REPORT BY THE
AUDITOR GENERAL
OF CALIFORNIA

A REVIEW OF
THE WORKERS' COMPENSATION SYSTEM

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OFFICE OF THE AUDITOR GENERAL

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Telephone:
(916) 445-0255

STATE OF CALIFORNIA
Office of the Auditor General
660 J STREET, SUITE 300
SACRAMENTO, CA 95814

Kurt R. Sjoberg
Acting Auditor General

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Honorable Elihu M. Harris, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 448
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the workers' compensation system in California. This audit was requested by Assemblyman Bruce Bronzan last year while he was Chairman of the Joint Legislative Audit Committee. This is one of a series of audits he proposed on policy issues being addressed by the Legislature.

The report indicates that the costs of California's workers' compensation system have steadily increased from 1984 through 1986. Most workers' compensation claims are resolved without litigation. In our sample, those that were litigated took an average of 526 days to resolve. Furthermore, the time taken to litigate claims did not change significantly for claims filed from 1985 through 1987. Finally, the report presents alternatives the Legislature may wish to consider for modifying the workers' compensation system.

Respectfully submitted,

Kurt R. Sjoberg

KURT R. SJOBERG
Acting Auditor General

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SUMMARY

RESULTS IN BRIEF

The costs of California's workers' compensation system have steadily increased. Premium costs to employers for workers' compensation insurance increased from $3.9 billion in 1984 to $5.2 billion in 1986. Further, benefits paid and reserved for future payment by insurance carriers increased from $2.6 billion in 1984 to $3.3 billion in 1986; benefits paid and reserved by self-insured employers increased from $980 million in 1984 to $1.1 billion in 1986. In addition to these cost increases, the number of employees participating in vocational rehabilitation has increased substantially. However, the proportion of employees who were employed after completing their plans increased only slightly.

In our review of workers' compensation claims, we found that most claims are resolved without litigation. Of those litigated at the Workers' Compensation Appeals Board (WCAB), the majority are opened with applications for adjudication, although most claims are resolved by the parties through compromise and release agreements or stipulations. The remainder are resolved before a judge at the WCAB, in which the judge receives evidence and decides on issues of fact and law. The time taken to litigate claims did not change significantly for claims filed from 1985 through 1987. The claims in our 1985 random sample took an average of 525 days to resolve. However, those claims opened with applications for adjudication took an average of 589 days to resolve whereas those opened with original compromise and release agreements or stipulations took an average of 47 days.

BACKGROUND

State legislation requires employers to provide compensation for an employee's work-related injury or illness and to rehabilitate and retrain injured employees. Employers can do this by purchasing workers' compensation insurance or by participating in the State's self-insurance program. The Department of Industrial Relations is responsible for administering and enforcing the workers' compensation laws. It also operates the WCAB, a state court that hears and decides litigated claims for workers' compensation benefits.

PRINCIPAL FINDINGS

Costs and Benefits of the Workers' Compensation System

The costs of California's workers' compensation system have been steadily increasing. For example, from 1984 through 1986, the indemnity benefits that insurance carriers paid and reserved increased 19.4 percent and their medical benefits increased 34.1 percent. Similarly, indemnity benefits that self-insured employers paid and reserved increased 8.6 percent; their medical benefits paid and reserved increased 15.4 percent. The number of new vocational rehabilitation cases has also increased, adding to the overall costs of the system.

From 1984 through 1986, premiums that employers paid for workers' compensation coverage also rose steadily. However, although benefit costs for insurance carriers increased, when compared with the premiums they earned, insurance carriers paid and reserved a lower percentage for benefits in 1986 than in the three previous years. Finally, from 1984 through 1986, administrative and tax expenses for insurance carriers fluctuated widely while, from 1983 through 1985, dividends as a percentage of premiums earned decreased.

Vocational Rehabilitation Plans

The number of employees completing vocational rehabilitation increased substantially from 1983 through 1987, yet the proportion of employees employed after completing their plans increased only slightly. Of the six types of vocational rehabilitation plans available, those chosen most often--schooling and direct placement--were the least effective in returning employees to work. The two most successful plans were either the modified job or alternative job plan, which were among the least expensive and resulted in better earning capacity. However, only a small portion of employees chose one of these plans.

Litigating Workers' Compensation Claims

If the parties to a workers' compensation claim dispute a claim, they may litigate the claim before the Workers' Compensation Appeals Board (WCAB). However, most claims are settled without litigation. Of those claims litigated, most were opened with applications for adjudication in our sample of 1985 claims, yet the parties used compromise and release agreements or stipulations most frequently to resolve their claims. The remaining claims were resolved with findings and awards, findings and orders, or orders of dismissal. As of December 1, 1988, the parties had resolved 77 percent of the 1985 claims; the remaining 23 percent were pending.

The Time Taken To Litigate Claims for Workers' Compensation Benefits

The time taken to litigate claims before the WCAB varies according to the parties and steps involved in the process. In our random sample of 1985 resolved claims, resolution took an average of 525 days. For those claims opened with applications for adjudication, resolution

took an average of 589 days. In contrast, those that were opened with original compromise and release agreements or original stipulations took an average of 47 days. The time taken to resolve claims has not changed significantly for claims filed from 1985 through 1987.

ALTERNATIVES FOR MODIFYING THE WORKERS' COMPENSATION SYSTEM

To better achieve the objectives of the California workers' compensation system, the Legislature may wish to consider the following alternatives, after evaluating the pros and cons, which are discussed more fully in Analysis Five:

- The Legislature could make the maximum weekly indemnity benefit equal to two-thirds of California's average weekly wage and provide for yearly adjustments for new claims;

- The Legislature could require that, when an employee receives a lump sum settlement, future temporary disability for vocational rehabilitation would be offset against that lump sum;

- The Legislature could hold the Department of Industrial Relations responsible for temporary disability payments if it does not hold pretermination conferences within the 30-day limit; and

- The Legislature could make compromise and release agreements and stipulations binding on the parties without requiring a judge's approval.

AGENCY COMMENTS

The Department of Industrial Relations generally agrees with the analyses and alternatives in this report. However, the department disagrees with our alternative to hold the department responsible for temporary disability payments if it does not hold rehabilitation pretermination conferences within the 30-day limit. The department believes this alternative appears to exceed the authority given to the Legislature pursuant to Article 14, Section 4 of the California Constitution. Further, according to the department, this alternative appears to conflict with California's public entity claims act, Government Code Section 819, et seq.

The Department of Insurance stated that the report represents a factual account of the department's activities, and the State Compensation Insurance Fund stated that the report presents an accurate description of the present workers' compensation system.

INTRODUCTION

In 1911, the state constitution was amended to include Article 20, Section 21, which established a system that requires employers to provide compensation for an employee's work-related injury or illness. This amendment--now Article 14, Section 4--authorized the Legislature to create and enforce a system that compensates employees for injuries and includes payment for the injured employees' medical treatment and payment of death benefits to the employees' beneficiaries. Subsequent legislation created a system to rehabilitate and retrain injured employees. In addition to providing compensation to employees for injuries or illnesses that result from employment, the workers' compensation system provides protection to employers against personal liability. Specifically, Section 3602 of the Labor Code prohibits an employee who has received compensation from bringing legal action against the employer.

The primary responsibility for promoting and developing the welfare of wage earners in California, for improving their working conditions, and for advancing their opportunities for profitable employment falls to the Department of Industrial Relations. Within the Department of Industrial Relations, the Division of Industrial Accidents (division) is responsible for administering and enforcing the workers' compensation laws. The division's objectives include preventing, settling, or adjudicating workers' compensation claims;

providing workers' compensation benefits under certain special programs; approving and enforcing rehabilitation plans; rating permanent disabilities; providing medical consultative services; and assuring that disputes are resolved fairly and in accordance with the law. The four bureaus within the division accomplish most of these objectives by providing services to injured employees. In addition, the division administers 22 district offices of the Workers' Compensation Appeals Board throughout the State. These district offices are responsible for resolving disputes between injured employees and their employers or the employers' insurance carriers.

Requirements and Regulations Governing Employers Other Than the State

Section 3700 et seq. of the Labor Code require all employers, except the State, to guarantee the payment of workers' compensation benefits. Employers can do this by obtaining insurance from either private insurance companies or the State Compensation Insurance Fund (SCIF) or by participating in the State's self-insurance program. Employers who purchase workers' compensation insurance from either a private insurance company or from the SCIF pay premiums to the insurance carrier. Employers who wish to participate in the State's self-insurance program must obtain a certificate of consent from the director of the Department of Industrial Relations. To obtain this certificate, they must demonstrate to the director the ability to self-insure and to pay any compensation that may become due if an

employee is injured at work. Section 3701 of the Labor Code requires that private employers who choose to self-insure establish or renew a security deposit equivalent to 135 percent of their estimated future liabilities: 125 percent for compensation to employees and 10 percent for administrative and legal costs. If a private, self-insured employer fails to pay workers' compensation claims as they become due, the director may use the security deposit to administer and pay the employer's outstanding claims.

Like private employers, cities, counties, public districts, or public agencies may also choose to provide their own workers' compensation insurance. These public employers must furnish proof to the director of their ability to properly administer and pay workers' compensation claims that may become due. However, in contrast to private employers, cities, counties, public districts, or public agencies do not have to deposit funds with the director to guarantee the payment of workers' compensation claims.

Workers' Compensation for State Employees

Although Section 3700 of the Labor Code does not require the State of California to guarantee the payment of workers' compensation benefits to its employees, the State does insure its employees for workers' compensation benefits. State employees receive benefits through either the SCIF or special programs. Any state agency may obtain workers' compensation insurance from the SCIF. In 1987,

61 state entities paid the SCIF over $5.8 million for workers' compensation insurance.

State agencies that do not purchase workers' compensation insurance from the SCIF are covered under a master agreement between the Department of General Services and the SCIF, as permitted by Section 11871 of the Insurance Code. This agreement allows the SCIF to adjust and dispose of workers' compensation claims for any uninsured state agencies. In accordance with this agreement, the SCIF pays benefits to injured state employees and is later reimbursed by the state agency where the injured employee worked. The appropriate state agency also reimburses the SCIF for the actual cost of administering the claim.

In addition, there are two special programs that provide benefits to certain employees of the State. For example, employees of the California Highway Patrol and the Department of Justice receive special payments under Section 4800 of the Labor Code. This code section allows employees of these two state agencies whose principal duties involve active law enforcement to receive their salary in lieu of disability payments for one year. If the disability period exceeds one year, the injured employees are eligible to receive temporary disability benefits during the remainder of the disability.

Similarly, Sections 19869 and 19871 of the Government Code provide industrial disability leave and payments in lieu of temporary

disability benefits to state employees who are members of either the Public Employees' Retirement System or the State Teachers' Retirement System and to legislative employees who are not members of the civil service. These employees are eligible for these benefits for up to 52 weeks within two years of the first day of the disability. Eligible employees receive full salary for not more than 22 working days of their disability and two-thirds of their full salary for the remaining period of disability, up to 48 weeks.

Special Funds for Injured Employees

Finally, the Department of Industrial Relations administers benefits to employees under certain conditions through two special funds: the Uninsured Employers' Fund and the Subsequent Injuries Fund. According to Section 3716 of the Labor Code, the Uninsured Employers' Fund may be used to pay benefits to an employee whose employer was illegally uninsured at the time the employee was injured. The director of the Department of Industrial Relations is responsible for seeking reimbursement from the uninsured employer for the amount of benefits paid out of this fund.

Until its termination on January 1, 1989, the Asbestos Workers' Account was included in the Uninsured Employers' Fund, providing compensation benefits to employees who suffer from asbestosis. Asbestosis is a lung disease resulting from exposure to asbestos fibers. The benefits to injured employees from the Asbestos

Workers' Account ended when the responsible employer or insurance carrier was identified. If the responsible employer or insurance carrier was not identified or denied liability, the injured employee could continue to receive benefits from the account.

The Subsequent Injuries Fund is used to provide benefits to an employee who has a permanent partial disability and subsequently sustains a second compensable injury. Section 4750 of the Labor Code exempts an employer from compensating an injured employee for a combined disability; the employer must compensate the injured employee only for the later injury. However, according to Section 4751 of the Labor Code, with certain exceptions, if an employee who has a permanent partial disability suffers a subsequent injury that, combined with the previous disability, results in a permanent disability of 70 percent or more, he or she is eligible to receive disability benefits in addition to those for the subsequent injury alone. The SCIF pays these additional benefits and is then reimbursed by the State Controller's Office.

Ratesetting Process

The Department of Insurance's primary purpose is to protect the policyholders of the State; one of the ways it accomplishes this is to regulate the rates that private employers and some state and local agencies pay for workers' compensation insurance. Both private insurance companies and the SCIF must use at least the minimum rates

set by the insurance commissioner, who governs the Department of Insurance, when computing premiums to charge employers. To determine these rates, the insurance commissioner uses recommendations submitted by the Workers' Compensation Insurance Rating Bureau of California (WCIRB), a nonprofit association empowered by Section 11750.3 of the Insurance Code to collect and tabulate information and statistics for the purpose of developing minimum rates.

In developing these rates, the WCIRB uses information submitted by insurance carriers. According to Section 11738.5 of the Insurance Code, all insurance carriers that provide workers' compensation insurance must report information related to those policies on premiums (payments from employers for the insurance), losses (benefit payments incurred), and dividends (the portion of premiums returned to employers after the policy has expired).

After the WCIRB has used this information to develop minimum rates, it submits its recommendations to the insurance commissioner, who reviews and modifies, rejects, or approves the WCIRB's recommended rate proposals. Generally, the WCIRB submits one rate proposal each year to the insurance commissioner; however, during calendar years 1985 through 1988, the WCIRB submitted interim rate proposals in addition to the yearly proposals. To determine the premium an employer pays for workers' compensation insurance, insurance carriers use the insurance rate set by the insurance commissioner and the employer's experience

rating, a premium increase or decrease based on the employer's accident history.

To obtain workers' compensation insurance, an employer first selects an insurance carrier licensed to write workers' compensation insurance in California. The insurance carrier categorizes each of the employer's workers into one of approximately 425 employee classifications established by the insurance commissioner. Each of these classifications has a corresponding rate that reflects the history of accidents and losses for employees in the classification compared to the accidents and losses for employees in other classifications.

After categorizing the employees, the insurance carrier obtains projected payrolls for the employees in each classification group. To determine the premium to charge, the insurance carrier multiplies the payroll for each classification group by the rate for that particular group. For example, the insurance carrier will consult the current rate table, which lists the rates for each of the classifications, and find that the rates per $100 of payroll are $34.84 for roofers and $.83 for clerical employees. If the total payroll for roofers is $100,000, the premium amount for the classification group of roofers would be $34,840. Similarly, if the payroll for the clerical employees is $10,000, the premium amount for this classification group would be $83. After calculating the premium amounts for each classification, the insurance carrier adds them together to determine

the preliminary total premium. In this case, the preliminary total premium for this employer would be $34,923.

If an employer is eligible for an "experience rating," the insurance carrier will adjust the preliminary premium to reflect that rating. As defined by Section 11730 of the Insurance Code, the experience rating refers to an increase or decrease in the preliminary premium that is determined by an employer's "accident experience," which reflects the employer's history of accidents. For example, with an experience rating of .75, the employer will pay 75 percent of the preliminary premium. Conversely, with an experience rating of 1.25, the employer will pay 125 percent of the preliminary premium. As the policy period progresses, the insurance carrier may adjust the premium amount to reflect the difference between the projected and the actual audited payrolls.

Employers must meet two conditions in order to be eligible for an experience rating: they must have had workers' compensation insurance for at least three years, and they must pay premiums that exceed a dollar amount determined by the WCIRB and approved by the commissioner each year. For example, effective January 1, 1989, the minimum premium employers must pay to be eligible for an experience rating is $17,300. In 1985, the most recent year for which data are available, 96,532 (17.4 percent) of the workers' compensation insurance policies issued in California had experience ratings applied to

premiums, whereas 458,751 (82.6 percent) of the policies did not receive experience ratings.

Comparative Statistics

While the WCIRB collects policy and claim information and develops rates for the State of California, the National Council on Compensation Insurance (NCCI) provides similar services for approximately 700 insurance companies in 33 jurisdictions throughout the United States. The NCCI receives information on workers' compensation policies from 32 states and the District of Columbia. In addition, another 12 states, including California, report to the NCCI statistics that are related to their respective workers' compensation systems. See Appendix C for tables that compare statistics from California's workers' compensation system with statistics from other states throughout the country.

SCOPE AND METHODOLOGY

The purpose of this audit was to review the administration of California's workers' compensation system. Specifically, we determined the costs of the system and the benefits provided by insurance carriers, employers, and the State. In addition, we reviewed the litigation process to determine what types of claims were being litigated, the time involved in litigating claims, and the results of litigation.

To determine the amount of premiums earned and dividends paid or credited to employers, we obtained data from the annual reports of insurance carriers submitted to the Department of Insurance for calendar years 1983 through 1987. We also obtained reports from the Workers' Compensation Insurance Rating Bureau (WCIRB) to determine the indemnity and medical benefits paid and reserved by insurance carriers. We also determined the indemnity benefits paid and reserved by category of disability for policy years 1983 through 1985. To do this, we obtained data from "Unit Statistical Reports" that insurance carriers submitted to the WCIRB.

To determine the amount of benefits provided through special programs, we obtained data from the claims bureau in the Department of Industrial Relations, from the SCIF, and from the Department of General Services. In addition, to determine the cost of providing benefits through these special programs, we obtained data from the Department of Industrial Relations and the SCIF.

To determine the expenses that insurance carriers incurred for providing workers' compensation insurance during calendar years 1983 through 1987, we obtained annual "expense call" data submitted to the WCIRB. In addition, to determine the federal and state taxes that insurance carriers paid during calendar years 1985 through 1987, we reviewed "Form 46s" submitted to the Department of Insurance.

To compare California's workers' compensation benefits with benefits provided in other states, we obtained data from the NCCI showing the maximum benefit amounts available in all 50 states and the District of Columbia. In addition, to determine the benefits an employee earning the average weekly salary would receive, we obtained the average weekly salary for each of the 50 states and the District of Columbia from the Bureau of the Census. Using this information and the established rates for each state, we calculated the benefits these employees would receive.

To develop analyses about self-insured employers, we obtained data from annual reports that self-insured employers submitted to the Office of Self Insurance Plans from 1983 through 1987. From these reports, we determined the employers' estimated future liabilities, the indemnity and medical benefits they paid and reserved, and the number of claims paid. In addition, for private, self-insured employers, we determined the amount of security deposits they submitted to the director of the Department of Industrial Relations.

To evaluate the vocational rehabilitation program, we selected a random sample of 230 claims from rehabilitation plans that injured employees completed during 1987. After selecting the sample, we visited 18 field offices to review case files. From the case files, we determined the type of plan completed, the length of the plan, and the employee's wages before the work-related injury and after completing the rehabilitation plan.

To obtain information regarding the litigation process at the Workers' Compensation Appeals Board (WCAB), we determined the number of claims that were submitted to the WCAB for resolution during calendar years 1985 through 1987. For each of the three years, we selected a random sample of 250 claims to review. After selecting our sample, we recorded data from the case files onto a questionnaire. Finally, using a computer program, we compiled the statistics to develop our analyses.

To determine the average cost of defense attorneys for closed claims, we obtained information from the SCIF on the number of closed claims litigated for calendar year 1985, the number of hours the SCIF's legal office charged for these claims, and the hourly rate the legal office charged. Using this information, we calculated the average legal cost per closed claim.

We also obtained data from the SCIF on the cost of medical reports for cases that were opened for litigation during calendar years 1985 through 1987. We selected a random sample of 350 claims and recorded cost information from invoices and payment documents in the case files. After recording the information, we compiled the data by medical specialty and calculated an average cost-per-claim for each of the medical specialties we identified.

Appendix A provides a detailed description of the methodologies we used to obtain information from the various sources mentioned above.

Finally, in addition to considering written comments from the Department of Industrial Relations, the Department of Insurance, and the State Compensation Insurance Fund, we met with officials from the Department of General Services to discuss our report. In preparing this report, we also considered their comments.

ANALYSIS

I

COSTS AND BENEFITS OF THE WORKERS' COMPENSATION SYSTEM

The costs of California's workers' compensation system have been steadily increasing. For example, from 1984 through 1986, indemnity benefits that insurance carriers paid and reserved for future payments increased from $1.54 billion to over $1.84 billion, a 19.4 percent increase. In addition, insurance carriers have experienced a 34.1 percent increase in medical benefits paid and reserved. However, indemnity benefits paid and reserved by self-insured employers increased only 8.6 percent, from $526 million in 1984 to $571 million in 1986. Similarly, medical benefits paid and reserved by self-insured employers increased only 15.4 percent from 1984 to 1986. Adding to the overall increase in costs of the workers' compensation system, the number of new vocational rehabilitation cases rose from 26,490 in 1984 to 36,269 in 1986, a 37 percent increase.

Premiums paid by employers for workers' compensation coverage have also risen steadily. From calendar year 1984 through calendar year 1986, premiums earned by insurance companies increased from $3.9 billion to $5.2 billion, a 33 percent increase. However, when we compared the total indemnity and medical benefits that insurance carriers paid and reserved as a percentage of the premiums they earned, we noted that insurance carriers paid and reserved a lower percentage

of benefits in 1986 than they had in 1984 and 1985. In addition, we found that the insurance carriers' administrative and tax expenses fluctuated widely from 1984 through 1986 and that dividends paid or credited to employers as a percentage of earned premiums decreased from 1983 through 1985.

WORKERS' COMPENSATION INSURANCE PREMIUMS AND DEPOSITS

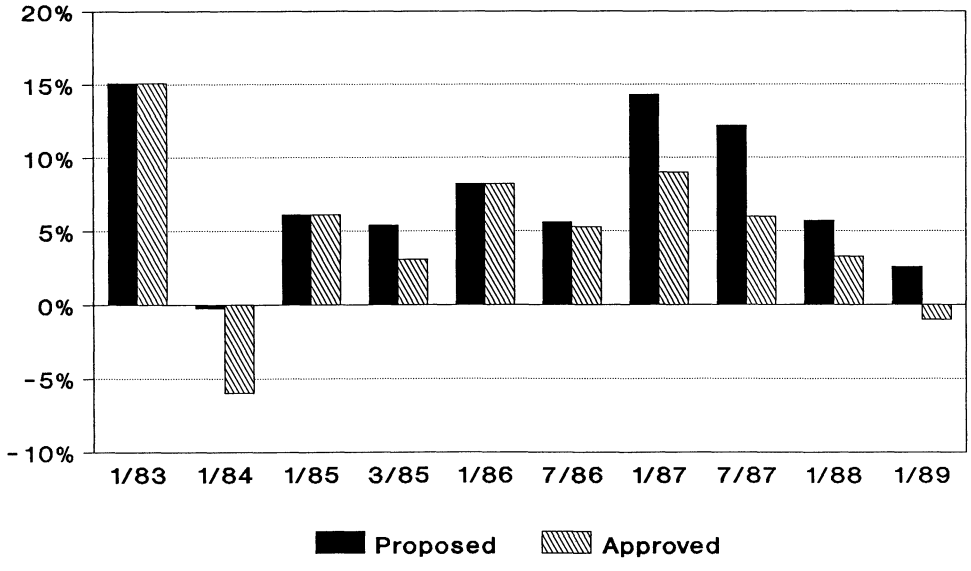
All public and private employers, except for the State, must guarantee workers' compensation benefits to their employees. Employers may either purchase workers' compensation insurance from an insurance carrier or they may self-insure through the State. The premium that an insurance carrier charges an employer for workers' compensation insurance is determined by the rates set by the insurance commissioner (commissioner) and by the employer's experience rating, if applicable. The commissioner uses recommendations submitted by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) to set rates. The WCIRB recommends rate changes that reflect the costs of operating the workers' compensation system and allow insurance carriers to earn profits and pay dividends.

From January 1983 through January 1989, the WCIRB submitted 11 proposals for rate changes to the commissioner, and the commissioner ruled on 10 of them, rejecting the eleventh as unnecessary. As Chart 1 shows, the commissioner approved 3 of the 10 proposals at the rate

proposed by the WCIRB and the remaining 7 at rates that were lower than those proposed by the WCIRB. As a result of the rate changes, the amount of premiums paid by employers increased 59.33 percent during the six years between January 1, 1983 and January 1, 1989. Excluding the effect of experience rating, an employer who paid $100 for workers' compensation insurance premiums in 1982 paid $159.33 for the same coverage in 1989.

CHART 1

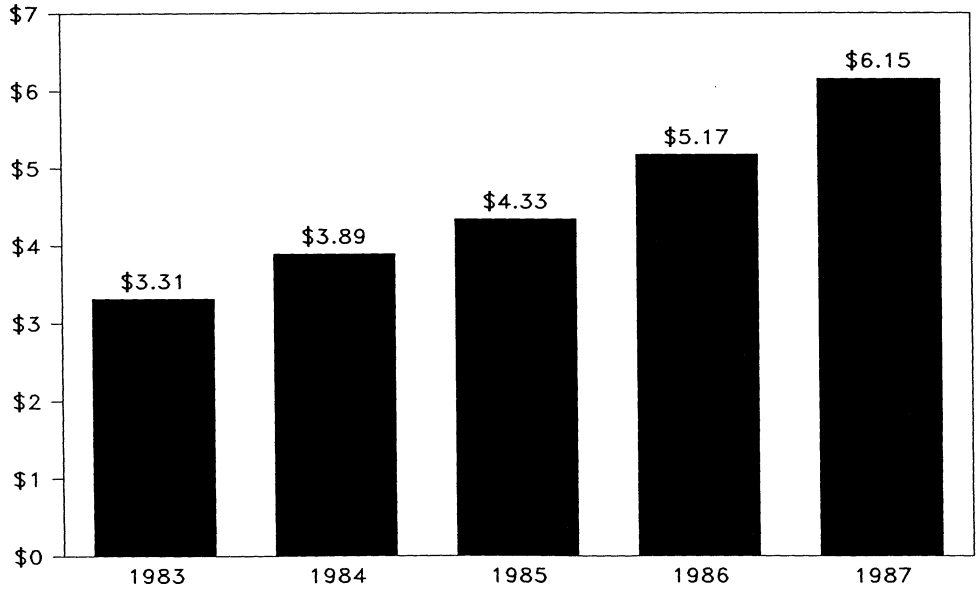
COMPARISON OF THE RATES PROPOSED BY THE WCIRB AND APPROVED BY THE COMMISSIONER



Insurance carriers report premiums earned to the WCIRB. A premium is earned on a prorated basis over the term of the insurance policy. For example, if an employer pays a $10,000 premium for a one-year policy that begins on July 1, 1988, the insurance carrier will earn $5,000 in 1988 and $5,000 in 1989. Chart 2 shows that, between calendar years 1983 and 1987, the premiums earned by insurance carriers rose from $3.3 billion to $6.1 billion, an increase of 85 percent.

CHART 2

PREMIUMS EARNED BY INSURANCE CARRIERS
CALENDAR YEARS 1983 THROUGH 1987
(IN BILLIONS)

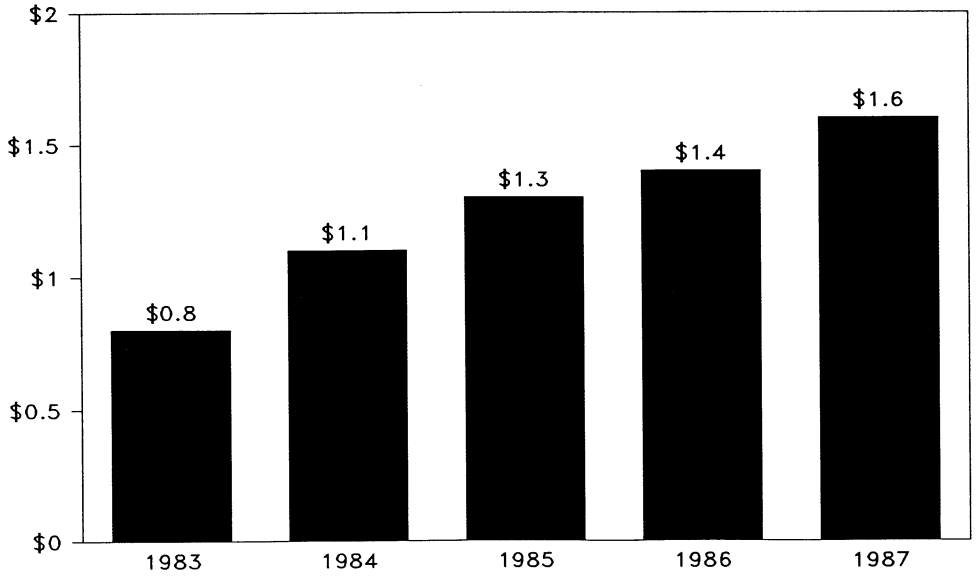


Source: Page 14 of the insurance carriers' annual reports submitted to the Department of Insurance for calendar years 1983 through 1987.

Private, self-insured employers fund their workers' compensation insurance by posting a security deposit equal to 135 percent of their estimated future liabilities for workers' compensation benefits. As Chart 3 shows, from calendar year 1983 through calendar year 1987, the total amount of security deposits made by private, self-insured employers nearly doubled, increasing from $820 million to $1.6 billion. During the same period, however, the number of private, self-insured employers decreased 15 percent, from 513 to 436.

CHART 3

SECURITY DEPOSITS MADE BY PRIVATE, SELF-INSURED EMPLOYERS CALENDAR YEARS 1983 THROUGH 1987 (IN BILLIONS)



Source: Office of Self Insurance Plans, Department of Industrial Relations.

WORKERS' COMPENSATION BENEFITS:
1983 THROUGH 1986

The total liability that an insurance carrier incurs for a workers' compensation claim comprises indemnity benefits, which include vocational rehabilitation benefits, and medical benefits. In any one year, the liability incurred for a claim and the benefits paid on that claim are not necessarily equal. For example, in 1989, an insurance carrier may incur a liability of $20,000, but it will pay out only a portion of that liability in benefits in 1989. The insurance carrier reserves the remainder of the liability for future benefit payments.

Indemnity benefits are cash payments made to injured employees or their heirs. These benefits are paid to compensate for death, permanent total disability, permanent partial disability, and temporary disability resulting from employment. Death benefits are cash payments made to an employee's beneficiaries when the employee is fatally injured at work. Permanent total disability benefits are cash payments made to an employee who sustains an injury that permanently impairs his or her ability to compete in the labor market; these benefits are paid for the remainder of the employee's life. Permanent partial disability benefits cover both major and minor disabilities: a permanent disability is determined to be major when it is rated between 26 and 99 percent and minor when it is rated between one and 25 percent. The percentage of disability determines how long an employee is eligible to receive benefits; some employees receive lifelong disability payments.

Finally, an employee who suffers an injury that causes a temporary disability is eligible to receive benefits for a specified number of weeks while recovering from the injury.

Differences in Reporting Data

In the following analyses, we use data reported by insurance carriers to the WCIRB, which collects information on the costs of various components of workers' compensation. Insurance carriers report data on benefits paid and reserved that cover both "policy years" and "accident years." A policy year refers to the year in which the workers' compensation policy begins. Insurance carriers use the policy year to report indemnity and medical benefits paid and reserved as of 18, 30, and 42 months from the beginning date of the policy. Insurance carriers also report benefits paid and reserved on the basis of the accident year, the year in which the employee was injured. For example, a payment made in 1987 for an injury that occurred in 1985 is charged to 1985, the accident year.

Because insurance carriers reassess injuries periodically, the amounts reported as paid and reserved may change with each report submitted. Also, employees generally have one year from the date of their injury to file a workers' compensation claim. Since we analyzed data reported as of June 30, 1988, some injuries occurring in 1987 may not yet have been reported; therefore, we do not present data for accident year 1987.

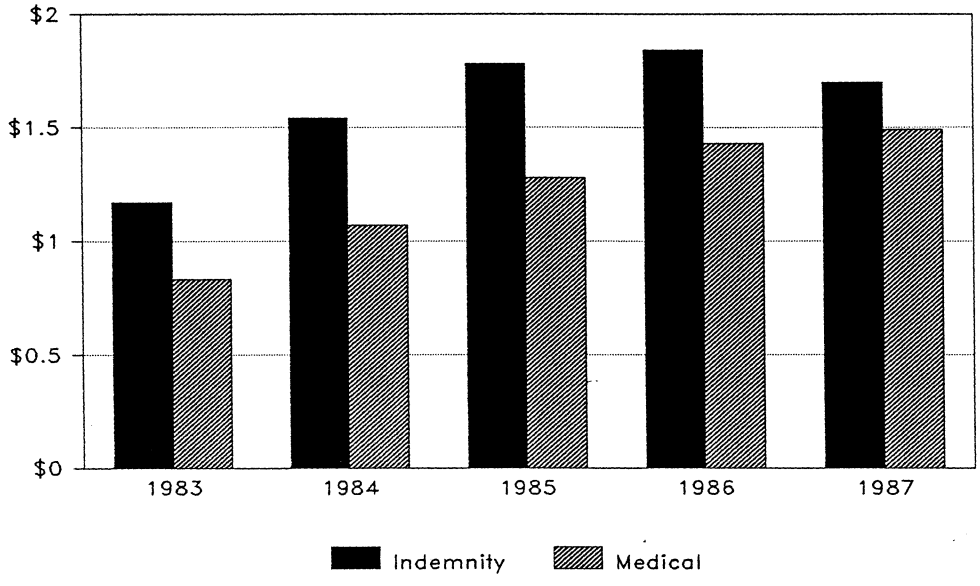
Both public and private, self-insured employers submit annual reports to the director of the Department of Industrial Relations showing data for three years. However, the reports of public employers are based on the State's fiscal year (July 1 through June 30), and the reports of private employers are based on the calendar year.

Benefits Paid and Reserved by Insurance Carriers

From accident year 1983 through accident year 1986, the indemnity benefits paid and reserved by insurance carriers steadily increased. As shown in Chart 4, insurance carriers reported that indemnity benefits paid and reserved totaled $1.16 billion for accident year 1983 and $1.84 billion for accident year 1986.

CHART 4

INDEMNITY AND MEDICAL BENEFITS PAID AND RESERVED BY INSURANCE CARRIERS ACCIDENT YEARS 1983 THROUGH 1987 REPORTED AS OF JUNE 30, 1988 (IN BILLIONS)



Source: Workers' Compensation Insurance Rating Bureau of California: Accident Year Report.

Note: Totals do not include reserves classified as "incurred but not reported."

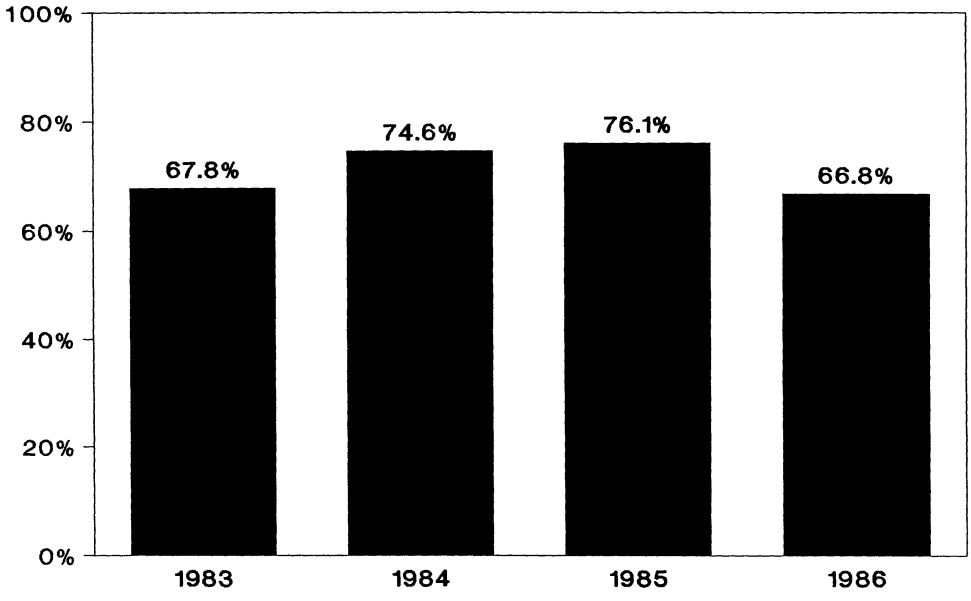
In addition to indemnity benefits, injured employees are entitled to receive all necessary medical treatment at no cost. As Chart 4 illustrates, the medical benefits paid and reserved by insurance carriers also increased from accident year 1983 through accident year 1986. For example, insurance carriers reported $832 million in medical benefits paid and reserved for accident year

1983; in accident year 1986, the insurance carriers reported medical benefits paid and reserved of $1.43 billion.

When we compared the total indemnity and medical benefits paid and reserved by insurance carriers as a percentage of premiums the carriers earned, we noted an increase in this percentage from accident year 1983 through accident year 1985 and a decrease from accident year 1985 through accident year 1986. (See Chart 5.) The decrease from 1985 to 1986 may have occurred because benefits paid and reserved increased only 6.9 percent while premiums earned increased 21.9 percent.

CHART 5

BENEFITS PAID AND RESERVED AS A PERCENTAGE OF PREMIUMS EARNED BY INSURANCE CARRIERS ACCIDENT YEARS 1983 THROUGH 1986 REPORTED AS OF JUNE 30, 1988



Source: Workers' Compensation Insurance Rating Bureau of California: Accident Year Report.

Note: Totals do not include reserves classified as "incurred but not reported."

Benefits Paid and Reserved for Each Category of Disability

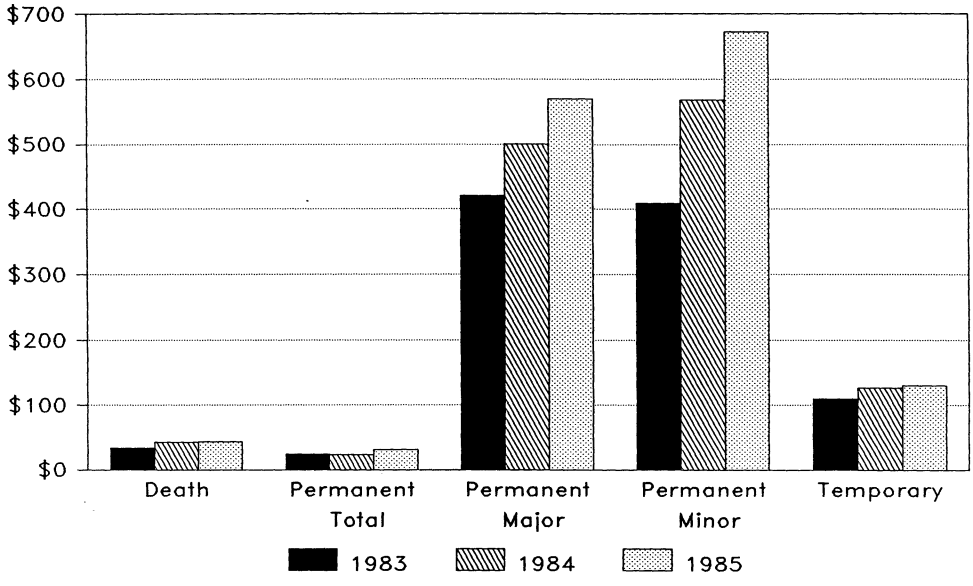
Insurance carriers report to the WCIRB the benefits they pay and reserve for each of the indemnity categories: death, permanent total, permanent major, permanent minor, and temporary. According to these reports, from policy year 1983 through policy year 1985, the most

recent year for which statistics were available at the time of our review, the indemnity benefits paid and reserved during the first 18 months after the workers' compensation policies began increased in four of the five categories. The only category for which benefits paid and reserved decreased from one policy year to another was that of permanent total disability benefits, which decreased from $24.3 million in policy year 1983 to $23.1 million in policy year 1984.

For the remaining four categories, indemnity benefits paid and reserved increased from policy year 1983 through policy year 1985. For example, benefits paid and reserved in the permanent minor disability category increased 39 percent, from $409 million for policy year 1983 to $568 million for policy year 1984. For policy year 1985, the amount increased further to $673 million. Similarly, the benefits paid and reserved for employees who suffered a temporary disability increased from $110 million in policy year 1983 to $127 million in policy year 1984, or 15.45 percent. (See Chart 6.)

CHART 6

INDEMNITY BENEFITS PAID AND RESERVED
BY INSURANCE CARRIERS
BY CATEGORY OF DISABILITY
POLICY YEARS 1983 THROUGH 1985
(IN MILLIONS)



Source: Workers' Compensation Insurance Rating Bureau of California: Unit Statistical Reports (18-month report) for policy years 1983 through 1985.

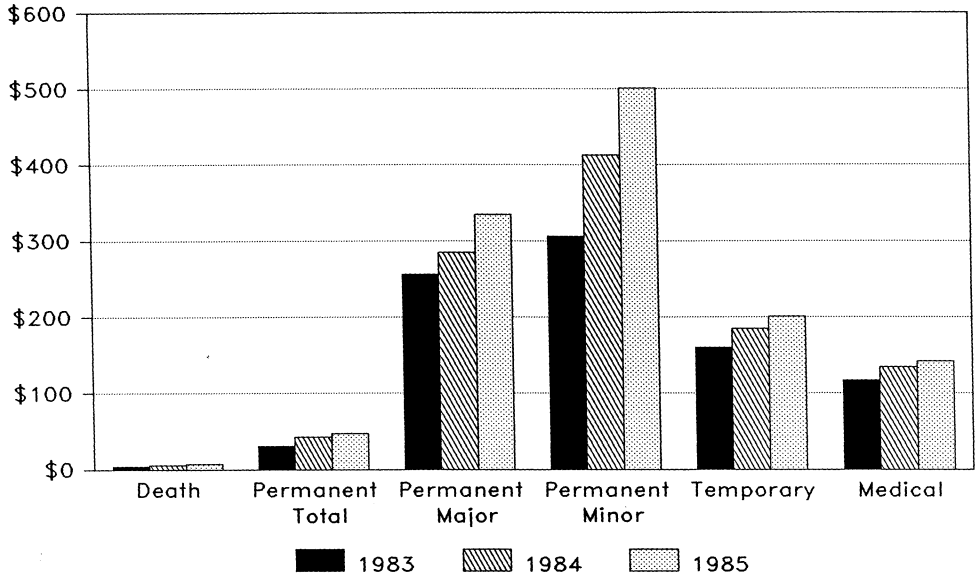
In most categories, there does not appear to be any correlation between the increase in the amount of benefits paid and reserved and the number of claims filed. For example, from policy year 1984 through policy year 1985, the number of claims for permanent minor disabilities decreased 12.7 percent, from 81,030 to 70,746. During the same time, however, the total indemnity benefits paid and reserved for these claims increased 18 percent, from $568 million in policy year 1984 to $672 million in policy year 1985.

Like the increases in permanent minor disabilities, the increases in temporary disability benefits do not seem to be related to the number of claims filed. For example, the number of claims for temporary disability benefits from policy year 1984 through policy year 1985 decreased 5.7 percent, from 187,915 to 177,292. However, the indemnity benefits paid and reserved for these claims increased 2.4 percent, from $127 million to $130 million.

In addition to reporting the indemnity benefits paid and reserved for each category of disability, insurance carriers must also report to the WCIRB the medical benefits paid and reserved during a particular policy year, including "medical only" claims. These claims are paid for injured employees who require medical treatment but do not receive any indemnity benefits because the injury does not cause the employees to miss more than three days of work.

CHART 7

MEDICAL BENEFITS PAID AND RESERVED
BY INSURANCE CARRIERS
BY CATEGORY OF DISABILITY
POLICY YEARS 1983 THROUGH 1985
(IN MILLIONS)



Source: Workers' Compensation Insurance Rating Bureau of California: Unit Statistical Reports (18-month report) for policy years 1983 through 1985.

As illustrated in Chart 7, medical benefits paid and reserved by insurance carriers increased from policy year 1983 through policy year 1985 for each of the categories. The greatest increase in medical benefits paid and reserved occurred from 1983 through 1984 in the permanent total disability category; benefits paid and reserved increased 38.4 percent, from $31 million in 1983 to $42.9 million in 1984. This increase was not caused by a rise in the number of claims

filed; in fact, from policy year 1983 through policy year 1984, the number of claims for permanent total disabilities decreased 29 percent, from 154 to 109.

Vocational Rehabilitation

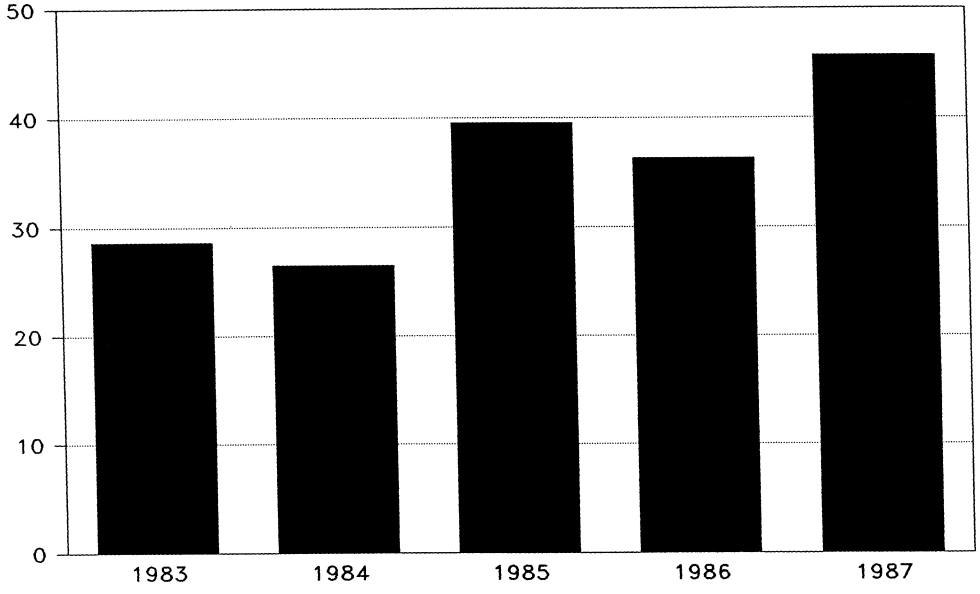
The Labor Code, Sections 139.5 and 6206, established the right of qualified injured employees to vocational rehabilitation and made employers, or their insurers, responsible for providing rehabilitation if the employees request it. Vocational rehabilitation benefits include temporary disability payments, evaluation to determine whether rehabilitation is feasible, the development of a rehabilitation plan, additional living expenses necessitated by the rehabilitation plan, the cost of the plan itself (training, supplies, etc.), and job placement assistance.

Before July 1, 1988, the rehabilitation bureau, within the Division of Industrial Accidents, opened rehabilitation cases when either employers or employees notified it of the potential need for vocational rehabilitation services. Although the number of new rehabilitation cases from 1983 through 1987 did not increase steadily from year to year, there was an overall increase of 59.4 percent in new cases, from 28,640 cases in calendar year 1983 to 45,657 cases in calendar year 1987. (See Chart 8.) During the same period, the average annual employment in California increased 18 percent, as reported by the United States Department of Labor, Bureau of Labor

Statistics. However, since the amount of these increases differs, we cannot say that one is a direct result of the other.

CHART 8

VOCATIONAL REHABILITATION CASES OPENED
CALENDAR YEARS 1983 THROUGH 1987
(IN THOUSANDS)



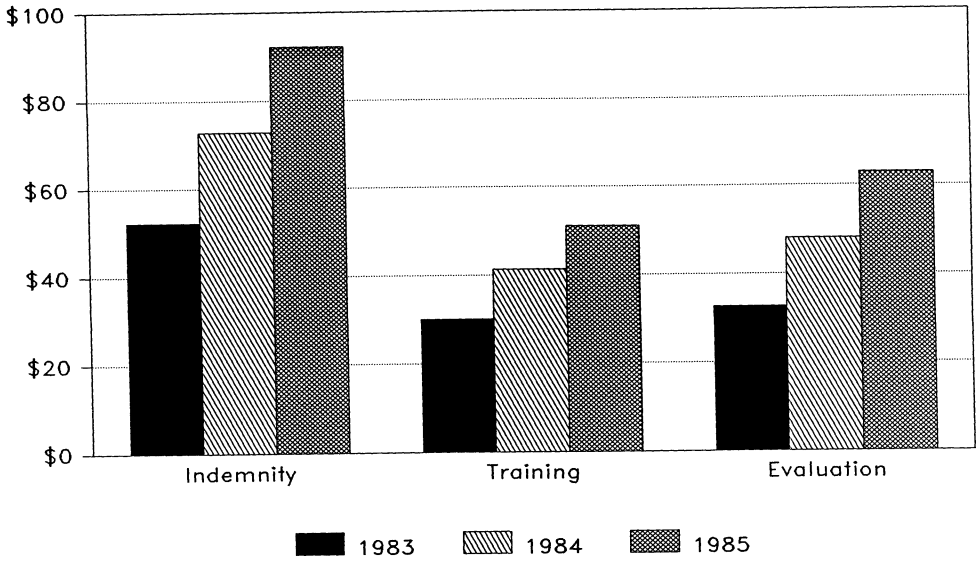
Source: The Rehabilitation Bureau, Division of Industrial Accidents.

According to the WCIRB, the benefits paid and reserved by insurance carriers for vocational rehabilitation services provided during the first 18 months after their workers' compensation policies began increased from $115 million in policy year 1983 to $206 million in policy year 1985, the most recent year for which statistics were available at the time of our analysis. These benefits paid and

reserved, which increased by 79.1 percent, cover the three categories of vocational rehabilitation benefits identified by the WCIRB: temporary disability, evaluation, and training. Evaluation costs include expenses for counseling and developing plans that do not involve training. Training costs cover items such as tuition, books, tools, transportation, and additional living expenses. According to the WCIRB, from policy year 1983 through policy year 1985, the first 18 months' costs increased by 76.2 percent for temporary disability, by 93.4 percent for evaluation, and by 70.1 percent for training. (See Chart 9.)

CHART 9

BENEFITS PAID AND RESERVED BY INSURANCE CARRIERS FOR VOCATIONAL REHABILITATION POLICY YEARS 1983 THROUGH 1985 (IN MILLIONS)



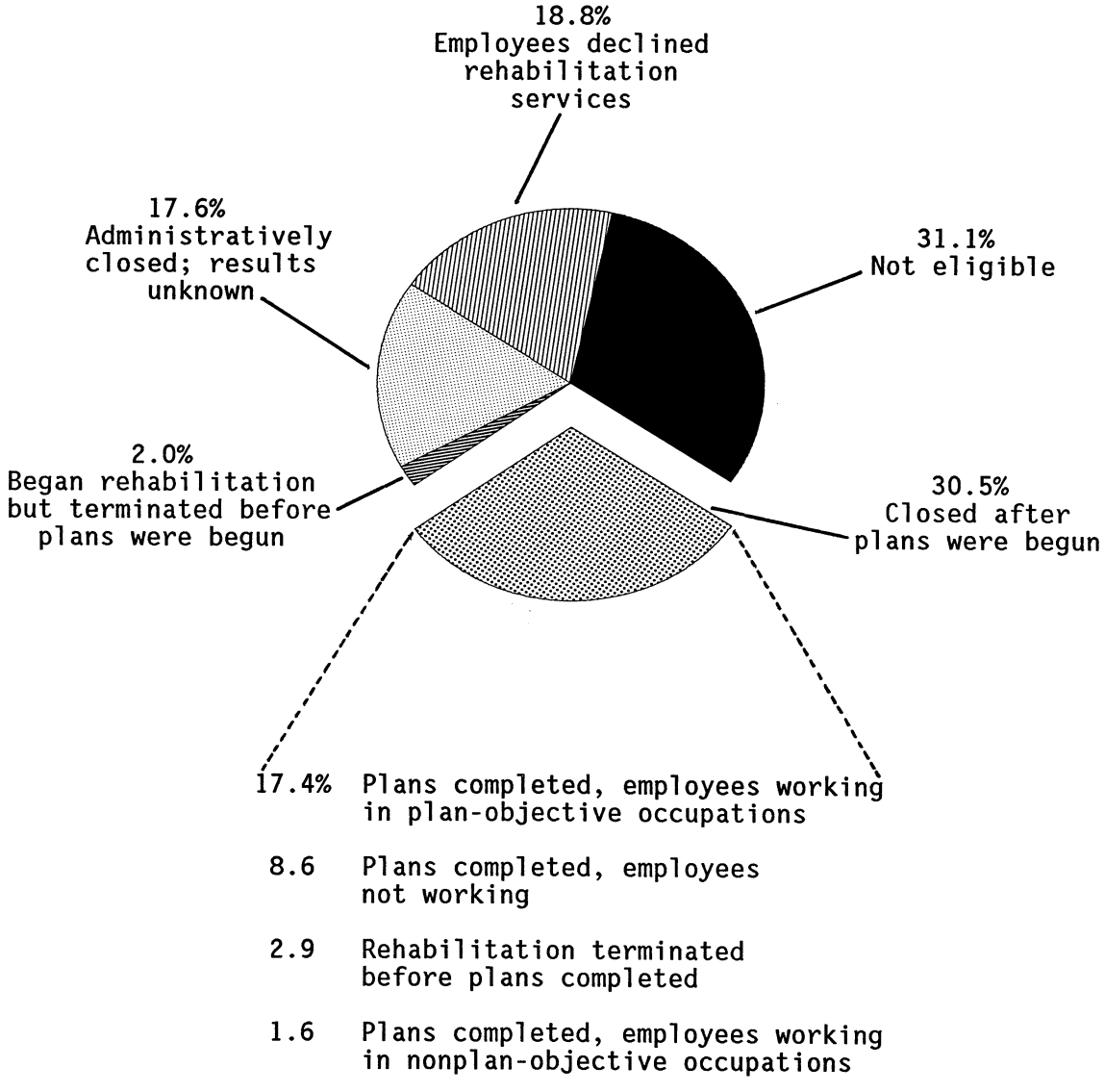
Source: Workers' Compensation Insurance Rating Bureau of California: Individual Case Report Summaries (18-month reports) for policy years 1983 through 1985.

Although rehabilitation benefits can include all of the costs listed above, not all employees for whom the rehabilitation bureau opens case files receive all rehabilitation benefits. For example, if vocational rehabilitation is not feasible for a particular employee, rehabilitation benefits will end before the employee participates in a rehabilitation plan. As Chart 10 shows, in over 50 percent of the rehabilitation cases closed in calendar year 1987, employees did not begin rehabilitation plans: 31.1 percent were not eligible,

18.8 percent declined services, and 2 percent began rehabilitation but did not begin plans. Records for the 17.6 percent of cases that were administratively closed did not indicate whether plans had been implemented. In some cases, employees begin a rehabilitation plan but do not complete it. This happened in 2.9 percent of the cases closed in calendar year 1987.

CHART 10

VOCATIONAL REHABILITATION CASES CLOSED IN CALENDAR YEAR 1987



Source: The Rehabilitation Bureau, Division of Industrial Accidents.

Benefits Paid and Reserved by Self-Insured Employers

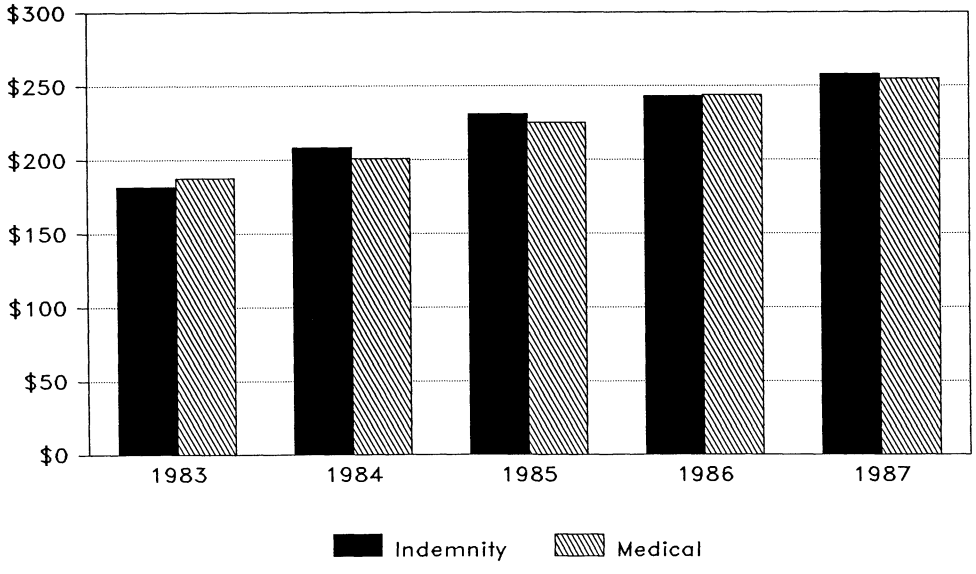
Section 3702.2 of the Labor Code requires all self-insured employers to submit an annual report in a form prescribed by the director of the Department of Industrial Relations. In addition, the California Code of Regulations, Title 8, Section 15251, states that, to continue to hold a certificate of consent to self-insure, every self-insured employer must submit an annual report. Each annual report, which includes data on indemnity and medical benefits paid and reserved, covers a three-year period. For example, the 1986 report includes data for 1984, 1985, and 1986; the 1987 report includes data for 1985, 1986, and 1987. Self-insured employers may adjust the data in subsequent reports to reflect additional benefits paid and reserved for a particular year. From 1984 through 1987, self-insured employers accounted for approximately 26 percent of benefits paid and reserved by insurance carriers and self-insured employers.

To accurately assess the trends in benefits paid and reserved by private, self-insured employers from calendar year 1983 through calendar year 1987, we analyzed data that were initially reported for each of the five years. Chart 11, which illustrates the results of this analysis, shows that indemnity and medical benefits paid and reserved steadily increased. In fact, indemnity benefits paid and reserved by private, self-insured employers from 1983 through 1987 went from $182 million to $258 million, an increase of 42 percent. During

the same period, medical benefits paid and reserved increased by 36 percent, going from $187 million to $255 million. Furthermore, even though the number of claims filed from 1983 through 1987 decreased by 6 percent, the average loss per claim rose by 51 percent for indemnity payments (from $915 to $1,383) and by 45 percent for medical payments (from $944 to $1,367).

CHART 11

ORIGINAL DATA REPORTED FOR INDEMNITY AND MEDICAL BENEFITS PAID AND RESERVED BY PRIVATE, SELF-INSURED EMPLOYERS CALENDAR YEARS 1983 THROUGH 1987 (IN MILLIONS)

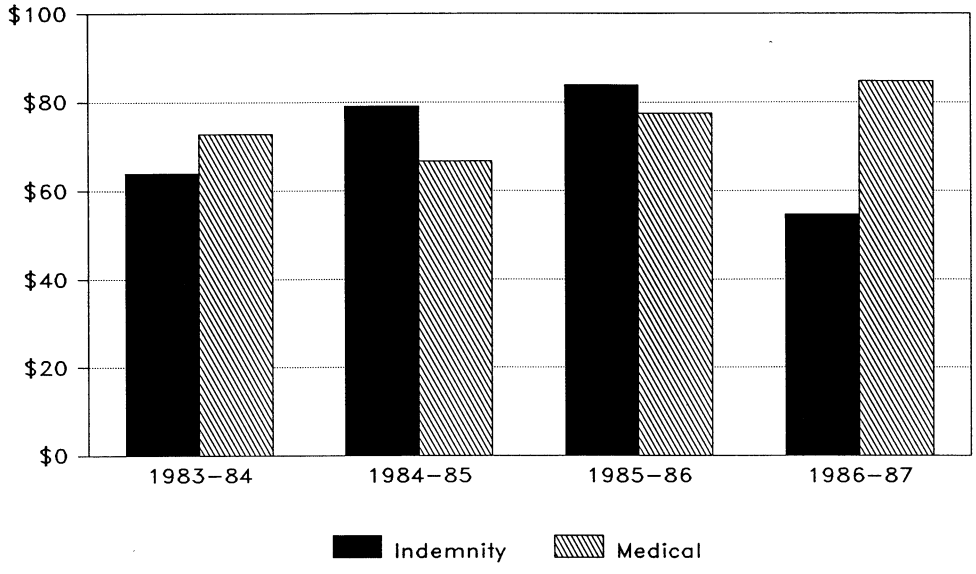


Source: Office of Self Insurance Plans, Department of Industrial Relations.

Like private, self-insured employers, public, self-insured employers submit annual reports to the director of the Department of Industrial Relations, and these reports contain data from the three previous fiscal years. However, the Office of Self Insurance Plans, within the Department of Industrial Relations, does not total the benefits paid and reserved by all of the public, self-insured employers. To make an assessment of the trends in benefits paid and reserved by the public, self-insured employers, we selected the five largest public, self-insured employers: the City of Los Angeles, the County of Los Angeles, the City and County of San Francisco, the Los Angeles Unified School District, and the Southern California Rapid Transit District. We analyzed the data they initially reported for each of the four fiscal years, as we did with the private, self-insured employers. As Chart 12 illustrates, indemnity benefits paid and reserved from fiscal year 1983-84 through fiscal year 1985-86 increased from $64 million to $84 million. From fiscal year 1985-86 through fiscal year 1986-87, the indemnity benefits paid and reserved decreased because four of the five public, self-insured employers paid less in benefits during that period than in previous years. However, we found no trend for the medical benefits paid and reserved by these five public, self-insured employers.

CHART 12

ORIGINAL DATA REPORTED FOR INDEMNITY AND MEDICAL BENEFITS PAID AND RESERVED BY FIVE PUBLIC, SELF-INSURED EMPLOYERS FISCAL YEARS 1983-84 THROUGH 1986-87 (IN MILLIONS)



Source: Office of Self Insurance Plans, Department of Industrial Relations.

Benefits Paid Through
Other Programs

From 1984 through 1987, approximately 4 percent of California's workers' compensation benefits were paid through programs administered either by the SCIF or through the Department of Industrial Relations. These programs, discussed in the introduction, cover certain employees, including those whose employers were uninsured,

disabled employees who suffer subsequent injuries, and employees who suffer asbestos-related disabilities.

Employees of the State of California who work for state agencies that do not purchase workers' compensation insurance from the SCIF are covered under a master agreement between the Department of General Services and the SCIF. From calendar year 1984 through calendar year 1987, the benefits that the SCIF paid to these state employees steadily increased. For example, as Table B-1 in Appendix B shows, in calendar year 1985, the SCIF paid $79.8 million in benefits to state employees; in 1987, the SCIF paid $100.7 million, a 26 percent increase. We could not determine if the upward trend correlated with the number of claims filed or with the costs-per-claim because the data for the number of claims filed was not available at the time we conducted our review.

According to an agreement required by Section 4381 of the Labor Code, the SCIF also pays benefits to disaster service workers who are injured while performing their duties. Through an agreement with the California Emergency Council, the SCIF adjusts and disposes of claims and provides compensation to disaster service workers and their dependents. As Table B-1 in Appendix B shows, from calendar year 1984 through calendar year 1987, the benefits that the SCIF paid to disaster service workers fluctuated. For example, from 1984 to 1985, the benefits the SCIF paid decreased from approximately $448,000 to

approximately $275,000. In calendar year 1986, the SCIF paid approximately $362,000 and, in 1987, over $774,000.

For those employees of the California Highway Patrol and the Department of Justice who receive benefits under Section 4800 of the Labor Code, Table B-1 in Appendix B shows that their benefits increased 15 percent from calendar year 1984 through calendar year 1985, from $5.2 million to $6.0 million. In 1986, the benefits paid decreased slightly to $5.8 million, and in 1987 they increased to over $6.6 million. We did not correlate the increase in benefits paid to the number of claims filed under this program or to the cost-per-claim because these data were not included in the annual reports we consulted (issued by the Department of General Services' Office of Insurance and Risk Management).

Another special program provides industrial disability leave and payments in lieu of temporary disability benefits to legislative employees and to state employees who are members of either the Public Employees' Retirement System or the State Teachers' Retirement System. As Table B-1 in Appendix B shows, from calendar year 1984 through calendar year 1987, the benefits paid to these employees steadily increased. We were not able to determine the correlation between this increase and the number of employees receiving these benefits because data on the number of employees were not available.

The Department of Industrial Relations provides benefits to employees through two funds: the Uninsured Employers' Fund and the Subsequent Injuries Fund. The Uninsured Employers' Fund pays benefits to injured employees who, at the time of their injury, were working for an uninsured employer. Until December 31, 1988, this fund also included the Asbestos Workers' Account, which provided benefits to employees who suffer from asbestosis. Table B-1 in Appendix B shows that the benefits paid from the Uninsured Employers' Fund steadily increased from calendar year 1984 to calendar year 1987. However, over the same period, the benefits paid from the Asbestos Workers' Account fluctuated.

Although the Division of Industrial Accidents within the Department of Industrial Relations is responsible for administering claims for subsequent injuries, the SCIF pays the benefits to the injured employees and is reimbursed by the State Controller's Office from the Subsequent Injuries Fund. Benefits paid from the Subsequent Injuries Fund fluctuated from calendar year 1984 through calendar year 1987. For example, from calendar year 1984 through calendar year 1985, the benefits paid decreased 7 percent, going from $4.2 million to $3.9 million. However, the benefits paid in 1986 and 1987 increased 9 percent and 7 percent, respectively, from the previous year's total. (See Appendix B, Table B-1.)

ADMINISTRATIVE COSTS INCURRED AND DIVIDENDS PAID

Insurance carriers incur various administrative costs to provide workers' compensation benefits. These costs include the following: loss adjustment expenses, which are the result of settling claims; commission and brokerage fees, which are incurred to market insurance policies; acquisition, supervision, and collection expenses, which relate to the preparation and sale of policies and the collection of premiums; general expenses for overhead; dividends, which are the premium portion returned to employers after the policy has expired; and federal and state taxes, licenses, and other fees. Table 1 summarizes the administrative expenses, taxes, and dividends reported to the WCIRB by insurance carriers, including the SCIF, for calendar years 1983 through 1987. As the table illustrates, these costs fluctuated widely with an overall increase from $876 million in 1983 to $1.39 billion in 1987 (58.6 percent).

TABLE 1

ADMINISTRATIVE EXPENSES, DIVIDENDS, AND TAXES
REPORTED BY WORKERS' COMPENSATION INSURANCE CARRIERS
CALENDAR YEARS 1983 THROUGH 1987
(REVISED)

	1983	1984	1985	1986	1987	Percent Change 1983 to 1984	1984 to 1985	1985 to 1986	1986 to 1987
Loss adjustment expenses incurred	$292,020,330	$346,568,345	$376,250,415	$ 462,409,722	$ 615,270,130	18.68	8.56	22.90	33.06
Commission and brokerage fees incurred	224,884,252	257,455,022	230,263,683	262,854,514	311,588,555	14.48	(10.56)	14.15	18.54
Other acquisition and collection expenses incurred	126,959,781	138,702,162	140,640,020	140,805,919	166,045,257	9.25	1.40	0.12	17.92
General expenses incurred	231,796,190	237,270,517	228,556,570	240,379,937	297,193,188	2.36	(3.67)	5.17	23.63
Total Expenses	$875,660,553	$979,996,046	$975,710,688	$1,106,450,092	$1,390,097,130	11.92	(0.44)	13.40	25.64
Dividends paid	$687,542,000	$728,532,000	$768,291,000	$ 666,988,000	$ 756,297,000	5.96	5.46	(13.19)	13.39
Federal and state taxes[a]	-- [b]	-- [b]	$113,809,130	$ 58,106,309	$ 133,950,564	--	--	(48.94)	130.53

Sources: The Workers' Compensation Insurance Rating Bureau of California and the Department of Insurance.

[a] Includes licenses and fees incurred.

[b] All 1983 and 1984 data omitted because data were available only for California carriers.

According to the manager of the Office of Self Insurance Plans, private, self-insured employers are not required to report their administrative costs to the director of the Department of Industrial Relations. However, in 1987, Section 3701 of the Labor Code was amended to require private, self-insured employers to submit 10 percent of their estimated future liabilities to cover administrative and legal costs. By calculating 10 percent of the total estimated future liabilities for private, self-insured employers, we estimated that their administrative and legal costs were approximately $132 million in calendar year 1987.

Administrative Costs Incurred
by the State of California

The Division of Industrial Accidents also incurs costs to administer and enforce the workers' compensation laws. From calendar year 1985 through calendar year 1987, these costs increased by 12.5 percent, from $40 million to $45 million. For example, the cost of administering the self-insurance program increased from approximately $590,000 to over $1.3 million. Similarly, the cost of administering the Workers' Compensation Appeals Board increased from $26 million to over $29 million.

In addition, the State pays the SCIF service charges to process claims for subsequent injuries, for disaster service workers, and for state employees covered by the master agreement with the

Department of General Services. To process claims for subsequent injuries, the SCIF may charge the Department of Industrial Relations a service charge of up to 5 percent. In calendar year 1984, this charge totaled approximately $212,000; in calendar year 1987, the SCIF charged approximately $233,000 to process these claims. To process claims for disaster service workers, the SCIF may assess the State a service charge of up to 12.5 percent. In calendar year 1984, the SCIF charged approximately $56,000; in calendar year 1987, the SCIF charged approximately $102,000. These service charges have increased because the benefits paid for subsequent injuries and for disaster service workers increased from calendar year 1984 through calendar year 1987.

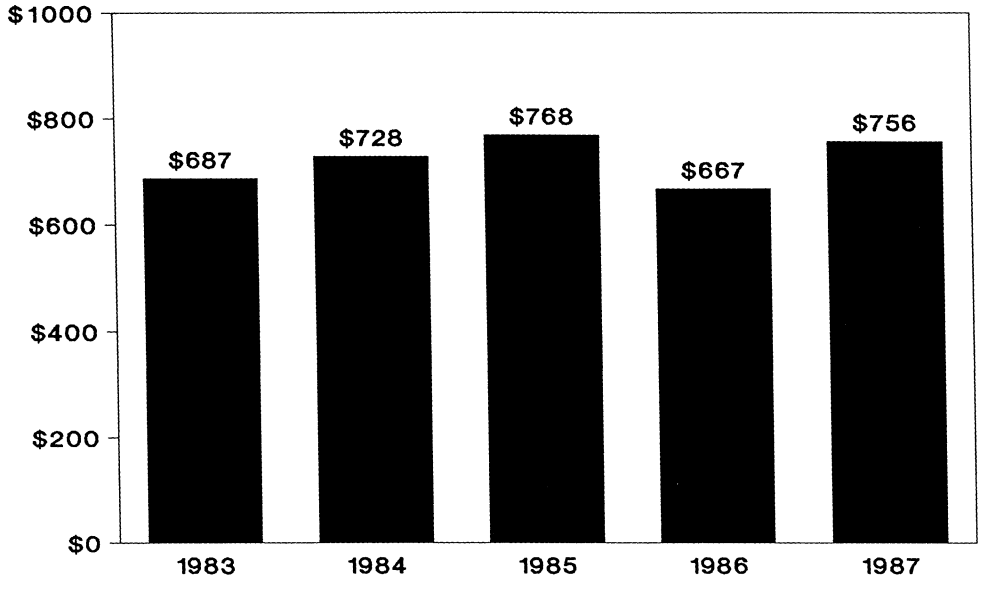
Finally, the SCIF charges state agencies a service charge equivalent to the actual costs it incurs to process claims for injured state employees who are covered by the master agreement between the SCIF and the Department of General Services. In calendar year 1984, the SCIF charged approximately $9.2 million and, in 1987, $13.3 million. Like benefits paid for subsequent injuries and disaster service workers, benefits paid to state employees steadily increased from calendar year 1984 through calendar year 1987. See Appendix B, Table B-1, for benefits paid to state employees.

Dividends Paid

Dividends may be paid to certain employers after their insurance policies expire. Insurance carriers may pay dividends when the premiums they have collected in a calendar year exceed the losses and expenses paid out during that year. From calendar year 1983 through calendar year 1987, there was an overall increase in dividends paid by insurance carriers from $687 million to $756 million. (See Chart 13.) However, assuming that dividends are paid two years after the policy expires, we determined that the dividends paid as a percentage of premiums earned decreased from 23.19 percent for premiums earned in 1983 to 17.48 percent for premiums earned in 1985. (See Chart 14.)

CHART 13

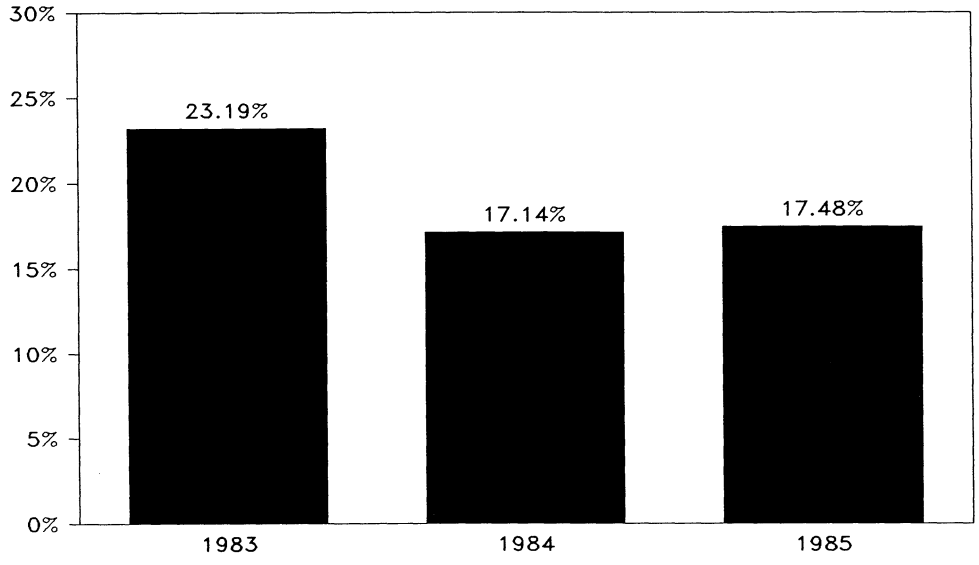
DIVIDENDS PAID OR CREDITED TO POLICYHOLDERS BY INSURANCE CARRIERS CALENDAR YEARS 1983 THROUGH 1987 (IN MILLIONS)



Source: Page 14 of the insurance carriers' annual reports submitted to the Department of Insurance for calendar years 1983 through 1987.

CHART 14

DIVIDENDS PAID OR CREDITED TO POLICY HOLDERS AS A PERCENTAGE OF PREMIUMS EARNED BY INSURANCE CARRIERS CALENDAR YEARS 1983 THROUGH 1985



Source: Page 14 of the insurance carriers' annual reports submitted to the Department of Insurance for calendar years 1983 through 1987.

II

VOCATIONAL REHABILITATION PLANS

Although the number of employees who completed vocational rehabilitation plans increased substantially from 1983 through 1987, the relative success of these employees finding jobs after completing their plans increased only slightly. This, in part, resulted from employees most frequently choosing the rehabilitation plans that were the least successful in returning them to work. For example, 149 of the 226 employees in our sample participated in schooling plans; however, at the end of rehabilitation, only 92 (61.7 percent) were working, the smallest ratio among all the plans.

The two vocational rehabilitation programs that were the most successful involved either a modified job or an alternative job with the same employer. These plans were among the least expensive and resulted in better earning capacity at the end of rehabilitation. Only 20 of our sample of 226 employees chose one of these two plans, and all 20 were employed at the end of their rehabilitation. The other three vocational rehabilitation plans--direct placement, on-the-job training, and self-employment--had varying degrees of success.

According to the California Code of Regulations, employees qualify for vocational rehabilitation if the effects of injury permanently prevent them, or are likely to prevent them, from working in their usual occupations or from keeping the positions they held at

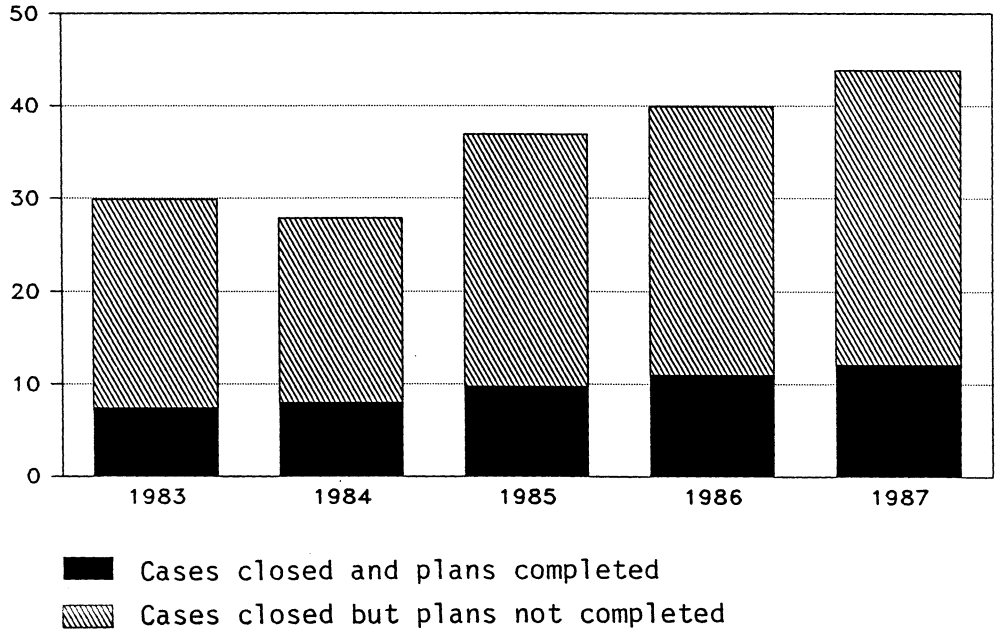
the time of injury and if the employees can reasonably be expected to return to suitable employment if vocational rehabilitation is provided. The Labor Code, Section 139.5, established the Rehabilitation Bureau (bureau) within the Department of Industrial Accidents to foster, review, and approve rehabilitation plans; to adopt rules and regulations that facilitate the identification and notification of industrially injured employees and their referral to rehabilitation services; and to coordinate and enforce the implementation of rehabilitation plans. Rules and regulations governing the bureau appear in the California Code of Regulations, Title 8, Section 10001.

ANALYSIS OF A SAMPLE OF CASES CLOSED IN 1987

In each calendar year from 1983 through 1987, fewer than 30 percent of the employees whose cases closed had completed rehabilitation plans. As Chart 15 illustrates, 7,394 employees completed plans in 1983, compared to 12,116 in 1987. Although the number of employees completing plans increased by 64 percent during this period, the proportion of employees employed after completing their plans increased only slightly, from 67.6 percent to 68.8 percent. As Chart 16 illustrates, 5,001 of the 7,394 employees who completed plans in 1983 were employed at the end of their rehabilitation plan; in 1987, 8,335 of the 12,116 employees who completed plans were employed at the end of their plan.

CHART 15

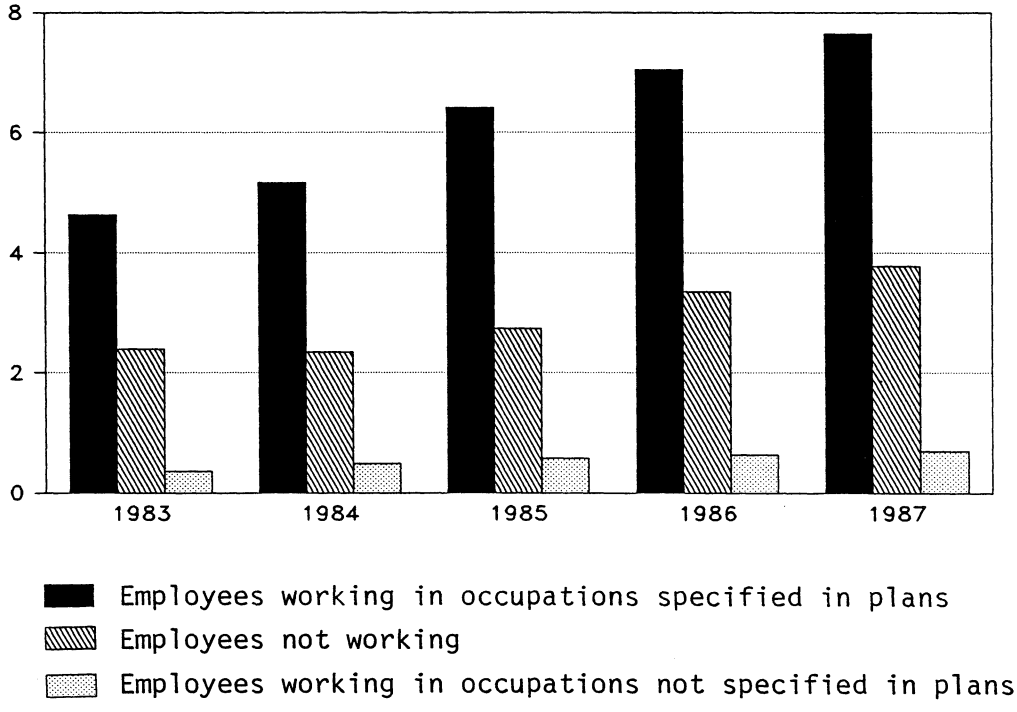
VOCATIONAL REHABILITATION CASES CLOSED AND PLANS COMPLETED CALENDAR YEARS 1983 THROUGH 1987 (IN THOUSANDS)



Source: The Rehabilitation Bureau, Division of Industrial Accidents.

CHART 16

WORK STATUS OF EMPLOYEES WITH VOCATIONAL REHABILITATION PLANS COMPLETED CALENDAR YEARS 1983 THROUGH 1987 (IN THOUSANDS)



Source: The Rehabilitation Bureau, Division of Industrial Accidents.

There are six types of vocational rehabilitation plans. Those involving an alternative job or modified job duties with the same employer provide a substantially similar job in a substantially similar workplace. Direct placement plans involve transferring the employee's existing job skills to a new workplace. Plans specifying on-the-job training or schooling provide employees with new skills to allow them to move to a new occupation. The final plan involves self-employment,

which may be used only after all other reasonable vocational alternatives have been explored. The employee, the employer, and a vocational rehabilitation professional are all involved in selecting the type of plan the employee will follow.

According to the California Code of Regulations, Title 8, Section 10012, effective July 1, 1988, some types of rehabilitation plans are preferable to others. The code states that rehabilitation plans that use an employee's transferable skills for an alternative job, for a modified job with the same employer, or for direct placement with a similar employer and that provide similar wages, hours, and working conditions to those at the time of injury are preferable to plans that provide training for an occupation for which the employee has no skills or experience. In addition, this code section specifies that employers should give preference to plans that speed the employee's return to work over plans of otherwise equal merit.

To determine the effect of certain factors on the success of vocational rehabilitation, we reviewed the bureau's records for 226 cases closed in 1987. We randomly selected this sample from among cases in which employees had completed their rehabilitation plans. We calculated the percentage of these employees working at the end of rehabilitation and compared their earnings to the wages they were earning before becoming disabled. Although the bureau closed all of the cases in our sample in 1987, employees were injured as long ago as

July 1978, and the bureau opened these cases as long ago as October 1978. As a result, we adjusted our calculations to reflect the change in average wages earned in California from the time the injuries occurred to the time the bureau closed the cases.

Rehabilitation Plans and the Success of Rehabilitation

In our sample of 226 cases closed in 1987, different types of rehabilitation plans varied in the rate at which injured employees returned to work and in the percentage of pre-injury wages they earned at the end of their rehabilitation. The employees in our sample participated in all six types of rehabilitation plans.

As Table 2 shows, the types of plans that employees chose most frequently were the least successful in returning the employees to work. For example, 149 (65.9 percent) of the 226 employees in our sample participated in schooling plans. However, at the end of rehabilitation, only 92 (61.7 percent) of those 149 employees were working, the smallest ratio among the six plans. The group of employees representing the second smallest percentage of employees working was the group participating in the second most frequently chosen type of rehabilitation plan: direct placement. In fact, the three types of plans for which the highest proportion of employees were working at the end of their rehabilitation were the ones least frequently chosen: an alternative job with the same employer, a

modified job, and self-employment. All of the employees who participated in these types of plans were working at the end of their rehabilitation.

TABLE 2

EMPLOYEES WORKING AFTER COMPLETING A REHABILITATION PLAN SAMPLE OF 226 CASES CLOSED IN 1987

Plan Type	Total Number of Employees	Percentage of Sample	Number of Employees Working	Percentage Working
Alternative job with same employer	13	5.8%	13	100.0%
Direct placement	37	16.4	30	81.1
Modified job	7	3.1	7	100.0
On-the-job training	19	8.4	17	89.5
Schooling	149	65.9	92	61.7
Self-employment	1	0.4	1	100.0
Total	226	100.0%	160	70.8%

To determine which plans resulted in better earning capacity, we compared working employees' wages at the end of their rehabilitation to the wages they earned before they were injured, adjusted for changes in California's average wage from injury to case closure. However, we were able to obtain both pre-injury and post-rehabilitation wages for only 136 of the 160 employees who were working at the end of

their rehabilitation. As Table 3 shows, 19.9 percent of the 136 employees earned as much as, or more than, they did before they were injured. On the average, the 136 employees earned 76.9 percent of their pre-injury wages.

TABLE 3

PRE-INJURY WAGES COMPARED TO POST-REHABILITATION WAGES SAMPLE OF 226 CASES CLOSED IN 1987

Plan Type	Total Number of Employees[a]	Percentage of Sample	Percentage Earning at or Above Pre-Injury Wages	Average Percentage of Pre-Injury Wages Earned[b]
Alternative job with same employer	13	9.6%	7.7%	86.7%
Direct placement	25	18.4	16.0	72.5
Modified job	7	5.1	28.6	93.0
On-the-job training	17	12.5	17.6	69.3
Schooling	73	53.7	23.3	77.0
Self-employment	1	0.7	0.0	63.1
Total	136	100.0%	19.9%	76.9%

[a] These are employees who were working at the end of rehabilitation and for whom we could determine pre-injury wages and post-rehabilitation wages.

[b] Adjusted to reflect the change in California's average wages from injury to case closure.

Employees who participated in plans that involved a modified job or an alternative job with the same employer earned on the average a higher percentage of their pre-injury wages than employees in other plans. The 7 working employees whose plans involved a modified job earned an average of 93.0 percent of their pre-injury wages. In addition, 2 of these employees earned at least as much as their pre-injury wages. Alternative jobs with the same employer resulted in the second best earning capacity: these 13 employees earned an average of 86.7 percent of their pre-injury wages. However, only one of the 13 employees earned at least as much after completing rehabilitation as at the time of injury.

Although schooling plans produced the smallest percentage of working employees at the end of their rehabilitation, 17 of those 73 employees who were working earned at least as much as they had been earning when they were injured. On the average, these employees earned 77.0 percent of their pre-injury wages at the end of their rehabilitation. Moreover, 2 of these employees earned more than twice as much as their pre-injury wages after they completed rehabilitation.

The type of rehabilitation plan that produced the worst earning capacity at the end of rehabilitation was self-employment. However, only one employee in our sample participated in this type of plan; that individual earned only 63.1 percent of his pre-injury wages at the end of rehabilitation.

Costs of Vocational Rehabilitation Plans

In a 1983 report, the California Workers' Compensation Institute (CWCI), a nonprofit research association, reported that vocational rehabilitation plans for modified jobs or alternative jobs with the same employer were the least expensive and took the least amount of time and that schooling plans were the most expensive and took the greatest amount of time. According to the report, rehabilitation plans in general ranged from under 100 days for modified or alternative work plans to 226 days for schooling plans. In 1985, the CWCI reported that plans for a modified job with the same employer averaged 164 days, that plans for an alternative job with the same employer averaged 112 days, and that schooling plans averaged 252 days. The CWCI also reported that average costs for rehabilitation plans ranged from $2,081 for modified jobs with the same employer to $18,386 for schooling plans.

Since the information was not in case files, we could not determine the actual cost of the rehabilitation plans in our sample. However, we were able to measure the time from the beginning of the rehabilitation plans to the end of rehabilitation services. Because employees receive temporary disability benefits during vocational rehabilitation, the longer a plan takes, the higher the cost for temporary disability benefits will be. According to the CWCI, temporary disability benefits account for approximately one-half of the cost of rehabilitation.

Table 4 summarizes the average cost in temporary disability benefits for employees in our sample who completed different rehabilitation plans. The cost for a schooling plan of average length, the longest of the six plans in our sample, was 92 percent higher than the cost for an alternative job plan of average length.

TABLE 4

AVERAGE COST OF TEMPORARY DISABILITY BENEFITS FOR EMPLOYEES IN DIFFERENT PLANS SAMPLE OF 226 CASES CLOSED IN 1987

Plan Type	Number of Employees[a]	Average Number of Days	Benefits Paid at Maximum Rate of $224/Week
Alternative job with same employer	12	203	$ 6,496
Direct placement	37	250	$ 7,997
Modified job	7	269	$ 8,602
On-the-job training	19	281	$ 8,982
Schooling	147	390	$12,477
Self-employment	1	290	$ 9,274

[a] For three employees in our sample, data were unavailable.

In our sample, two of the three rehabilitation plans that took the least amount of time, alternative jobs and modified job duties, seemed to be most successful. The largest proportion of employees who were working at the end of their rehabilitation chose one of these

plans, and they were earning the largest percentage of pre-injury wages.

As we pointed out earlier in the report, employers other than the State may either purchase workers' compensation insurance or self-insure. Self-insured employers pay for the actual cost of workers' compensation benefits, including vocational rehabilitation. Assuming that self-insured employers may be more inclined to promote types of rehabilitation plans that take less time and are, therefore, less expensive, we compared the types of plans in which employees of insured employers participated to those in which employees of self-insured employers participated. In our sample, we found no significant difference between insured and self-insured employers in the proportion of employees participating in the three shorter plans. Specifically, 25.6 percent of the employees who worked for insured employers participated in plans for alternative jobs with the same employer, modified jobs, or direct placement, and 25.4 percent of the employees who worked for self-insured employers participated in those types of plans.

Identification of the
Need for Rehabilitation

Regulations covering the vocational rehabilitation cases in our sample required employers to report employees' disability status to the bureau as soon as the employers determined that the employees were

unlikely to be able to return to their occupations or immediately following 180 days of total disability. Since July 1, 1988, regulations no longer require employers to notify the bureau that rehabilitation services may be necessary.

Employers may have identified employees as rehabilitation candidates before notifying the bureau; however, notifying the bureau was the most commonly available indicator in the bureau's files of when candidates were identified. Therefore, in the analysis that follows, references to notification dates represent the earliest identification date we could ascertain.

Employers in our sample notified the bureau as early as 62 days and as late as over six years after their employees' injuries; the average length of time between injury and notification was 550 days. In 16 (7.1 percent) of the 226 cases in our sample, employers did not notify the bureau that employees required vocational rehabilitation. Employees in our sample who were identified as candidates for rehabilitation less than six months from the date of injury were generally more successful in returning to work. However, the percentage of employees working did not always decrease the longer employers took to notify the bureau.

Table 5 shows the time employers took to notify the bureau and the proportion of employees working after rehabilitation.

TABLE 5

TIME TAKEN TO NOTIFY THE BUREAU AND THE PROPORTION OF EMPLOYEES WORKING AFTER REHABILITATION SAMPLE OF 226 CASES CLOSED IN 1987

Time Elapsed Between Injury and Bureau Notification	Total Number of Employees	Percentage of Sample	Number Working	Percentage Working
Less than 6 months	27	11.9	23	85.2
6 months to less than 12 months	66	29.2	43	65.2
12 months to less than 18 months	44	19.5	35	79.5
18 months to less than 24 months	26	11.5	20	76.9
24 months to less than 30 months	9	4.0	5	55.6
30 months to less than 36 months	14	6.2	9	64.3
36 months or more	24	10.6	18	75.0
Not notified	16	7.1%	7	43.8%
Total	226	100.0%	160	70.8%

Approval of Plans

The California Code of Regulations, Title 8, Chapter 4.5, Article 12, Section 10006, in effect during the time of the rehabilitation cases in our sample, required employers to develop plans for rehabilitation and to submit the plans to the bureau before

implementing them. The same section specified that the bureau would approve or disapprove plans within 30 days after receiving them. However, if the bureau did not approve a plan within 30 days, a properly documented plan to which no one had objected would be deemed approved.

We were able to determine whether employers submitted plans before implementation for 222 of the 226 cases in our sample. In only 23 (10.4 percent) of the 222 cases did employers submit plans to the bureau before implementing them. Furthermore, the bureau approved only 5 plans before they were implemented.

A smaller proportion of employees whose employers submitted plans to the bureau before they were implemented were working at the end of rehabilitation than other employees. Specifically, 140 (71.8 percent) of the 195 employees whose employers submitted plans late were working at the end of rehabilitation, while only 14 (60.9 percent) of the 23 employees whose employers submitted plans early were working at the end of rehabilitation. Three (60.0 percent) of the 5 employees whose plans the bureau pre-approved were working at the end of their rehabilitation.

Employers must submit most types of plans to the bureau within 15 days after the employer and the employee have agreed to a plan. However, the new regulations for vocational rehabilitation specify that employers need not submit a plan to the bureau for a modified or an

alternative job with the same employer until after the employee completes the plan, as long as the employee has agreed to the plan. The new rules have essentially the same provisions regarding the bureau's approval of plans within 30 days after receiving them. However, they do not specifically require employers to submit plans to the bureau before employees begin the plans.

Twenty of the employees in our sample participated in alternative job or modified job plans. We were unable to determine when one employee began an alternative job plan; however, none of the other 19 employers in our sample submitted alternative job plans or modified job plans before employees started the plans. In fact, employers submitted these types of plans an average of 117 days after employees started the plans. Nevertheless, all of the employees who participated in these plans were working after rehabilitation.

Of the 176 employees whose employers submitted late direct placement, on-the-job training, schooling, and self-employment plans to the bureau, 121 (68.8 percent) were working at the end of rehabilitation. As pointed out earlier, only 60.9 percent of the employees whose employers submitted plans early were working at the end of rehabilitation.

Temporary Disability Benefits
Paid to Employees in Our Sample

As stated earlier, employees are entitled to temporary disability payments while they are in vocational rehabilitation. Temporary total disability payments equal two-thirds of an employee's weekly wages at the time of injury, subject to minimum and maximum weekly benefits established by law. Temporary partial disability payments--made to employees who obtain some type of work despite their disabilities--equal two-thirds of the difference between earnings on the new job and earnings at the time of injury. The current minimum and maximum benefits established for injuries occurring on or after January 1, 1984, are $112 per week and $224 per week, respectively. According to the Labor Code, Section 4453.5, benefits payable for an injury are to be based on the amounts stipulated by the law in effect at the time of injury. However, Section 4661.5 of the same code stipulates that when any temporary total disability payment is made two years or more from the date of injury, the amount of the payment must reflect the amounts specified in the law in effect on the date that each payment is made.

We were able to determine the employees' wages at the time of injury for 221 of the 226 employees in our sample. At the time of their injuries, 53.9 percent of these employees qualified for maximum benefits, 6.3 percent qualified for minimum benefits, and 39.8 percent qualified for benefits that were between minimum and maximum benefits.

III

LITIGATING WORKERS' COMPENSATION CLAIMS

If an employee, employer, or insurance carrier disputes a claim for workers' compensation benefits, the parties may litigate the claim before the Workers' Compensation Appeals Board (WCAB), a state court that hears and decides litigated claims for workers' compensation benefits. Most claims for workers' compensation are settled without litigation by the parties. We could not determine the exact number of work-related injuries incurred by the more than 11 million California workers employed in 1985 because the injuries are reported for noncomparable time-periods depending on the type of coverage. We do know, however, that workers' compensation insurance carriers, including the State Compensation Insurance Fund (SCIF), reported approximately 855,000 claims for work-related injuries for policies that began in 1985. Also, private, self-insured employers filed approximately 180,000 claims in calendar year 1985, and employees of public, self-insured employers filed an estimated 162,000 claims for fiscal year 1985-86. While these nearly 1.2 million claims filed by these employees cannot be directly compared because of the differences between policy, calendar, and fiscal years, we found that the WCAB received only 175,000 claims for litigation during calendar year 1985.

We reviewed a random sample of claims filed with the WCAB during 1985, 1986, and 1987 and determined the disposition of the claims as of December 1, 1988. In our sample, the parties had resolved

77 percent of the claims opened in 1985. Of those claims resolved, parties most frequently used compromise and release agreements and stipulations, which are settlement agreements between the parties, to resolve workers' compensation claims filed in 1985. Of the claims resolved, 87 percent had been settled with compromise and release agreements or stipulations. The remaining 13 percent were resolved with findings and awards, findings and orders, or orders of dismissal. As of December 1, 1988, the parties had resolved 77 percent of the claims opened in our 1985 sample.

THE ROLE OF THE WCAB IN LITIGATION

The WCAB is a unit of the Department of Industrial Relations and consists of seven members who are appointed by the governor. It maintains 22 district offices statewide with 122 judges. The Labor Code vests judicial powers in the WCAB, including the authority to hear and decide litigated claims for benefits.

The WCAB does not become involved unless a party files an opening document with the WCAB to have some disputed issue resolved. Once an opening document is filed, the WCAB may conduct hearings and issue orders either approving or denying workers' compensation benefits. The parties filed approximately 175,000 opening documents in calendar year 1985. As of December 1, 1988, the parties had resolved 77 percent of these claims at the WCAB. The remaining 23 percent of the claims are pending.

FILING CLAIMS AT THE WCAB

Any of the parties affected by a work-related injury, including employees, employers, insurance carriers, and lien claimants, may file a claim at the WCAB. However, employees file most claims. An employee includes a person who performs a service for another under any appointment or contract of hire or apprenticeship, whether expressed or implied, whether oral or written, or whether lawfully or unlawfully employed. In our random sample of claims filed from 1985 through 1987, employees filed over 90 percent of the claims. We selected our random sample from 175,000 claims opened in calendar year 1985, 187,000 in calendar year 1986, and 187,000 in calendar year 1987.

As we noted in the scope and methodology section, we looked at claims filed at the WCAB in 1985, 1986, and 1987 and the activity on those claims through December 1, 1988. The claims filed in 1985 covered as many as 47 months, those filed in 1986 covered as many as 35 months, and those filed in 1987 covered as many as 23 months. Because the number of months differs among the years reviewed, the data from these years are not always comparable. When the data are not comparable, we present the statistics from our 1985 sample only.

In our random sample of claims filed from 1985 through 1987, employers and their insurance carriers filed only a small percentage of claims with the WCAB. An employer is any person or entity engaging the services of another person and may include individual employers,

partnerships, or corporations. Also included in this definition are the State and every state agency, all counties, cities, and public and quasi-public corporations and agencies.

In our random sample, lien claimants rarely filed claims with the WCAB. Lien claimants, who cannot be employees, employers, or insurance carriers, seek payment for services performed on behalf of the employees or reimbursements for assistance provided to the employees. Services include medical and hospital care, and reimbursements include assistance for temporary disability payments from the Employment Development Department.

Table 6 shows which party filed a claim at the WCAB in our random sample of claims filed from 1985 through 1987.

TABLE 6

PARTY FILING A CLAIM AT THE WCAB
1985 THROUGH 1987

	Percentage of Claims Filed[a]		
	1985	1986	1987
Employee	96%	92%	96%
Employer/insurance carrier	8	8	8
Lien claimant	0	1	1
Other	1	2	0

[a] These percentages exceed 100 percent because some claims were filed by more than one party.

Types of Opening Documents
Filed at the WCAB

To file a claim at the WCAB, the filing party must submit an opening document. Opening documents for new claims include applications for adjudication, original compromise and release agreements, or original stipulations.

Applications for adjudication are the most commonly used opening documents filed at the WCAB. A form completed by the filing party, the application should list the material facts in dispute, including which body part was injured and what workers' compensation benefits the employee seeks. In our random sample, the parties opened claims with applications for adjudication in approximately 90 percent of the claims filed from 1985 through 1987.

When a claim is filed with an original compromise and release agreement, the parties agree to settle any and all injury claims for a lump sum of money. However, the agreement is not binding on the parties unless approved by a judge at the WCAB. This type of opening document must include the date of the injury, nature of the disability, and benefits paid or due. In our random sample of claims filed from 1985 through 1987, the parties used compromise and release agreements for opening approximately 5 percent of the claims.

The third type of opening document, an original stipulation, is an agreement among the parties that the employer will pay the employee temporary or permanent disability benefits each week for a specified time. Further, the parties agree on the need for future medical treatment. Like an original compromise and release agreement, an original stipulation is not binding on the parties unless a WCAB judge approves it. Unlike an original compromise and release agreement, an original stipulation may be reopened for litigation at a later date. The parties filed stipulations as opening documents for approximately 5 percent of our random sample of claims filed from 1985 through 1987.

Table 7 presents the percentages of opening documents filed at the WCAB in our random sample of claims filed in 1985, 1986, and 1987.

TABLE 7

OPENING DOCUMENTS FILED AT THE WCAB
1985 THROUGH 1987

	Percentage of Claims Filed		
	1985	1986	1987
Application for adjudication	91%	89%	90%
Compromise and release agreement	4	5	7
Stipulation	5	6	3

Workers' Compensation Coverage for Claims Litigated at the WCAB

Of the insurance carriers who represented employers in our random sample of 1985 claims, private insurance companies were involved in 59 percent of the claims litigated at the WCAB while the SCIF was involved in 11 percent of the claims. Self-insured programs by private-sector employers represented 19 percent, and governmental agencies represented 11 percent. Finally, illegally uninsured employers accounted for one percent of the 1985 claims. Table 8 presents the percentages of providers of workers' compensation coverage for claims in our random sample.

TABLE 8

WORKERS' COMPENSATION COVERAGE IN LITIGATED CLAIMS FILED 1985 THROUGH 1987

	Percentage of Claims Filed[a]		
	1985	1986	1987
Private insurance companies	59%	56%	59%
SCIF	11	17	17
Self-insured programs by private-sector employers	19	15	13
Self-insured program by governmental agencies	11	10	8
Illegally uninsured employers	1	3	2
Unknown	0	0	2

[a] These percentages exceed 100 percent because employees may be covered by more than one type of workers' compensation coverage.

As Table 8 shows, the involvement of self-insured programs in litigation has decreased from 30 percent in 1985 to 21 percent in 1987. In contrast, the SCIF's involvement has increased from 11 percent in 1985 to 17 percent in 1987. The SCIF's involvement has increased, in part, because its share of the insurance market for workers' compensation has increased from almost 17 percent in 1985 to over 23 percent in 1987.

Work-Related Injuries

According to Section 3208 of the Labor Code, a work-related injury is any injury or disease arising out of employment. This definition includes trauma to the body, such as blows, falls, cuts, twists, or strains that result in physical damage to the body. It also includes traumatic neurosis, hysteria, or other medical conditions resulting from a physical injury, shock, or emotional experience. In addition, injuries include contracting or developing a disease or aggravating a pre-existing disease or condition.

Specific and Cumulative Injuries

Injuries may be either specific or cumulative. A specific injury results from one incident or exposure that causes a disability or need for medical treatment. For example, an injury caused by a fall from a roof would be a specific injury. In contrast, a cumulative injury results from mentally or physically traumatic activities that are repeated over a period of time, causing a disability or need for medical treatment. For example, the inflammation of a carpet-layer's knees from constant kneeling would be a cumulative injury.

In our random sample of claims filed, employees had incurred more specific injuries than cumulative injuries. For example, for claims filed in 1987, employees claimed specific injuries in 70 percent of the claims and cumulative injuries in the remaining 30 percent.

Table 9 compares incidences of specific and cumulative injuries claimed by employees in our random sample for the three years from 1985 through 1987.

TABLE 9

SPECIFIC AND CUMULATIVE INJURIES
CLAIMS FILED 1985 THROUGH 1987

	Percentage of Claims Filed		
	1985	1986	1987
Specific	75%	77%	70%
Cumulative	25	23	30

When a workers' compensation claim is filed at the WCAB, the claimant must indicate in the opening document which parts of the body are injured. The filing party may claim injury to one or more parts of the employee's body. Table 10 shows which parts of the body were claimed as injured in the opening documents filed in 1985, 1986, and 1987 in our random sample.

TABLE 10

INJURIES CLAIMED IN OPENING DOCUMENTS FILED 1985 THROUGH 1987

	Percentage of Claims Filed		
	1985	1986	1987
Back	55%	46%	46%
Lower extremities	25	27	29
Upper extremities	25	26	28
Other torso	18	15	17
Emotional and psychological	15	12	16
Neck	14	18	14
Shoulders	12	10	14
Head	11	19	15

As Table 10 shows, the most common injury was to employees' backs. In our random sample of claims filed, injuries to an employee's back only, with no other part of the body injured, accounted for approximately 20 percent of the claims filed at the WCAB from 1985 through 1987. Back injuries were also involved in approximately 30 percent of the multiple-injury claims filed from 1985 through 1987. Employees claimed that most back injuries occurred from specific injuries rather than cumulative injuries for claims filed from 1985 through 1987. For example, specific back injuries accounted for 86 percent of all back injuries for 1985 claims.

Emotional and Psychological Injuries

As shown in Table 10, emotional and psychological injuries were involved in 15 percent of the claims filed in 1985, in 12 percent of those claims filed in 1986, and in 16 percent of those filed in 1987. Further, employees claimed that most emotional and psychological injuries occurred from cumulative injuries rather than specific injuries for claims filed from 1985 through 1987. Cumulative injuries accounted for 71 percent of the emotional and psychological injuries for 1985 claims. For example, in a claim filed in 1985, an employee claimed that repetitive occupational stresses caused cumulative emotional and low-back injuries.

Filing parties claimed emotional and psychological injuries, with no other parts of the body injured, in 3 percent of the opening documents filed in 1985, in 3 percent filed in 1986, and in 6 percent filed in 1987. In an example of a psychological injury, a utility company employee claimed a work-related psychological injury because of harassment and the stress and strain of the job. In another example, an employee claimed emotional distress because of employer harassment following a work injury.

THE HEARING PROCESS AT THE WCAB

After receiving an opening application, the WCAB assigns the claim a case number; it will not take action on the claim until one of the parties files a declaration of readiness to proceed (declaration). However, declarations are not always required when a claim is resolved with a compromise and release agreement or a stipulation. After receiving the declaration, the WCAB notifies the other parties that a declaration has been filed.

Declarations of Readiness To Proceed

When a party files a declaration, the party is stating, under penalty of perjury, that the filing party is ready to proceed with the claim and requests a hearing before the WCAB. The declaration states that the filing party has attempted to resolve the claim with the other parties. In addition, the filing party lists the principal issues in dispute. In our random sample of claims filed from 1985 through 1987, the most frequently disputed issue was the existence and extent of a permanent disability. Disputed issues may include temporary disability, the compensation rate to be paid, the payment for self-procured medical treatment, the need for future medical treatment, and other issues. Table 11 lists the principal issues in dispute and

the frequency with which the parties have disputed them as of December 1, 1988, for claims filed from 1985 through 1987 in our random sample.

TABLE 11

PRINCIPAL DISPUTED ISSUES AS STATED ON DECLARATIONS AS OF DECEMBER 1, 1988 CLAIMS FILED 1985 THROUGH 1987

	Percentage of Claims Filed[a]		
	1985	1986	1987
Permanent disability	72%	67%	80%
Future medical treatment	70	61	75
Self-procured medical treatment	60	57	66
Temporary disability	62	58	69
Compensation rate	43	35	44
Rehabilitation	40	28	44
Injuries arising out of employment or occurring during the course of employment	8	6	4
Lien claims	2	4	3
Other	41	43	43

[a] More than one principal issue may be listed on a declaration.

In our random sample of claims, employees filed significantly more declarations for claims opened from 1985 through 1987 than did lien claimants and insurers.[1] Table 12 shows the percentage of declarations filed by each of the parties as of December 1, 1988, for claims filed from 1985 through 1987.

TABLE 12

PARTIES FILING DECLARATIONS AS OF DECEMBER 1, 1988 CLAIMS FILED 1985 THROUGH 1987

	Percentage of Declarations		
	1985	1986	1987
Employees	78%	71%	77%
Insurers	20	22	18
Lien claimants	2	7	5

After the WCAB notifies the other involved parties that a declaration has been filed, any of the other parties may object to the filing. To do this, the objecting party must explain to the WCAB why the requested proceedings are inappropriate. In our random sample of claims filed, the WCAB received objections to declarations for approximately 7 percent of the claims filed from 1985 through 1987.

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[1] In the remainder of this chapter, "insurers" specifies self-insured employers or employers and their providers of workers' compensation insurance.

In addition to initial declarations, parties may file subsequent declarations to reactivate cases that judges have taken off the WCAB calendar of proceedings. A claim can be taken off the calendar for several reasons, including the employee's medical condition changing or the parties not being prepared to proceed to hearing. In our random sample of 1985 claims with declarations filed, the judges removed from the calendar of proceedings 37 percent of the claims. When one of the parties files another properly executed declaration, the judge will place a claim back on the calendar of proceedings.

In our random sample, the parties had filed an average of 1.1 declarations for each 1985 claim as of December 1, 1988. Table 13 presents the percentage of claims for which declarations were filed as of December 1, 1988, from our random sample of claims filed in 1985.

TABLE 13

DECLARATIONS FILED FOR EACH CLAIM
AS OF DECEMBER 1, 1988
CLAIMS FILED IN 1985

Number of Declarations Filed	Percentage of Claims Filed
0	34%
1 to 2	55
3 to 4	9
5 to 6	2

Hearings Held at the WCAB

After resolving any objections filed, the WCAB will schedule a hearing and notify the parties involved in the disputed claim. The notification specifies the date and location of the scheduled hearing, which may be either a conference hearing or a regular hearing. A conference hearing is a proceeding to ascertain if the parties have genuine disputes requiring WCAB resolution, to provide the parties with assistance in resolving disputes, to narrow the issues, and to expedite the preparation and trial if a regular hearing is necessary. A regular hearing is a proceeding to receive evidence. Claims may have more than one hearing.

In our random sample of 1985 claims that had declarations, the WCAB had conducted an average of 1.7 hearings per claim as of December 1, 1988. It had conducted at least two hearings in 30 percent of the claims. Table 14 presents the percentage of hearings conducted by the WCAB as of December 1, 1988, on 1985 claims in our random sample.

TABLE 14

NUMBERS OF HEARINGS CONDUCTED AS OF DECEMBER 1, 1988 CLAIMS FILED IN 1985

Number of Hearings Conducted	Percentage of Claims Filed
0	42%
1	28
2	18
3	7
4	3
5 and over	2

The WCAB has conducted most of the hearings that it has scheduled for claims opened in 1985. In our random sample of claims, the WCAB has conducted 82 percent of hearings scheduled. A hearing would not be conducted if, for example, one of the parties did not appear or the judge was unavailable.

Medical Reports Used as Evidence

During the WCAB proceedings, the judges must use medical evidence to decide medical questions. For most claims, medical evidence is presented in the form of medical reports written by specialists, including medical doctors, psychologists, and chiropractors. The medical reports should contain a detailed

description of the injury, the parts of the body affected, and the employee's symptoms and complaints as well as the result of the examination. Medical reports should also describe any disability from the injury, explain the cause of the disability, and state whether the disability is temporary or permanent.

The WCAB receives medical reports from both the employee's and the insurer's medical specialists. Also, the WCAB may refer a disputed medical question to a medical examiner, agreed upon by the parties, who will examine the employee and submit a medical report to the WCAB. Further, the WCAB may refer a disputed medical question to an independent medical examiner that it selects.

Based on our random sample of 1985 claims, the parties have so far submitted to the WCAB an average of 2.5 medical reports for each claim. Table 15 shows which party filed medical reports for claims as of December 1, 1988.

TABLE 15

PERCENTAGE OF MEDICAL REPORTS SUBMITTED BY THE PARTIES AS OF DECEMBER 1, 1988 CLAIMS FILED IN 1985

	Percentage of Medical Reports
Employees	44%
Insurers	48
Agreed-upon examiners	7
Independent examiners	1

In our random sample of claims, various medical specialists submitted medical reports to the WCAB. For 1985 claims, orthopedic physicians submitted 51 percent of all reports while psychiatrists and psychologists submitted 15 percent. Neurologists and neurosurgeons submitted 13 percent, internal medicine physicians and cardiologists submitted 7 percent, and other specialists submitted the remaining 14 percent.

The SCIF's Costs for Medical Reports

Insurers generally pay the costs of medical reports. Since the WCAB does not maintain cost information on the amounts paid for medical reports, we reviewed a random sample of claims at the SCIF, the largest workers' compensation insurer in the State. Based on our sample, the average cost to the SCIF of a medical report prepared in

1985 was $470. In 1986, the cost was $555 and, in 1987, the cost was $623. The average amount that the SCIF paid for a medical report that it requested was $420 in 1985 as compared with $522 for an employee-requested report. In 1986, the SCIF paid an average of $516 for an insurer-requested report and $573 for an employee-requested report. In 1987, it paid an average of $577 for an insurer-requested report and $651 for an employee-requested report. Table 16 presents the average cost of medical reports by medical specialty for 1985 through 1987 from our random sample of claims at the SCIF.

TABLE 16

AVERAGE COST OF MEDICAL REPORTS BY MEDICAL SPECIALTY SUBMITTED TO THE SCIF 1985 THROUGH 1987

	1985	1986	1987
Psychiatry/psychology	$816	$735	$843
Orthopedic	421	547	601
Neurosurgery/neurology	471	510	560
Internal medicine/cardiology	448	718	685
Other	449	399	548
Overall Average Cost	470	555	623

The United States Health Care Financing Administration reported that physician services increased 24.2 percent from 1985 to 1987, yet the average medical report costs to the SCIF increased

33 percent for all medical reports from 1985 to 1987. Costs increased most substantially for cardiology and internal medicine reports, a 53 percent increase from 1985 to 1987; the next largest increase was 43 percent for orthopedic reports. The increase from 1985 to 1987 was 19 percent for neurosurgery and neurology, 3 percent for psychiatry and psychology reports, and 22 percent for medical reports from all other types of medical specialties.

Rating Disabilities With Medical Reports

The WCAB may request that the Disability Evaluation Bureau, a unit within the Department of Industrial Relations, prepare a recommended rating on the percentage of an employee's permanent disability. To determine a permanent disability rating, the Disability Evaluation Bureau uses the medical reports submitted to the WCAB, basing the rating on the nature of the physical injury or disfigurement, the occupation of the injured employee, the employee's age at the time of the injury, and the diminished ability of the injured employee to compete in an open labor market. In our random sample of claims, the Disability Evaluation Bureau, as of December 1, 1988, had provided ratings to the WCAB for 50 percent of the claims filed in 1985.

THE RESOLUTION OF WCAB CLAIMS

The WCAB resolves disputed claims for workers' compensation benefits in several ways. For example, the parties may agree to settle the dispute for workers' compensation benefits by submitting either a compromise and release agreement or a stipulation to the WCAB judge for approval. Alternatively, the WCAB may conduct hearings to obtain evidence and issue a decision to award or deny workers' compensation benefits. Also, the WCAB may dismiss the claim.

Compromise and Release Agreements

The parties may settle a claim for workers' compensation benefits with an original compromise and release agreement or with a compromise and release agreement filed at a later time during the WCAB process. Although the parties must resolve their disputes before they submit the compromise and release agreement to the WCAB judge, the agreement is not valid unless a WCAB judge approves it. Before approving a compromise and release agreement, the judge determines if the settlement is fair and adequate considering the circumstances of the claim. Once the agreement is approved, it releases the insurer from any further claim by the employee for workers' compensation benefits. If the judge believes the agreement is not fair or adequate, the judge may disapprove the agreement or conduct a hearing on the adequacy of the agreement.

The parties may choose to use compromise and release agreements for various reasons. An employee may settle a claim to receive a lump sum payment instead of periodic payments from the insurer. Also, an employee may prefer to accept some recovery rather than risk receiving nothing or a small award if the claim is disputed or the evidence is conflicting. For example, medical specialists may differ on the degree to which an employee is permanently disabled. In one claim from our random sample of claims, the Disability Evaluation Bureau determined the permanent disability rating as 35 percent based on the employee-requested medical report. However, the rating was only 4 percent based on the insurer-requested medical report. The employee could receive either $1,104 or $13,869 for the permanent disability, depending on which medical report was used. Instead, with a compromise and release agreement, the parties settled the claim for $4,500.

An insurer may agree to a compromise and release agreement to settle a claim and prevent the employee from filing new or further disability claims against the insurer. Also, an insurer may use this agreement to reduce further administrative costs of handling the claim and to release reserves for future anticipated benefits.

As of December 1, 1988, the parties had used compromise and release agreements to settle 49 percent of all claims in our random sample of 1985 claims. The WCAB judges approved 95 percent of these compromise and release agreements. The average settlement amount was $14,300 for these claims. In addition to settlement amounts, the

insurers may already have paid temporary and permanent disability indemnity and medical and hospital bills. For example, in one claim in our sample, the parties agreed that the insurer would pay $32,500 to settle any and all claims for back and psychological injuries. In addition, the insurer had already paid $6,018 for temporary disability indemnity, $5,800 for permanent disability indemnity, and $16,783 for medical and hospital bills. Table 17 presents the average amounts insurers paid on claims settled with compromise and release agreements as of December 1, 1988, for claims filed in 1985.

TABLE 17

AVERAGE AMOUNTS PAID ON CLAIMS SETTLED BY COMPROMISE AND RELEASE AGREEMENTS AS OF DECEMBER 1, 1988 CLAIMS FILED IN 1985

Type of Payment Made by the Insurer	Average Amount
Amount to settle all claims	$14,300
Temporary disability indemnity	2,500
Permanent disability indemnity	1,000
Medical and hospital costs	4,900

The parties often resolve disputes with a compromise and release agreement before the WCAB conducts a hearing. Although a judge must review the agreement, a hearing may not be necessary. The WCAB did not conduct hearings on 49 percent of the claims filed in 1985 that were settled with compromise and release agreements.

Stipulations

Parties may also use stipulations to settle workers' compensation claims, including original stipulations or stipulations filed at a later time in the WCAB process. In our random sample of 1985 claims, the parties had settled 18 percent of all of these claims with stipulations as of December 1, 1988. As with compromise and release agreements, the WCAB judges approved nearly all of the stipulations submitted by the parties. For these stipulations, the parties agreed that the insurer would pay the employee an average of $13,200. In addition, they agreed that approximately 88 percent of the employees would or may need future medical treatment, which the insurer would pay.

Like compromise and release agreements, the parties often agree to stipulations without needing the judges to conduct hearings on the disputed issues. However, a judge must approve the stipulation before it is valid. As of December 1, 1988, the WCAB did not conduct hearings on 51 percent of the stipulations in our random sample of 1985 claims that were settled with stipulations.

Findings, Awards, and Orders

If the parties do not resolve the claim with a compromise and release agreement or a stipulation, the WCAB may hear and determine all issues of fact and law for the claim. The judge will then decide on

the obligations of the parties, based upon the evidence presented during the proceedings, and issue a finding and award, a finding and order, or an order of dismissal.

In our random sample of 1985 claims, the WCAB had issued findings and awards, findings and orders, and orders of dismissal for 10 percent of all of these claims as of December 1, 1988. The judges had issued findings and awards, which favor the employees, for 4 percent of the claims filed in 1985 and findings and orders for 2 percent of the 1985 claims. For these findings and orders, the judges ruled that the insurers were not liable for any workers' compensation benefits. In an example from our sample, a judge determined the employee had not sustained, in the course of employment, the neck and shoulder injury he was claiming. Consequently, the judge issued a finding and order denying benefits to the employee.

In addition to findings and awards and findings and orders, judges issued orders of dismissal for 4 percent of the claims filed in 1985. The judges dismissed the claims for various reasons. For example, in one instance, an employee failed to prosecute her claim. In another instance, the claim duplicated another claim.

Pending Claims

In our random sample of claims filed in 1985, 23 percent of the claims were pending at the WCAB as of December 1, 1988. Claims were pending for many reasons: For example, in some cases, the parties had not yet filed declarations of readiness to proceed; the WCAB cannot proceed with the claim until one of the parties files the declaration. Alternatively, the parties may have been waiting for reports from medical examiners. Finally, the WCAB was still in the process of conducting hearings.

We categorized pending claims as either active or inactive. Claims are inactive if the parties have not filed any documents since the claims were opened. In our random sample, as of December 1, 1988, the parties had not yet filed any documents in 4 percent of the 1985 claims. Table 18 presents the status of all claims as of December 1, 1988, in our random sample of claims filed in 1985.

TABLE 18

STATUS OF 1985 CLAIMS AS OF DECEMBER 1, 1988

Claim Status	Percentage of Claims
Closed claims	
Compromise and release agreements	49%
Stipulations	18
Findings and awards	4
Findings and orders	2
Orders of dismissal	4
Total Closed Claims	77
Pending claims	
Active claims	19
Inactive claims	4
Total Pending Claims	23
Total Claims	100%

ATTORNEYS IN THE WCAB PROCESS

Both insurers and employees may hire attorneys to represent their interests at WCAB proceedings. Among other services, attorneys prepare the documents for the proceedings, including applications for adjudication, declarations, compromise and release agreements, and stipulations. Also, attorneys represent their clients at WCAB proceedings, presenting evidence and examining witnesses.

Employees' Attorneys

Most employees retained attorneys to present their claims for workers' compensation benefits. In our random sample of claims filed from 1985 through 1987, employees hired attorneys for approximately 90 percent of the claims.

Employees pay attorneys' fee, which the judges must approve from any award the employees receive for workers' compensation benefits. The judges will approve only attorneys' fees that are reasonable, based on the responsibility assumed by the attorney, the care exercised in representing the employee, the time involved, and the results obtained. The WCAB believes that reasonable attorneys' fees for claims of average complexity range from 9 to 12 percent of the amount for disability indemnity, death benefits, or compromise and release awards. However, it may approve attorneys' fees of less than 9 percent for less complex claims or more than 12 percent for more complex claims.

Based on our random sample of 1985 claims, the judges approved an average fee of $1,662 for employees' attorneys on closed claims. Table 19 presents a range of attorneys' fees and the related percentages of claims for which attorneys' fees were awarded for closed claims as of December 1, 1988.

TABLE 19

APPROVED FEES FOR EMPLOYEES' ATTORNEYS
1985 CLOSED CLAIMS
AS OF DECEMBER 1, 1988

	Percentage of Closed Claims
$ 1 to $ 500	22%
$ 501 to $1,000	29
$1,001 to $1,500	11
$1,501 to $2,000	11
$2,001 to $2,500	10
$2,501 to $3,000	5
$3,001 to $3,500	3
$3,501 or more	9

Employers' Attorneys

Since the WCAB does not maintain information on the legal costs for insurers, we obtained the number of hours that attorneys devoted to all closed claims at the SCIF. The SCIF hires attorneys as employees to represent it at WCAB proceedings. As of January 1988, the SCIF had 185 attorneys located in 22 offices statewide. The duties of the attorneys include representing the SCIF at pretrial and trial proceedings, reviewing claim files, and preparing and reviewing legal documents. The SCIF's attorneys spent an average of 8.6 hours representing the SCIF for each closed claim that was filed in 1985.

Based on this average number of hours, the SCIF's average cost for attorneys was $649 for each closed claim filed in 1985.

IV

THE TIME TAKEN TO LITIGATE CLAIMS FOR WORKERS' COMPENSATION BENEFITS

The time taken to determine an employee's eligibility for workers' compensation through the WCAB varies. Further, each of the parties involved in litigating claims, including employees, employers, employers' insurance carriers, and the WCAB, can delay the process. In our random sample of 1985 claims that were resolved, the resolution took an average of 525 days. The average time taken to resolve 1985 claims opened with applications for adjudication was 589 days, approximately 1.6 years. The parties used applications for 91 percent of 1985 claims in our random sample. In contrast, the average time taken to resolve 1985 claims that were opened with original compromise and release agreements and original stipulations was only 47 days. In our 1985 sample, original compromise and release agreements and original stipulations accounted for 9 percent of the opening documents used at the WCAB.

The time taken by the parties to process claims has not changed significantly from 1985 through 1987. For example, the number of days to resolve claims and the percentages of claims resolved in 1985 changed only slightly in both 1986 and 1987. Also, the processing time for various steps varied only moderately among the three years.

TIME TO LITIGATE CLAIMS FILED IN 1985

When an employee is injured, the time taken to determine the employee's eligibility for workers' compensation benefits varies. If one or more of the parties, including employees, employers, employers' insurance carriers, and the WCAB, is slow to perform procedures, this may delay the entire process. In addition, the type of opening document the parties use and the complexity of the steps will affect the resolution time of a claim.

Filing Opening Documents

The Labor Code limits the time that a party may take to file a claim, depending upon the circumstances of a claim. For example, the filing party must submit an opening document within one year from the date of the specific injury if no compensation, medical treatment, or benefits have been furnished by the employer or the insurance carrier. Further, a filing party must open a claim within one year after the date that the last payment or other benefit was provided.

Although the prefiling period between the injury date and the date the opening document is filed is not a part of the litigation process at the WCAB, a delay in filing a claim can affect how quickly the claim is resolved. In our random sample of claims opened in 1985, the filing parties took an average of 379 days per claim to submit opening documents at the WCAB after the date of injury.

Resolved Claims

The resolution time for a litigated claim at the WCAB begins when the filing party submits an opening document and ends when the WCAB awards or denies workers' compensation benefits or dismisses the claim. In our random sample of 1985 claims, the parties took an average of 525 days to resolve all of the closed claims. As of December 1, 1988, the parties had resolved 77 percent of the 1985 claims in our random sample.[2] Resolved claims were closed by original compromise and release agreements, original stipulations, nonoriginal compromise and release agreements, nonoriginal stipulations, findings and awards, findings and orders, and orders of dismissal.

The settlement time for a claim opened with an original compromise and release agreement or original stipulation is the number of days between the filing date and the date that the WCAB awards or denies workers' compensation benefits. In our random sample of claims filed in 1985, the parties took an average of 47 days to resolve claims when original compromise and release agreements or original stipulations, were used to open claims.

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[2]Although the WCAB may have continuing jurisdiction over claims, we defined a claim as resolved when the WCAB awards or denies workers' compensation benefits or dismisses the claim.

The resolution time for a claim opened with an application for adjudication is the number of days between the application date and the date that the claim was resolved with a nonoriginal compromise and release agreement, nonoriginal stipulation, finding and award, finding and order, or order of dismissal. In our random sample of 1985 claims filed with applications for adjudication, the parties took an average of 589 days to reach a resolution.

At any time after an application is filed at the WCAB, the parties may settle a claim for workers' compensation benefits with a nonoriginal compromise and release agreement, which differs from an original compromise and release agreement in that it may not be used as an opening document. As of December 1, 1988, the parties took an average of 600 days to resolve claims with nonoriginal compromise and release agreements in our random sample of 1985 claims.

At any time after they file applications with the WCAB, the parties may also settle claims with nonoriginal stipulations, which are similar to nonoriginal compromise and release agreements in that they may not be used as opening documents. As of December 1, 1988, the parties took an average of 543 days to resolve claims with nonoriginal stipulations in our random sample of 1985 claims.

If the parties do not settle the claim with a compromise and release agreement or a stipulation, a judge may determine all issues of fact and law for the claim with a finding and award or a finding and

order. In addition, the judge may dismiss the claim. The resolution time for these claims is the number of days between the date of the opening document and the date that the judge awards or denies benefits or dismisses the claims. For claims filed in 1985, an average of 600 days had elapsed as of December 1, 1988, before the judge awarded or denied benefits or dismissed the claim.

Table 20 shows the time taken by the parties to resolve claims in our random sample of 1985 claims.

TABLE 20

AVERAGE NUMBER OF DAYS TO RESOLVE 1985 CLAIMS AS OF DECEMBER 1, 1988

Method of Resolution	Number of Days
All Resolved Claims	525
Original compromise and release agreements and original stipulations	47
Claims opened with applications	589
Nonoriginal compromise and release agreements	600
Nonoriginal stipulations	543
Findings and awards, findings and orders, orders of dismissal	600

As Table 20 shows, original compromise and release agreements and original stipulations took fewer days to resolve than other types of

resolutions used in our random sample. Original compromise and release agreements and original stipulations are generally resolved faster than claims opened with applications for adjudication because, in the latter case, the process may include such steps as obtaining medical reports, attending hearings, and preparing additional documents.

Pending Claims

If a claim was not resolved when we completed our review, we considered it pending, and we categorized it as either active or inactive. A pending claim is inactive when the parties have not filed any documents with the WCAB since the claim was opened. It is active if one of the parties has filed one or more documents with the WCAB after the claim was opened.

The time elapsed on a pending claim is the number of days between the opening date and the date that we completed our review of claims as of December 1, 1988. In our random sample, an average of 1,204 days had elapsed on active claims since the 1985 claims were opened. For inactive claims, an average of 1,219 days had elapsed. In our random sample as of December 1, 1988, 23 percent of the 1985 claims were pending.

PROCESSING TIME FOR LITIGATION STEPS

The steps involved in processing claims at the WCAB may differ for each claim, and the time taken for each of those steps will affect the overall resolution time of claims. For example, if the parties are slow to file a declaration of readiness to proceed, which they must do before the WCAB can schedule and hold a hearing, the resolution time for the claim may be correspondingly delayed. In contrast, if the WCAB schedules and holds hearings promptly after receiving declarations, the claim's overall resolution time may reflect that promptness.

Time Taken To File Declarations of Readiness To Proceed

When parties file declarations of readiness to proceed, they are stating that they are ready to proceed with their claims, and they are requesting a hearing before the WCAB.

The time taken to file a declaration is the number of days from the date that the opening document is filed to the date that the first declaration is filed at the WCAB. Since injured employees file most of the declarations, employees contribute to most of the time involved in filing declarations. As of December 1, 1988, the average time to file a declaration was 397 days for the 1985 claims in our random sample.

Time Taken To Schedule
and Hold Hearings

After a party files a declaration and if the other parties do not object, the WCAB may schedule a hearing before a judge. The WCAB then notifies the parties of the date when the hearing will occur.

Section 5502 of the Labor Code requires that a hearing be held not less than 10 days nor more than 30 days after the declaration is filed. As of December 1, 1988, the WCAB took approximately 106 days to hold hearings after receiving declarations for 1985 claims in our random sample.

The time that elapses between hearings also adds to the processing time of claims. In our random sample, the average time between hearings was 159 days for claims filed in 1985.

Time Taken by Physicians
To Prepare Medical Reports

During the WCAB proceedings, the judges must use medical evidence to decide medical questions. In most cases, medical evidence is presented in the form of written medical reports from physicians.

The time to prepare a medical report is the number of days between the date that the physician examines the employee and the date

that the physician prepares the medical report. In our random sample of claims filed in 1985, physicians took an average of 18 days to prepare medical reports.

Time Taken by the WCAB
To Review Requests for Awards

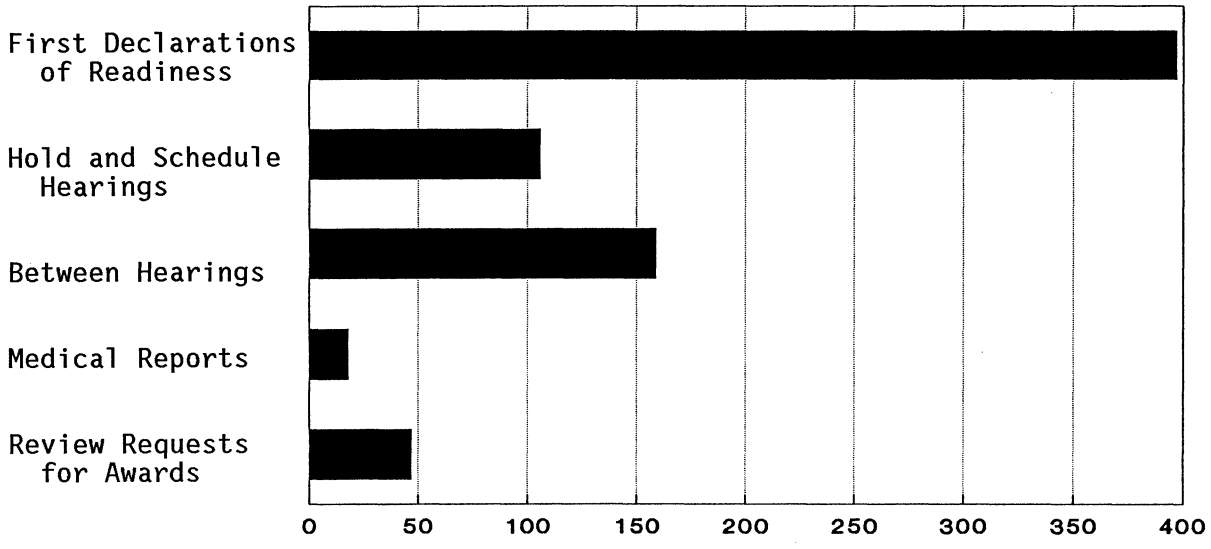
If the parties resolve their disputes, they submit to the WCAB a request for award on a compromise and release agreement or a stipulation. The WCAB Policy and Procedural Manual requires that the judges give priority to processing these requests. If a compromise and release agreement or stipulation is deemed fair and adequate, the judge will approve the terms of the agreement, awarding workers' compensation benefits.

The time taken by the WCAB to process an award in a compromise and release agreement or stipulation is the number of days between the date that the parties submit it to the WCAB and the date that the judge acts upon the request for award. As of December 1, 1988, the WCAB processed the request for awards in an average of 47 days for the 1985 claims in our random sample.

Chart 17 shows the time taken by the parties to file opening documents, file declarations of readiness to proceed, schedule and hold hearings, prepare medical reports, and review requests for awards.

CHART 17

AVERAGE NUMBER OF DAYS TO COMPLETE
LITIGATION PROCEDURES FOR 1985 CLAIMS
AS OF DECEMBER 1, 1988



COMPARISON OF 1985, 1986, AND 1987 CLAIMS

The time taken by the parties to process claims has not changed significantly from 1985 to 1987. For example, the number of days from the date that the injury occurred to the date that the WCAB received the opening documents has changed only slightly during this time. In our random sample of 1985 claims, the parties took an average of 379 days to open claims after injury. The filing parties took an

average of 390 days for those opened in 1986 and an average of 363 days for those opened in 1987. From 1985 through 1987, the number of days decreased by 16 days (4 percent).

The number of days to file the first declaration of readiness to proceed within the first 335 days has not changed significantly among the three years.[3] Within the first 335 days, the parties used an average of 186 days to file first declarations in our random sample of 1985 claims, an average of 175 days for 1986 claims, and 183 days for 1987 claims.

The number of days to schedule and hold hearings also did not significantly change among the three years. In our random sample of 1985 claims, the WCAB took an average of 106 days to schedule and hold hearings after receiving the declaration of readiness to proceed. It took an average of 111 days for 1986 claims and an average of 108 days for 1987 claims.

The number of days to resolve claims within the first 335 days has fluctuated only slightly from 1985 through 1987. The parties took an average 164 days to resolve 23 percent of the 1985 claims in our

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[3]To determine if the time for processing claims changed from 1985 through 1987, we compared the first 335 days for claims filed in each year. Three hundred thirty-five days is the number of days from when the last claim in our sample was filed in 1987 to the cutoff date of our field review, December 1, 1988. We used the last claim filed in 1987 to ensure comparability among the three years.

random sample. For 1986 claims, the parties took an average of 147 days for 22 percent of the claims, 17 fewer days than for 1985 claims. However, the parties took an average of 166 days to resolve 22 percent of the 1987 claims, an increase of 19 days from 1986. The overall increase was only 2 days for claims filed from 1985 through 1987.

As of December 1, 1988, the percent of claims resolved and pending differed for claims filed in 1985, 1986, and 1987 because the claims for each year cover different lengths of time. The parties resolved 77 percent of the 1985 claims in our random sample, leaving 23 percent of the claims pending. These claims covered as many as 47 months, from January 1985 to December 1, 1988. For claims filed in 1986, 69 percent of the claims were resolved and 31 percent of the claims were pending as of December 1, 1988. These 1986 claims covered as many as 35 months, from January 1986 to December 1, 1988. For 1987 claims, the parties had resolved only 38 percent of claims while the remaining 62 percent were pending. These claims covered as many as 23 months, from January 1987 to December 1, 1988.

V

ALTERNATIVES FOR MODIFYING THE WORKERS' COMPENSATION SYSTEM

The California workers' compensation system was established to provide compensation to employees for injuries or illnesses they suffer as a result of employment. In addition to indemnity benefits, the system also provides medical benefits to employees who are injured at work and provides vocational rehabilitation for disabled employees so they may eventually return to the work force in some capacity. To better achieve the purposes of the workers' compensation system, the Legislature may wish to consider the following alternatives for modifying the system.

INDEMNITY BENEFITS

As our report points out, the costs of workers' compensation have steadily increased; from 1984 through 1987, for example, benefits paid increased from $2.37 billion to $3.70 billion. (See Appendix B, Table B-1.) Despite rising costs, however, there is a disparity between the acknowledged indemnity benefit an impaired employee is due and the benefit the average wage earner in California is actually paid. The established rate for indemnity benefits is two-thirds of the injured employee's weekly salary; in 1987, a California employee earned an average of $444, two-thirds of which equaled $296.15. However, during the same year, the statutory maximum for benefits was $224 a

week, $72.15 less than two-thirds of an employee's average weekly salary.

To compare California's workers' compensation system with those in other states, we attempted to make a comparative analysis of costs and benefits. However, we were unable to obtain comparative cost data from other states. In addition, we could not obtain comparative information from other states about the number of employees covered by workers' compensation and the amount of net premiums earned by insurance carriers. Finally, the rates and employee classifications used in other states may differ from those used in California. For example, the National Council on Compensation Insurance (NCCI) develops rates for over 600 classifications in the 33 jurisdictions it serves, whereas in California, the insurance commissioner sets the rates for approximately 425 classifications. Although we were not able to compare the cost of California's workers' compensation system with the costs in other states, we were able to compare California's maximum indemnity benefit with the maximum indemnity benefits provided in other states throughout the country.

In comparing California's workers' compensation benefits with those of other states, we used data reported to the NCCI by each of the states. The compensation benefit for each state is based on a percentage of the injured employee's weekly salary. Among the 50 states and the District of Columbia, these rates range from 60 percent to 80 percent of the average weekly salary. However, each state has

also established a maximum weekly benefit. The injured employee is paid the maximum if the computed benefit, based on the state's pre-established rate, is higher than the maximum benefit amount.

California's average weekly salary of $444 is the sixth highest in the United States. (See Appendix C, Table C-2.) As noted above, California's weekly indemnity benefits would average $296.15 a week if computed at the rate of two-thirds of the average weekly salary. At that rate, California would have the seventh highest benefit among the 51 jurisdictions we analyzed. However, California's maximum benefit is $224 a week, the thirteenth lowest of 51 jurisdictions. (See Appendix C, Table C-3.) Furthermore, in 1987, only 12 of the 51 jurisdictions that we analyzed had a maximum weekly benefit amount that was less than the computed benefit. Not only is California one of those twelve jurisdictions, but the difference between its maximum benefit and its computed benefit was the second largest among the 51 jurisdictions. In 1987, employees earning the average weekly salary in California received $72.15 a week less than they would have if the established rate of two-thirds of the average weekly salary had been used to calculate the benefits.

To fully indemnify the average California worker, the Legislature would need to increase the current maximum of $224 to equal two-thirds of California's current average weekly salary and provide for yearly adjustments for new claims based on the average weekly salary. Because this would increase the benefits paid to injured

employees who are earning at least the average weekly salary, the workers' compensation system would incur additional costs.

CONCURRENT PAYMENTS

According to the Labor Code, Section 6207, vocational rehabilitation benefits are additional benefits and may not replace any workers' compensation benefits available to injured employees. For example, an employee may settle a claim for workers' compensation benefits with a compromise and release agreement, through which an insurer pays a lump sum, including an amount for permanent disability, to the employee to settle any and all claims for workers' compensation benefits. However, according to the Labor Code, the employee is also entitled to vocational rehabilitation and may receive temporary disability payments through vocational rehabilitation in addition to the lump sum payment.

In contrast, an injured employee may receive a series of permanent disability payments under a finding and award or stipulation before beginning vocational rehabilitation. However, according to a ruling in a workers' compensation court case (Tangye vs. Henry C. Beck and Company and Fidelity and Casualty Company of New York), when an employee begins vocational rehabilitation, permanent disability payments will be stopped until after completion of the rehabilitation plan because the employee will receive temporary disability during

rehabilitation. In this way, the employee does not receive concurrent permanent and temporary disability payments.

Although employees may not receive concurrent payments under the above circumstances, the law in its present form allows injured employees to receive concurrent payments if they have settled their claims with compromise and release agreements before beginning vocational rehabilitation. For example, in our review of a sample of 28 cases from the Sacramento district office of the State Compensation Insurance Fund (SCIF), we found 2 cases in which the claimant received temporary disability benefits through vocational rehabilitation immediately after receiving, in a lump sum, a permanent disability payment resulting from a compromise and release agreement. In one case, the SCIF paid one claimant a total of $896 in vocational rehabilitation temporary disability benefits five days after the claimant had received a $20,200 payment from a compromise and release agreement.

Since the lump sum payment includes all future indemnity benefits, when employers pay temporary indemnity during rehabilitation after the employee has already received a lump sum payment, they are essentially paying the indemnity benefit twice. If the Legislature did not intend to allow concurrent payments of this nature, it could require a reduction in the temporary disability benefits paid during rehabilitation that is equal to the amount of permanent disability the employee received in the lump sum payment. This would apply only if

the employee receives a lump sum payment before or during vocational rehabilitation. Such a requirement would reduce employers' costs; however, employees affected by the requirement would receive smaller total indemnity benefits.

PRETERMINATION CONFERENCES

According to the California Code of Regulations, employers must inform the bureau and employees that they are stopping rehabilitation benefits. Employees then have 20 days to object to the termination of benefits. If employees object, the bureau requires employers to continue paying temporary disability until the bureau holds a pretermination conference. This ruling was upheld in a workers' compensation court case (Veilleux v. Workers' Compensation Appeals Board and the City of San Luis Obispo) wherein the California Court of Appeal upheld the decision of a workers' compensation judge that an employer's termination of rehabilitation benefits without a hearing violated regulations and judicial decisions.

The cases in our sample, since they were closed in 1987, were not subject to a time limit in the bureau's scheduling of pretermination conferences. However, effective July 1, 1988, the California Code of Regulations requires the bureau to schedule a pretermination conference or otherwise obtain the employee's reasons for objecting and issue a decision within 30 days of the employee's objection.

We reviewed the cases in our sample to determine what effect the 30-day time limit would have had on the payment of benefits. We found that employers paid some employees temporary disability benefits that could have been avoided if the bureau had been more prompt in scheduling pretermination conferences.

In at least 20 of the 226 cases in our sample, employees objected to their employers' attempts to terminate their benefits. The bureau took an average of 74 days after employees' objections to hold the pretermination conferences. In only 5 (25 percent) of the 20 cases did the bureau hold conferences within 30 days of the employees' objections. In those 5 cases and in 7 other cases in our sample, the bureau decided that the employers could not terminate the employees' benefits, and the rehabilitation cases continued. However, in 7 of the 8 remaining cases, the bureau eventually concluded that the employers were justified in terminating rehabilitation benefits. Yet insurers had paid these 7 employees over $14,000 in temporary disability payments from the date that the employees objected to the termination of benefits to the date of the pretermination conferences. In the eighth case, the employee and the employer settled their dispute before the bureau held a conference, which it scheduled 266 days after the worker objected to the closure of the case.

As long as the Department of Industrial Relations rules in favor of the employee, there is no adverse financial impact on the employer, even if the conference is not held within the 30-day time

limit. However, if the department rules in favor of the employer, there may be adverse financial impact because the employer pays temporary benefits until the issue is settled, regardless of how long it takes. To limit an employer's liability, the Legislature could restrict to 30 days the employer's responsibility for temporary disability benefits if the Department of Industrial Relations does not hold pretermination conferences within the 30-day limit.

The Legislature could make the Department of Industrial Relations responsible for the benefits paid after the 30-day limit expires if it does not set the pretermination conference within that limit. Although the employers would still be responsible for making the payments, they would have recourse for reimbursement from the Department of Industrial Relations if it rules in their favor. This shift in responsibility would help to ensure that the Department of Industrial Relations hold pretermination conferences within 30 days. In addition, employers would be assured of reimbursement for payments made after the 30-day limit expires when the Department of Industrial Relations rules in their favor. A possible disadvantage to this is that the Department of Industrial Relations may not adhere to the 30-day limit, thus increasing its expenses.

ADMINISTRATIVE SETTLEMENTS

Litigating claims at the Workers' Compensation Appeals Board (WCAB) is a costly and time-consuming process. Contributing to the expense of litigating claims is the cost of the WCAB's administrative staff and its 122 judges in 22 offices statewide who process claims and schedule and hold hearings.

In the current litigation process, the parties settled 87 percent of the resolved claims with compromise and release agreements and stipulations as of December 1, 1988. Approximately one-half of the claims settled with compromise and release agreements and stipulations were resolved by the parties before a hearing was held. Yet judges must review and approve compromise and release agreements and stipulations before they are valid. Judges approved 95 percent of the compromise and release agreements and nearly all of the stipulations in 1985 without modifying the agreements or stipulations.

Rather than requiring a judge's approval of compromise and release agreements and stipulations, the Legislature could amend the Labor Code to make compromise and release agreements and stipulations binding on the parties without requiring a judge's approval. Instead, the agreement would become binding when the parties file a copy of their settlement agreements with the WCAB. In addition, since judges would no longer be responsible for determining the fairness of the

attorneys' fees, the Legislature or the Department of Industrial Relations could establish a fee schedule for employees' attorneys similar to the existing WCAB guidelines on reasonable attorney's fees.

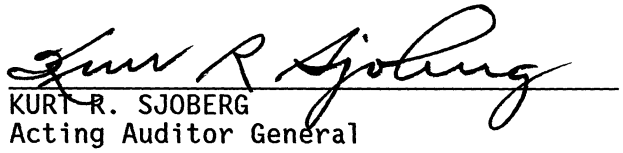
This procedure would divert a large number of claims away from litigation. Based on 1985 data as of December 1, 1988, we estimate that at least 50,700 of the 175,000 claims filed with the WCAB could have been settled in this way without involving the WCAB. With fewer claims to process, WCAB judges would have more time available for the claims that require hearings. In addition, the parties could settle their claims faster. In our random sample of 1985 claims, the WCAB took an average of 47 days to approve settlements through compromise and release agreements and stipulations. However, with this procedure, once the parties resolve their disputes, they could complete the settlement rather than waiting for a judge's approval.

Although the procedure has several advantages, it is not without disadvantages. Without the judges' impartial review of settlement agreements, the parties would not be ensured of the adequacy and fairness of the settlements. For example, an employee might settle with a compromise and release agreement and waive future medical benefits when a more appropriate settlement for the employee would be a stipulation that allows future medical treatment. In our random sample of 1985 claims settled with compromise and release agreements, judges intervened in the settlements of approximately 5 percent of the claims; judges rarely intervened for stipulations.

The lack of a judge's review might especially affect employees who do not have legal representation. Although 92 percent of the employees in our random sample of 1985 claims were represented by attorneys, the remaining 8 percent who submitted claims before the WCAB in 1985 did so without legal representation by attorneys. However, in only one of these claims, less than one percent of the random sample, the judge intervened and the employee's settlement increased from $2,200 to $11,500. Without a judge's impartial review, this unrepresented employee might not have received an adequate and fair settlement.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



KURT R. SJOBERG
Acting Auditor General

Date: March 28, 1989

Staff: Thomas A. Britting, Audit Manager
Dore C. Tanner, CPA
Michael R. Tritz
Margaret E. Vanderkar
Elaine M. Howle
Ann K. Campbell
Darcy Anderson
Keith Kuzmich
James D. Lynch, Jr.
Nancy McBride
Diana L. Oretsky
Kay E. Overman
Susan Wynsen
Duane E. Butler
Stephen Cho
Gretchen Coyle
April Gray
Becky Valdellon

APPENDIX A

A DETAILED DESCRIPTION OF THE METHODOLOGY AND LIMITATIONS OF OUR REVIEW

Several of the analyses we developed for this report required complex methodologies or limited our conclusions in some way. What follows is a detailed description of those methodologies and limitations.

Premiums Earned and Dividends Paid

To determine the amount of premiums earned and dividends paid or credited to employers by insurance carriers, we obtained computer summaries of data that insurance carriers submitted to the Department of Insurance for calendar year 1983 through calendar year 1987. These summaries include the individual amounts reported by each insurance carrier as well as total amounts for all carriers. To validate the information on these summaries, we selected a sample of annual reports and traced the amounts reported in each annual report to the amounts shown on the summaries.

Medical and Indemnity Benefits Paid and Reserved

To determine the medical and indemnity benefits paid and reserved by insurance carriers and the premiums they earned, we obtained a computer report from the Workers' Compensation Insurance Rating Bureau of California (WCIRB). This report summarized data included in the quarterly reports that the WCIRB received from individual insurance carriers for calendar year 1983 through calendar year 1987. These quarterly reports include data on the premiums earned and the benefits paid and reserved. The data are reported on the basis of an "accident year," the year in which an injury occurred. We verified the summary data provided by the WCIRB by submitting data for a hypothetical carrier and checking the new totals calculated by the WCIRB. According to our review, the WCIRB correctly calculated the yearly totals for the data reported in accident year 1983 through accident year 1987.

Indemnity Benefits by Category

To determine the indemnity benefits paid and reserved by category, we obtained computer printouts summarizing data that each insurance carrier submitted to the WCIRB on a form called a "Unit Statistical Report" (USR). These reports summarize data collected

18, 30, and 42 months after each insurance policy begins. Because the USRs include data based on individual policies, the reporting period is the "policy year," which is the year that the policy began. For example, data from a policy beginning on December 15, 1983, and ending on December 14, 1984, would be summarized on the policy year 1983 form, even though a majority of the policy period falls in 1984. We obtained summary data from carriers' 18-month reports for policy year 1983 through policy year 1985. In addition, we obtained USR summaries compiled by the WCIRB for each individual insurance carrier. Using the USR summaries, we calculated the total benefits paid and reserved for each category of disability and compared this total to the WCIRB's summary data. We found that the WCIRB's summary data were accurate.

We also validated the process the WCIRB used to summarize the USR data. To do this, we selected a sample policy and obtained a USR summary showing the breakdown of claims by category of disability and by benefits paid and reserved for all policies, excluding the sample policy. Next, we obtained a USR summary showing the breakdown of claims by category of disability and by benefits paid and reserved for all policies, including the sample policy. We calculated the difference, and the result matched the number of claims and benefits paid and reserved for the sample policy. Therefore, we concluded that the WCIRB's process to summarize data was accurate.

Total Expenses Incurred
by Insurance Carriers

To determine the total expenses insurance carriers incurred to provide workers' compensation insurance, we obtained copies of each insurance carrier's annual "expense call" submitted to the WCIRB for calendar year 1983 through calendar year 1987. We then totaled the amounts for the various categories of expenses for each of the years. Since we were able to review originals of the forms submitted by insurance carriers, we did not need to validate the WCIRB's processing of the data.

Finally, we obtained the insurance carriers' federal and state tax data by reviewing the form they each submitted to the Department of Insurance. This form, called "Form 46," contains the insurance carrier's expense information required by the Department of Insurance. We reviewed each carrier's original Form 46 for calendar year 1985 through calendar year 1987. We were unable to review earlier years because the Department of Insurance had destroyed Form 46s for carriers not domiciled in California. Since we were able to review originals of the forms, we did not attempt any further validation.

Vocational Rehabilitation Benefits

To determine the breakdown of vocational rehabilitation benefits by category and amount paid, we obtained computer summaries of the Individual Case Reports (ICR) that insurance carriers submit to the WCIRB for all claims exceeding $5,000. The ICRs, like the USRs, are

based on individual policies and, therefore, are summarized by policy year at the same intervals as the USRs. The summary data originates from the carriers' 18-month reports for policy year 1983 through policy year 1985.

To validate the process the WCIRB uses to summarize the data from the ICRs, we selected a sample policy and totaled the number of claims and the benefits paid by category of vocational rehabilitation benefits, excluding the sample policy's data. Next, we obtained the same information for all of the policies, including the sample policy. We calculated the difference in the totals, and the result matched the number of claims and the benefits paid as listed on the sample policy. Therefore, we concluded that the WCIRB's process to summarize the data was accurate.

Self-insured Employers

To develop analyses about the activities of self-insured employers from 1983 through 1987, we reviewed annual reports they submitted to the Department of Industrial Relations' Office of Self Insurance Plans. We recorded the employers' estimated future liabilities, the benefits they paid and reserved for indemnity and medical benefits, and the number of workers' compensation claims reported in each year. In addition, for private self-insured employers, we determined the amount of security deposits they submitted to the director of the Department of Industrial Relations.

Since private, self-insured employers report data related to workers' compensation claims on a calendar-year basis and public, self-insured employers report data on a fiscal-year basis, we developed separate analyses for private and public, self-insured employers. Furthermore, the Office of Self Insurance Plans compiles yearly totals for private, self-insured employers but not for public, self-insured employers. Therefore, we selected a sample of annual reports submitted by the public, self-insured employers and projected totals for the benefits these employers paid and reserved during fiscal year 1983-84 through fiscal year 1986-87.

To project totals for public, self-insured employers, we reviewed the annual reports of the 40 public, self-insured employers we assumed to be the largest. In addition, we selected a random sample of 178 additional reports and determined the average number of workers' compensation claims reported and the average amount of benefits paid and reserved. Using this information, we projected totals for all public, self-insured employers excluding the 40 largest public, self-insured employers. After making our projections, we added the projected totals to the amounts reported by the 40 largest public, self-insured employers.

Finally, we developed analyses using data that were initially reported for each of the five years in our review. For private, self-insured employers, we analyzed the summary data initially reported

to the Office of Self Insurance Plans by all employers, whereas for public, self-insured employers we selected the five largest employers based upon their reported estimated future liabilities.

Vocational Rehabilitation Plans

To obtain data regarding the costs, success rates, and length of time required for vocational rehabilitation, we selected a random sample of 230 claims from the 12,116 rehabilitation plans injured employees completed during 1987. To select our sample, we first obtained a computer list of all of these completed rehabilitation plans from the Department of Industrial Relations' data processing unit. After selecting a random sample of 230 plans, we were able to obtain pertinent data from the case files for 226 plans.

From the case files, we recorded information to include the employee, his or her employer, and the date and type of injury. In addition, we recorded information concerning the type of rehabilitation plan completed, the length of the plan, and the employee's wages before and after completing the plan. We adjusted employees' wages earned at the end of their rehabilitation to reflect changes in average weekly wages earned in California from 1978 through 1987 as compiled by the United States Department of Labor, Bureau of Labor Statistics. In addition, we recorded the length of time the rehabilitation bureau took to settle any disputes.

The Litigation Process

To obtain information regarding the litigation process at the Workers' Compensation Appeals Board (WCAB), we analyzed a random sample of workers' compensation claims that were submitted to the WCAB for resolution. First, we identified all claims filed at the WCAB offices during calendar year 1985 through calendar year 1987. For each of the three years, we selected a random sample of 250 claims to review. Next, we developed a questionnaire to record data from source documents in the claim files. After reviewing the files and recording the appropriate information on the questionnaires, we used a computer program to compile the statistics.

We compiled statistics on the basis of the year that the claims were opened at the WCAB. However, statistics for each of these years cover different periods of time. For claims opened in 1985, the statistics covered as many as 47 months, from January 1985 through December 1, 1988. For claims opened in 1986, the statistics covered as many as 35 months, from January 1986 through December 1, 1988. The statistics for claims opened in 1987 covered up to 23 months, from January 1987 through December 1, 1988. Because the processing time for claims differed, the data for the three years are not always comparable. When the data are not comparable, we present only the statistics from our 1985 sample.

To determine the average cost of defense attorneys for litigated cases, we obtained from the State Compensation Insurance Fund (SCIF) the total number of hours charged by the legal office for claims that were opened for litigation during calendar year 1985 and that are currently closed. We determined the average number of hours the legal office charged per claim by dividing the total number of legal hours by the total number of cases. In addition, we obtained the hourly attorney's cost for the legal department. Using this information, we calculated the average hourly cost for the SCIF's legal office. Finally, to determine the average legal cost-per-claim, we multiplied the average number of hours-per-claim by the average hourly cost the SCIF's legal office charged per claim.

To determine the cost of medical reports, we obtained data from the SCIF for claims that were opened for litigation during calendar years 1985, 1986, and 1987. We selected a random sample of 350 claims--150 from calendar year 1985 and 100 each from calendar years 1986 and 1987. We recorded information from medical reports, corresponding invoices, and payment documents in the files. After recording the information, we sorted the costs for each year by medical specialty. Next, we calculated the average report cost-per-specialty by dividing the total cost by the total number of medical reports. Finally, we grouped the medical specialties into five categories: orthopedic, cardiology/internal medicine, neurology/neurosurgery, psychiatry/psychology, and other.

APPENDIX B

TABLES SHOWING BENEFITS PAID AND RESERVED 1984 THROUGH 1987

The tables in this appendix present information regarding the workers' compensation benefits paid from calendar year 1984 through calendar year 1987 and the benefits paid and reserved by insurance carriers and self-insured employers during the same period. Table B-1 presents benefits paid by insurance carriers including the State Compensation Insurance Fund, self-insured employers, and the Department of Industrial Relations. In addition, the table presents information regarding the benefits paid through special programs. Table B-2 presents the benefits paid and reserved by insurance carriers and self-insured employers from calendar year 1984 through calendar year 1987.

TABLE B-1

WORKERS' COMPENSATION BENEFITS PAID
CALENDAR YEARS 1984 THROUGH 1987

Source of Benefit	1984	1985	1986	1987	Total Benefits Paid 1984 Through 1987	Percentage of Total Benefits
Insurance carriers	$1,857,939,000	$2,262,661,000	$2,617,284,000	$2,951,465,000	$ 9,689,349,000	79.257%
Self-insured:						
Private employers	419,812,401	483,145,798	553,495,456	603,723,906	2,060,177,561	16.852
Public employers[a]	--	--	--	--	--	--
Legally uninsured state agencies	66,055,998	79,836,761	91,308,613	100,696,146	337,897,518	2.764
Disaster Service Workers' Relief Fund	447,905	274,883	361,592	774,662	1,859,042	.015
Subsequent Injuries Fund	4,246,562	3,972,453	4,335,053	4,669,022	17,223,090	.141
Department of Justice/California Highway Patrol	5,215,959	6,048,151	5,798,974	6,676,154	23,739,238	.194
Industrial Disability Leave	9,610,726	12,864,783	15,672,981	18,044,689	56,193,179	.460
Uninsured Employers Fund	7,735,838	7,928,342	9,077,432	13,479,668	38,221,280	.313
Asbestos Workers' Account	101,982	143,772	105,012	184,151	534,917	.004
Total	$2,371,166,371	$2,856,875,943	$3,297,439,113	$3,699,713,398	$12,225,194,825	100.000%

Sources: The Department of Industrial Relations; the State Compensation Insurance Fund; the Department of Insurance; and the Department of General Services.

Note: The Office of the Auditor General did not audit these data.

[a] Records on benefits paid by public, self-insured employers are not available; however, Appendix B, Table B-2, shows the benefits they paid and reserved from 1984 through 1987.

TABLE B-2

WORKERS' COMPENSATION BENEFITS
PAID AND RESERVED BY INSURANCE CARRIERS
AND SELF-INSURED EMPLOYERS FOR INJURIES
CALENDAR YEARS 1984 THROUGH 1987

Source	1984	1985	1986	1987	Total Benefits Paid and Reserved 1984 Through 1987
Insurance carriers	$2,610,678,972	$3,060,642,165	$3,273,884,817	$3,190,592,946	$12,135,798,900
Self-insured:					
Private employers	532,019,575	616,123,703	610,518,172	512,714,248	2,271,375,698
Public employers[a]	447,669,011	544,223,960	484,248,422	443,800,081	1,919,941,474
Total	$3,590,367,558	$4,220,989,828	$4,368,651,411	$4,147,107,275	$16,327,116,072

Sources: The Department of Industrial Relations; the Workers' Compensation Insurance Rating Bureau.

Note: The Office of the Auditor General did not audit these data.

[a] Data for public, self-insured employers cover fiscal year 1983-84 through fiscal year 1986-87. The benefits paid and reserved are based on our statistical projections; the error rate is ± 14 percent.

APPENDIX C

A COMPARISON OF MAXIMUM BENEFITS WITH COMPUTED BENEFITS

The tables in this appendix present information about the maximum benefit amount, the average weekly salary, and the computed benefit amount for all 50 states and the District of Columbia. In Table C-1 the jurisdictions are ranked by maximum benefit amount from highest to lowest. Table C-2 presents the average weekly salary for each jurisdiction and the computed benefit amount based upon the average weekly salary. In addition, the jurisdictions in this table are ranked from highest to lowest based upon the computed benefit amount. Finally, in Table C-3, we compare the computed benefit amount with the maximum benefit amount to determine the lesser of the two amounts. Based on the lesser amount, we ranked the jurisdictions from highest to lowest.

TABLE C-1

RANKING OF JURISDICTIONS
BY STATUTORY MAXIMUM BENEFIT
FOR PERMANENT TOTAL DISABILITIES
1987

	Maximum Benefit Amount
1. Alaska	$1,108.00
2. Iowa	632.00
3. Illinois	548.56
4. New Hampshire	525.00
5. Vermont	489.00
6. District of Columbia	458.28
7. Maine	447.92
8. Connecticut	429.00
9. Massachusetts	411.00
10. Michigan	392.00
11. Minnesota	376.00
12. Ohio	376.00
13. Wyoming	368.42
14. Pennsylvania	361.00
15. Maryland	359.83
16. Colorado	357.63
17. Oregon	355.04
18. Virginia	344.00
19. West Virginia	343.06
20. Nevada	341.95
21. Rhode Island	337.00
22. Wisconsin	336.00
23. Florida	331.00
24. Alabama	331.00
25. Kentucky	322.19
26. Hawaii	318.00
27. South Carolina	314.60
28. North Carolina	308.00
29. New Jersey	302.00
30. New York	300.00
31. Montana	299.00
32. North Dakota	296.00
33. Utah	285.00
34. Indiana	285.00
35. Idaho	278.10
36. South Dakota	272.00
37. Washington	271.78
38. New Mexico	270.97
39. Missouri	269.81
40. Louisiana	262.00
41. Delaware	250.53
42. Kansas	247.00
43. Nebraska	235.00
44. Texas	231.00
45. California	**224.00**
46. Oklahoma	217.00
47. Tennesse	210.00
48. Arizona	205.59
49. Arkansas	189.00
50. Georgia	175.00
51. Mississippi	140.00

Source: The National Council on Compensation Insurance.

Note: The Office of the Auditor General did not audit the data in this table.

TABLE C-2

RANKING OF JURISDICTIONS
BY COMPUTED BENEFIT
FOR PERMANENT TOTAL DISABILITIES
1987

	Average Weekly Salary[a]	Computed Benefit Amount
1. Alaska	$539.00	$431.20
2. Dist. of Col.	548.00	365.52
3. Michigan	444.00	355.20
4. New Jersey	459.00	321.30
5. New York	474.00	316.16
6. Connecticut	468.00	312.16
7. California	444.00	296.15
8. Washington	387.00	290.25
9. Massachusetts	432.00	288.14
10. Illinois	428.00	285.48
11. Maryland	410.00	273.47
12. Iowa	333.00	266.40
13. Colorado	399.00	266.13
14. Delaware	399.00	266.13
15. Ohio	396.00	264.13
16. Texas	394.00	262.80
17. Minnesota	393.00	262.13
18. Pennsylvania	392.00	261.46
19. Virginia	384.00	256.13
20. West Virginia	362.00	253.40
21. Indiana	379.00	252.79
22. Georgia	378.00	252.13
23. Arizona	377.00	251.46
24. Missouri	377.00	251.46
25. Nevada	375.00	250.13
26. New Hampshire	373.00	248.79
27. Hawaii	367.00	244.79
28. Oregon	363.00	242.12
29. Rhode Island	363.00	242.12
30. Wisconsin	363.00	242.12
31. Wyoming	362.00	241.45
32. Louisiana	360.00	240.12
33. Florida	359.00	239.45
34. Oklahoma	358.00	238.79
35. Tennessee	356.00	237.45
36. Kansas	354.00	236.12
37. Alabama	352.00	234.78
38. Utah	352.00	234.78
39. Kentucky	346.00	230.78
40. North Carolina	343.00	228.78
41. New Mexico	342.00	228.11
42. Vermont	340.00	226.78
43. Maine	336.00	224.11
44. South Carolina	332.00	221.44
45. Arkansas	318.00	212.11
46. Nebraska	318.00	212.11
47. Montana	316.00	210.77
48. North Dakota	311.00	207.44
49. Mississippi	307.00	204.77
50. Idaho	328.00	196.80
51. South Dakota	288.00	192.10

Note: The Office of the Auditor General did not audit the data in this table.

[a] The source of this information is the Bureau of the Census.

TABLE C-3

RANKING OF JURISDICTIONS BY BENEFIT AMOUNTS (COMPUTED OR STATUTORY MAXIMUM) AVERAGE WAGE EARNER QUALIFIES FOR PERMANENT TOTAL DISABILITY PROGRAM 1987

	Average Weekly Salary [a]	Computed Benefit	Statutory Maximum Benefit	Benefit Average Wage-Earner Qualifies for
1. Alaska	$539.00	$431.20	$1,108.00	$431.20
2. Dist. of Col.	548.00	365.52	458.28	365.52
3. Michigan	444.00	355.20	392.00	355.20
4. Connecticut	468.00	312.16	429.00	312.16
5. New Jersey	459.00	321.30	302.00	302.00
6. New York	474.00	316.16	300.00	300.00
7. Massachusetts	432.00	288.14	411.00	288.14
8. Illinois	428.00	285.48	548.56	285.48
9. Maryland	410.00	273.47	359.83	273.47
10. Washington	387.00	290.25	271.78	271.78
11. Iowa	333.00	266.40	632.00	266.40
12. Colorado	399.00	266.13	357.63	266.13
13. Ohio	396.00	264.13	376.00	264.13
14. Minnesota	393.00	262.13	376.00	262.13
15. Pennsylvania	392.00	261.46	361.00	261.46
16. Virginia	384.00	256.13	344.00	256.13
17. West Virginia	362.00	253.40	343.06	253.40
18. Indiana	379.00	252.79	285.00	252.79
19. Missouri	377.00	251.46	269.81	251.46
20. Delaware	399.00	266.13	250.53	250.53
21. Nevada	375.00	250.13	341.95	250.13
22. New Hampshire	373.00	248.79	525.00	248.79
23. Hawaii	367.00	244.79	318.00	244.79
24. Wisconsin	363.00	242.12	336.00	242.12
25. Oregon	363.00	242.12	355.04	242.12
26. Rhode Island	363.00	242.12	337.00	242.12
27. Wyoming	362.00	241.45	368.42	241.45
28. Louisiana	360.00	240.12	262.00	240.12
29. Florida	359.00	239.45	331.00	239.45
30. Kansas	354.00	236.12	247.00	236.12
31. Alabama	352.00	234.78	331.00	234.78
32. Utah	352.00	234.78	285.00	234.78
33. Texas	394.00	262.80	231.00	231.00
34. Kentucky	346.00	230.78	322.19	230.78
35. North Carolina	343.00	228.78	308.00	228.78
36. New Mexico	342.00	228.11	270.97	228.11
37. Vermont	340.00	226.78	489.00	226.78
38. Maine	336.00	224.11	447.92	224.11
39. California	444.00	296.15	224.00	224.00
40. South Carolina	332.00	221.44	314.60	221.44
41. Oklahoma	358.00	238.79	217.00	217.00
42. Nebraska	318.00	212.11	235.00	212.11
43. Montana	316.00	210.77	299.00	210.77
44. Tennessee	356.00	237.45	210.00	210.00
45. North Dakota	311.00	207.44	296.00	207.44
46. Arizona	377.00	251.46	205.59	205.59
47. Idaho	328.00	196.80	278.10	196.80
48. South Dakota	288.00	192.10	272.00	192.10
49. Arkansas	318.00	212.11	189.00	189.00
50. Georgia	378.00	252.13	175.00	175.00
51. Mississippi	307.00	204.77	140.00	140.00

Note: The Office of the Auditor General did not audit the data in this table.

[a] The source of this information is the Bureau of the Census.

STATE OF CALIFORNIA GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF INSURANCE
100 VAN NESS AVENUE
SAN FRANCISCO, CALIFORNIA 94102

March 21, 1989

P-830

Mr. Kurt R. Sjoberg
Acting Auditor General
State of California
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Sjoberg:

Thank you for your letter of March 20, 1989, addressed to John Geoghegan and attaching certain portions of your report entitled "A Review of the Workers' Compensation System."

Mr. Geoghegan has asked me to respond on his behalf.

We have read the document that was sent to us. It represents a factual account of the activities of the Department of Insurance.

Sincerely,

Roxani M. Gillespie
Insurance Commissioner

RMG:hc

cc: John Geoghegan, Secretary
Business, Transportation & Housing Agency

STATE OF CALIFORNIA GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF INDUSTRIAL RELATIONS
OFFICE OF THE DIRECTOR
1121 L STREET, SUITE 307
SACRAMENTO, CA 95814
(916) 324-4163
ATSS: 8-454-4163

March 24, 1989

Mr. Kurt R. Sjoberg
Acting Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, California 95814

Dear Mr. Sjoberg:

In a letter dated March 20, 1989, the Auditor General's draft report entitled "A Review of the Workers' Compensation System" was transmitted to my office for our review and response in writing by March 24, 1989.

The Administration and the Department appreciate that the scope of the review was immense and that much time and effort was expended by the Auditor General's Office staff in its development. The Department welcomes constructive suggestions for improvement of the workers' compensation system and of its operations that support the system.

Overall Report Content

The report is a comprehensive and readily understandable treatise of the various elements of the system and how they interact. While the Auditor General refrains from reaching specific recommendations, the report suggests that the legislature give consideration to four alternatives for modifying the workers' compensation system. In addition, the report focuses on several areas and processes such as the method of proposing and establishing premium levels for workers' compensation insurance. The report states that these premiums have been increasing, yet offers no recommendations or suggestions regarding that process. The lack of specific recommendations is, however, understandable given the scope of the review and the apparent conclusion that many of the findings in the report would not support additional specific recommendations. (1) *

*The Office of the Auditor General's comment on this specific point appears after the Department of Industrial Relations' response.

Comments on Draft Report Recommendations

AG Recommendation 1: The Legislature could make Workers' Compensation indemnity benefits two-thirds of the California employee's average weekly wage and provide for yearly adjustments for new claims.

DIR Response 1:

The Administration and the Department have and continue to support an increase in benefit levels. However, the Department continues to believe that equitable and legitimate modifications are essential to help fund increased benefits.

Alternatives that will effectively reduce cost growth, reduce litigation, address the growth of stress claims, provide medical/forensic cost containment and provide incentives for employers and employees involved in vocational rehabilitation as well as mechanisms to insure the timely delivery of benefits are long overdue.

AG Recommendation 2: The Legislature could require that when an injured worker receives a lump-sum workers' compensation settlement, future temporary disability for vocational rehabilitation would be offset against that lump sum.

DIR Response 2:

The report is correct that under the current law permanent disability could be awarded either after a WCAB hearing or by stipulation before the commencement of the rehabilitation plan. It is also correct that if a rehabilitation plan is started and temporary disability payments are to be made, that those permanent disability payments would be interrupted or not started pursuant to the Tangye case.

However, even though permanent disability payments are interrupted by the commencement of the rehabilitation plan, the injured employee could petition to commute all or part of the permanent disability award to enable him or her to complete the plan or for some other reason that would be in the applicant's best interest if so determined by a workers' compensation judge.

DIR agrees that some modification to these procedures should be considered. There have been some suggestions that the injured worker should elect whether or not to accept a rehabilitation plan, or be rated on the permanent disability. Legislation requiring determination of any rehabilitation entitlement prior to the rating or settlement of any permanent disability issues could also be considered.

There must be incentives for employees to actively participate in and complete Vocational Rehabilitation plans. Offsetting the payment of temporary disability benefits during vocational rehabilitation against a lump sum payment received as a result of a compromise and release, as a single solution, may not in and of itself be sufficient. The Department has suggested and supported some type of across the board offset of the payment of temporary disability indemnity against the permanent disability payments awarded to the injured worker as an incentive to the worker to get into and complete the rehabilitation process as quickly as possible.

For example, an offset that commences only after the injured worker's condition becomes permanent and stationary will encourage workers to enter into and complete vocational rehabilitation prior to that event, resulting in a reduction in lost wages to the worker and an incentive to complete the process.

As the report indicates, rehabilitation plans that employ alternative or modified work with the same employer are the most successful. Where these plans are selected by the injured worker the Department believes an offset may be inappropriate.

AG Recommendation 3: The Legislature could hold DIR responsible for temporary disability payments if it does not hold Rehabilitation pretermination conferences within the 30 day limit.

DIR Response 3:

The Auditor General staff conducted a survey of Rehabilitation cases closed in 1987 to determine the efficacy of the Rehabilitation benefit.

The Auditor General reports that the cases it reviewed in its sample were <u>not</u> subject to the Bureau's rule pertaining to the scheduling of pretermination conferences. That rule, which was promulgated by the DIA on July 1, 1988, provides for the holding of a conference within 30 days of an employee's objection to termination of benefits.

Of the 43,740 "pre-rule" cases closed by the Bureau in 1987, the Auditor General examined 226. In 20 of these cases, employees objected to plan termination. Pretermination hearings were held an average of 74 days after the employees' objections were received by the Bureau.

The Department believes the Auditor General should have looked at the process that currently exists. In that regard, the appropriate question is whether or not there is a current problem in scheduling pretermination conferences within 30 days so as to justify legislative or other action? The Department does not believe so.

A survey by the Division of Industrial Accidents in the San Francisco office indicated that the average time to pretermination hearing was 30.2 days. The Department believes the expectations of the parties have significantly changed since the implementation of the revised rules.

In our view the alternative suggested appears to exceed the authority given to the Legislature pursuant to Article 14, Section 4 of the California Constitution. That section explicitly authorizes the statutory creation of liability to provide workers'compensation benefits on the employer--not on an administrative agency.

It also appears to be in conflict with California's public entity claims act, Government Code Section 819, et. seq.. Under the act a public entity is generally not liable for injuries, whether or not the injury arose out of an act or omission of the public entity. A public entity may, however, be liable for an injury caused by its failure to discharge a mandatory duty unless the public entity establishes that it exercised reasonable diligence to discharge the duty (Government Code Section 815.6).

Assuming the rule requiring the holding of a predetermination hearing within 30 days of an employee's objection imposes a mandatory duty on the Department, then a remedy already exists for an alleged violation of the duty. that remedy is codified in Government Code Section 815.6. If the public entity can demonstrate that it exercised reasonable diligence in discharging its duty to set the hearing within the specified timeframe, then it has no liability.

AG Recommendation 4: The Legislature could make Compromise and Release agreements and Stipulations binding on the parties without requiring a WCAB Judge's approval.

DIR Response 4:

The Department of Industrial Relations concurs with the AG's determination that WC Judge time can be more efficiently utilized by modifying the process of reviewing proposed Compromise and Releases (C&R) and proposed Stipulations.

The Department supports alternatives to the workers' compensation judge review of compromise and release agreements. However the Department also recognizes the potential risks in the elimination of review and believes some form of administrative/legal review seems necessary.

There are many reasons why review is necessary not the least of which are the many numbers of liens filed by medical and other providers which the parties either ignore or are not aware of at

the time of settlement. Also, many of the settlements take place before the hearing but with the aid and assistance of the workers' compensation judge and often the Information and Assistance Officer, and an evaluation by the Disability Evaluation Bureau.

Since the review of compromise and release agreements accounts for more than 70% of the decisions issued, the implementation of an alternative review process would make more judge time available to hear cases.

The Department would suggest that the Information and Assistance Officers working closely with an assigned staff attorney could handle the current volume of agreements, maintain the safeguards inherent in a review process, and provide a reasonable alternative to the workers'compensation judge review, particularly if the employee is unrepresented.

Conclusion:

The Department of Industrial Relations recognizes and appreciates the efforts and professionalism of the Auditor General's Office in its review of the workers' compensation system in California.

DIR has and continues to support comprehensive modification of the California's workers' compensation system. The Department believes certain benefit levels should be increased, accompanied by changes directed at controlling unnecessary and rising costs; providing for expanded oversight of the system and providing for the expedited delivery of benefits. The Department also supports the modification of internal procedures that would accelerate the settlement process and would free up our judicial resources to hear and decide those complex and compelling issues that deserve their full and complete attention. However, the department opposes any piecemeal approach to change in the system, without addressing and recognizing the interdependency of the various parts and processes.

Thank you for the opportunity to review and comment on the draft audit report prior to its issuance.

Very truly yours,

RON RINALDI
Director

THE OFFICE OF THE AUDITOR GENERAL'S COMMENT ON THE RESPONSE BY THE DEPARTMENT OF INDUSTRIAL RELATIONS

(1) The Department of Industrial Relations is concerned that we do not make specific recommendations for each of the areas discussed in the report. However, in developing the alternatives in the report, we focused only on those areas that can be evaluated through quantitative and statistical analyses. Certain components of the system, while quantifiable, cannot be evaluated solely through quantitative and statistical means. For instance, the costs of legal fees and medical reports used as evidentiary material have risen over the years and contribute to the increased costs of premiums. Although we are able to measure these costs, it is difficult to place limitations on these costs without giving adequate consideration to the protections afforded employees through due process. Furthermore, while it is desirable to have an expeditious resolution of workers' compensation claims, an expeditious resolution must be weighted against the need to spend sufficient time to properly hear and resolve the claims. These are policy considerations that the Legislature, governor, and affected parties will need to address.

75 Years
STATE COMPENSATION INSURANCE FUND
1914 1989

March 22, 1989

J. A. WEBB
PRESIDENT

Mr. Kurt R. Sjoberg
Acting Auditor General
State of California
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Sjoberg

Thank you for the opportunity to review and comment on draft excerpts, from your report entitled "A Review of the Workers' Compensation System," received on March 20, 1989.

At a meeting with your staff on Tuesday, March 21, 1989 we suggested some minor wording and phrasing changes to help to clarify some points. Your staff has taken those suggestions under advisement.

Your report has done an excellent job of describing the functioning of today's workers' compensation system. It should prove to be a tremendous educational tool for those empowered to make necessary changes.

Again, thank you for the opportunity to participate. Please extend my congratulations to your staff for their professional and thorough work.

Sincerely

John A. Webb

President

kms

1275 MARKET STREET • SAN FRANCISCO, CA 94103-1410
(415) 565-1456

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