

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

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Executive Director

A REVIEW OF
THE CURRENT PROBLEMS IN CALIFORNIA'S
WORKERS' COMPENSATION SYSTEM

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Executive Director

March 1, 1988

The Honorable George Deukmejian
Governor of California

The Honorable David A. Roberti
President pro Tempore of the Senate
and the Members of the Senate

The Honorable Kenneth L. Maddy
Senate Minority Floor Leader

The Honorable Willie L. Brown, Jr.
Speaker of the Assembly
and the Members of the Assembly

The Honorable Patrick Nolan
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

The Commission on California State Government Organization and Economy, also known as the Little Hoover Commission, has completed a review of current problems in California's workers' compensation system. The Commission commenced this study out of concern for the system's escalating costs, the expansion of liability into new and subjective areas of benefits, and the perceived negative effects of the increasing cost of the system upon workers, employers and the State's business climate.

The Commission believes that the increase in the costs of California's workers' compensation system may be threatening the system's viability. For example, direct written premiums have increased from \$2.9 billion in 1982 to \$5.3 billion in 1986, an increase of 83 percent.

The Commission's study also revealed that, while written premiums have increased significantly, the weekly benefit rates paid to injured workers in California remain among the lowest of the urban, industrialized states in the country. In addition, the number of injuries reported per 1,000 workers has decreased from 39.17 in 1979 to 35.89 in 1986, a decrease of 8.4 percent. Thus, the increase in system costs is primarily due to an increase in the number of people in the workforce and an increase in the average cost per claim, not to an increase in the rate of claims filed.

Currently, several areas of the workers' compensations system are increasing rapidly in size and cost. For example, "soft tissue" claims, mental stress claims, and employer liability claims have all increased dramatically in recent years. Unless controlled, the increasing costs of benefits and administration in these areas may strain the workers' compensation system to the breaking point.



The Commission's report presents eight findings regarding the operation of California's workers' compensation system, including:

- o The cost of operating California's workers' compensation system is among the highest in the United States;
- o Neither private insurers nor the Department of Insurance are actively encouraging the investigation and prosecution of fraud and abuse in the workers' compensation system;
- o Delays in the workers' compensation system have slowed payments to injured workers and increased administrative costs;
- o Employers who do not report accurate wages to insurance carriers raise premium rates for other employers;
- o The escalating use of employer liability insurance has significantly raised the costs of employers and carriers;
- o The increase in subjective claims for psychological disability has had a negative impact on the workers' compensation system;
- o The effectiveness of the use of vocational rehabilitation training in California has not been evaluated; and
- o Opportunities exist to better control the cost of vocational rehabilitation programs.

To address these problems, the Commission recommends the following actions be taken:

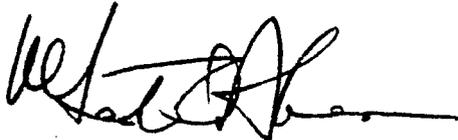
1. Establish written criteria for opening and closing workers' compensation fraud and abuse cases and encourage the reporting and prosecution of such cases.
2. Establish a method to identify employers who intentionally fail to report wages or misclassify employees to reduce workers' compensation premiums.
3. Establish a policy and method to identify employers who change business or corporate identities to avoid being properly rated based upon prior claims experience.
4. Modify current allowable vocational rehabilitation services based upon the evaluation of results of studies currently being performed.
5. Provide the authority to identify insurance carriers for audits based on poor performance.
6. Require that information be collected on employer liability policy sections, establish industry standards, and actuarially determine if a premium is needed for this section and its specific coverages.



7. Consider the use of professional court administrators to assess and manage the ongoing administrative systems and calendars of the Workers' Compensation Appeals Board Offices.
8. Consider assigning Motions and Settlements Judges to review only Compromise and Release agreements as a method of expediting the workers' compensation adjudication process within the Department of Industrial Relations.
9. Require a single and final "agreed upon third party" medical report when the results of two previous reports do not provide agreement on the nature or extent of injury to the worker.
10. Repeal the "power press" exception to general workers' compensation coverage.
11. Examine the impact of recently implemented regulatory examination protocols on the evaluation of claims for psychological and stress-related injuries.
12. Consider adopting legislation to clarify and strengthen the Insurance Commissioner's and Director of Industrial Relations' powers to assess penalties upon carriers and self-insured employers for delaying payment to the injured employee as an incentive to reduce litigation.
13. Require that employers provide employees with a thorough description of the full spectrum of benefits available through the workers' compensation insurance program when an employee is hired.

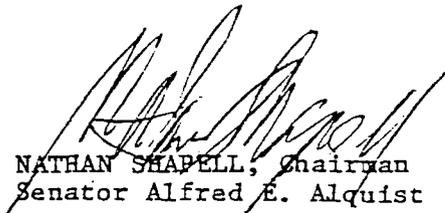
The Commission believes that the implementation of these recommendations will help control costs and improve the administration of California's workers' compensation system. This will enable the system to operate better for the good of the workers, employers and citizens of California.

Respectfully,



M. LESTER OSHEA, Chairman
Workers' Compensation System
Subcommittee

Haig Mardikian
Mary Anne Chalker



NATHAN SHAPELL, Chairman
Senator Alfred E. Alquist
Albert Gersten
Senator Milton Marks
Assemblywoman Gwen Moore
George E. Paras
Abraham Spiegel
Barbara Stone
Richard Terzian
Assemblyman Phillip Wyman

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EXECUTIVE SUMMARY

California's workers' compensation system has grown rapidly in recent years. Direct written premiums have increased from \$2.9 billion in 1982 to \$5.3 billion in 1986, an increase of 83 percent. As a result, California's workers' compensation system is the largest system of its kind in the United States.

While the amount of written premiums have been rising, the weekly benefit rates paid to injured workers in California is among the lowest of the urban industrialized states in the country. At the same time, the operational cost of the workers' compensation system has rapidly increased. Total losses incurred by insurance carriers for benefit payments increased from \$1.2 billion in 1980 to \$2.3 billion in 1984, an increase of approximately 92 percent. However, the number of injuries reported per 1,000 workers decreased from 39.17 in 1979 to 35.89 in 1986, a decrease of 8.4 percent. The increased costs of the system are therefore attributable to an increase in the average cost of claims as well as an increase in the number of persons in the workforce, not to an increase in the rate of claims filed.

Due to the recent growth in the State's workers' compensation system and its escalating costs, the Little Hoover Commission initiated a study to determine what measures could be taken to improve the system's administration and operation.

The Commission found that the cost of operating California's workers' compensation system is among the highest in the country. Although comparisons between states are difficult to make, several recent studies indicate that California's premium rates for coverage in certain categories are among the highest in the country and have been increasing at a relatively faster rate than those of other states. The number of claims filed, number of claims litigated, and administrative costs of operating the system have all increased in recent years, and have been passed on to employers as increased premiums. The increasing costs have had a negative impact on the perception of California's business climate.

The Commission also determined that the State of California and private insurers are not actively encouraging the investigation and prosecution of cases of fraud and abuse in the workers' compensation system. Private insurers have referred only 160 cases of suspected fraud and abuse in the workers' compensation system to the Department of Insurance's Fraud Bureau during the last eight years. Only 17 of the 160 cases, or approximately 11 percent, have been opened for investigation by the Department, and only one of these cases has been prosecuted.

The Commission also found that delays in the workers' compensation system have slowed benefit payments to injured workers and increased the administrative costs of the system. In the first half of calendar year 1987, the average injured worker had to wait 32.5 days for the first benefit payment. This is more than twice the 14 days required by regulation. In addition, litigation costs have increased 304 percent in

the period from 1977 through 1986, and forensic medical costs have increased 224 percent during the same period. Moreover, in 1986, it cost 52 cents in direct overhead to deliver one dollar in benefits, compared to 32 cents ten years earlier.

The Commission determined that some employers also attempt to abuse the workers' compensation system by either misreporting wages or inappropriately classifying their employees to gain lower premium rates. This forces other employers to carry a heavier burden of losses through increased rates. While the extent of such inaccurate reporting is not known, no central organization is focussing significant attention on locating and penalizing such employers who do not accurately report wages or inappropriately classify employees.

The study also showed that the escalating use of employer liability insurance has significantly raised the costs of employers and carriers. Workers' compensation policies provide both coverage for work-related injuries and employer liability, the latter to cover any potential liability not anticipated in the basic policy. Prior to 1979, claims made under the employer's liability portion of a workers' compensation policy were extremely rare. Since then, there has been a dramatic increase in the number of civil suits filed by employees under the employer's liability policy sections. This has raised costs for employers and carriers and has caused some carriers to modify or limit employer liability coverage.

The Commission's study further revealed that claims for mental stress injuries increased by 531 percent from 1980 to 1986. Such claims, because of their subjective and controversial nature, result in more frequent litigation which drives up administrative costs, increases hearing backlogs, and further delays payments to injured workers.

Finally, the Commission determined that the effectiveness of California's vocational rehabilitation programs has not yet been fully evaluated, but that opportunities currently exist to better control costs in such programs. Vocational rehabilitation benefits are a rapidly growing part of the workers' compensation benefit structure, accounting for approximately 15 percent of all benefit costs in 1986. This is a significant increase from the two percent of all benefit costs in 1976, the first year vocational rehabilitation benefits were available by law. Although systems in other states may differ from California's, measures used elsewhere to track and control costs may be applicable in California.

The Commission's report presents 13 recommendations for improving various aspects of California's workers' compensation system. These actions include:

1. The Department of Insurance Fraud Bureau should establish written criteria for opening and closing workers' compensation fraud and abuse cases. In addition, the Department should encourage carriers to report potential fraud and abuse and should actively prosecute such cases or cause them to be prosecuted.

2. The Governor's Multi-Agency Task Force on the Underground Economy should specifically establish a method to identify employers who intentionally fail to report wages to misclassify employees in order to reduce workers' compensation premiums.
3. The Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau should establish a policy and method to identify employers who change business or corporate identities to avoid being properly rated based upon prior claims experience.
4. The current allowable vocational rehabilitation services should be modified by the Legislature based upon the evaluation of results of the study currently being performed by the Division of Industrial Accidents in corporation with the California Workers' Compensation Institute and other studies of the long-term effectiveness and control of vocational rehabilitation programs. Specifically, there should be uniform standards for vocational rehabilitation programs.
5. The Governor and the Legislature should provide the Division of Industrial Accidents with the authority to identify insurance carriers for audits based on poor performance, including untimely payment of benefits, and to specify the necessary audit procedures. The Department of Insurance should be required to report to the Division of Industrial Accidents the results of those audits.
6. The Department of Insurance should require the Workers' Compensation Insurance Rating Bureau to collection information on the carrier's employer liability policy sections and to recommend a standardization of policies. The Department of Insurance should use this information to establish industry standards and actuarially determine if a premium is needed for this section and its specific coverages. In addition, the information on each carrier's policies should be provided to the public.
7. The Department of Industrial Relations should consider the use of professional court administrators to assess and manage the ongoing administrative systems and calendars of the Workers' Compensation Appeals Board Offices.
8. As an interim measure, the Department of Industrial Relations should consider assigning Motions and Settlements Judges to review only Compromise and Release agreements as a method of expediting the adjudication process.
9. The Governor and the Legislature should enact legislation to require a single and final "agreed upon third party" medical report when the results of two previous reports do not provide agreement on the nature or extent of injury to the worker.

10. The Governor and the Legislature should enact legislation to repeal the "power press" exception to general workers' compensation coverage.
11. The Department of Industrial Relations should examine the impact of recently implemented regulatory examination protocols on the evaluation of claims for psychological and stress-related injuries. If the results of this review indicate that minimum standardized examination procedures are of value in assessing injury, the Department should work to establish examination protocols for other injuries not covered by current protocols.
12. The Governor and the Legislature should consider adopting legislation to clarify and strengthen the Insurance Commissioner's and Director of Industrial Relations' powers to assess penalties upon carriers and self-insured employers for delaying payment to the injured employee as an incentive to reduce litigation.
13. The Governor and the Legislature should consider requiring employers to provide the employee with a thorough description of the full spectrum of benefits available through the workers' compensation insurance program when an employee is hired.

I. INTRODUCTION

The State of California's workers' compensation system is the largest workers' compensation system in the United States. Moreover, the system has grown rapidly in recent years. The amount of direct written premiums has increased from \$2.9 billion in¹ 1982 to \$5.3 billion in 1986, an increase of 83 percent in four years.

While the amount of written premiums in the State's workers' compensation system has increased significantly, the weekly benefits paid out to injured workers are among the lowest in the nation. Presently, California ranks among the lowest urban, industrialized states in the weekly rates paid for temporary and permanent disability,² according to a study by the National Council on Compensation Insurance.

The cost of the workers' compensation system has also increased rapidly in recent years. For example, the total loss incurred by insurance carriers due to workers' compensation benefit claims increased from \$1.2 billion to \$2.3 billion between 1980 and 1984, an increase of more than 90 percent.³ However, the number of injuries reported per 1,000 workers decreased 8.4 percent between 1979 and 1986.⁴ Thus, the increased costs in the system are attributable to the increase in the number of persons in the work force and the rise in the cost of claims, not to an increase in the rate of claims being filed.

Due to the recent growth in the State's workers' compensation system and its escalating costs, the Commission decided to undertake a study of current problems in the system and determine what could be done to improve the administration and operation of the system.

SCOPE AND METHODOLOGY

The Commission initiated its review of current problems in the State's workers' compensation system in July 1987. Commission Chairman Nathan Shapell appointed Commissioner Lester Oshea as Chairman of the Subcommittee responsible for overseeing and directing the study. In addition, Commissioners Mary Anne Chalker and Haig Mardikian were appointed as members of the Subcommittee. The Commission also retained an independent consultant, Karl W. Dolk, CPA to assist with the fieldwork and technical analysis performed in the study.

¹California's Workers' Compensation Institute, Bulletin, June 10, 1987.

²National Council on Compensation Insurance -- 1985 Annual Statistical Bulletin.

³Workers' Compensation Insurance Rating Bureau -- First Reports of Injury 1980-1984.

⁴Department of Industrial Relations, Division of Labor Statistics and Research -- 1986 California Work Injuries and Illnesses.

The purpose of the study was to review potential problem areas in the workers' compensation system, including:

- o Escalating premiums;
- o Delays in the payment of benefits;
- o Increasing legal and medical costs; and
- o Impact of the expansion of liability into new and more subjective benefits.

As part of this study, the Commission held a public hearing on August 19, 1987 in San Francisco. At this hearing, the Commission received testimony from state agencies responsible for the regulation or issuance of workers' compensation insurance, private insurance carriers, and representatives of employers and employees associations. Commission staff also conducted extensive fieldwork to collect information from various state agencies, public and private research organizations, and other organizations and individuals involved in various aspects of the workers' compensation system. In addition, Commission staff attended administrative and legislative hearings and public conferences dealing with the State's workers' compensation system.

REPORT FORMAT

The report is presented in four chapters. Chapter II provides background information and a description of the current system in California. Chapter III presents the Commission's findings, and Chapter IV provides the Commission's conclusions and recommendations for resolving the specific problems identified during the study.

II. BACKGROUND

This chapter presents an overview of California's workers' compensation law and the types of benefits provided in the State's workers' compensation system. It also discusses the administration, payment and regulation of benefits and presents summary data on the costs and benefits paid in the State's system.

CALIFORNIA'S WORKERS' COMPENSATION LAW

The enactment of workers' compensation laws in the early part of this century dramatically changed the manner and circumstances in which personal injuries sustained in the course of employment are compensated. The principle that a person should be responsible for injuries caused by his or her own fault was largely abandoned. Instead, workers injured in the course of employment, or their dependents in the case of death, were provided limited compensation without regard to who was at fault.

The fundamental purposes in establishing workers' compensation laws were to assure injured workers that they would receive limited, specified compensation for industrial injuries and to limit employers' liability for employee injuries to a specified amount of compensation. The laws and system were designed to assure prompt, certain payment of benefits and to allow employees, employers, and insurance carriers to deal with one another in an extra-legal atmosphere.

The California system of workers' compensation was largely developed between 1911 and 1918, a period during which three major workers' compensation acts and three related constitutional amendments were enacted. While workers' compensation laws have been amended over the years, the basic structure has changed little since this initial development period.

TYPES OF BENEFITS

There are five basic types of benefits which may be provided under workers' compensation. The benefit that is provided depends on the nature and severity of the injury. Each benefit was originally intended to serve a separate function, although in practice, especially in the last several years, the use of the benefits overlap. These benefits include:

- o Medical Treatment - Employers are responsible for providing medical and hospital treatment reasonably required to cure or relieve the effects of an industrial injury, as soon as the employer learns of the injury. If treatment is not provided, the employer is liable for treatment obtained by the injured worker. Treatment may be obtained during the first 30 days after injury notification by a practitioner or facility designed by the employer, unless the worker notifies the employer that he or she has a personal physician. If the injured worker has provided this notice, the worker may be treated from the date of injury by that physician. Otherwise, the worker may change to a practitioner or facility of his or her choice 30 days after reporting the injury. A schedule of recommended minimum fees for medical treatment is established by the Division of Industrial

Accidents, and medical treatment is available until the injured employee has recovered.

- o Temporary Disability Benefits - Temporary benefits are provided to replace a portion of lost earnings while the injured worker is recovering. These benefits are generally payable after a three-day waiting period, unless the worker is hospitalized. The first payment is effective from the fourth day after injury, unless the waiting period is waived, and continues until the worker is able to return to work, or the injury condition is determined by the insurance carrier to be permanent and stationary.

If the injured worker is totally disabled, the temporary disability benefit is two-thirds of his or her average weekly earning at the time of the injury, subject to a statutory minimum and maximum of \$112 and \$224, respectively. If partially disabled, the temporary disability benefit is two-thirds of the injured worker's wage loss, subject to the same minimum and maximum. Payments must be made at least twice each calendar month as long as benefits are payable. For injuries occurring after January 1, 1979, there is no limit on the period of temporary total disability benefits paid. Temporary benefit schedule amounts are set by statute and subject to periodic legislative change.

- o Permanent Disability Benefits - Permanent disability benefits are paid if an injury is determined to have permanent consequences which impair the earning capacity of the injured worker. If the injured worker is determined to have lost all of his or her earning capacity, permanent total disability benefits are paid for life at the same rate, and subject to the same minimum and maximum, as temporary total disability benefits. Permanent disability payments are not adjusted after two years to reflect any changes in the minimum and maximum, but remain subject to those in effect at the time of injury. There are very few cases of permanent total disability.

If a worker is found to have permanently lost a portion of his or her earning capacity, permanent partial disability benefits are payable for up to 619 weeks, at a rate of two-thirds of the worker's average weekly wage, within a minimum and maximum range of \$70 to \$140 weekly. Workers with a permanent partial disability may also be entitled to a small weekly life pension up to a maximum of \$64.21 per week when regular benefits cease. Permanent benefit schedules are also set by statute.

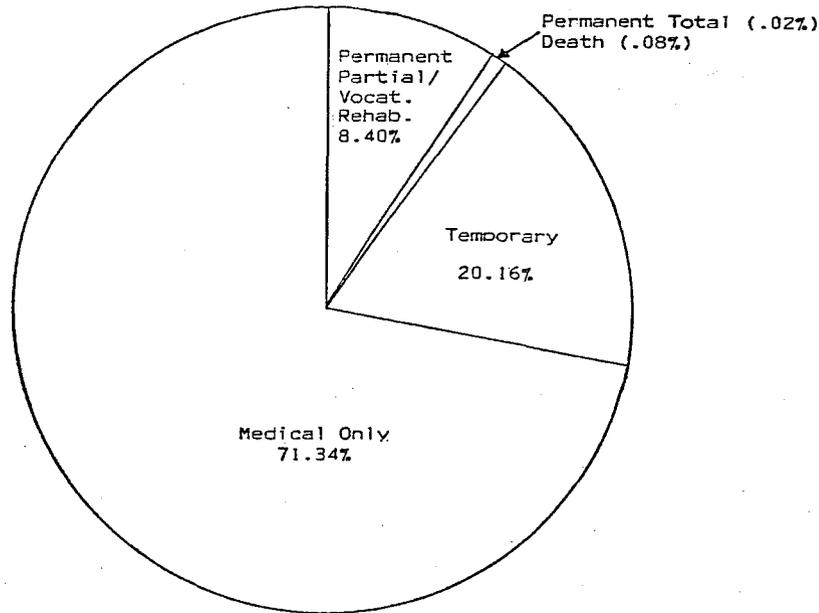
- o Vocational Rehabilitation - These benefits were enacted as a mandatory benefit in 1974, entitling qualified injured workers to vocational rehabilitation under the supervision of a rehabilitation unit in the Division of Industrial Accidents within the State's Department of Industrial Relations. The statutory provisions are skeletal. They provide undefined qualified injured workers disability benefits as well as necessary additional living expenses while in rehabilitation. The specifics of this benefit have been fleshed out in administrative regulations and judicial interpretations and are the subject of great disagreement as to their application and effectiveness.

- o Death Benefits - The dependents of a fatally injured worker are entitled to receive reasonable burial expenses, up to \$2,000 and a death benefit, the amount of which varies with the number of dependents and the extent of their dependency. The death benefit can range from \$70,000 to a maximum of \$95,000. Such benefits comprise a very small part of the total number of claims filed and benefits paid each year.

Exhibit II.1 shows the distribution of insured claims, by type, for calendar 1983, the most recent year for which published data is available.

EXHIBIT II.1

CALIFORNIA WORKERS' COMPENSATION SYSTEM
DISTRIBUTION OF INSURED CLAIMS
CALENDAR YEAR 1983



Source: Workers' Compensation Insurance Rating Bureau

Exhibit II.1 shows that 71.34 percent of insured cases reported in 1983 involved medical treatment costs only. Temporary disability claims, including medical treatment, comprised 20.16 percent of all recorded claims; permanent partial disability claims totalled 8.40 percent of all claims, and permanent total disability comprised .02 percent of all claims; and death claims totalled 0.08 percent of all claims.

ADMINISTRATION, PAYMENT AND REGULATION OF BENEFITS

Workers' compensation benefits in California are largely privately administered. These benefits are markedly different than other social insurance programs in which government directly finances and determines

eligibility for benefits. The State assumes primarily a supervisory role in administering the workers' compensation benefit system.

Employers, other than the State of California, are required to secure payment of workers' compensation benefits by either of two methods: (1) purchase of insurance from a privately authorized insurer of the State Compensation Insurance Fund (SCIF); or (2), by formal consent from the Director of the Department of Industrial Relations to self-insure compensation liability. The statutory requirements for certification as a self-insured employer are such that this is a practical option only for public agencies and large private employers, so most employers purchase workers' compensation insurance policies.

Insurers and self-insured employers are expected to make payments to injured workers in the appropriate amount at mandated intervals without the involvement of the State. The State generally becomes involved in the benefit payment process either through services to the policyholders of the SCIF, or to provide information to the various parties and to resolve disputes when necessary. Governmental and quasi-governmental agencies are also heavily involved in the rate-making and regulatory processes of workers' compensation insurance. These government agencies include:

- o State Compensation Insurance Fund (SCIF) - Established concurrently with the workers' compensation system in 1914, SCIF's purpose is to act as a competitive insurer in the free marketplace and act as the "safety net" or carrier of last resort for the system. By law, SCIF is required to offer workers' compensation coverage to any employer in the State who meets minimum defined workplace safety standards. The SCIF is the largest workers' compensation insurer in the State, currently covering approximately 30 percent of the policyholders in the State.
- o Workers' Compensation Insurance Rating Bureau (WCIRB) - The WCIRB is funded and operated by the workers' compensation carriers, and is licensed by the Insurance Commissioner to periodically develop and recommend rates for each of the more than 400 employment classifications, based on prior benefits and administrative costs. The recommended rates are then forwarded to the Department of Insurance for public review and approval. After approval, rates are applied to the employer's payroll in each appropriate category and vary with each classification's degree of risk. The Bureau also hears appeals from employers regarding the appropriateness of their classification by the insurance carriers.
- o Department of Insurance (DOI) - The Department of Insurance is responsible for the review of proposed rate changes developed by the WCIRB. The Department reviews these rates in public hearings and may then adopt without change, modify, or refuse to adopt the rate schedules. The approved rate becomes the minimum rate charged by an insurer, except by application of a merit rating plan approved by the Insurance Commissioner. These approved minimum rates may be supplemented by carrier's experience modification surcharges to the insured, also filed with the WCIRB and DOI. These surcharges are not subject to regulation. After the expiration of a policy, the carrier may choose to pay dividends to policy holders on the basis of that

insured's claims history, thus lowering net premium costs in some instances. Finally, the DOI and the Insurance Commissioner license and regulate the business practices of the more than 400 insurance carriers admitted to offer workers' compensation insurance in California.

- o Department of Industrial Relations (DIR) - The Department maintains several functions relating to workers' compensation insurance. The Division of Industrial Accidents (DIA) is charged with preventing, settling, adjudicating and administering disputes under the workers' compensation statutes and regulations. This is done either informally by Information and Assistance Officers within the DIA's regional offices, or more frequently, by formal hearing and resolution before the Workers' Compensation Appeals Board (WCAB). The WCAB is a court of limited jurisdiction with exclusive authority to resolve workers' compensation disputes. Proceedings are initiated by filing an "application for adjudication of claim" with the WCAB. A hearing may be held before a workers' compensation judge in one of the 22 local offices after the applicant declares he or she is ready to proceed with the case. The decision of a workers' compensation judge may be reconsidered by the seven member WCAB, and its decision is then reviewable only by the appellate courts.

The DIA also maintains a Disability Evaluation Bureau to assist parties and workers' compensation judges determine the appropriate amount of permanent disability benefits. Informal or consultative rates are issued to assist the parties in determining the amount of permanent disability benefits payable or to assist the parties reach a settlement of this frequently disputed issue. Formal ratings are issued at the request of workers' compensation judges when settlements are not reached.

Finally, the DIA by regulation and administrative policy sets standards for approval and application of vocational rehabilitation plans for qualified injured workers. It also provides workers' compensation benefits under certain special mandated programs.

The Department separately operates two additional programs: a Division of Labor Statistics and Research, which compiles data on occupational illnesses and injuries; and the Bureau of Self-Insurance Plans, which reviews, approves and regulates employers' self-insurance plans.

The DIR also administers three special funds from which benefits may be paid under certain conditions. The Uninsured Employer's Fund may make benefit payments to an injured worker when that worker's employer at the time of injury is illegally uninsured. This fund is financed by recoveries from uninsured employers and contributions from the State's General Fund. The Asbestos Worker's Fund, established as a revolving fund in 1980, may advance medical, total disability and death benefits to workers with asbestos pending identification of the liable employer or insurer. The Subsequent Injuries Fund, primarily financed by general fund monies, may pay benefits when a permanently disabled worker sustains a subsequently greater permanent disabling injury.

COSTS AND BENEFITS OF WORKERS' COMPENSATION

The Workers' Compensation Insurance Rating Bureau collects data on workers' compensation costs and recommends rate adjustments to the Insurance Commissioner. These minimum premium rates provide the basis for insurance carriers' charges to employers. Some of the premiums charged to the employer may be returned through a dividend from the insurance carrier. This dividend is based on the carrier's income and the claim experience of the employer.

The workers' compensation insurance rates have been increasing significantly during the past five years in California. Exhibit II.2 displays the approved rate level changes for workers' compensation insurance in California since January 1983.

EXHIBIT II.2

RATE LEVEL CHANGES FOR
WORKERS' COMPENSATION INSURANCE
CALENDAR YEAR 1983 THROUGH 1988

<u>Effective Date</u>	<u>Percent Change in Rate Levels</u>
January 1, 1983	15.1
January 1, 1984	(6.0)
January 1, 1985	6.1
March 1, 1985	3.1
January 1, 1986	8.2
July 1, 1986	5.3
January 1, 1987	9.0
July 1, 1987	6.0
January 1, 1988	<u>3.3</u>
TOTAL	<u>50.1</u>

Source: Department of Insurance

The overall effect of the above changes over the last five years has been a total increase of 50.1 percent in minimum approved rates since January 1983. Rate increases during the last several years have been attributed by the carriers and the WCIRB to rising medical costs, the increasing cost of vocational rehabilitation benefits, and an increase in the cost and frequency of stress-based disability claims.

There are two primary cost components of workers' compensation: the cost of benefits to injured employees; and, the cost of administering those benefits. Exhibit II.3 shows the WCIRB's estimate of the 1986 distribution of benefits and expenses, as used to determine minimum rates.

EXHIBIT II.3

WORKERS' COMPENSATION COSTS IN CALIFORNIA
DISTRIBUTION OF BENEFITS AND EXPENSES
CALENDAR YEAR 1986

<u>Benefits</u>	<u>Percent</u>
Medical	28.8
Temporary	9.2
Vocational Rehabilitation	10.0
Permanent Partial	17.2
Permanent Total	1.0
Death	<u>1.1</u>
Sub-total	67.3
<u>Operating Costs</u>	
Commissions and Fees	5.8
Taxes	4.0
Loss Adjustment Expenses	8.7
Other Expenses	<u>9.4</u>
Sub-total	27.9
<u>Profits</u>	
Profits	<u>4.8</u>
TOTAL	<u><u>100.0</u></u>

Source: Workers' Compensation Insurance Rating Bureau

Exhibit II.3 shows that benefits to injured employees make up 67.3 percent of the costs to the workers' compensation system. Operating costs comprise 27.9 percent of the costs and profit accounts for 4.8 percent of the costs.

The California Department of Industrial Relations, Division of Labor Statistics collects information on the number and rate of disabling injuries and illnesses. Exhibit II.4 displays this information for the period between calendar year 1979 and 1986.

EXHIBIT II.4

COMPARISON OF NUMBER AND RATE OF
DISABLING INJURIES AND ILLNESSES BETWEEN
CALENDAR YEAR 1979 AND 1986

	<u>1979</u>	<u>1986</u>	<u>Percent Change</u>
Number of Claims Filed	382,227	406,683	6.39
Number of Workers in Workforce	9,578,100	11,330,100	16.10
Number of Injuries per 1,000 Workers	39.17	35.89	(8.40)

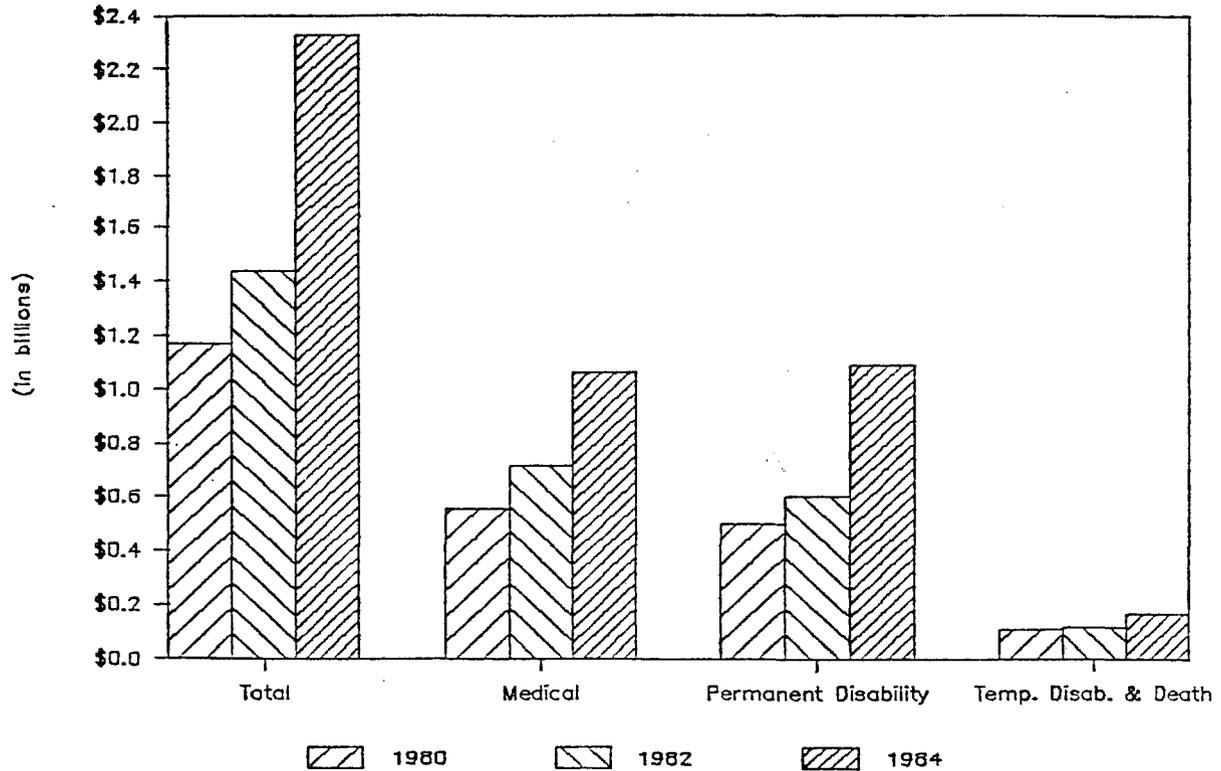
Source: California Department of Industrial Relations, Division of
Labor Statistics

Exhibit II.4 shows that while the number of claims filed by injured workers increased by 6.39 percent between 1979 and 1986, the number of workers in the workforce increased 16.1 percent during this period. Thus, the rate of injuries per 1,000 workers in the workforce actually declined during this period from 39.17 to 35.89, a decline of 8.4 percent.

Total costs for the workers' compensation system in California have increased dramatically in recent years. Exhibit II.5 shows the insurance carriers' dollar increases for various benefits and costs based on first reports of benefits paid for policy years 1980, 1982, and 1984.

EXHIBIT II.5

CALIFORNIA WORKERS' COMPENSATION SYSTEM
COMPARISON OF CARRIERS' TOTAL INCURRED LOSS
POLICY YEARS 1980, 1982 AND 1984



Source: Workers' Compensation Insurance Rating Bureau

Exhibit II.5 shows that the total incurred loss due to workers' compensation benefit claims increased from \$1.2 billion to \$2.3 billion between 1980 and 1984, an increase of more than 90 percent. It should be noted that the maximum permanent disability rate was raised from \$70 to \$140 per week during this period. The increase took effect over a two-year period beginning in January 1983.

TYPES OF CLAIMS FILED

While the rate of claims filed per 1,000 workers has decreased slightly since 1979, the type of injury or illness for which workers' compensation benefits have been claimed has changed significantly in certain categories. Exhibit II.6 displays the changes in the types of injury or illness claimed from 1979 to 1986.

EXHIBIT II.6

CALIFORNIA WORKERS' COMPENSATION SYSTEM
 COMPARISON OF OCCUPATIONAL ILLNESSES AND INJURIES CLAIMED
 BETWEEN CALENDAR YEAR 1979 and 1986

<u>Type of Injury or Illness</u>	<u>Number Claimed 1979</u>	<u>Number Claimed 1986</u>	<u>Percent Change</u>
Amputations	658	973	47.9
Burns and Scalds	11,432	9,350	(18.2)
Contusions and Crushing Injuries	39,748	32,712	(17.7)
Cuts and Punctures	54,010	54,522	0.9
Fractures	21,308	40,776	91.4
Occupational Illnesses	18,896	30,647	62.2
Scratches and Abrasions	19,024	15,148	(20.4)
Strains, Sprains, Dislocations and Hernias	160,257	176,289	10.0
Other Injuries	3,729	6,034	61.8
Nature Not Stated	<u>53,165</u>	<u>40,232</u>	(24.3)
TOTAL	<u>382,227</u>	<u>406,683</u>	6.4

Source: Department of Industrial Relations - Division of Labor
 Statistics

Exhibit II.6 shows that the occupational illnesses and "soft tissue" claims have accounted for a larger share of the claims filed. Strains, sprains and occupational illnesses accounted for 160,257 claims in 1979, or 46.9 percent of all injuries. Similarly, in 1986, strains, sprains and occupational illnesses accounted for 176,289 claims, or 50.9 percent of all claims. These "soft tissue" claims are much more difficult to diagnose and, therefore, the cost of adjudicating the claims tend to be higher. In addition, a recent study by the California Workers' Compensation Institute on mental stress claims indicates that as a subcomponent of occupational illnesses, stress claims have increased dramatically in recent years. The CWCI study indicates that from 1980 to 1986 mental stress claims increased by 531 percent, from 1,282 claims in 1980 to 6,812 claims in 1986. Mental stress claims in 1986 comprised 22 percent of all occupational illness claims, and 1.7 percent of all claims filed of all types in 1986.

III. STUDY FINDINGS

This chapter presents the Commission's findings regarding problems within the workers' compensation system in California. Each finding is presented separately in the following sections.

FINDING #1 - THE COST OF OPERATING CALIFORNIA'S WORKERS' COMPENSATION SYSTEM IS AMONG THE HIGHEST IN THE UNITED STATES

Although it is difficult to make comparisons between workers' compensation costs and benefits, several recent studies indicate that in certain categories California's premium rates for coverage are among the highest in the country. Moreover, these studies indicate that California's premium rates have been increasing relatively faster than those of other states. California paid out 16 percent of all benefits nationwide in 1984. The number of claims filed, the number of claims litigated and the cost of operating the system have all increased in recent years. As a result, these increased costs have been passed on to employers. The increased workers' compensation costs have had a negative impact on the perception of California's business climate.

A number of comparisons of workers' compensation costs and benefits have been attempted between states. However, the ability to draw meaningful comparisons has been limited by the differences in each state's laws, regulations and business makeup. Comparisons of aggregate benefit payments are invalid because of the disparity between workforce size, makeup, and benefit rates in different states.

A more accurate comparison of interstate costs is to compare premium rates for similar categories. The concerns in making such a comparison lie in the differences in the adequacy of the various states' premium rates and in the differing systems of rating and classification that are used. California's unique classification and rating system presents particular problems when an attempt is made to compare it with other states.

The Commission reviewed the results of two studies of interstate premium rates. An interstate cost comparison using classification comparisons was prepared several years ago for the State of Michigan. California is included in the comparison, but with the qualification that only a rough comparison can be drawn because of California's different classification and rating system. Even with this qualification California appears among the "high cost" states.⁵

The second study of interstate rates by classification was completed in November 1987 by the WCIRB. The report's findings are qualified by the differences in classification systems and the question of adequacy of rates, but two items stand out. First, for the 30 classifications surveyed

⁵Burton, Hurst and Krueger, "Interstate Variations in Employers' Costs of Workers' Compensation, With Particular Reference to Michigan and Other Great Lake States."

in eight large industrial states in 1987, California had the highest rates in 10 classifications. Second, the report concludes that ". . .⁶ rates in California have increased compared to the rates in other states."

A variety of other reports has been published in recent years that point a finger at California's rising workers' compensation costs. The 1987 Annual Statistical Bulletin prepared by the National Council on Compensation Insurance ranked California sixth highest in frequency of medical injuries. Another publication, the CWCI Bulletin of February 2, 1987, stated that almost 16 percent of all state workers' compensation benefits nationally were paid to California employees in 1984. The amount of workers' compensation benefits paid in California in 1984 was \$2,687,267, an increase of 18.9 percent over the previous year. These negative statistics regarding California's workers' compensation system may reduce the number of companies willing to locate in the state.

The negative perception of California's workers' compensation system was also reinforced by a national accounting firm's study of the various states' general manufacturing climates, published in June 1987. The annual report of the firm of Grant Thornton on the general manufacturing and business climates of all states in the nation rated California as the 30th most desirable location to establish or run a manufacturing operation. California ranked highly for the availability and education of its workforce, but state-regulated workers' compensation costs were cited as a primary reason for the State's lower overall ranking.

FINDING #2 - NEITHER PRIVATE INSURERS NOR THE DEPARTMENT OF INSURANCE ARE ACTIVELY ENCOURAGING THE INVESTIGATION AND PROSECUTION OF FRAUD AND ABUSE IN THE WORKERS' COMPENSATION SYSTEM

The State of California and private insurers are not actively encouraging the investigation and prosecution of cases of fraud and abuse in the workers' compensation system. Private insurers have referred only 160 cases of suspected fraud and abuse in the workers' compensation system to the Fraud Bureau of the Department of Insurance during the last eight years. Only 17 of these 160 cases have been opened for investigation by the Department, and only one of these cases has been prosecuted.

Since the Department of Insurance established the Fraud Bureau eight years ago, all insurance companies are required to notify the Bureau of suspected workers' compensation fraud. These referrals of suspected cases of fraud may be done by the carrier in addition to litigation of the case to the Workers' Compensation Appeals Board (WCAB). A total of 160 referrals have been made since 1979 for suspected fraud. When a suspected fraud case is first referred to the Bureau, a supervisor will review the case file, determine the case complexity, degree of evidence present and necessary for successful prosecution, and the actual dollar amount involved in the disputed claim.

⁶Workers' Compensation Insurance Rating Bureau, private communications of November 30, 1987.

A review of the Bureau's operations and records indicates that there are no firm written guidelines or criteria for determining which potential fraud cases should be investigated. This process has resulted in only 17 cases being opened for investigation out of the 160 cases reported. As of January 14, 1988, only three cases remain open and one case has been prosecuted. The single case being prosecuted began preliminary hearing on January 14, 1988.

According to personnel of the Fraud Bureau, the quality of evidence provided by both the insurance carriers and the self-insured employers is very poor, which makes a subsequent investigation very difficult. However, insurers have stated that the Fraud Bureau has discouraged the filing of workers' compensation fraud cases due to the Bureau's lack of resources and reluctance to prosecute such cases.

Most carriers and self-insured employers do not maintain staff primarily responsible for fraud detection nor do they train their workers' compensation personnel to detect fraud. The insurers' important determinations are whether the claim justifies payment and, if so, what amount of payment is due. If the claim is denied, further investigation does not appear to be encouraged. In addition, many insurance companies keep only the necessary data to process the claims. Information concerning past claims, doctors, attorneys, types of claims and other data useful for determining fraud are not generally maintained. This situation, combined with carriers' concerns about bad faith lawsuits should they report a potential fraud, and the discouraging reception given workers' compensation fraud cases previously submitted, has probably limited the number of fraud cases reported to the Fraud Bureau.

Further, in some counties, the District Attorney's fraud investigative unit will not take a case that is under a given dollar amount, or will not prosecute a case because they believe that other legal remedies exist. Since most workers' compensation fraud would tend to be in smaller dollar amounts, this limits the possibility of prosecuting the individual. According to Fraud Bureau personnel, workers' compensation cases are the least popular type of insurance case with both the District Attorneys and the investigators of the Bureau.

A review of the closed case files of the Fraud Bureau provide a range of examples of case closures. In one case, the county District Attorney refused to prosecute a case referred by the Bureau because "adequate civil remedies" existed. In another case, a Workers' Compensation Judge in a case decision stated that, "this is one of the clearest cases of fraud and perjury that has been presented to this trier of fact in many years." At the hearing, the carrier had introduced as evidence undercover films of the alleged blind injured worker loading a truck with building materials and then driving the truck. The case was referred directly to the local District Attorney, who referred it to the Fraud Bureau. After review and preliminary investigation by the Bureau, the case was closed with the statements that "case would require a significant investment of time to determine worthiness for prosecution" and "Bureau has several cases more deserving of investigative hours than this one."

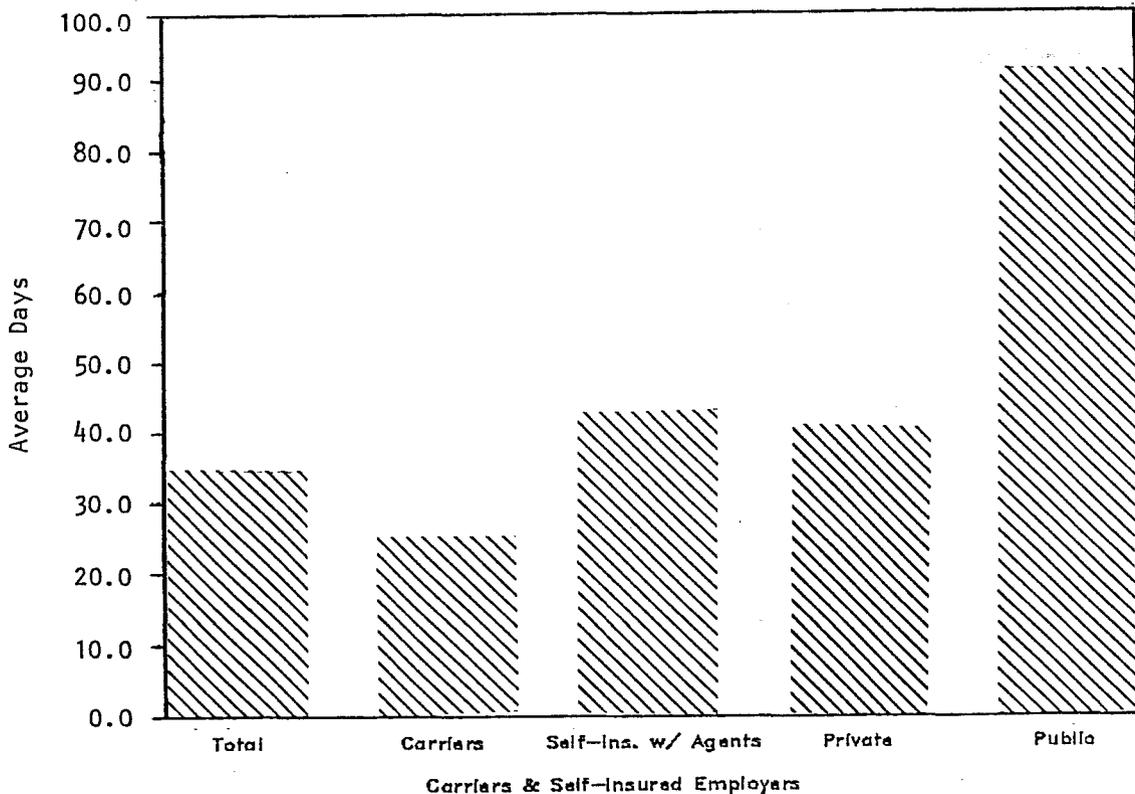
**FINDING #3 - DELAYS IN THE WORKERS' COMPENSATION SYSTEM HAVE SLOWED
PAYMENTS TO INJURED WORKERS AND INCREASED ADMINISTRATIVE COSTS**

Delays in processing claims and settling litigated claims results in employees not receiving timely benefits and in increased costs to the employers. The average injured employee in California during the first half of calendar year 1987 had to wait 32.5 days for the first benefit payment. This is more than twice as long as the 14 days standard established in Benefit Notice regulation. In addition, forensic medical costs have increased 224 percent in the ten years ending in 1986 and litigation costs have increased 304 percent in the same period. Moreover, it costs 52 cents in direct overhead to deliver one dollar in benefits in 1986 compared to 32 cents ten years earlier. The delays in payments to injured workers combined with the increased forensic medical costs and litigation costs have dramatically increased the administrative overhead costs of delivering workers' compensation benefits.

California regulation requires that an injured worker receive either the first benefit payment within 14 days of notification of injury, or notification of the reason benefits have been delayed or denied. However, this requirement has not been met. Exhibit III.1 shows the results of the most recent published surveys of benefit time lags by the Division of Labor Statistics of the Department of Industrial Relations.

EXHIBIT III.1

**TIME DELAYS IN FIRST BENEFIT PAYMENTS
JANUARY 1987 THROUGH JUNE 1987**



As Exhibit III.1 shows, in the first half of 1987 the time-lag between the date of disability and the first payment of indemnity benefits for both insurance carriers and self-insured employers averaged 32.5 days. During that period, insurers made 87,458 payments with an average time-lag of 25.3 days. Of these payments, 54.2 percent were paid within 14 days. Private self-administered entities paid 7,354 claims with an average time lag of 41.0 days and 58.7 percent paid with 14 days. Public self-administered entities paid 5,749 claims with an average time lag of 90.5 days and 33.7 percent paid within 14 days. Third party administrators paid 24,166 claims with an average time lag of 42.2 days and 37.4 percent paid within 14 days.

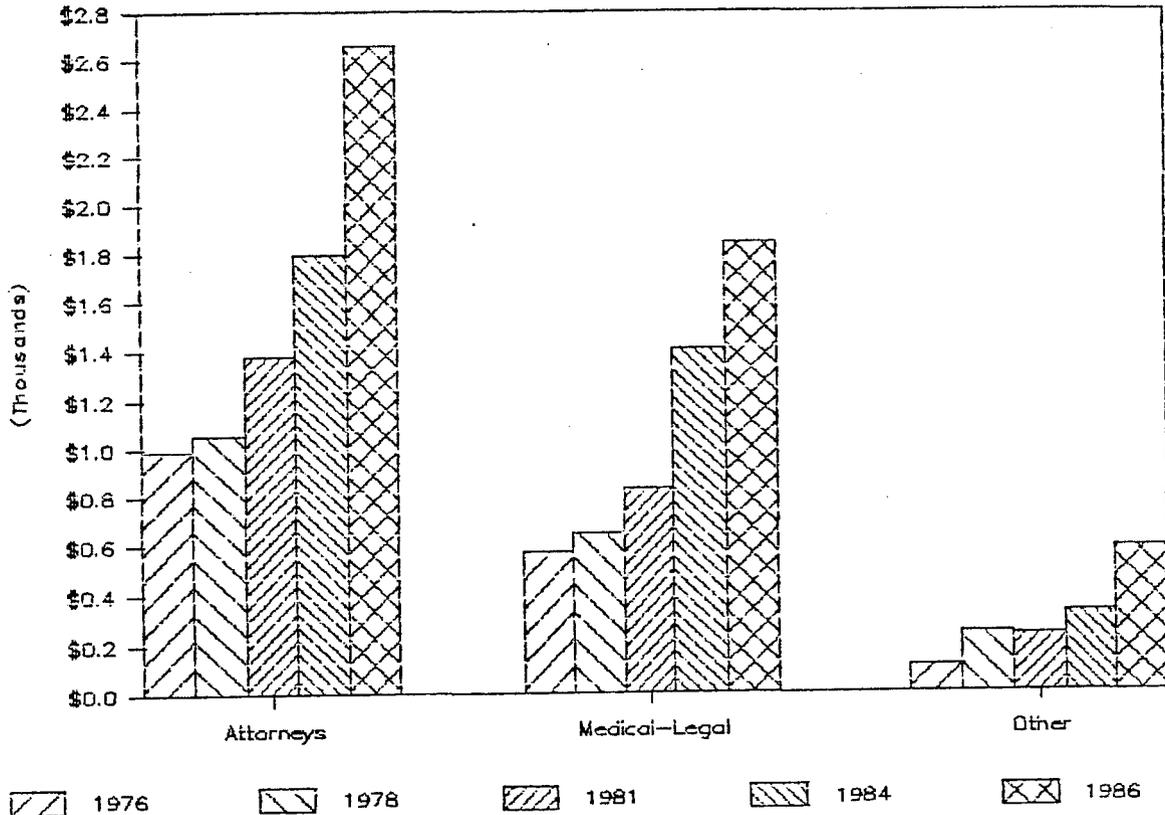
The Department of Industrial Relations has not been able to enforce the regulatory 14-day payment notice requirement since they lack the authority to effectively discipline the carriers. Recently, DIR has placed some carriers on notice regarding late payments, but the legal authority to discipline insurance carriers for such matters lies with the Department of Insurance. The Department of Insurance to date appears to have taken no action to cause insurers to speed payment of benefits. The Department of Industrial Relations, through its Office of Self-Insurance Plans, does have full legal authority and oversight over self-insured employees, and has taken action to audit those employers or plan administrators who excessively delay benefit payments.

The time-lag delay in making benefit payments becomes even more pronounced in litigated cases. According to a 1986 CWCI study, the average time-lag from injury to case resolution is 35.5 months. The study further discloses that an average of 10.5 months passes after the injury before the Application for Adjudication is filed, 14.5 additional months pass before the Declaration of Readiness is filed with an additional 10.4 months required to resolve the case.⁷ During the time-lag, injured employees seldom receive any benefits from the workers' compensation system.

When cases are litigated the two primary costs incurred as a result of delays are forensic-legal costs and attorneys' fees. Exhibit III.2 shows the increases in these two costs during the last ten years.

⁷California Workers' Compensation Institute, 1986 Litigation Cost Survey.

EXHIBIT III.2
FORENSIC-LEGAL COSTS AND
ATTORNEYS' FEES
CALENDAR YEAR 1976 to 1986



Source: California Workers' Compensation Institute

Exhibit III.2 shows that the average attorney fees increased from \$987 in 1976 to \$2,658 in 1986, an increase of 169 percent. It also reveals that forensic medical costs increased from \$569 to \$1,841 for the same periods, an increase of 223 percent. In addition, other costs increased from \$110 to \$579 or 426 percent.

Forensic Medical Costs

Medical-legal costs are direct costs to the workers' compensation system. It is not uncommon in a litigated claim for three or more physicians or health professionals to be involved. In fact, a WCIRB study conducted in 1986 showed an average of 2.1 medical-legal reports for each permanent

disability claim filed.⁸ The employee has the right to choose a doctor and may, in fact, elect to be examined by more than one doctor. The insurance carrier or employer may also elect to have a doctor or doctors of their choice examine the injured employee to better identify the extent of injury.

In litigated cases, additional medical reports may be required to update the status of an injured worker during the months and years the claim is in litigation. The dollar amount of medical-legal costs has approached 20 percent of the value of the award in 1986. This is based on a point-in-time study conducted by CWCI which shows an average medical-legal cost of \$1,841⁹ in 1986 compared to \$569 in 1976, an increase of 223 percent in ten years.

Attorneys' Costs

According to a CWCI study published in June 1987, the average out-of-pocket expense of litigating a California workers' compensation claim increased 44 percent from 1984 to 1986, with the direct cost three times higher than ten years ago. The average litigation expense increased from \$1,666 in 1976 to \$5,078 in 1986, an increase of 205 percent. As a result, the estimated total 1986 litigation costs amounted to \$985 million.¹⁰

Moreover, the average litigation expense has grown three times as fast as the benefit levels and eight times the increase in employers' average payroll costs.¹¹ The CWCI study states "last year it cost 52 cents in direct overhead to deliver \$1 in benefits in a litigated case, a significant deterioration from 44 cents in 1984 and 32 cents ten years ago."¹²

Employers' and carriers' attorney's fees for multiple appearances, multiple file reviews and other billable events that occur in the course of extended litigation are direct expense passed through to the employers in the form of higher rates and premiums. The average cost of attorney fees incurred per claim has increased from \$987 in 1976 to \$2,658 in 1986, an increase of 169 percent.¹³

⁸Workers' Compensation Insurance Rating Bureau, "1986 Medical-Legal Claim Survey" October 1986

⁹California Workers' Compensation Institute, Bulletin, June 3, 1987.

¹⁰Op. cit.

¹¹Op. Cit.

¹²Op. Cit.

¹³Op. Cit.

Increased Litigation

Uncertainty regarding an injured worker's right to compensation has also led to increased litigation. The insured employer generally relies on the insurance carrier to provide information to the employee and is, therefore, not always responsive to the employee's questions. The CWCI in 1974 commissioned a study of employees who had filed an Application for Adjudication of Claim. This application is the first point at which an applicant's attorney becomes formally involved in the process. The research organization found that 73 percent of the employees had negative feelings about the employer's responsiveness to their questions. In addition, 80 percent were referred to an attorney by their union. More than 90 percent of the employees in the study sought legal assistance because of their unfamiliarity with workers' compensation law and claims procedures¹⁴ and felt that settlement would be too difficult without an attorney.

This uncertainty, together with the open advertising of the legal profession found in various media, leads the employee to seek legal advice at no risk to himself. As employees become more aware of injuries that may be compensated under the law, there is a greater tendency to consider filing an application for benefits.

The adjudication process is also delayed by increasing caseloads within the Workers' Compensation Appeals Board (WCAB) system. In 1970, the WCAB had approximately 69,000 cases filed. The WCAB has 105 hearing officers, and it took an average of 3.5 weeks to bring a case to hearing. In 1986, approximately 186,000 cases were filed, with 130 hearing officer positions established to review them. The minimum average time needed to schedule a case now varies from seven weeks to more than a year, based upon the individual appeals office's operations.¹⁵

These delays may be caused by several factors. The number of judges has not proportionally kept pace with the number of cases filed, nor has the administrative structure of the WCAB been significantly updated. Although there exists a uniform procedures manual for judges, system administration is still carried out by the presiding judges of each of the regional offices. These presiding judges in effect set the workload and administration standards, while at the same time hearing cases themselves. No central court administration or administrator exists, although the WCAB in 1986 had a civil court caseload larger than any of the State's superior court systems, with the exception of Los Angeles.

Much of the WCAB's workload also consists of approval of case compromises worked out by the various parties prior to hearing. Approximately 80

¹⁴"Litigation in Workers' Compensation - A Report to the Industry," California's Workers' Compensation Institute.

¹⁵Senate Rules Committee Hearing, August 26, 1987-Confirmation Hearing of Barry Carmody, Administrative Director, Division of Industrial Accidents.

percent of cases filed are settled by a Compromise and Release (C&R) prior to hearing.¹⁶ The various judges will routinely review and certify such C&Rs as a part of their workload, rather than having a central office, or designated judges in each office, for such a duty.

FINDING #4 - EMPLOYERS WHO DO NOT REPORT ACCURATE WAGES TO INSURANCE
CARRIERS EFFECTIVELY RAISE PREMIUMS RATES FOR OTHER EMPLOYERS

Some employers successfully reduce their premium payments by either not reporting all wages to their insurance carrier or by inappropriately classifying employees to get the benefit of reduced rates. These employers force other employers to carry a heavier burden of the losses through increased rates. While the extent of such inaccurate reporting is not known, no central organization is focusing significant attention on locating and penalizing employers who do not accurately report wages or inappropriately classify employees.

Limited information is available regarding the incorrect reporting or lack of reporting of payroll by employers. Carriers and the WCIRB both believe that the practice of not reporting all payroll or misclassifying personnel to obtain lower premiums is somewhat widespread. An employer may pay an employee in cash and not report a portion of that employee's wages to the carrier. Since premiums are based on total wages payable, the employer can reduce the premium through the lower-than-actual reported payroll. Another way for employers to inappropriately reduce their premium is to classify employees working in higher rated jobs to lower rated job categories. The employee's chance of being injured remains higher and the carrier is obligated to compensate any injury.

Some employers looking for ways to reduce their expenses do not fully report their entire payroll thereby avoiding the employer's cost for social security, disability insurance and workers' compensation insurance. These employers are difficult to locate since they may be reporting sufficient amounts of payroll to reduce their overall expense. In addition, carriers do not normally maintain large audit staffs to seek out employers avoiding the appropriate premium.

One indication of the impact of uninsured employers is the number of claims made by injured workers to the State's Uninsured Employers Fund. These claims are filed by workers whose employers have no workers' compensation insurance coverage. The fund, administered by DIA, extends needed benefits and then attempts to recover costs from the employer. Exhibit III.3 shows the changes for this Fund over the last several years.

¹⁶California Workers' Compensation Institute, Bulletin, June 3, 1987.

EXHIBIT III.3

CASELOAD AND BENEFITS PAID
UNINSURED EMPLOYERS FUND

<u>Fiscal Year</u>	<u>Cases Opened</u>	<u>Cases Closed</u>	<u>Average Open Caseload</u>	<u>Claims Paid</u>
1981/82	1,809	1,412	4,366	\$ 4.8 million
1982/83	1,406	1,125	4,935	\$ 6.4 million
1983/84	2,392	1,587	5,415	\$ 6.9 million
1984/85	3,196	3,193	5,123	\$ 8.0 million
1985/86	2,678	1,274	6,160	\$ 8.9 million
1986/87	2,996	2,473	7,201	\$10.1 million

Source: Department of Industrial Relations; Division of Industrial Accidents

Exhibit III.3 shows that during the period from fiscal year 1981/82 to 1986/87, the number of new cases opened increased from 1,809 to 2,996, an increase of 65.6 percent. The benefits paid for the same period increased from \$4.8 million to \$10.1 million, an increase of 110 percent.

Underreporting of payroll by some employers drives up the premium rates for all other employers. The total cost of all compensation payments used to derive the premiums must be allocated over the total reported payroll for all employers of that category. This results in higher premiums than would be necessary if all payroll was reported by all employers. The total effect on premiums cannot currently be ascertained because information is not available on the total amount of unreported payroll. In addition, classifying employees in an inappropriate job category will distort the premiums in those categories thereby also forcing other employers to bear the premium load for other employers.

FINDING #5 - THE ESCALATING USE OF EMPLOYER LIABILITY INSURANCE HAS SIGNIFICANTLY RAISED THE COSTS OF EMPLOYERS AND CARRIERS

The California workers' compensation system has authorized carriers to provide employer liability coverage since its inception in the early 1900s. Prior to 1979, claims made under the employers' liability portion of the workers' compensation policy have been extremely rare. However, since 1979 there has been a dramatic rise in the number of civil suits by employees against their employers. The increased number of civil suits in this area have raised the costs for employers and carriers and have caused some carriers to modify their employer liability coverage.

The workers' compensation system in California was designed to be the exclusive remedy for work-related injuries. When the system was

established from 1913 to 1916, the Legislature also authorized carriers to offer companion employer liability coverage, the "part B" of workers' compensation policies, to cover any potential liability not anticipated in the basic policy. For more than 60 years, claims made under the employer's liability portion of a workers' compensation policy were extremely rare. As intended, work-related injuries were covered by the primary portion of the workers' compensation policy.

Since 1979 there has been a dramatic rise in the number of civil suits by employees against their employers. Employees and their attorneys are currently successfully using the employer liability section of the workers' compensation coverage to file personal grievances and termination injury claims. One carrier, the State Compensation Insurance Fund, stated in testimony at the Commission's August 1987 public hearing that it currently has 300 open employer liability claims, and is receiving new claims for benefits under the employer's liability sections of policies at the rate of 30 to 40 per month, twice the rate of past years. More than \$1 million in defense costs have been incurred, and SCIF estimates future liability at \$8.7 million. Since the premium rates are established using cost and frequency data from the past, when such claims were very infrequent or nonexistent, the effects of these claims are only now beginning to be felt by the employers. However, the limited number of claims that have been filed indicate an escalation in defense costs.

Exhibit III.4 shows the results of 440 open employer's liability cases reported to CWCI in a 1985 survey.

EXHIBIT III.4

EMPLOYER'S LIABILITY CLAIMS REPORTED
CALENDAR YEAR 1985

<u>Claim Type</u>	<u>Number of Claims</u>	<u>Percent</u>	<u>Average Incurred Loss</u>	<u>Average Incurred Expense</u>
Wrongful Termination	204	46	\$ 18,512	\$ 8,402
Discrimination	64	15	23,049	10,901
Power Press	26	6	61,919	4,509
Dual Capacity	47	11	49,628	5,072
Other	<u>99</u>	<u>22</u>	56,303	9,923
Total	<u>440</u>	<u>100</u>	\$ 33,512	\$ 8,524

Source: California Workers' Compensation Institute

Exhibit III.4 shows that 268 of the 440 employer's liability claims reported in 1985, or 61 percent, alleged wrongful termination or discrimination. These types of cases were virtually nonexistent in 1979.

During the same period of time, insurance carriers reported that 85 cases were closed with an average incurred loss of \$16,941 and average incurred expenses of \$3,643.¹⁷

Workers' compensation was intended to be an exclusive remedy for the injured employee. Work-related injuries logically should be subject to a single source of remedy. In 1982, an exception to the exclusive remedy allowed workers injured by a power press to sue the employer for civil damages. This set a precedent for other potential employment law damage suits. These expanding areas of civil liability coexisting with workers' compensation have prompted insurance companies to support legislative repeal of the "power press" exception.

Insurance companies are taking different approaches to handling the issue. Some are specifically excluding coverage for wrongful termination from new policies. Others are determining that these cases fall under workers' compensation and are not using the employer liability coverage. The State Fund has responded by establishing an employer's liability claims unit to handle the processing requirements generated. To date, there is a lack of clarity in this area by the courts or the regulatory agencies.

FINDING #6 - THE INCREASE IN SUBJECTIVE CLAIMS FOR PSYCHOLOGICAL DISABILITY HAS HAD A NEGATIVE IMPACT ON THE WORKERS' COMPENSATION SYSTEM

During the period from 1980 to 1986, claims for mental stress injuries increased by 531 percent. Such claims, because of their subjective nature, result in more frequent litigation. Claims alleging mental stress or psychiatric injury comprised less than two percent of all injury claims filed in 1986, but accounted for more than seven percent of all claims litigated. Such litigation drives up administrative costs, increases administrative hearing backlogs and further delays payment of benefits to injured workers.

California is almost unique in its treatment of claims based upon job-related stress. All work is to some degree stressful. Such stress may occur in a variety of forms and may be handled differently by different people. During the last five to eight years, an increasing number of claims for job-related stress have been filed in California. These claims are often based on the concept that stress like some physical injuries, can be cumulative, and that such stress need only be perceived by the worker in order to be disabling and compensable. This interlocking set of doctrines, i.e., the concept of cumulative psychiatric injury and the compensability of subjectively perceived stress, has evolved in civil case law in California during the last 10 years. Perhaps the best statement on the evolution of case law regarding psychiatric injury was presented by Bertram Cohen of the WCAB before the Senate Industrial Relations Committee in December 1987 (See Appendix I). Judge Cohen traced the evolution of case

¹⁷ California Workers' Compensation Institute, "Employers Liability Survey," October 1985.

law in this area, and also pointed out some of the adverse effects, including the increased litigation accompanying such claims.

Mental stress claims have two immediate adverse impacts on the workers' compensation system: they excessively put employers and workers against each other over subjective criteria of disability; and they are beginning to create backlogs in up the adjudication process. Because the "perception of disabling stress" is sufficient to file a claim for benefits, such subjective claims are seen by employers as a method marginal workers can and will use to claim benefits rather than working. Workers who file such claims, whether legitimate or not, will often have such claims denied, angering the worker and causing him or her to file a claim through the WCAB. Alternatively, the worker may file the WCAB application first, then notify the employers. This claim, because of the subjective standards currently used to judge "injury" is usually settled only with difficulty and bitterness on both sides.

A recent draft study of mental stress claims by CWCI provides information on the growing extent of the problem. Between 1980 and 1986, mental stress claims grew from a total of 1282 to 6812, an increase of 531 percent. Seventy-five percent of all stress claims cite "job pressures" as the major stresser, with 90 percent of the stress cited being cumulative. Psychiatric injuries in 1986 comprised only 1.7 percent of all claims filed, but 7.3 percent of all claims litigated. The insurer is first notified of a stress claim by notice of an application for adjudication filed with the WCAB in 84 percent of the cases studied.

Several remedies have been proposed to deal with aspects of this problem. Several pieces of current legislation attempt to remove specified stress claims arising out of disciplinary actions or company or industry-wide changes from compensable status in the workers' compensation system. This concept is opposed by labor organizations who consider such a measure to be a limitation of legal benefits. Problems of legal jurisdiction also arise, since such claims, if blocked, may flood into the tort arena, further overburdening the already overburdened courts and possibly opening employers and insurance carriers to even greater liability.

Another recent administrative measure by DIA attempts to reduce the subjectivity of medical evaluations of stress claims. The DIA in mid-1987 established protocols and procedures for physicians to use when evaluating psychological disability claims. These protocols will hopefully make conflicting medical opinions more definitive, by specifying minimum criteria for evaluation.

FINDING #7 - THE EFFECTIVENESS OF THE USE OF VOCATIONAL REHABILITATION TRAINING IN CALIFORNIA HAS NOT BEEN EVALUATED

Vocational rehabilitation benefits were established by law beginning in 1975. The statutory provisions give injured workers vocational rehabilitation training and temporary disability benefits while in rehabilitation. The specifics of this benefit are provided by administrative regulations and judicial interpretations. The benefit is a relatively small but growing part of the workers' compensation benefit structure. Vocational rehabilitation costs have grown from a total of two

percent of all benefit costs in 1976 to approximately 15 percent of benefit costs in 1986. The annual cost growth rate from 1980 to 1984 was 41 percent.¹⁸ Although vocational rehabilitation training has been shown to be cost-effective when it is used appropriately, the effectiveness of California's administration of vocational rehabilitation training has not yet been evaluated.

Exhibit III.5 shows the cost to one carrier--the State Compensation Insurance Fund--of the various types of vocational rehabilitation:

EXHIBIT III.5

AVERAGE COST PER PLAN TYPE
Calendar Year 1985

<u>Plan Type</u>	<u>Average Cost</u>
Modified Job, Same Employer	\$ 3,868
Modified Job, New Employer	1,733
Alternative Work, Same Employer	4,650
Direct Job Placement	9,696
On-the-Job Training, New Employer	14,031
Formal Schooling	18,873
Schooling and On-the-Job Training	17,344
Self-Employment	20,545

Source: State Compensation Insurance Fund

While some studies have been prepared showing the cost of vocational rehabilitation, to date, there has not been a formal assessment of the effectiveness of the benefits to the injured workers. As the above table demonstrates, the cost of the different types of rehabilitation plan vary greatly. Whether the benefit of the plan types also vary has not yet been determined. The California Worker's Compensation Institute, in conjunction with the Division of Industrial Accidents and other agencies, is currently conducting a major study of the long-term effects of vocational rehabilitation programs. The study is due to be completed in April 1988, and should provide important information to assess the impact of California's administration of vocational rehabilitation training. The Rehabilitation President's Council of California, an association of rehabilitation providers, is also completing a study of the State's rehabilitation programs, due to be released in March 1988.

The rapid rise in costs for vocational rehabilitation is due in large part to the increased awareness of the injured workers of the availability of the benefit. In addition, judicial interpretations have been very

¹⁸Workers' Compensation Insurance Rating Bureau, "Report on Vocational Rehabilitation" March 1987.

favorable to the injured employee in allowing them to determine their method of rehabilitation. There are also short-term economic benefits to the injured workers in enrolling in a vocational rehabilitation program. The basic benefit provided to the injured employee may be as low as \$140 per week. If an injured employee qualifies for vocational rehabilitation, the injured employee's basic benefit level increases to \$224 per week.

Without a review of the effects of the differing types of vocational rehabilitation, the injured worker may not be getting the best benefit possible to insure future compensation. In addition, the carriers and employers may be unknowingly paying for training that is not cost-effective.

FINDING #8 - OPPORTUNITIES EXIST TO BETTER CONTROL THE COST OF VOCATIONAL REHABILITATION PROGRAMS

One of the major factors which increase the cost of California's vocational rehabilitation program is the delay and disruption in commencing and completing such plans by qualified workers. Employers, insurance carriers and injured workers each have minimal incentives to promptly commence and complete rehabilitation programs. Although systems may differ, other states have taken measures to track and control vocational rehabilitation costs and results. Such measures may be applicable to California's program.

The prompt beginning and completion of a vocational rehabilitation plan by a qualified injured worker is a major component in both returning workers to employment, as well as limiting program costs. According to a CWCI study completed in 1986, nearly half of the total cost of vocational rehabilitation case costs consists of the temporary disability benefits paid while the plan is being developed and implemented.¹⁹

Referral to a rehabilitation program is mandatory as soon as it is known that a worker cannot return to his or her original job, or at 180 days after being disabled. Mandatory referral can be delayed beyond the 180-day period if the injured worker has not yet been determined to be medically stable, i.e., permanent and stationary, and so potentially eligible for benefits. There are currently no requirements or incentives for workers to begin vocational rehabilitation programs promptly, and there are, in fact, disincentives in some cases. Workers in the midst of litigation over the amount or extent of permanent disability compensation may find it more advantageous to delay vocational rehabilitation until the litigation is completed. The basic incentive of employers and insurers is to provide legally mandated rehabilitation services at the lowest possible cost. If such costs can be delayed or reduced through the litigation process, there is little incentives to commence plans on the part of employer or insurer.

¹⁹California Workers' Compensation Institute, Research Notes, Vocational Rehabilitation: 1985 Costs and Results, November 1985.

The February 1986 draft staff report by the Legislature's Joint Study Committee on Workers' Compensation recognized this dilemma, and recommended that eligible workers "should have an obligation to commence vocational rehabilitation as soon as the possible need for these services is identified." This recommendation is similar to the prompt commencement requirement in force in the State of Michigan and which was cited in a recent study of proprietary sector vocational rehabilitation programs done for the U.S. Department of Education by Berkeley Planning Associates.

Selection of vocational rehabilitation providers and periodic monitoring of progress is also vital for successful program completion and cost control. Currently, rehabilitation plans are developed by individual rehabilitation counselors or firms under contract to the carrier or self-insured employer. These plans are reviewed and approved by the Rehabilitation Bureau of the DIA; however, there is no regulation of the counselor or firm. Such regulation, or at least registration along with associated information on the qualifications, experience and prior performance of the counselor or firm, would be useful to insurers, employers and workers in selecting a competent. Similar systems are in use in other states; New York's voluntary system refers eligible workers to either the State Office of Vocational Rehabilitation or a screened group of non-profit vocational rehabilitation programs. Michigan's mandatory system also gathers data and tracks the performance of various vocational rehabilitation counselors and firms. Michigan also requires the service provider to submit progress reports periodically so that progress can be assessed in comparison with state guidelines.

One other cost control idea which has been used in several states is a limitation on the length of time vocational rehabilitation services may be provided. Such an idea was considered in the February 1986 draft staff report of the Joint Study Committee on Workers' Compensation. Michigan's mandatory vocational rehabilitation programs have a similar provision, with retraining limited to a total of 52 weeks, with an additional 52 weeks possible by order of the State Director after an administrative review.

IV. CONCLUSIONS AND RECOMMENDATIONS

This section presents the conclusions and recommendations of the Commission's review of selected areas of concern in the California workers' compensation system.

CONCLUSIONS

California has the largest workers' compensation system in the United States. The amount of direct written premiums has increased from \$2.9 billion in 1982 to \$5.3 billion in 1986, an increase of 83 percent. Although the amount of direct written premiums is significant, the weekly benefits paid out to injured workers in California are among the lowest for urban industrialized states.

The cost of California's workers' compensation system has also increased rapidly in recent years, from \$1.2 billion in 1980 to \$2.3 billion in 1984. These increased costs reflect an increase in the number of persons in the workforce and a rise in the cost of claims. It is not due to an increase in the rate of claims being filed, because such claims have actually declined from an average of 39.17 per 1,000 workers in 1979 to 35.89 in 1986, a decrease of 8.4 percent.

While it is difficult to make direct comparisons between workers' compensation costs and benefits in different states, several recent studies indicate that in certain categories California's premium rates for coverage are among the highest in the country. Moreover, California's premium rates have been increasing faster than those in other states. The high cost of workers' compensation insurance coverage in California have had a negative impact on the perception of the State's business climate.

The State of California and private insurers are not actively encouraging the investigation and prosecution of cases of fraud and abuse in the workers' compensation system. Private insurers have referred only 160 cases of suspected fraud and abuse in the workers' compensation system to the Fraud and Abuse Bureau of the Department of Insurance during the last eight years. Only 17 of these cases have been opened for investigation by the Department and only one of these cases has been prosecuted.

The delays in payments in injured workers combined with the increased forensic medical costs and litigation costs have dramatically increased the administrative overhead costs of delivering workers' compensation benefits. In 1986 it cost 52 cents in direct overhead to deliver one dollar in benefits as compared to 32 cents 10 years ago.

The escalating use of employer liability insurance has significantly raised the costs of workers' compensation insurance in California. Since 1979, when the first civil suit was filed under the employers' liability section of a workers' compensation policy, employees have been successfully using this section of workers' compensation coverage to file personal grievances and termination injury claims.

The increase in subjective claims for psychological disability also has had a negative impact on the workers' compensation system. Between 1980 and

1986, the number of mental stress claims grew from a total of 1,282 to 6,812, an increase of 531 percent. Such claims, because of their subjective nature, result more frequently in litigation and highest costs. While these claims filed in 1986, they accounted for more than seven percent of all claims litigated.

The effectiveness of vocational rehabilitation in California has not been evaluated. These benefits were established by law in 1975 and they represented 15 percent of benefit costs in 1986. Although vocational rehabilitation has been shown to be cost-effective when it is used appropriately, the effectiveness of California's administration of vocation rehabilitation training has not been evaluated.

One of the major factors that increases the cost of California's vocational rehabilitation program is the delay and disruption in commencing and completing vocational rehabilitation plans. Currently, there are minimal incentives for employees, insurance carriers and injured workers to promptly commence and complete rehabilitation programs. Other states have taken more stringent measures to track and control vocational rehabilitation activities and costs which may be useful in California.

RECOMMENDATIONS

The Commission believes that the following actions should be taken to address the problems that the Commission identified in the State of California's workers' compensation system and to control the rising costs of those benefits:

1. The Department of Insurance Fraud Bureau should establish, written criteria for opening and closing workers' compensation fraud and abuse cases. In addition, the Department should encourage carriers to report potential fraud and abuse and should itself actively prosecute such cases. or cause them to be prosecuted.
2. The Governor's Multi-Agency Task Force on the Underground Economy should specifically establish a method to identify employers who intentionally fail to report wages or misclassify employees, in order to reduce workers' compensation premiums.
3. The Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau should establish a policy and method to identify employers who change business or corporate identities in order to avoid being properly rated based upon prior claims experience.
4. The current allowable vocational rehabilitation services should be modified by the Legislature based upon the evaluation of results of the study currently being performed by the Division of Industrial Accidents in cooperation with the California Workers' Compensation Institute and other studies of the long-term effectiveness and control of vocational rehabilitation programs. Specifically, there should be uniform standards for vocational rehabilitation programs.

5. The Governor and the Legislature should provide the Division of Industrial Accidents with the authority to identify insurance carriers for audits based on poor performance, including untimely payment of benefits, and to specify the necessary audit procedures. The Department of Insurance should be required to report to the Division of Industrial Accidents the results of those audits.
6. The Department of Insurance should require the Workers' Compensation Insurance Rating Bureau to collect information on the carrier's employer liability policy sections and to recommend a standardization of policies. The Department of Insurance should use this information to establish industry standards and actuarially determine if a premium is needed for this section and its specific coverages. In addition, the information on each carrier's policies should be provided to the public.
7. The Department of Industrial Relations should consider the use of professional court administrators to assess and manage the ongoing administrative systems and calendars of the Workers' Compensation Appeals Board Offices.
8. As an interim measure, the Department of Industrial Relations should consider assigning Motions and Settlements Judges to review only Compromise and Release agreements as a method of expediting the adjudication process.
9. The Governor and the Legislature should enact legislation to require a single and final "agreed upon third party" medical report when the results of two previous reports do not provide agreement on the nature or extent of injury to the worker.
10. The Governor and the Legislature should enact legislation to repeal the "power press" exception to general workers' compensation coverage.
11. The Department of Industrial Relations should examine the impact of recently implemented regulatory examination protocols on the evaluation of claims for psychological and stress-related injuries. If the results of this review indicate that minimum standardized examination procedures are of value in assessing injury, the Department should work to establish examination protocols for other injuries not covered by current protocols.
12. The Governor and the Legislature should consider adopting legislation to clarify and strengthen the Insurance Commissioner's and Director of Industrial Relations' powers to assess penalties upon carriers and self-insured employers for delaying payment to the injured employee as an incentive to reduce litigation.
13. The Governor and the Legislature should consider requiring employers to provide employees with a thorough description of the full spectrum of benefits available through the workers' compensation insurance program when an employee is hired.

A P P E N D I X

WORKERS' COMPENSATION PSYCHIATRIC CLAIMS IN CALIFORNIA

Address to the Senate Industrial Relations Committee, 12/2/87

Bertram Cohen, Workers' Compensation Judge

A BRIEF HISTORY

The concept of adverse emotional consequences, that is, psychiatric disability, arising in an industrial context is as old as the California workers' compensation system itself. Our system dates back to 1912, and beginning with the very first year after creation of the system the Industrial Accident Commission was called upon to consider allegations of post-traumatic emotional disability. In a couple of cases in the very early years the IAC displayed considerable skepticism when confronted with the idea that for psychiatric reasons a worker not otherwise organically impaired should be entitled to compensation, expressing the opinion that such mentally-based illnesses were virtually akin to malingering. However, not long afterward, as early as 1915, the IAC in Finley v. U.S. Fidelity & Guar. Co. (2 IAC 195) did award compensation to a worker with a traumatic neurosis, and although some skepticism continued to prevail, as early as 1922, in an opinion remarkable for its approach that presaged doctrines to be expressed by the courts decades later, the IAC held, in the case of a worker with a back injury who was afraid to return to work for fear of further injury, that the employer took the worker as it found him, neurotic tendencies and all, and that even though a more normal worker probably would not have experienced such a reaction, it was precipitated by the injury and had a cause-and-

effect relationship to it. The case was Bethlehem Shipbuilding Corp. v. Kostrekin (9 IAC 97).

Although most of the early cases dealt with emotional reactions to specific physical injuries, the idea of an injury caused by events over time, psychiatric or otherwise (legally termed a cumulative injury) has been ingrained in the law since the landmark 1959 decision of the California Court of Appeal in Beveridge v. IAC, 24 CCC 274, in which Justice Tobriner opined that although the effect of a single bit of work strain may not be disabling in and of itself, the combined result of such strains over time can be destructive and produce compensable disability. Labor Code §3208.1, enacted 1968, now defines a cumulative injury as "repetitive mentally or physically traumatic activities occurring over a period of time, the combined effect of which causes any disability or need for medical treatment."

The cumulative injury doctrine was first applied to psychiatric injury in Baker v. WCAB (1971) 36 CCC 431, in which a firefighter claimed that over a period of time he developed cardiac-like symptoms after exposure to fumes and smoke, increasing progressively thereafter. No heart trouble was found, but he was medically determined to have a "cardiac neurosis" of emotional origin, related to the dangers of his job. The Court of Appeal concluded that such a psychoneurotic injury caused by the job environment is compensable, finding no difference between cumulative physical and emotional injuries, the latter being every bit as real and disabling as the former.

But what about the amount of work stress necessary before a

reaction may be deemed compensable? Again, a considerable body of doctrine has developed over the years. As far back as 1946, in the case of Liberty Mutual Ins. Co. v. IAC (Calabresi) 11 CCC 66, the Court of Appeal, per Justice Peters, dealt with the case of an elderly laborer who suffered a heart attack while lifting sacks of peanuts, a normal requirement of his job. The court referred to the line of cases holding that the employer takes the worker as it finds him, and went on to declare that, where work strain exists, even though the strain is usual to that type of employment, injury resulting therefrom is compensable so long as a causal connection is shown by substantial evidence to exist between the strain and the disability or death. Many cases since then have reconfirmed and refined that doctrine. For example, in the leading case of Lamb v. WCAB (1974) 39 CCC 310, the California Supreme Court pulled the threads together in the case of a machinist found dead of a heart attack beneath his gear-cutting machine. On a record that included existence of certain deadlines and a history of the decedent expressing worry about performing the job well, the Court reiterated the doctrine that the employer takes the worker as it finds him, and held further that it is not the amount of stress inherent in the job that is relevant in stress cases, but the stress that the job has in fact exerted on that particular worker.

Thus, by the early 1980's, the basic doctrines were all in place: the concept of cumulative psychiatric injury was well established, as was the doctrine that the employer takes the worker as it finds him. It was clear under the leading cases that the job need not entail an unusual amount of stress, so long as it is stressful to the particular worker, causing disability. It remained for a case to come along that dealt with a frank situation of cumulative

psychiatric injury caused by allegations of perceived stress.

SUBJECTIVE PERCEPTIONS OF STRESS

That case was Albertson's v. WCAB (Bradley), 47 CCC 460, in which the Third District Court of Appeal was confronted with a supermarket worker who alleged that difficulties with perceived harassment by a manager were the cause of her psychiatric disability and need for medical care. The employer's psychiatrist stated that the worker had a preexisting and nonindustrial progressively deteriorating mental condition of many years duration, but that she did subjectively perceive job harassment, and the claimant's evaluator felt that she had an obsessive-compulsive personality that hypersensitized her to the stresses at work. The Court of Appeal affirmed a WCAB decision in favor of the claimant, in a landmark 1982 unanimous opinion. The court noted that job harassment is a type of work stress, like other stressful factors such as numerous deadlines, repetitive tasks, etc., and that the cumulative effects of stress and strain can cause compensable disability. No basis exists for separating psychoneurotic injuries from others in that regard. Since the employer takes the worker as it finds him, the proper test in cases such as this is a subjective one. To quote the court:

"The proper focus of inquiry, then, is not on how much stress should be felt by an employee in his work environment, based on a "normal" reaction to it, but how much stress is felt by an individual worker reacting uniquely to the work environment. His perception of the circumstances (e.g., crowded deadlines, mountains of paper, a too-fast assembly line) is what ultimately determines

the amount of stress he feels."

The court did, however, agree with the WCAB that no compensable psychiatric injury would exist where the work is a mere passive element that a nonindustrial condition happened to focus on, i. e., simply a stage upon which a nonindustrial problem is played out, or the allegations of work stress are merely after-the-fact rationalizations.

The Albertson's decision is the law at the present time with respect to causation, but a great many questions have arisen about its application to specific situations. Where, for example, does subjective perception leave off and pure imagination begin? What constitute active stressors in the employment as opposed to mere passive factors? These are evidentiary questions that must be addressed on a case-by-case basis. It must be remembered that the burden is on the worker to prove his or her case by a preponderance of the evidence, and in psychiatric cases both competent lay testimony and accurate medical reportage are the determining factors.

If a preexisting problem or abnormality combines with perceived stress to cause disability, who should bear the burden of paying compensation? The law of apportionment in this area is no different than in any other type of industrial injury (Callahan v. WCAB (1978) 43 CCC 1097). Apportionment may be appropriate if the worker had a preexisting disability (not simply a pathological yet nondisabling condition)(Labor Code §4750) or an underlying disease that was aggravated by the industrial exposure (to the extent that the work injury "lights up" the disease process and renders it

disabling, the employer is responsible for payment of compensation - Labor Code §4663). Although the worker bears the initial burden of proof in his claim, the burden is on the employer to prove apportionment (Pullman Kellogg v. WCAB (Normand) (1980) 45 CCC 170) and this can only be done with factually and legally accurate medical reports. The only type of disability that can be so apportioned is permanent disability; neither TD nor medical treatment are apportionable as to the worker, although liability for these benefits can be shared as among carriers in cumulative injury cases. As the California Supreme Court held in the leading case of Granado v. WCAB (1968) 33 CCC 647, payment of such benefits should not have to await determination of the complex legal issues involved in apportionment. The employer is therefore responsible for the entire award of TD and medical treatment if the industrial exposure contributed to the disability. This also applies to the vocational rehabilitation benefit, under Labor Code §139.5.

SPECIAL SITUATIONS

The courts have ruled in many special areas in psychiatric cases, but for the sake of brevity I shall only cover a couple of them. One is that of psychiatric disability resulting from criminal activity. In its 1980 opinion in Pac. Tel. & Tel. v. WCAB (Blackburn) 45 CCC 1127, the Court of Appeal held that disability caused by stress occasioned by the worker's criminal activity is not compensable. The employer must, however, prove all the elements of the crime by a preponderance of the evidence. This rule has been extended to situations in which the worker was engaged in activities prohibited by the employer's rules, thus outside the course of employment.

The area of psychiatric injuries suffered as a result of job termination is a confusing one that has generated much controversy. To be compensable, an injury must arise out of and occur in the course of employment, and be proximately caused by the employment (Labor Code §3600). In the 1983 case of Georgia Pacific Corp. v. WCAB (Byrne) 48 CCC 443, the 2d District Court of Appeal held that an injury arising out of termination of employment does not meet those criteria, and is therefore not compensable within the compensation system.. This view is consonant with the recent California Supreme Court decision in Cole v. Fair Oaks Fire Prot. Dist. (1987) 52 CCC 27, in which the Court appeared to hold that the exclusive remedy rule in workers' compensation precludes an employee from seeking civil damages against the employer for disabling intentional infliction of emotional distress if the employer's actions relate to normal aspects of the job, such as criticism, demotion, etc., however outrageous. No reference is made in the Cole decision to termination, thus the court's opinion does not run contrary to Georgia Pacific. However, in a line of cases beginning in 1978 with Renteria v. City of Orange (43 CCC 899), the courts had held that an employee could avoid the exclusive remedy rule by asserting that the mental distress was not accompanied by physical injury or disability. The Cole court recognized the anomaly here, stating that intentional infliction of emotional distress causing physical injury is worse than that which does not, but a civil suit is precluded in the latter case. In 1987 the Third District Court of Appeal confused the issue further in Shoemaker v. Myers (192 CA3d 788), by holding that termination is one of the normal employment risks envisioned by Cole, thus a claim for damages resulting from disabling intentional infliction of

emotional distress by wrongful termination is subject to the exclusive remedy rule. This area is presently in considerable dispute, but the Supreme Court has granted review in Shoemaker and we are currently awaiting the outcome.

SOME GENERAL COMMENTS

I would like to conclude with a few general comments, spoken from personal perspective, and not as a representative of the Administration. I am aware that a number of bills are presently proposed that would make certain changes in how we deal with claims of psychiatric injury. It is not my place to state what the law should be regarding such matters; as a workers' compensation judge, it is my task to apply the law as it is, and it is up to the Legislature to state the law and the courts of appeal and Supreme court to interpret it for me, my colleagues and the lawyers who litigate before me. Without overstepping my bounds, however, I would respectfully submit a few general comments. First, it is quite true that there has been an increase in the number of claims of psychiatric injury in the workers' compensation system in California in recent years, especially since the Albertson's case. While I do not have the numbers, this fact is very apparent to any WCJ now on the bench. That does not tell the whole story, however; such claims are matters of very high profile compared to other claims, for several reasons, including the fact that a much smaller proportion of such claims are adjusted informally than is the case with other types of injury. In the majority of cases the employer or carrier will deny the claim based on little more than the fact that it is psychiatric in nature. We therefore see a greater portion of them going through the formal litigation process.

Another factor is that psychiatric claims are generally more complex and people-intensive than other injury cases, arising often as they do out of failed interpersonal relationships. This leads to extended proceedings and production of a lengthy record, all of which generates a heavy drain on a system that is presently attempting to operate with severely limited resources, but must at the same time afford all parties full entitlement to due process of law.

However, I would respectfully urge the Committee to proceed with caution in analyzing any proposed legislation that would change the standards for dealing with psychiatric injury cases. The problem is not simple, and any simplistic solutions must be viewed with caution. Psychiatric injuries are seldom clearly discrete; they are more often part and parcel of injuries to other parts of the body, such as the cardiovascular system, gastrointestinal system, etc., and treating the psychiatric aspect differently can raise substantial questions of equal protection. Moreover, stress can manifest itself in ways other than psychiatric; do we afford different treatment to one worker who suffers emotional problems as a result of work stress than to one whose symptoms from the same stress appear organically? In addition, workers with clear-cut, unquestionably valid organic injuries often suffer emotional consequences from such factors as depression caused by the economic loss during disability or the pain of the injury. Do we wish to set different criteria for compensating those aspects of the worker's problems simply because they are branded psychiatric?

Finally, as you have seen from the foregoing summary, the legal concepts presently used to determine compensability of

psychiatric cases did not arrive with a single, cataclysmic proclamation from on high, but are the results of many years of evolving doctrine going back to the beginnings of our compensation system. I would respectfully urge the Committee to look with great care at any legislation that would abruptly alter these standards, all of which were developed through painstaking analysis by some of our very best appellate justices.

Thank you.