have found it difficult to obtain appointments for medical evaluations before the end of State Fund's 90-day decision period. For example, State Fund automatically denied one claim because the employee was not able to obtain a medical evaluator's report until five months after State Fund denied the claim. As a result, the employee did not receive any workers' compensation benefit payments. According to CAL FIRE, he had to use accrued time off for almost nine months until the evaluator provided a report and State Fund subsequently accepted the claim. After accepting the claim, the agency retroactively restored the employee's accrued time off and provided IDL payments from his first day of disability. Of the 32 claims we reviewed, State Fund automatically denied four—or 12.5 percent—because the employees had not yet seen medical evaluators.

When we asked DWC about the increased number of replacement panels, the chief of medical services administration questioned whether an unavailability problem exists and stated that she has seen no indication of an access problem to obtain an appointment with a medical evaluator. However, our analysis indicates that 42 percent of all replacement panels DWC issued during fiscal year 2017–18 were because medical evaluators were not available for appointments within the 60-day window. As Figure 4 shows, the number of panels DWC replaced because of unavailability of medical evaluators more than quadrupled from fiscal year 2013–14 to fiscal year 2017–18. In addition, our data indicate that during this period, the number of medical evaluators decreased by 375, while the proportion of all panels that were replacement panels due to unavailability of medical evaluators increased from

***During fiscal year 2017–18, 42 percent of all replacement panels DWC issued were because medical evaluators were not available for appointments within the 60-day window.***

4 percent to 13 percent. In fact, in the past four fiscal years, the total number of panel requests increased by 37 percent, while the total number of medical evaluators decreased by 12 percent.

**Figure 4**  
The Number of Panels DWC Had to Replace Because of Unavailable Medical Evaluators More Than Quadrupled From Fiscal Years 2013–14 Through 2017–18



Source: Analysis of panel requests from DWC’s medical evaluators database for fiscal years 2013–14 through 2017–18.

Further, according to a State Fund specialist, a shortage of medical evaluators in certain medical specialties and geographic areas has contributed to some injured employees’ being unable to schedule appointments promptly. For example, from fiscal years 2013–14 through 2017–18, the number of panel requests for the field of orthopedic surgery increased by 66 percent, while the number of evaluators decreased by 7 percent. Addressing this issue will require that DWC secure and maintain enough medical evaluators to meet demand.

***State employees are not eligible for either IDL or permanent disability payments while they are waiting for State Fund's decisions on their claims.***

***Delayed Appointments for Medical Evaluations May Result in Employees Waiting Longer to Receive Disability Payments or Return to Work***

When a lack of medical evaluators delays appointments for evaluations to determine whether injuries are work-related or to resolve other disputes, the employees may not receive or may be delayed in receiving the appropriate type of disability benefits. As we explain in the Introduction, eligible state employees are generally entitled to receive IDL payments for a maximum of 52 weeks within two years from the first day of disability. However, they receive these benefits only after State Fund has accepted their claims. In addition, State Fund provides permanent disability payments when doctors determine that injured employees have reached maximum improvement and will never recover completely or will always be limited in the work they can perform. However, state employees are not eligible for either IDL or permanent disability payments while they are waiting for State Fund's decisions on their claims. As we describe previously, we identified one employee in our review whose IDL payments were delayed by several months because he was unable to obtain an appointment for a medical evaluation when needed.

According to the four agencies we reviewed, when injured employees do not receive IDL and permanent disability payments because of their inability to promptly obtain appointments for medical evaluations, the burden to seek out other benefits falls on those employees. Although state law requires the agencies to provide up to \$10,000 worth of specified medical treatment after an employee files a employee form, it does not require them to make disability benefit payments until the claim is accepted. CAL FIRE's injury and accommodations unit manager (unit manager) explained that when State Fund automatically denies claims while employees wait for appointments for medical evaluations, those employees can apply for insurance payments through EDD for non-work-related disabilities. The unit manager explained that employees' other options while awaiting their medical evaluations include applying for catastrophic leave—which is accrued leave donated by other state employees—or taking unpaid leaves of absence.

In addition to possibly delaying benefit payments to injured employees, the four agencies we reviewed agreed that in some cases, not promptly obtaining appointments for medical evaluations has delayed employees' return-to-work processes and may have unnecessarily increased the agencies' workers' compensation costs. Injured employees can return to work when their primary workers' compensation physicians release them to do so. However, representatives from several of the agencies we reviewed stated that

when an employee and an agency cannot agree on the employee's work status, a timely medical evaluation report is necessary to determine whether that employee is ready to return to work. For example, Caltrans' return-to-work program branch chief (branch chief) explained that in certain situations, Caltrans may believe that an employee can return to work even though the employee's primary workers' compensation physician has placed the employee on total temporary disability status, which generally means that the employee is unable to perform job duties while healing. Similarly, CAL FIRE's unit manager explained that at times an employee may disagree with a workers' compensation physician's decision to release that employee to return to work. In these instances, a state agency or the employee may request a medical evaluation to help determine the nature of work, if any, an employee is capable of performing. According to CAL FIRE's unit manager and Caltrans' branch chief, a lack of available medical evaluators to resolve such disputes has led to delays in employees returning to work, reducing the agencies' workforce productivity and increasing their backfill and overtime costs.

In addition, under most circumstances, agencies pay IDL payments at a higher rate than permanent disability. Because an agency is generally required to pay IDL until a physician says that an employee can return to work or has reached maximum improvement, the CAL FIRE and Caltrans managers concluded that a delayed appointment for a medical evaluation to determine an employee's disability status might result in that employee receiving higher overall benefit payments in the meantime. For example, in one case, State Fund may have paid a Caltrans employee who exhausted his IDL benefits more than twice the amount in disability payments—almost \$1,500 in total—than it would have if it had promptly received an evaluation report declaring he had reached maximum improvement. Had it received such a report, State Fund may have transitioned this employee to permanent disability sooner.

Ensuring that medical evaluators are available for appointments to evaluate injured employees will require DWC to recruit more evaluators and to improve the panel assignment process. In November 2019, we issued Report 2019-102, titled *Department of Industrial Relations: Its Failure to Adequately Administer the Qualified Medical Evaluator Process May Delay Injured Workers' Access to Benefits*, which provides additional information on the causes of medical evaluator unavailability and presents recommendations for addressing this issue.

***Ensuring that medical evaluators are available for appointments to evaluate injured employees will require DWC to recruit more evaluators and to improve the panel assignment process.***

### State Agencies Have a Variety of Options for Effectively and Efficiently Resolving Claims

Employers and injured employees have multiple options for resolving workers' compensation cases once the injured employees have reached maximum improvement. In many instances, the resolutions are fairly straightforward: of the claims that State Fund closed from fiscal years 2015–16 through 2017–18, 69 percent involving state agencies using the master agreement were closed administratively because of inactivity or because all necessary treatment had been provided, and resulted in an average of \$4,000 in total costs paid per claim. According to State Fund's claims compliance director, State Fund administratively closes claims if injuries do not result in permanent disability and do not require additional medical care. For example, an employee suffering from a shoulder injury would receive medical treatment until the treating doctor determines that the employee has no permanent disability, has reached maximum improvement, and requires no further treatment. State Fund may then close the claim.

However, other claims end in a settlement, such as a compromise and release agreement or a stipulation. In a compromise and release agreement, the employee agrees to forgo future benefits in exchange for a lump-sum payment, and the agency is no longer responsible for future medical care related to the case. Alternatively, the agency and the injured employee may voluntarily enter into a stipulation, whereby the agency generally agrees to make permanent disability payments up to a specified limit over time and to cover future medical costs related to the claim through the workers' compensation system.

If the agency and the injured employee cannot agree on a settlement, either party may request a settlement conference with a workers' compensation judge who assists in resolving the dispute. If the parties do not resolve their dispute at the settlement conference, the judge may set the case for trial. During the trial, the judge will review the evidence and determine the outcome of the case. If a claim goes to trial, both parties lose a degree of control because the judge may find in favor of either the injured employee or the agency on disputed aspects of the case, such as whether the claimed injury was work-related or how much the employee will receive in disability benefits.

*The practice of resolving claims through compromise and release agreements is less common for state agencies than using other methods.*

The practice of resolving claims through compromise and release agreements is less common for state agencies than using other methods. As Table 5 shows, State agencies using the master agreement settled 5 percent of their claims through compromise and release agreements from fiscal years 2015–16 through 2017–18, compared to 16 percent of claims resolved through stipulations and

10 percent through findings and awards. The decision about the type of resolution that the parties agree to during their settlement negotiations depends on many different and often complex factors. Consequently, it is not possible to determine whether those claims resolved through compromise and release would have cost the state agencies less through a different resolution type.

**Table 5**  
**State Agencies That Used the Master Agreement During Fiscal Years 2015–16 Through 2017–18 Rarely Closed Cases Through Compromise and Release**

OPTIONS FOR RESOLVING CLAIMS	STATE AGENCIES USING THE MASTER AGREEMENT	
	PERCENTAGE OF TOTAL	AVERAGE PAID PER CLAIM
<i>Compromise and release agreement</i>	5%	\$73,000
<i>Findings and award</i>	10	72,000
<i>Stipulations</i>	16	68,000
<i>Administrative closure</i>	69	4,000
	<b>Average</b>	<b>\$24,000</b>
	<b>Total number of claims</b>	<b>66,895</b>
	<b>Total benefits paid over the life of the claims</b>	<b>\$1,598,935,000</b>

Source: Analysis of all State Fund workers' compensation claim closures for fiscal years 2015–16, 2016–17, and 2017–18 and CalHR data for State Fund administrative costs per claim for fiscal years 1998–99 through 2017–18.

Using compromise and release agreements for settling state employee claims offers certain advantages and disadvantages for agencies and employees depending on the circumstances. Specifically, compromise and release agreements do not allow employees to file for new and additional disability benefits if their conditions deteriorate. Further, if their injuries lead to death, their dependents may be unable to file for death benefits. In addition, Social Services' workers' compensation unit manager stated that the focus for current employees should be on medical care, and compromise and release agreements do not necessarily address medical care as well as stipulations. Similarly, a CAL FIRE unit manager stated that not all employees want to settle through compromise and release agreements because they prefer to maintain their rights to future medical treatment related to their injuries. In other instances, compromise and release agreements can reduce the amounts agencies pay to State Fund

in administrative fees, and because they limit future liability the agreements allow agencies to determine their actual costs so they can budget more effectively.

### **State Fund's Failure to Provide Timely Settlement Documents to Agencies Has Affected Its Ability to Resolve Claims Efficiently**

State Fund has frequently failed to provide state agencies with sufficient time to review and approve requests for settlement authority before settlement conferences, which can limit its ability to negotiate an agreement. Under the master agreement, State Fund must obtain approval from an agency before entering into a settlement, unless the agency has established prior settlement authority with State Fund. To this end, State Fund completes a request for settlement authority and submits it to the agency before the settlement conference. According to the agencies' staff we interviewed, if an agency reviews a settlement request and believes that State Fund has overlooked some issues, it may return the request for correction. State Fund cannot enter into stipulations or a compromise and release agreement on behalf of an agency participating in the master agreement unless the agency has agreed with State Fund on the proposed settlement or the proposed settlement is within State Fund's pre-established authority. If State Fund and the injured employee are unable to resolve the dispute, the case may proceed to trial, which can add time and expense to the process. Further, because of the uncertainty of a trial's outcome, the agency may have to pay far more to resolve the claim.

Several of the agencies we spoke with explained that they need State Fund to provide them with 30 days to review a settlement request prior to the settlement conference. Some state agencies indicated that they need this time to properly review the documents and allow State Fund to correct any discrepancies. Settlement requests can include numerous pages and may require multiple levels of review within state agencies. The vice president of State Fund's claims operations (vice president) stated that State Fund attempts to provide the settlement requests at least 30 days before settlement conferences. Although we did not identify specific timeline requirements in law or regulations for State Fund to provide settlement requests to state agencies, the master agreement requires CalHR and State Fund to work together to develop guidelines for the interactions between State Fund and state agencies. The guidelines state that an agency should generally provide a reply to State Fund's request for authorization within 30 days of receiving it. To allow an agency 30 days to review the settlement request and grant authority for the settlement conference, State Fund would need to provide the request more than 30 days before the settlement conference.

*To allow an agency 30 days to review the settlement request and grant authority for the settlement conference, State Fund would need to provide the request more than 30 days before the settlement conference.*

Nonetheless, our review of 15 claims at CAL FIRE, Social Services, and Caltrans found that in many cases, State Fund did not provide agencies with at least 30 days to respond to the settlement requests before the settlement conferences, which may have limited the agencies' ability to effectively resolve the claims through stipulations or compromise and release agreements in some instances.<sup>6</sup> State Fund provided less than 30 days for eight, or 53 percent, of the 15 claims that we selected. We found that State Fund's ability to negotiate a settlement was hindered in at least four of these cases because it did not have authority from the agencies in place before the settlement conferences. In fact, in these four instances, State Fund did not resolve the claims until an average of 10 months after the settlement conferences.

We found similar results when performing a more extensive analysis of Social Services' and CAL FIRE's settlement tracking logs for fiscal years 2015–16 through 2017–18.<sup>7</sup> As Table 6 shows, State Fund provided the agencies with less than 30 days before the settlement conference to review settlement requests for 57, or 63 percent, of the 90 claims that went to settlement conferences. Until State Fund consistently provides settlement requests to agencies at least 30 days before settlement conferences, it risks undermining the settlement conference process because the agencies may not have enough time to provide it with settlement authority.

**Table 6**  
**State Fund Provided Most Settlement Proposals to Social Services and CAL FIRE Less Than 30 Days Before Settlement Conferences**

	TOTAL SETTLEMENT PROPOSALS	NUMBER OF SETTLEMENT PROPOSALS STATE FUND PROVIDED TO THE AGENCY WITHIN THE SPECIFIED DAYS BEFORE A SETTLEMENT CONFERENCE		
		30 DAYS OR MORE	LESS THAN 30 DAYS	PERCENTAGE LESS THAN 30 DAYS
<i>Social Services</i>	25	7	18	72%
<i>CAL FIRE</i>	65	26	39	60%
<b>Totals</b>	<b>90</b>	<b>33</b>	<b>57</b>	<b>63%</b>

Source: Analysis of Social Services' and CAL FIRE's settlement logs for fiscal years 2015–16 through 2017–18.

Note: We did not conduct this testing for CHP and Caltrans because these agencies did not maintain sufficient electronic information for us to do so.

<sup>6</sup> We were unable to review settlement requests that State Fund sent to CHP because CHP does not maintain the information necessary to determine which claims CHP received settlement requests for before settlement conferences.

<sup>7</sup> We did not perform a similar analysis of Caltrans' claims because its settlement log did not provide sufficient detail.

Various circumstances may hamper State Fund's ability to meet the 30-day timeline for some claims. In certain time-sensitive situations, such as when the injured employee's attorney files paperwork to proceed to conference before State Fund has completed its settlement request, State Fund may have a shortened time frame within which to act. In some of these instances, it may be unable to request settlement authority from the agency 30 days before the settlement conference. Additionally, the vice president indicated that State Fund could miss this deadline if it is waiting for medical reports that may impact the settlement amount. Nonetheless, it is important that agencies have adequate time to review settlement requests before the settlement conferences because delays in the settlement authorization process may result in the agencies' paying more in the end, including higher ongoing medical expenses and court-related expenses if cases go to trial.

## **Recommendations**

### ***CalHR***

To ensure that all state agencies provide workers' compensation in the most cost-effective manner, CalHR should provide each agency that purchases workers' compensation insurance with a cost-benefit analysis every five years that compares the cost of purchasing this insurance through State Fund with the cost of obtaining coverage through the master agreement. It should begin providing these analyses to state agencies no later than six months after the Legislature gives it authority to request the necessary information from these agencies.

### ***Legislature***

To ensure CalHR has the data necessary to compare insurance and master agreement costs for agencies using State Fund insurance policies, the Legislature should give CalHR the authority to obtain that information.

### ***State Fund***

To ensure that state agencies have adequate time to review settlement requests and provide settlement authority, State Fund should create and follow a policy by May 2020 to provide settlement authorization requests to agencies at least 30 days before settlement conferences.

We conducted this audit under the authority vested in the California State Auditor by Government Code 8543 et seq. 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,

A handwritten signature in black ink that reads "Elaine M. Howle". The signature is written in a cursive style with a long, sweeping tail on the letter "e" at the end.

ELAINE M. HOWLE, CPA  
California State Auditor

Date: November 21, 2019

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## Appendix A

### BENEFITS PAID ON STATE FUND'S OPEN CLAIMS AS OF JANUARY 1, 2019

We obtained summary-level data from State Fund for all open claims as of January 1, 2019, that involved state agencies participating in the master agreement. These data included the total incurred costs and total benefits paid for claims that were less than one year old, from one to two years old, and more than two years old. Table A shows that the average cost of benefits paid per claim increased significantly with the age of the claims.

**Table A**  
State Fund's Master Agreement and Insurance Claims Open as of January 1, 2019

	STATE AGENCIES USING THE MASTER AGREEMENT				
	NUMBER OF CLAIMS	BENEFITS ALREADY PAID	AVERAGE COST PER CLAIM	ESTIMATED COST NOT YET PAID	TOTAL COSTS
<i>Claims open less than one year</i>	9,142	\$31 million	\$3,400	\$208 million	<b>\$239 million</b>
<i>Claims open from one to two years</i>	5,078	81 million	16,000	232 million	<b>313 million</b>
<i>Claims open more than two years</i>	32,043	3.3 billion	104,200	2.5 billion	<b>5.8 billion</b>

Source: State Fund's summary of all open workers' compensation claims in its database as of January 1, 2019.

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## Appendix B

### AGENCIES IDENTIFIED IN OUR COST-EFFECTIVENESS ANALYSIS

As we describe in the Audit Results, some state agencies or units within those agencies have overpaid to provide workers' compensation coverage through insurance with State Fund rather than through the master agreement. Table B presents the 10 agencies we selected for our analysis.

**Table B**  
**Agencies Identified in Our Cost-Effectiveness Analysis**

1	California Department of Food and Agriculture
2	California Department of Pesticide Regulation
3	California Department of Transportation
4	California Department of Veterans Affairs
5	California Military Department
6	Commission on Peace Officer Standards and Training
7	Governor's Office of Business and Economic Development
8	Secretary of State's Office
9	State Council on Developmental Disabilities
10	State Treasurer's Office

Source: Analysis of CalHR data.

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# Appendix C

## SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor to review the management of workers’ compensation claims by State Fund and four state agencies—CAL FIRE, Caltrans, Social Services, and CHP. Table C lists the audit objectives that the Audit Committee approved and the methods we used to address them.

**Table C**  
**Audit Objectives and the Methods Used to Address Them**

AUDIT OBJECTIVE	METHOD
<p>1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.</p>	<ul style="list-style-type: none"> <li>• Identified and reviewed the laws, rules, and regulations for State Fund, CAL FIRE, Caltrans, CHP, and Social Services related to processing claims.</li> <li>• Identified CalHR’s role in managing the State’s master agreement with State Fund.</li> </ul>
<p>2 For each of the four agencies and State Fund, evaluate the intake process for employees filing claims to identify areas of strength or weakness.</p>	<ul style="list-style-type: none"> <li>• Reviewed the four agencies’ policies and procedures related to claim intake and tracking and determined that they processed claims in a similar manner. We did not observe any best practices that resulted in more accurate or timely claim submission. In addition, although CAL FIRE submitted claims electronically to State Fund, that process did not improve the accuracy or timeliness of its claims.</li> <li>• Reviewed training programs and determined that CalHR and the four agencies provide training on the claims process for return-to-work coordinators and supervisors.</li> </ul>
<p>3 Review each agency’s policies and practices for handling claims in order to do the following:</p> <p>a. Determine whether the agencies are complying with key requirements in the law for reviewing and processing claims. To the extent that the agencies outsource these duties, assess their oversight of contractors’ performance.</p> <p>b. Compare and contrast the agencies’ policies and practices to identify the most effective ways to handle claims.</p>	<p>Evaluated eight claims from each of the four agencies and determined that the agencies generally complied with key elements for reviewing and processing claims. Based on our compliance testing at the four agencies, we determined that none of the agencies we reviewed used a contractor to oversee claims that State Fund processed.</p> <p>Reviewed the four agencies’ policies and procedures related to claim intake and tracking. We determined that the monitoring mechanisms ensured that State Fund administered claims efficiently and effectively. All four agencies adequately tracked claims from the time they submitted them to State Fund until their resolution.</p>

*continued on next page...*

AUDIT OBJECTIVE	METHOD
4 Identify any best practices the agencies have implemented for setting their reserve amounts for claims.	<ul style="list-style-type: none"> <li>• Interviewed staff at the four agencies to determine how they budget staff benefits, including workers' compensation benefits, and fund their claim-related costs. We determined that state agencies do not maintain reserves but develop reasonable workers' compensation budgets annually.</li> <li>• Reviewed industry best practices and determined if they are applicable to these agencies.</li> <li>• Interviewed State Fund, CalHR, and University of California Office of the President staff to determine whether they have implemented any best practices that might be applicable.</li> <li>• Analyzed the four agencies' injury reports and found that the agencies generally track and use injury data to identify trends and inform changes to policies and procedures.</li> <li>• Interviewed staff and analyzed documentation from the Orange County Risk Management Office concerning its efforts to limit claim costs. We found that although Orange County realized some cost savings, state agencies cannot adopt some of its strategies because of structural differences in how it processed and paid claims. We found that other cost-saving strategies Orange County implemented are already a part of the process at the state level.</li> </ul>
5 To the extent possible, evaluate whether State Fund and the agencies efficiently and effectively care for employees receiving workers' compensation by doing the following:	<ul style="list-style-type: none"> <li>a. For a selection of claims, assess whether workers' compensation claims are processed in a timely and appropriate manner. <ul style="list-style-type: none"> <li>• Reviewed a total of 32 claims that the four agencies submitted to State Fund and found that State Fund generally processed them in a timely and appropriate manner.</li> <li>• Determined whether CAL FIRE, Social Services, and Caltrans were able to settle claims in a timely and efficient manner by reviewing 15 settlement requests that State Fund created and gave to the agencies before settlement conferences. We also analyzed CAL FIRE's and Social Services' settlement tracking logs.</li> </ul> </li> <li>b. Calculate the average rate of completion for each agency's claims and compare those rates to industry standards. <ul style="list-style-type: none"> <li>• Analyzed State Fund claims data from fiscal years 2013–14 through 2017–18 and determined the claim closure rates for all of State Fund's state agencies using the master agreement, including administrative closures, stipulations, compromise and release agreements, and findings and awards. In addition, we determined the closure rates for each of the four agencies selected for review. We attempted to compare these data to information State Fund maintains about its insured employers, but State Fund asserted that information was confidential.</li> </ul> </li> </ul>
6 Evaluate loss run reports focusing on total incurred costs, total benefits paid, and outstanding reserves for all open claims, including reports on those claims that have been open for more than a year and those that have been open for more than two years.	<ul style="list-style-type: none"> <li>• Obtained summary-level data from State Fund for claims open as of January 2019 and determined the total incurred costs and total benefits paid for all state agencies using the master agreement, including claims less than one year old, from one to two years old, and more than two years old. We attempted to compare these data to information State Fund maintains about its insured employers, but State Fund asserted that information was confidential.</li> <li>• Compared the costs for 10 agencies of using insurance policies from State Fund to estimated master agreement costs for fiscal years 2013–14 through 2017–18.</li> </ul>
7 Review and assess any other issues that are significant to the audit.	<ul style="list-style-type: none"> <li>• Reviewed external and internal claim compliance audits of State Fund and determined that it had followed up on findings and implemented recommendations.</li> <li>• Interviewed CalHR staff to determine the steps CalHR takes to oversee its master agreement with State Fund.</li> </ul>

Source: Analysis of Audit Committee's audit request number 2019-106, planning documents, and analysis of information and documentation identified in the table column titled Method.

### **Assessment of Data Reliability**

The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of the computer-processed information that we use to support our findings, conclusions, and recommendations. In performing this audit, we relied on State Fund's claims data. To evaluate these data, we performed dataset verification procedures and electronic testing of the key data elements and found the data used are sufficiently reliable for the purposes of selecting a sample for our claims testing. We verified accuracy of the data by randomly selecting claims from State Fund's database and tracing key data elements from each claim to supporting evidence maintained by three of the four agencies we reviewed. We also verified completeness of the data by haphazardly selecting claims from independent claims databases maintained by three of the four agencies we reviewed and ensuring that each claim existed in State Fund's data. According to CHP's injury and illness program manager, its independent claims database is primarily populated with data from State Fund, so we were therefore unable to use CHP's data to verify the accuracy or completeness of State Fund's database.

In addition, to assess State Fund's administration of claims during the settlement process, we reviewed a selection of claims from settlement logs maintained by three of the four agencies we reviewed. For a selection of records in these logs, we confirmed key dates by reviewing supporting documentation. In addition, we analyzed the data in the settlement logs for two of the agencies we reviewed. Because the agencies update these logs as settlements progress, we were unable to verify their completeness. However, we assessed the information we obtained to be sufficiently reliable in total for the purpose of supporting our findings and conclusions.

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**Acting Secretary, Government Operations Agency** Julie Lee  
**Director** Eraina Ortega

October 29, 2019

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

Re: Report 2019-106

Dear Ms. Howle,

This is the response of the California Department of Human Resources (CalHR) to the draft audit report regarding Workers' Compensation Insurance. CalHR is committed to administering the State's workers' compensation program in an efficient, effective, and fiscally responsible manner.

The report concludes that CalHR should, in the interest of fiscal responsibility, provide a cost-benefit analysis to each of the insured state departments comparing the estimated cost of participation in the master agreement with State Compensation Insurance Fund (State Fund) with the cost of insurance.

CalHR will work with State Fund to prepare these estimates and provide them to the affected departments. We will provide details about our efforts in our follow-up responses to you.

Please do not hesitate to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Eraina Ortega". The signature is written in a cursive, flowing style.

Eraina Ortega  
Director

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October 29, 2019

Elaine M Howle, CPA\*  
California State Auditor  
621 Capital Mall, Suite 1200  
Sacramento, CA 95814

Dear Ms. Howle:

State Compensation Insurance Fund (State Fund) hereby provides response to the draft finding of the California State Auditor (CSA) report entitled, *Some State Agencies Are Paying Millions of Dollars More than Necessary to Provide Benefits to Their Employees*. The CSA conducted this audit and issued one recommendation.

State Fund appreciates the work performed by the CSA and the opportunity to respond to the recommendation. Attached are our comments and response to the recommendation contained in the draft report.

If you have questions or require additional information, please contact Donna Babineau, Claims Compliance Director, at (323) 981-3113.

Sincerely,

A handwritten signature in cursive script that reads "Donna M. Babineau".

Donna Babineau  
Claims Compliance Director  
State Compensation Insurance Fund

Enclosure: State Fund's Response to Draft State Audit Report  
Workers' Compensation Finalizations

Cc: Vern Steiner, President and CEO, State Compensation Insurance Fund  
Margie Lariviere, General Counsel, State Compensation Insurance Fund

\* California State Auditor's comments appear on page 45.

**STATE FUND RESPONSE TO DRAFT STATE AUDIT REPORT**

State Fund has prepared the following comment and plan.

**Recommendation:** To ensure that the State Agencies have adequate time to review settlement requests and provide settlement authority, State Fund should create and follow a policy by May 2020 to provide settlement authorization requests to agencies at least 30 days before settlement conferences.

- ① **Comment and Plan:** The Agencies and State Fund have established guidelines for communicating finalizations which contemplate that State Fund will complete a settlement authorization request (SAR) at the earliest opportunity. Pursuant to the guidelines, State Fund strives to provide the SAR to the agencies within 30 days of receipt of all Maximum Medical Improvement (MMI) reports. This means that the proposed finalization worksheet will generally be forwarded to the agencies *at least* 30 days before settlement conferences. However, as stated in the Audit Report, there are factors outside State Fund's control that make it impossible for us to anticipate and submit a SAR 30 days prior to a hearing in every single instance. The established finalization guidelines take these factors into consideration. There are also exceptions to the SAR recommended timelines such as agreements with specific agencies for delegated authority. State Fund will continue to make every effort to provide the agencies as much time as possible to review the SAR by following the guidelines and providing oversight to ensure adherence.

*The finalization guidelines are enclosed and available at <https://www.calhr.ca.gov/employees/Pages/workers-comp-finalizations.aspx>.*

- ② **Target Completion Date:** May 2020

State Fund also provides the following comment to the audit's factual findings:

- ③ The amounts in Table 4 do not include the liability reserve for incurred but not reported (IBNR) claims. IBNR refers to claims that have been incurred during the policy period and have not yet been reported to the insurance company and future development on claim reserves that have been reported to the insurer. While most insurance claims can be settled within a few years of the date of injury, some claims, due to their size and complexity may take years, or even decades to reach resolution. The amount of the adjuster case reserve estimate is not known with certainty until the claim is resolved. The IBNR reserve exists to ensure that adequate funds are set aside and available to pay all costs associated with the claim benefits due to the injured worker and also the administration costs of administering the claims incurred against the policy.

## Comments

### CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM STATE COMPENSATION INSURANCE FUND

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

State Fund's comment is misleading. Although State Fund is correct that the guidelines it mentions establish a time frame for completing settlement requests, State Fund has consistently failed to comply with these guidelines. We reviewed 15 settlement requests and found only one instance in which State Fund sent the settlement request within 30 days of receiving the maximum medical improvement (MMI) report. More importantly, the state agencies we reviewed assert and our testing demonstrates that the amount of time State Fund provides agencies to review the settlement request is not meeting the needs of the agencies that receive services from State Fund. As we state on page 29, our testing found that State Fund did not provide agencies with at least 30 days to respond to many settlement requests, which limited the agencies' ability to delegate the authority necessary to effectively resolve claims during settlement conferences.

①

State Fund's claims compliance director clarified in subsequent correspondence that State Fund does not intend to implement the recommendation. Rather, she indicated that State Fund will assess how well it is meeting the guideline and implement any changes by May 2020.

②

We acknowledge State Fund's perspective that there is a degree of uncertainty in estimating the cost of workers' compensation claims, as we state on page 17 and further discuss throughout the report when describing the various factors associated with settlement alternatives. In addition, as State Fund notes, the amount of such reserves is not known with certainty until the claim is resolved. However, this uncertainty also encompasses the possibility of costs being greater than or less than the estimated incurred cost we used to develop our estimates. Based on the significant difference between the estimated costs and the cost of insurance purchased by these agencies, we stand by our conclusion that the State could save significant amounts by using the master agreement rather than purchasing insurance.

③