STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
300 Capitol Mall, 17th Floor
Sacramento, CA 95814

PROPOSED DECISION

JULY 1, 2009 WORKERS' COMPENSATION CLAIMS COST BENCHMARK AND PURE PREMIUM RATES

FILE NUMBER REG-2009-00015

In the Matter of: Proposed adoption or amendment of the Insurance Commissioner's Workers' Compensation Claims Cost Benchmark and regulations pertaining to pure premium rates for workers' compensation insurance and the California Workers' Compensation Experience Rating Plan—1995. These regulations will be effective on the date of the Commissioner's Decision and Order.

PROCEDURAL HISTORY

A public hearing in the above captioned matter was initially held on April 28, 2009 at the time and place set forth in the Notice of Proposed Action and Notice of Public Hearing, File Number REG 2009-00015 dated March 30, 2009, which is included in the record. At the conclusion of that hearing, and as later noticed in the Notice of Continued Public Hearing dated May 13, 2009, the hearing officer announced that the hearing was continued to June 8, 2009 at 1:00 p.m. in Sacramento and the record would be kept open for additional written comment until 5:00 p.m. on June 8, 2009. The Continued Hearing was held on June 8, 2009 at the time and place set forth in the Notice of Continued Public Hearing, File Number REG 2009-00015. The record was closed at 5:00 p.m. on June 8, 2009.

The record discloses the persons and entities to whom or which the Notices were disseminated. The Notice of Public Hearing and the Initial Statement of Reasons summarized the proposed changes and action to be taken by the Insurance Commissioner and were available to the public. In addition, the "Filing Letter" dated March 27, 2009 and related documents submitted by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) regarding the changes requested were available for inspection by the public at the Sacramento office of the Department of Insurance and were available online at the WCIRB website, www.wcirbonline.org.

The WCIRB's filings proposed a change to the Workers' Compensation Claims Cost Benchmark, which reflects insurer loss costs and loss adjustment expenses, and adjustments to the California Workers' Compensation Experience Rating Plan—1995 to conform to the proposed Benchmark change. The initial filing requested that the Commissioner adopt a record 24.4% increase to the Benchmark, reflecting a 24.4% increase to each of the current pure premium rates in each employee classification for

worker's compensation insurance policies incepting or renewing on or after July 1, 2009. Subsequently, the WCIRB obtained revised aggregate financial data from a specific insurance company group that resulted in a re-filing of the requested rate change to reflect a reduction of the increase to 23.7%.

The WCIRB's 23.7% requested increase to the Benchmark consists of a 5.8% increase to reflect the impact of two recent Workers' Compensation Appeals Board (WCAB) *en banc* decisions, *Ogilvie v. City and County of San Francisco* and *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District*, and a further 16.9% increase attributable to the impact of increasing medical costs in the workers' compensation system.

At the hearing on April 28, 2009, the Commissioner requested that the WCIRB withdraw the portion of its filing related to the permanent disability impact of the WCAB decisions. This request was based upon the WCAB's order for further reconsideration of its decisions and request for amicus briefs from interested persons or entities, which put the original decisions in question as to whether they would be implemented or, if implemented, what their impact on costs would be. The WCIRB responded to the Commissioner's request by letter dated June 4, 2009 and declined to withdraw the permanent disability portion of the filing, asserting that the WCAB decisions were final and binding upon parties before the WCAB until the WCAB issues its decisions upon reconsideration.

Testimony, written and oral, was taken at hearings in San Francisco on April 28, 2009 and in Sacramento on June 8, 2009 and exhibits were received into the record. Additional documentation requested by the hearing panel was submitted subsequent to the hearing but prior to the close of the time period to receive written comment, along with correspondence and documents submitted by the public. The matter was submitted for decision at the conclusion of the period to receive written comment on June 8, 2009. The matter having been duly heard and considered, the following Proposed Decision and Proposed Order are hereby made.

PUBLIC RESPONSE TO THE PROPOSED INCREASE AND THE EFFECT OF THE CLAIMS COST BENCHMARK

In response to the WCIRB's request for a dramatic increase of the Benchmark, the Commissioner received a variety of letters and emails from members of the public opposing the increase and urging that it be rejected. Most of the opposition asserted that California employers cannot afford record increases at a time when business and the economy are suffering through a painful recession. A letter was also received from California Governor Arnold Schwarzenegger, asking that the increase be rejected because the *Ogilvie* and *Almaraz/Guzman* cases were inappropriately decided by the WCAB.

The concerns expressed reflect that California employers would find it difficult to bear further increases in their costs of doing business, including the costs for workers' compensation insurance, and that the Claims Cost Benchmark is not well understood.

First, and foremost, the Claims Cost Benchmark is a determination of future costs in the California workers' compensation system. The WCIRB, on behalf of its insurance company members, presents to the Commissioner its analysis of system-wide claims costs, and its analysis and recommendation for projecting such claims costs for the upcoming insurance policy period. This latter recommendation is presented as a proposed increase or decrease to the existing Benchmark, reflecting the WCIRB's conclusion that costs will head either up or down in the future. The Benchmark approved by the Commissioner reflects only projected loss costs; it does not include any provision for general expenses, commissions, other acquisition expenses, premium taxes, or profits, all of which are reflected in the rates filed separately and individually by each workers' compensation insurance company.

Second, the Claims Cost Benchmark is advisory only and is a determination by the Commissioner of the loss costs expected in the workers' compensation system. The Benchmark does not reflect the actual premiums that insurers may charge employers. The law does not require insurers to adopt the change in Claims Cost Benchmark recommended by the WCIRB and determined by the Commissioner, and insurers may file rates as they deem appropriate so long as they are in compliance with the California Insurance Code and associated regulations and are neither discriminatory nor affect an insurer's financial solvency. The California workers' compensation rate laws do not limit the profit a workers' compensation insurance company may make.

While dramatic increases in workers' compensation costs could have a negative effect on California's employers and economy, the Commissioner must adjust the Claims Cost Benchmark to accurately reflect the costs of the workers' compensation system, both to inform the public and stakeholders of trends in the system, and to create a benchmark against which to measure insurer rates to ensure insurer solvency.

DETERMINATION ON WORKERS' COMPENSATION CLAIMS COST BENCHMARK AND RECOMMENDATION TO THE INSURANCE COMMISSIONER

It is the determination of this Hearing Officer that the Insurance Commissioner adopt a 7.3% increase (+7.3%) to the Workers' Compensation Claims Cost Benchmark. The change in the Claims Cost Benchmark recommended herein is based upon the hearing testimony and an examination of all materials in the record developed by the hearing panels, which included Insurance Commissioner Steve Poizner, Assistant Chief Counsel Reid McClaran, Senior Actuary Ron Dahlquist, Senior Actuary Eric Johnson, and myself.

Department of Insurance actuaries Dahlquist and Johnson have reviewed the record, and have prepared an actuarial analysis and conclusion, fully set forth below, regarding changes to the Claims Cost Benchmark. The Hearing Officer agrees with the actuaries' analysis and conclusion except in one respect, namely the action taken by the WCAB in granting reconsideration and allowing additional amicus briefs on the permanent disability issues presented by the *Ogilvie* and *Almaraz/Guzman* cases. Based upon the unique circumstances created by the WCAB's action and the fact that there exists definite

uncertainty as to the effect of those decisions and what the subsequent outcome will be, it is inappropriate at this time to include the estimated increase related to permanent disability.

The analysis by the Department's actuaries suggests that the benchmark should be increased for these WCAB decisions based upon the "greater than zero" probability of the WCAB doing something other than reversing itself. However, there exists some probability, also greater than zero, that the WCAB may reverse itself, and that probability has not been analyzed. Likewise, there are various unanalyzed probabilities that these WCAB cases may be taken to the courts of appeal and the cases upheld or reversed or that the Legislature or Governor may take action.

At this point in time, all that is conclusively known is that the WCAB is rethinking itself on its decisions and that the outcome and effect of it is unknown. The evidence presented is not persuasive as to whether or not there will be added costs in the workers' compensation system.

Therefore, the WCIRB is directed to monitor the status of those cases before the WCAB and, upon issuance of the decisions from the WCAB, promptly review, analyze, and file with the Commissioner any recommended change to the Claims Cost Benchmark. The Department, upon receipt of the WCIRB's recommendation, will institute an expedited hearing before the Commissioner to address the WCAB's decisions.

Finally, due to the investigatory inquiry into the workers' compensation medical treatment costs at the continued hearing of June 8, 2009, a separate document entitled Investigatory Hearing Report on Workers' Compensation Medical Cost Drivers is attached as an Addendum to this Proposed Decision, and incorporated herein by reference, which summarizes the findings of that portion of the hearing.

The purpose for this separate Report is to provide to the Commissioner an analysis and recommendations concerning the issues surrounding the current increases in medical treatment costs developed at the hearing and to provide it to the stakeholders of the California workers' compensation system, including worker's compensation insurers; the various agencies that oversee benefits and claims handling, such as the Department of Industrial Relations, its Division of Workers' Compensation, and the WCAB; the Governor; and the Legislature. It is imperative that these issues be promptly evaluated and addressed with an effort made toward creating a more predictable and cost-effective system of delivering efficient medical outcomes that return injured workers back to work and maintain the cost savings experienced by California's employers and insurers.

ACTUARIAL ANALYSIS AND DISCUSSION

Medical Loss Severity

The WCIRB analysis shows that significant increases in medical loss severity continue to occur.

In the previous filing for the January 1, 2009 workers' compensation claims cost benchmark, we observed large increases in medical severity for both accident years 2006 and 2007, with somewhat lesser increases being experienced for accident year 2007. At that time, we formed the opinion that the large increases in 2006 must have involved a "rebound" effect from the dramatically lowered cost levels seen in 2004 and 2005, which were due to the impact of the reform legislation of 2003 and 2004. We were optimistic that the somewhat lower inflation rates seen in 2007 were indicative of a longer-term trend that would be less than that seen in 2006.

In this filing, the WCIRB presents data on accident year 2008 for the first time. It shows a continuation of elevated medical cost increases. In the amendment to the filing dated April 23, the Bureau's ratemaking analysis yields estimated ultimate medical severity increases of 14.8% for accident year 2006 relative to accident year 2005, 13.0% for accident year 2007 relative to 2006, and 18.2% for accident year 2008 relative to 2007. On-level medical pure premium ratios are estimated at 0.458 for accident year 2005, 0.513 for 2006, 0.558 for 2007, and 0.602 for accident year 2008. These ratios imply pure premium cost increases of 12.0% for 2006, 8.8% for 2007, and 7.9% for 2008. The WCIRB has selected a 7.0% pure premium trend to project future medical costs.

While the cost increases for accident year 2008 appear to be lower than those experienced in 2006, they are fairly similar to those of 2007 and exceed the assumptions we made in our last Proposed Decision. It appears that significant medical cost increases are persisting.

The WCIRB also contracted with the California Workers Compensation Institute (CWCI) to provide an analysis of transaction-level detailed data on medical payments in an effort to provide additional support for the requested increase to the pure premium rate level, as well as some indication of which categories of injuries and which types of medical expenses might be contributing to the overall increase in cost levels.

The CWCI presented results from two different data sets. The first, representing approximately 40% to 50% of the entire California workers compensation insurance industry, includes all medical payments reported to the CWCI. The second, representing approximately 20% to 30% of the industry, includes only data from detailed medical billing review information, and excludes all hospital inpatient expenses and other non-itemized expenses.

The CWCI's original presentation, which was included in the filing, also showed significant medical cost increases. It was limited to claims valued no later than June 30, 2008 that were at least 12 months old, so no information on accident year 2008 claims was included. It showed that the average medical payment in the larger data set increased by 12.7% from accident year 2005 to accident year 2006 for claims valued as of 12 months, and by 23.0% over the two-year span from accident year 2005 to accident year 2007 for claims valued as of 12 months. It also showed that these increases impacted a wide range of types of injuries. Interestingly, costs for three separate groups of expenses: prescriptions and durable medical equipment, medical management and medical cost containment, and medical legal all increased at a higher rate than did medical treatment over the same time periods.

The smaller CWCI data set on detailed medical billing information for outpatient services also showed significant medical cost increases. On an overall basis, these costs increased by 12.0% from accident year 2005 to accident year 2006 for claims valued as of 12 months, and by 21.2% over the two-year span from accident year 2005 to accident year 2007 for claims valued as of 12 months. Medical-legal costs increased at a greater rate than the average, as did the categories of orthotics and prosthetics, supplies and durable medical equipment, and "other miscellaneous services." The two middle categories listed showed particularly large increases but did not represent a significant percentage of the total of medical expenses.

The CWCI study also included an exhibit labeled "Exhibit 8-Case-mix-adjusted 12 Month Medical Development Trends and Slope Analysis: 3Q 2004 – 2Q 2007". This exhibit and the accompanying text offered the prospect that all of the medical inflation recently experienced could be explained by changes in the mix of variables included in the analysis. This appeared to indicate that it would be possible to identify what factors are the causes of increasing medical costs.

There were several individuals who offered testimony with respect to the WCIRB filing and commented specifically on the subject of medical trend.

Mark Priven, an actuary with the firm of Bickmore Risk Services & Consulting, is the statutorily authorized actuary for the public members of the WCIRB Governing Committee. In his testimony, Mr. Priven presented his independent analysis of the indicated claims cost benchmark level. In the course of his written presentation, he made a number of comments regarding the WCIRB estimates of medical trend.

On page 5 of his letter, Mr. Priven observes that most of the methods he applied imply that medical severity increased by less in 2007 than it had in 2006. He states that this is consistent with the assumption that some of the claims inflation in 2006 was based on adjustments to the reforms. He further notes that the large increase indicated for accident year 2008 is highly leveraged. He finally selects medical severity increase assumptions for 2009 and 2010 of "between 12% and 19% on an annual basis, depending on the year and method."

On page 4 of his letter, Mr. Priven also makes note of the CWCI's case-mix adjusted analysis, and expresses his desire to know which factors are driving medical inflation.

Mr. Frank Neuhauser, Project Director of the UC DATA/Survey Research Center, also submitted comments on behalf of the Commission on Health and Safety and Workers' Compensation concerning the WCIRB filing.

On page 5 of his letter, Mr. Neuhauser mentions that the WCIRB ratemaking methodology generates estimated increases in accident year medical severity of 15.0% for 2005-2006, 13.2% for 2006-2007, and 19.3% for 2007-2008. He compares these very large increases to much lower increases for the same time periods derived from Unit Statistical Plan data: 8.1% for 2005-2006 and 3.8% for 2006-2007. He points out that the higher percentage increases implied by the accident year analysis are based on paid loss data while the lower increases implied by the unit stat data are based on case incurred losses. He states that developing a preference for one of these indications as opposed to the other would be difficult without extensive further study, but concludes that "at the very least, the divergent estimate from the incurred data should temper the estimate from the paid data."

Mark Gerlach, insurance consultant for the California Applicants Attorneys Association (CAAA), also testified. Todd McFarren, president of CAAA, submitted written comments.

One observation in the CAAA letter is that the CWCI produced a "case-mix adjusted" analysis which "showed a decline in average severity over this period." This observation was used as part of the reasoning expressed in the letter as to why the 7% medical loss trend proposed by the WCIRB should be lowered to 1% per year, as the Commissioner selected in his previous Decision and Order on the January 1, 2009 filing.

We are concerned about both the size and the persistency of the observed medical cost increases. The reform legislation of 2003 and 2004 imposed new requirements that were expected to control the utilization of medical services in California workers compensation. This control was expected to be achieved by requiring conformity to specified medical treatment utilization guidelines and by allowing insurers to control medical treatment for the life of the claim by the use of medical provider networks. It was assumed that these controls would not only lower medical costs but would put limits on future escalation of these costs. While costs have been very dramatically lowered, they have now been escalating at substantial rates for the last three years.

In the face of this evidence, it is natural to ask whether the reforms are eroding. Related questions that come to mind include the following: Are the recent cost increases a rebound effect from extraordinarily lower cost levels immediately post-reform? Or are they a return to high level of medical cost inflation? Are they one-time adjustments to a higher level of cost for some expenses-or can they be expected to continue to increase in the future? What specific segments or types of medical benefits are increasing the fastest, and do their increases indicate problems with the effectiveness of the reforms?

Ratemaking data is designed to inform us as to what is going on with total costs, and costs within certain subdivisions such as classifications. It is not well-suited to provide answers to questions about what is causing changes in cost trends. We thought the CWCI data and analysis could help answer some of these questions, so we reviewed the original CWCI submission carefully prior to the hearing and asked for explanations and further data at the hearing.

Our review of the CWCI data provided in response to our request has yielded the following overall conclusions:

1. The larger paid medical loss data set obtained by the CWCI shows double-digit medical cost increases in each of the last three accident years, with the increase from 2006-2007 being somewhat less than the increase from 2005-2006, and the increase from 2007-2008 being very large.

   As shown on Exhibit 2 of the latest CWCI submission, the average medical benefit payment increased by 12.7% from accident year 2005 to accident year 2006 (with claims being evaluated at 24 months from the date of injury.) The average increase from accident year 2006 to accident year 2007 (valued at 12 months) was 10.5%. The average increase from accident year 2007 to accident year 2008 (valued at 6 months) was 25.8%.

2. The smaller data set, taken from detailed medical billing review data, shows smaller increases overall, and shows an actual *decrease* in paid medical severity from 2007-2008. It does not include any hospital inpatient medical expenses, however.

   As shown in the "All Services" section on Exhibit 7 of the latest CWCI submission, the average medical benefit payment increased by 12.0% from accident year 2005 to accident year 2006 (with claims being evaluated at 24 months from the date of injury.) The average increase from accident year 2006 to accident year 2007 (valued at 12 months) was 8.1%. The average change from accident year 2007 to accident year 2008 (valued at 6 months) was a *decrease* of 0.6%.

3. The medical billing review data shows detail by type of medical service performed, but approximately 30% of the data is not categorized by type of service; instead, it is lumped into one of two "miscellaneous" categories. A substantial proportion of the three-year increase in medical costs experienced for the total of the medical billing review data from accident year 2005 to accident year 2008 is included in these "miscellaneous" categories.

   The medical billing review data is subdivided into 17 categories, 13 of which are displayed in Exhibits 10 and 11 of the CWCI study provided with the original filing, as well as in Exhibits 6 and 7 of the new material provided in response to our inquiry. The new material provided details (in Exhibit 5) on the four

categories excluded from the original 13. These additional categories do explain entirely the difference between the "All Services" totals and the sum of the thirteen individual categories, but they raise additional questions. Two of the four additional categories- osteopathic manipulation and acupuncture- show minimal volume. The other two are labeled "Revenue Codes" and "Unknown/Non-Identified." These two categories include approximately 30% of the total medical payments included in the billing review detail. For example, for accident year 2007 as of 12 months, the total "all claims" severity for these two categories is $724, as shown on Exhibit 5. This is 29.7% of the total severity of $2,435 found on Exhibit 7. These two categories contain the majority of the increases in cost experienced from accident year 2005 to 2006, yet they are essentially miscellaneous categories with no available breakdown of costs into the types of medical services provided.

4. Taken together, these observations indicate that the detailed data provided in the CWCI studies are of limited usefulness in analyzing where the increases in medical costs are coming from, because detailed information is not available for significant portions of the total universe of medical expenses incurred under California workers compensation, and cost increases appear to be higher than average in the categories for which detailed information is unavailable.

   In the case of accident year 2008, all of the cost increases experienced appear to be concentrated in the categories for which detailed information is unavailable. As noted above, the larger CWCI data set shows a 25.8% increase in paid medical severity for accident year 2008 relative to accident year 2007. In stark contrast, the detailed billing information on outpatient medical costs shows a slight decrease in medical severity relative to accident year 2007. While the large increase in severity in the larger data set would normally be cause for great concern, the lack of any increase at all in the smaller, more detailed data set raises serious questions. There would seem to be three distinct possibilities. The first is that the wide divergence in the indications from the two data sets could simply be the result of the immaturity of the data. The second is that there are significant cost increases being experienced in inpatient medical expenses that are not being experienced in outpatient expenses. The third is that one or the other data set (or both data sets) contains faulty or incomplete data. In any event, this significant disparity casts doubt on any conclusions that may be made regarding the degree of medical cost increases experienced on accident year 2008.

5. It appears that a significant improvement in the quality and quantity of detailed billing information is called for.

   Specifically, detailed information is needed on hospital inpatient medical expenses, as well as on the 30% or so of outpatient expenses that were not classified in the current version of the ICIS database. If this is not accomplished, efforts to understand the sources and causes of increases in California workers

compensation medical expenses will continue to be frustrated by the lack of complete information.

6. To the extent that detailed data is available, it appears to indicate that increases in utilization of medical services may be more important in increasing costs than are increases in unit costs per procedure.

   While unit costs per procedure were up substantially from accident year 2005 to 2006, they have decreased significantly since then. At the same time, the average numbers of procedures performed per office visit have risen, and the average numbers of office visits per claim have increased significantly. Of course, this information is available for outpatient services only; no such detail was available for inpatient services.

7. Finally, it appears that the CWCI's "Case Mix Adjusted" analysis is not sufficiently well developed to be of any use in identifying the causes of observed medical inflation at this time.

   The analysis presented in the filing appeared to indicate that all of the observed medical trend could be explained by changes in the mix of the significant variables. This was of considerable interest to us, since we believe there is a critical need to understand what is driving the observed cost increases. Information we received in response to our questioning, however, shows that the CWCI has only begun to identify higher-cost variables and has no information as yet as to whether any of these variables are increasing in importance. We encourage the CWCI to continue its analysis, but expect that it will be some time before useful results will be obtained.

We agree with the observations attributed to Mr. Priven above. In our last Proposed Decision, we advanced the theory that part of the medical cost increase observed in 2006 was due to a "rebound" effect as the impact of the reforms was more fully understood. We have also commented above that medical evaluation and management, medical cost containment, and medical legal costs have all increased at a greater rate than have medical treatment expenses. We understand that these costs should have increased significantly under the new post-reform system, which puts much more emphasis on evaluating the appropriateness of medical treatment. We believe, however, that the majority of the increases we have seen in these areas are one-time, permanent upward adjustments in cost levels rather than elements of continuing medical cost inflation. While we have made our adjustments in a somewhat different manner than Mr. Priven's, our combined assumptions about medical frequency and severity trends are similar.

We also agree with the comment attributed to Mr. Neuhauser, and share this concern. It is entirely possible that, if medical cost inflation has changed significantly, that adjusters may be slow to reflect this fact in the case reserves. We think the significant difference between the severity increases displayed by the two different sets of data needs to be studied and explained, however. The WCIRB attempted to explain this discrepancy in its

May 29 letter to us, but did not go beyond stating that the two data sets were prepared based on differing assumptions, and that this meant that the results are not comparable. We do not think this is a satisfactory answer. Certainly, observing these differences as well as the differences between the indications from the two CWCI data sets, we are impressed that there is a lot of uncertainty surrounding the magnitude of medical inflation in 2008.

As previously mentioned, we are of the opinion that too much can be made of the CWCI case-mix adjusted analysis. All of the individuals whose testimony is referenced in this Proposed Decision were very interested in the results and implications of this analysis. The CAAA in particular appears to argue that the CWCI analysis has reached a definitive conclusion. Our questioning and the CWCI response indicate that instead the CWCI has just begun to study this, and has no information on which characteristics are driving medical cost increases. In our estimation, much more work needs to be done before definitive conclusions can be gained.

Medical Loss Trend

We have selected a 5.0% medical loss cost trend.

While we find that the WCIRB's selected 7% medical pure premium trend would be reasonable if all medical cost elements could be expected to continue to experience the same levels of cost increases that have been experienced recently, we do not believe this will be the case. We note evidence in the filing record that costs associated with medical cost containment, medical legal, and medical management have increased at a greater rate than medical expenses as a whole have increased. We believe that these increases are the result of an increased level of effort in these areas that is necessitated by the new post-reform environment that requires greater scrutiny of all medical treatment and expenses. As such, we believe these are permanent but one-time upward adjustments in costs, and should not be assumed to be indicative of continuing inflationary trends.

We observed in Exhibit 2 of the CWCI study submitted with the original filing that the categories of medical management, medical cost containment, and medical legal comprised approximately 15% of all medical payments in the study. These expenses were escalating at a rate between 16% and 20% over the most recent available 12-month period, according to the CWCI data. We assume that these costs will increase in the future at a rate similar to the medical care component of the Consumer Price Index, or approximately 4.5% per year, instead of the very high rates that have been seen recently. This assumption implies an overall reduction in medical trend of approximately 2% per year.

We have also made a 5% downward adjustment to both medical and indemnity losses to reflect the anticipated impact of the economy on claim frequency, as explained in the following section entitled "indemnity claim frequency".

Indemnity claim frequency

We discuss the WCIRB's indemnity claim frequency subsequently in the Permanent Disability section as it relates to increased utilization due to benefit increases. The model also incorporates economic factors.

The latest update to the model, provided to us on May 29th, forecasts a change in frequency of -11.3% in accident year 2009 and -3.2% in 2010. (These forecasts are based on a constant term of -2% rather than on the -4.0% produced by the model.) The -11.3% is driven by the economic variables, which contribute -9.4%. For accident year 2008, the observed frequency change was –6.7.

Mr. Priven provided a copy of a report titled "What Does Recession Mean for Workers Compensation?" by Harry Shuford, chief economist of the National Council on Compensation Insurance. The report addresses the belief that claim frequency will increase as unemployment rises and laid-off workers file claims. Mr. Shufford predicts instead that, "Frequency will continue to decline, perhaps at a modestly faster pace over the course of the recession." He makes the general observation that, "As the economy moves into recession, employers typically lay of their newest hired, least experienced workers", explaining why claim frequency actually declines as unemployment goes up.

Mr. Priven's middle range adjustment used a residual pure premium trend of -3.8% (2008 to 2009) and -1.2% (2009 to 2010) for indemnity and +4.9% and 5.9% for medical. His written testimony says that the indemnity trend implicitly includes a frequency change of -8.9% between 2008 and 2009 and -6.0% between 2009 and 2010. He says the former is based on the WCIRB frequency model and the latter on the average annual change between 2006 and 2008. The modeled number in the filing is -5.9% and the -8.9% Mr. Priven uses was discussed at a WCIRB actuarial committee meeting, reflecting more recent data. As noted above, the WCIRB subsequently submitted a new calculation of -11.3%.

In his comments, Mr. Neuhauser observes that indemnity claim frequency has declined by more than either the WCIRB's previous estimate of -3.9% or his own estimate of -5.0%. We believe that the adverse economic situation has much to do with this, as the rapid changes in the indications of the WCIRB frequency model demonstrate.

The CAAA letter commented at length on indemnity claim frequency. It stated that the WCIRB's analysis does not include specific recognition of the substantial decrease in indemnity claim frequency that has occurred in recent years. It claimed that "the WCIRB's analysis is flawed because the comparison of year-to-year average severities makes the implicit assumption that the characteristics of the "average claim" are identical from year to year and that any change in average cost represents a change in underlying costs. " The letter advances the hypothesis instead that claims in each successive year represent more severe injuries. The letter concludes that, since "there is no indication that the recent plunge in claim frequency has abated, the WCIRB's proposed 7% annual

factor is not justified." It recommends instead that the Commissioner use the same 1% medical trend factor used for the January 1, 2009 pure premium rates.

It should be pointed out that the WCIRB filings include the impact of reductions in claim frequency that have already occurred in the most recent experience years used in the filing. Furthermore, there is undoubtedly some implicit recognition of declining claim frequency in the selection of the pure premium trend, as the on-level exhibits include the combined impacts of recent frequency and severity changes in the most recent accident years. At the same time, actual frequency decreases have continued to outstrip prior expectations.

We believe the WCIRB should pay more attention to the effects of the California economy on frequency. It is particularly important to do so when it is experiencing such upheavals as now.

We therefore adjust the calculated pure premium ratio by 5% (by multiplying by a factor of .95). The amount of the adjustment is not arrived at by an explicit calculation. It rather takes as a starting point the -11.3% and judgmentally reduces it based on the following considerations: that a reduction in frequency may increase the average claim size as smaller claims are eliminated, that medical losses may decrease by a smaller amount, that economic effects may already be beginning to manifest themselves in the 2008 accident year, and that a portion of the -11.3% is the long-term downward trend in frequency that is already reflected in the on-level pure premium trend.

If the model forecast is borne out then, going forward, the on-level pure premium time series will include an implicit step-down in accident year 2009, followed, if the economy recovers, by a steeper than usual trend. We recommend that the WCIRB consider explicitly including an economy-related frequency adjustment in its on-leveling calculation, possibly as part of a larger effort to separate out frequency and severity on-leveling and trend projections.

Permanent disability

The WCIRB adds 5.8% to the indicated change to reflect the estimated cost impact of two recent WCAB en banc decisions, *Ogilvie v. City and County of San Francisco* and *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District.* The WCAB concluded, in *Ogilvie*, that the diminished future earning capacity adjustment is rebuttable and, in *Almaraz/Guzman*, that the AMA whole person impairment ratings are rebuttable.

The WCIRB estimate has four parts: impacts on average PD rating, proportion of lost time claims involving PD, indemnity claim frequency, and frictional costs.

The first part, the impact on average PD rating, is based on two assumptions. First, the WCIRB assumed that 40% of permanent disability claims would be affected. This number is based on data from the Rand Corporation that 40% of workers with PD claims

have a wage loss of 50% or more. Second, they assumed that these workers would, on average, get a 25% increase in their ratings. The WCIRB notes that the reforms reduced ratings by more than half and a reversal of the reforms could more than double ratings, thus using 25% reflects a 75% tempering. These assumptions result in an impact of 2.0%.

The second part, the impact on proportion of lost time claims involving PD, also has two assumptions. First, the WCIRB assumed that the ratio of PD to lost time claims would return to their pre-reform levels, from 40% back to 50%. Second, they assumed these new claims would have the same average ratings. The result is an impact of 0.8%.

The third part, the impact on indemnity claim frequency, is based on the long-established .26 benefit utilization factor. The resulting impact is 1.7%. This includes an impact of about 1% on medical.

The fourth part, the impact on frictional costs, has three subparts. ULAE is assumed to increase proportionally. According to the WCIRB's unit statistical data, ALAE on PD claims is 75% of all ALAE. From the first two parts of the calculation 46.25% of PD claims are affected. The WCIRB speculates that ALAE could more than double for these claims, then tempers this to a 25% increase. This results in an overall increase in ALAE of 9%, which translates into a 0.8% increase in overall costs. Using these same assumptions, medical legal costs would increase 12%, for an overall effect of 0.4%.

Mark Priven's testimony included three estimates, a low, middle and high. For the en banc decisions, his low end estimate is zero, because the cases are still pending and the outcome is unknown. (Delay typically increases claims costs but Priven noted that the claims covered by this filing would unlikely to be ready for permanent disability rating until 2011 or later.) For his middle value, Priven modified the WCIRB approach. He assumed that non-ratable claims under the AMA guidelines are 20-25% lower severity than other PD claims, he reduced the WCIRB's utilization factor by 25% and he tempered by an additional 50%, this last to reflect the WCAB has agreed to reconsider. The result was an increase of 2.5%. For his high estimate, he calculated 12.7% by removing the 75% tempering from his middle number.

The public members of the governing committee, Bruce Wick and Angie Wei, proposed using 3.7%, the amount the WCIRB previously estimated as the cost for a proposed regulatory change to the PDRS diminished future earnings capacity formula that did not occur. They say that this number, being lower than the WCIRB's 5.8% could be considered a reasonable tempering, given WCAB's subsequent agreement to reconsider the cases.

Mark Gerlach and Todd McFarren testified that the number for permanent disability should be zero while the WCAB cases are being reconsidered. Mr. Gerlach said, "These cases will not and cannot reverse the unintended 50% reduction in permanent disability benefits" and that they "should actually reduce litigation and claim adjustment costs".

Frank Neuhauser said that "the 5.8% increase proposed by the Bureau is an appropriate cautionary increase in the face of this uncertainty." But he also qualified his support by saying, "On the other hand, I do not think that this increase, and the potential increase in the number of PD claims should be used to increase medical costs on the same cases.... The underlying medical condition did not change."

As actuaries, we are obliged to determine an estimate that is based on the expected value of future costs. To calculate an expected value, one multiplies the cost of each outcome by its probability, then sum up these results. Here we have no clear grasp on what the possible outcomes might be, what are their costs, or what are their probabilities. Whatever result we calculate will have to be the result of crude simplifications. However, we do know that the probability of the WCAB doing something other than completely reversing itself is greater than zero. Therefore, we reject the low estimate of Mr. Priven and the recommendation of Mr. Gerlach.

We also reject the recommendation of the public members of the governing committee. The calculation of the cost of some other proposed regulatory change that was never implemented simply has no bearing on the question at hand.

We are troubled by the WCIRB's calculations. There are many other possible scenarios in addition to the ones the WCIRB assumes. The tempering allays these concerns, but may err by going too far. To avoid compounding the possible error, we reject recommendations from the various other witnesses to temper even further.

We are sympathetic to Mr. Priven's point that formerly non-ratable claims are presumably the less serious claims and should have lower severities than average. The effect of such an adjustment would be slight, about 0.2%. To tinker with the calculation in such a minor way creates a false impression about the level of confidence we have in the rest of the calculation.

For now, we reject Mr. Neuhauser's recommendation to disallow the increased utilization on the medical portion. On occasions in the past, we have disallowed it, but we have not been consistent about it. The econometric model the WCIRB relies on only considers indemnity. We recommend that the WCIRB revisit this question in the future. In addition, we noted during the hearing that the current version of the model gives a significantly lower result than .26. We understand the desire not to change the number each quarter as the model is updated, but it has been some time now since the model did support .26. We recommend that the WCIRB also revisit this question.

For all the above reasons, we accept the WCIRB's 5.8% adjustment.

Loss development

The WCIRB used the latest year's paid development factors. For medical, the factors were adjusted for benefit changes.

Mr. Priven made three loss development projections. His middle range gave 50% weight to the three-year average unadjusted paid development factors and 25% weight each to the latest-year unadjusted and adjusted paid development factors. His low-end estimate used the three-year unadjusted paid factors and his high-end estimate was to increase his middle estimate by 10%. He explained the high-end estimate by saying he was "concerned that the projections are lagging behind cost increases in the system".

This is a legitimate concern and it is why we accept the WCIRB's recommendation and reject the alternatives offered. The California workers compensation is big enough that development factors are not significantly affected by random variations from year to year. Therefore, in most circumstances multi-year averages are not necessary to avoid the usual credibility problems. Observed changes from year to year usually do reflect real underlying changes in the system, whether gradual in years without law changes or quick in years with. We have also found that paid development factors, though more highly leveraged than case incurred factors, usually perform better over time.

The WCIRB has been criticized at various times and by various parties for relying so heavily on one-year paid development factors. While we appreciate the concern that the WCIRB should make available more alternative calculations, generally over the years we have agreed with the WCIRB's loss development choices and, retrospectively, we do not believe that the WCIRB could have substantially improved the accuracy of its ultimate loss estimates using the standard actuarial tools.

Loss Adjustment Expense

We have excluded State Compensation Insurance Fund (SCIF) data from the determination of both the Unallocated Loss Adjustment Expenses (ULAE) and Allocated Loss Adjustment Expenses (ALAE) provisions for the same reasons we did so in previous filing decisions. As we previously stated, the State Fund has had a level of excess expense in its claims operation for the last few years, as it has not been able to decrease its claims staffing as quickly as its volume of claims has decreased. Prior to its loss of market share, SCIF's combined loss adjustment expense as a percentage of loss was similar to that of the total of all private insurers. It is important to exclude both SCIF's ULAE and ALAE experience, since a much greater proportion of SCIF's loss adjustment expense is ULAE than is true for the private insurers.

Mr. Priven excludes State Compensation Insurance Fund ULAE experience from his "low" and "middle" calculations, and states that his reasons are the same reasons we stated in the decision on the previous filing. He makes no mention of excluding SCIF ALAE data, however.

On page 10 of his letter, Mr. Priven argues that ULAE should be excluded from the pure premium rates recommended by the WCIRB and approved by the Commissioner. While we agree in principle with his stated reasons, we believe that the WCIRB and the Commissioner are obligated by statute to continue to recommend and approve pure premium rates that include a provision for all loss adjustment expense. This is because

the statute defines the pure premium as inclusive of all loss adjustment expenses, requires the WCIRB to develop pure premium rates and requires the Commissioner to pass judgment on them.

We are also in general agreement with Mr. Priven's comment that medical cost containment expenses should be classified as ALAE rather than lumped in with medical losses. This would be consistent with statutory insurance accounting principles. While this subject may be under review in the near future, the Department has already indicated its desire to the WCIRB that medical cost containment expense data should be separately collected. If this expense were to be reclassified as ALAE, maintaining separate medical cost containment expense data may be a desirable outcome.

Claims Cost Benchmark Impact

Projected Loss Ratio:

As explained above, we have selected a medical loss ratio trend of 5.0% per year, instead of the 7.0% trend selected by the WCIRB. The WCIRB's developed on-level medical loss ratios are 55.8% for accident year 2007 and 60.2% for accident year 2008. The average of these is 58.0%. We apply our selected trend over the same period the WCIRB does: the period from January 1, 2008 to April 1, 2010, a time interval of 2 ¼ years. This yields our trended medical loss ratio of 64.7%.

As also explained above, we apply a multiplier of .95 to this result to recognize the expected effect of the adverse economy on indemnity claim frequency. This yields our projected medical loss ratio of 61.5%.

We accept the WCIRB projected indemnity loss ratio of 28.8%, but also apply the .95 multiplier to it, resulting in our projected indemnity loss ratio of 27.4%.

Our overall projected loss ratio, prior to the impact of the recent *en banc* WCAB decisions affecting permanent disability, is the sum of these two projected loss ratios, or 88.9%.

Loss Adjustment Expense Multiplier:

As previously mentioned, we exclude all SCIF experience from the determination of the loss adjustment expense provision to be included in the pure premium rates. We otherwise accept the WCIRB's loss adjustment expense methodology. The result of these decisions is that our preliminary selected unallocated loss adjustment expense load is 7.9% of loss, and our preliminary selected allocated loss adjustment expense load is 11.2% of loss, for a total loss adjustment expense provision of 19.1% of loss.

As we did in our Proposed Decision on the January 1, 2009 pure premium rate filing, we adjust this provision upward in recognition of the fact that our selected projected loss ratio of 88.9% is lower than the WCIRB's projected loss ratio of 96.3%. The result of

this adjustment is our final loss adjustment expense provision of 20.7% of loss, and a loss adjustment expense multiplier of 1.207.

Overall Impact:

Prior to consideration of the impact of the recent WCAB decisions affecting permanent disability, our overall indicated change to the pure premium rate claims cost benchmark is the product of the 88.9% projected loss ratio and the loss adjustment expense multiplier of 1.207. This result is an increase of 7.3%.

Since we have accepted the WCIRB's estimate of a 5.8% overall impact due to the permanent disability decisions, our final recommended change to the pure premium rate claims cost benchmark is a 13.5% increase.

Uncertainty

There is considerable uncertainty in the estimation of medical severity trend. The data presented in the filing record provides a wide range of indications of the medical severity increases experienced recently.

The higher indications of medical severity increases come from the WCIRB's standard accident year ratemaking analysis and from the CWCI's larger data set of medical payment data. The WCIRB's amended filing's ratemaking analysis yields an 18.2% increase in medical severity for accident year 2008 over accident year 2007 when the Bureau's estimates of changes in claim frequency are backed out. The CWCI's larger data set of medical payment data shows a shows a 25.8% increase in medical severity for the incomplete accident year 2008 relative to accident year 2007.

On the other hand, the CWCI's smaller data set from detailed medical billing records on outpatient services shows an actual decline in severity for accident year 2008.

Similarly, while the WCIRB ratemaking analysis yields estimates of medical severity increases of 14.8% for accident year 2006 and 13.0% for accident year 2007, its analysis of Unit Statistical Plan data shows an 8.1% increase in medical severity for 2006 and only a 3.8% increase for accident year 2007. The larger CWCI data set shows increases of 12.7% for accident year 2006 and 10.5% for accident year 2007, while their smaller data set shows increases of 12.0% for accident year 2006 and 8.1% for accident year 2007.

At the same time, as previously discussed, we expect that some cost increases have been due to a "rebound" effect from the lowest cost levels experienced when the reforms were first implemented, and others have been due to the need for greater evaluation and documentation of injured workers' medical conditions. Both of these are likely to be one-time phenomena as opposed to indications of ongoing trends, but this is not known with certainty.

Given the wide range of recently observed increases in medical costs, and the uncertainty as to what portions of these increases are one-time events and which are likely to be ongoing trends, it would appear that there is currently an unusually high degree of uncertainty in estimating what future rates of increase in medical severity will be.

For permanent disability, there is comparable uncertainty. The WCAB will reconsider its en banc decisions in *Almaraz/Guzman* and *Ogilvie*, and it is possible that they will completely reverse themselves, and the cost impact will be nil. On the other hand, they could reaffirm the decisions. The WCIRB states, "If permanent disability benefits were to increase to their pre-reform level, the indicated pure premium level increase attributable to these WCAB decisions would be approximately 40%." This is equivalent to saying that there is a distinct possibility that the permanent disability reforms could be completely reversed. Mr. Gerlach of the CAAA asserts strongly that this will not happen, but there are those who believe it is possible. Mr. Priven affirms the uncertainty, with a range of cost estimates from zero to 12.7%, but even his high-end estimate includes a tempering of 50%.

There was uncertainty at the time of the reforms as well, but of a different nature. Then the question was whether the reforms would be effective in reducing costs. There was, however, early on, evidence that the reforms, particularly the permanent disability changes, would be effective. Now the uncertainty is over whether and by how much costs will increase. As we've discussed, there is data on medical costs, but it is confusing and often contradictory. For permanent disability, not only is there little or no data, there is no certainty what the final outcome of both the WCAB's reconsideration will be or how the various appellate courts will deal with the issues.

Therefore, while we have arrived at a particular number through what we believe is sound reasoning, we believe that the very great uncertainty surrounding our estimate means that it should be viewed with caution.

OTHER MATTERS

Amendments to the California Workers' Compensation Experience Rating Plan—1995

The WCIRB has proposed amendments to the California Experience Rating Plan—1995 to be effective on July 1, 2009 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after July 1, 2009. Those amendments include the following:

- Amend Section I, *General Provisions*, Rule 2, *Effective Date*, to show that the effective date of the amended Experience Rating Plan is 12:01 A.M., July 1, 2009.

- Amend Section III, *Eligibility and Experience Period*, Rule 1, *Eligibility Requirements for California Workers' Compensation Insurance*, to adjust the experience rating eligibility threshold from $15,700 to $19,421 to reflect the proposed 23.7% increase in the overall Benchmark.

The amendments to the California Workers' Compensation Experience Rating Plan—1995 have been reviewed, and no objection to them has been received. These amendments are also reasonable and consistent with the Plan and are approved; however, I have concluded the change of the Pure Premium Rates should be +7.3%. Therefore, the WCIRB is directed to adjust the eligibility threshold to reflect the Insurance Commissioner's adopted Claims Cost Benchmark in order to maintain approximately the same volume of experience rated employers. In addition, the effective date shall be in conformance with the date of the Commissioner's Decision and Order.

Directive to Change Medical Loss Definitions and Reporting

During the April 28, 2009 hearing, the Commissioner brought to the attention of the WCIRB that there were a number of complaints concerning the inclusion of medical cost containment expenses in the definition of medical losses and the fact that medical costs in rate filing submissions did not separate out actual medical treatment costs from medical cost containment costs. This had been reviewed by the Department, and the recommendation to the Commissioner was for the WCIRB to revise the rules concerning data collection and reporting and to have future rate filings, subject to the effective date of the rule change, separate actual medical treatment costs from medical cost containment expenses.

At the time of the hearing, the WCIRB was directed to provide rule changes to accomplish this, and the WCIRB was to determine if the medical cost containment expenses should continue to be included in the total medical loss category for experience rating purposes. However, since that time, it has come to the attention of the Department that standard accounting rules that govern the reporting of insurance companies throughout the country require the reporting of medical cost containment expenses as loss adjustment expenses. In addition, no other state has medical cost containment expenses reported as medical loss.

Therefore, the WCIRB is directed to prepare rule changes to be effective by January 1, 2010 to be heard at the next hearing in these matters to require the reporting by insurers of medical cost containment expenses as loss adjustment expenses. In addition, the data on medical cost containment expenses shall be appropriately defined and separately reported so as to be able to be monitored.

PROPOSED ORDER

WHEREFORE, IT IS ORDERED, by virtue of the authority vested in the Insurance Commissioner of the State of California by California Insurance Code sections 11734, 11750, 11750.3, 11751.5, and 11751.8 that the advisory workers' compensation pure premium rates filed by the WCIRB and Section 2353.1 of Title 10 of the California Code of Regulations are hereby amended and modified in the respects specified herein and in accordance with the Commissioner's adjustment to the Workers' Compensation Claims Cost Benchmark;

IT IS FURTHER ORDERED that the experience rating threshold be calculated to reflect the adjustment of the Workers' Compensation Claims Cost Benchmark and is effective on the date of the Commissioner's Decision and Order;

IT IS FURTHER ORDERED that the WCIRB prepare rule changes to be effective by January 1, 2010 to be heard at the next hearing in these matters to require the reporting by insurers of medical cost containment expenses as loss adjustment expenses. In addition, the data on medical cost containment expenses shall be appropriately defined and separately reported so as to be able to be monitored.

IT IS FURTHER ORDERED that these regulations shall be effective upon the date of the Commissioner's Decision and Order for all new and renewal policies with anniversary rating dates on or after that date.

I HEREBY CERTIFY that the foregoing constitutes my Proposed Decision and Proposed Order in the above entitled matter as a result of the hearing held before me as a Senior Staff Counsel of the Department of Insurance on April 28, 2009 and June 8, 2009, and I hereby recommend its adoption as the Decision and Order of the Insurance Commissioner of the State of California.

July 7, 2009

Christopher A. Citko
Senior Staff Counsel