STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

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JANUARY 1, 2012 WORKERS' COMPENSATION CLAIMS COST BENCHMARK AND PURE PREMIUM RATES

PUBLIC HEARING

SAN FRANCISCO, CALIFORNIA

TUESDAY, SEPTEMBER 27, 2011

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State of California January 1, 2012 Workers' Compensation Claims Cost Benchmark and Pure Premium Rates, Public Hearing, taken at State of California, Department of Insurance, 45 Fremont Street, 22nd Floor, San Francisco, California, commencing at 10:00 a.m., Tuesday, September 27, 2011, before Maryann P. Costa, RPR, RMR, CSR No. 5820.

TUESDAY, SEPTEMBER 27, 2011 10:00 A.M.

P R O C E E D I N G S

--oOo--

THE COMMISSIONER: Good morning.

My name is Dave Jones. I am California's Insurance Commissioner. And I want to welcome all of you to the California Department of Insurance, and to this hearing on the Workers' Compensation Rating Claims Benchmark and Pure Premium Rate Filing.

With me on the dais, today, is Mr. Ron Dahlquist, the Department's Senior Actuary, and Mr. Chris Citko, who is a Senior Attorney with the Department's Legal branch.

Mr. Citko will be functioning as the hearing officer for today's hearing, in charge of making sure that all of the testimony that we receive, both from the Workers' Compensation Insurance Rating Bureau, and any other member of the public who wishes to testify, is duly entered into the record.

Mr. Citko is going to make some admonishments, which is a fancy legal term for just kind of laying down the rules of the road for the hearing; and then I'm going to make an opening statement; and we can proceed with the rest of the hearing.

But, most importantly, we want to welcome you; and, hopefully, someone has pointed out where the public

restrooms are on this floor, and where the drinking fountains are; and, if you don't know, you can, certainly, ask one of my staff, who are present in the room. Welcome.

MR. CITKO: Good morning, everybody. Thank you, Commissioner.

We're here today, as the Commissioner announced, regarding the Claims Cost Benchmark and Pure Premium Rates.

We received a filing from the Workers' Compensation Insurance Rating Bureau of California regarding those items on August 22, 2011.

We did issue a hearing notice concerning this hearing on August 23, 2011; and it was published in the Notice Register on September 2, 2001.

The issues to be determined at this hearing, based on the filing that we did receive, concern the -- as was stated -- the Claims Cost Benchmark and the Pure Premium Rates, as well as the amendments to the California Workers' Compensation Uniform Statistical Reporting Plan, the Experience Rating Plan, and the miscellaneous regulations concerning collection of data.

So, with that, I do want to remind everybody that, as the proceedings go on here, today, if you are going to testify, we do have a reporter present, who is going to

take all the testimony that is presented today. I would ask that you speak clearly. I ask that you also respond, if you are questioned, with yes or no rather than an uh-huh or huh-uh, or, nodding your head or shaking your head. I will remind you, please, also, speak slowly and clearly so that the reporter can take down your testimony. I am sure the reporter will tell you, or, I will be able to tell you, if you speak too quickly, to slow down; and it's not meant to, you know, cause concern for you, but, just to allow the reporter to take all the information today.

Now, the record is noted to be closed this Friday, September 30th, at 5:00 p.m. Typically, we do that to allow the Rating Bureau, or other members of the public, to submit supplemental information to the filing.

Before we close the record, we usually ask a lot of questions and need more information, but, the record is going to close this Friday, September 30th at 5:00 p.m.

Currently, the information that we've received -- the written information that we've received -- is the filing by the Rating Bureau, along with a correction that they provided to their filing.

We've also received a letter from the public members of the Governing Committee of the Workers' Compensation Insurance Rating Bureau, along with an analysis from the

public members actuary.

Other than that documentation, I don't believe we have anything else that we've received in the record. But, we, certainly, would welcome anybody submitting additional written documents, today, and also up to and including this Friday, September 30th.

And, with that, we will go ahead and begin the proceedings.

Commissioner?

THE COMMISSIONER: Thank you.

And the only thing I'd add is, if you have a cellphone, now is the time to turn it off.

Again, welcome to the Department of Insurance. We're delighted to have you here today at this hearing. I thought it might be useful to set the stage, as I know there's a great deal of public interest, particularly, amongst California businesses and employers with regard to this rate filing each year. I think it's important to set the stage because I also think that there's a lot of misunderstanding, in the broader public, about the import of this hearing, and the import of the Commissioner's decision as it relates to Pure Premiums.

Pure Premiums and this rate filing are advisory. You'll hear me say that, probably, about 20 different times during this hearing, because I think it's

critically important that the public understand, and businesses and employers understand, in California, that the California Department of Insurance and the Insurance Commissioner do not set Workers' Compensation rates. Those rates are set, if you will, by the insurers. They determine how much they're going to charge. They file those rates.

Our Department's role and mission is to make sure that Workers' Compensation carriers remain solvent, and that the rates are neither discriminatory nor inadequate.

But, we have a free market rate system for Workers' Compensation, and so, even though this hearing has been viewed by many in the public as somehow setting the rates for Workers' Compensation, it does not do that.

The purpose of this hearing is to collect information with regard to the Pure Premium, which is, essentially, the cost of Workers' Compensation benefits and the expense to provide those benefits.

The purpose of this hearing is to receive expert testimony from the Workers' Compensation Insurance Rating Bureau, which is a licensed rating organization, licensed by the Department, of which all Workers' Compensation insurers are required to be a member.

One purpose of the rating organization is to collect insurer loss information and to assess and evaluate and

make recommendations to the Department with regard to what the Workers' Compensation Insurance Rating Bureau believes the Pure Premium Rate should be; that is that rate that is necessary to cover Workers' Compensation benefits and the costs associated with the provision of those benefits -- but, again, it's advisory in nature. We're not setting the rates for Workers' Compensation through this hearing or through the decision that I will, ultimately, make.

The other important thing to note is that there are, actually, 500 classifications -- job classifications -- that are assessed by the Workers' Compensation Insurance Rating Bureau, and that -- each classification has a Pure Premium Rate assigned to it, which is the projected cost to insure that -- that classification.

Workers' Compensation benefits and costs are covered -- the Workers' Compensation Insurance Rating Bureau collects the data for purposes of developing Pure Premium Rates for each classification -- and, before it's provided to us, there's an extensive analysis that is performed by the Workers' Compensation Rating Bureau.

After this hearing, the Department of Insurance staff -- my staff -- will review the testimony provided at the hearing, as well as the submission by the Workers' Compensation Insurance Rating Bureau, and they will make

a recommendation to me as to whether to approve, modify, or reject the Pure Premium and Claims Benchmark filing of the Worker's Compensation Insurance Rating Bureau.

What I approve, reject, or modify, again, is advisory in nature. It is not binding on the insurers. They can choose to use that information or not use that information in setting their rates as they see fit. But, it does provide information to the market, to employers, to businesses, to policymakers, with regard to what's happening in the market as it relats to the actual costs of the provision of Workers' Compensation benefits.

Again, I want to underscore that these Pure Premium Rates are only the estimated costs and not the actual premiums that are charged to employers; in fact, as we know, as well, those of you who follow this system, closely, the rates that are actually filed by the Workers' Compensation carriers don't necessarily reflect the actual rates charged in the market, because the carriers are also able to offer credits and discounts to particular employer customers, if you will. So, even the filed rates may not necessarily reflect what is actually being charged in the market.

Nonetheless, the Pure Premium Rate filing is important. It's important because it is allows this Department, and the broader public, the employer

community, the business community, to have a better sense of what actual costs are in the Workers' Compensation system. It provides us with information we need to make sure that there's not underpricing of insurance, so that we can carry out our critical mission of ensuring that Workers' Compensation carriers remain solvent.

It also provides information to small Workers' Compensation carriers who might not have the same capacity to collect data in this way. And it gives them the opportunity to compete at a more level playing field with the large carriers by providing them with critical information about what's happening in the market.

So, these are the things that we're going to be dealing with today -- but, there is one new thing that we're doing, as a result of an order that I issued earlier this year, and I want to spend a moment on that, as well.

I have directed the Worker's Compensation Insurance Rating Bureau to use a new approach that better reflects what's, actually, occurring in the market with regard to Pure Premium -- or costs.

In prior years, the rate filing that was provided by the Workers' Compensation Insurance Rating Bureau would reflect the proposed change, up or down, in Pure Premium based on the last time the Insurance Commissioner, or the

Department of Insurance, made a determination with regard to the Pure Premium Rate.

What has happened, over time, since, in the last two years the rate filing has been disapproved by the prior Commissioner, is that this prior approach has become, totally, disconnected from what's happening in the market.

And so I asked the Worker's Compensation Insurance Rating Bureau -- and I appreciate their having done so -- to change the approach to one that is more closely connected to what's happening in the market and what's happening with regard to filed rates.

Specifically, what I asked them to do is to take a look at the Pure Premium associated with the filed rates and market rates of the carriers and make a recommendation based on that.

In my mind -- and I believe it's our Department's view, as well -- or -- I know it's our Department's view, as well -- this will provide much better information, greater transparency, and more timely and useful information to employers, businesses, and the overall market with regard to what's happening as it relates to Pure Premium Rates for Workers' Compensation.

The reason, again, being that, in the past, we had a recommendation that was detached from what was actually

happening vis-a-vis Pure Premium market rates. Now, what we're going to get is an assessment of what the carriers, themselves, have filed in terms of the Pure Premium -- or -- actual costs associated with their premiums -- and what the Worker's Compensation Insurance Rating Bureau believes needs to be changed, up or down, associated with that, to make sure that we can cover these costs looking into the future.

So, this is a significant change and one, again, that, I think, will provide great benefit to the overall market, to employers, and to other policymakers, because this will more closely connect the filing with what's happening in the market.

So, with that, I'm very excited to hear the testimony of the Bureau, and the testimony of others who wish to share with us their views and thoughts on this matter today. And thank you for giving me an opportunity to say a little bit about the framework for what we're about to do today.

MR. CITKO: The outline for today is, we will first hear from the Workers' Compensation Insurance Rating Bureau; and then, during that time, we may ask them questions concerning the filing; but, then, we would like to hear from the public members who have submitted written commentary and analysis and their actuary.

I would ask that you keep your comments brief; that they not duplicate the written material that we've received; but, give us a good summary of what you're providing us today; and please respond to our questions as best you can.

After that, we'd be glad to take any further public comment concerning the Claims Costs Benchmark and Pure Premium Rates.

After we conclude that portion, we'll likely have a break at that time, and then we'll go back and deal with the rule changes that were submitted by the Rating Bureau, and, again, hear from them, generally, about those, and take any public comment concerning those; and, after that, we should be able to conclude the hearing.

MR. MIKE: Good morning. My name is Robert Mike. I'm President of the Worker's Compensation Insurance Rating Bureau of California.

As noted in our August 22nd filing cover letter, at the direction of the Commissioner, we modified the manner in which we present our proposed January 1, 2012 Pure Premium Rates to address the concerns raised by the Commissioner.

Let me begin by re-emphasizig that the Pure Premium Rates proposed are a projection of loss and loss adjustment expense per $100 of payroll. They reflect a

projection of what it will cost insurers, collectively, to pay for loss and loss adjustment expenses expected to be incurred in connection with policies incepting on or after January 1, 2012.

They're not premium rates in the sense that they are not used, directly, by insurers in determining the premium an insurer will charge a policyholder.

Also, as noted, these Pure Premium Rates are projections -- are advisory -- that insurers may and often do use Pure Premium Rates other than those proposed or approved, and have broad discretion regarding the premium rates it charges.

Also, as noted in past filings, the proposed Pure Premium Rates were compared to the existing advisory Pure Premium Rates. In this filing, we have compared our average proposed Pure Premium Rate, or, projected loss and loss adjustment expenses per $100 of payroll, to what insurers, directly, have filed with the Department of Insurance, and charge in the marketplace, as directed by the Commissioner.

Specifically, as noted in our filing, we are proposing an average Pure Premium Rate of $2.33 per $100 of payroll -- for policies incepting on or after January 1, 2012. As shown in our handout, this is, slightly, less than the industry average filed Pure Premium Rate,

and the industry averaged charged rate of $2.37 and $2.38 per $100 of payroll, respectively.

At this time, Mr. Dave Bellusci, our Chief Actuary, will summarize the key cost drivers and methodologies underlying our loss and loss adjustment expense projection of $2.33 per $100 of payroll.

MR. BELLUSCI: Good morning. I'm Dave Bellusci, Chief Actuary, Worker's Compensation Insurance Rating Bureau.

Given the time constraints, I won't go through a full discussion of the methodologies underlying the filing; instead, I'll focus on the key cost drivers of the average Pure Premium Rate of $2.33, that Mr. Mike referred to, as well as provide a very high level of description of the basis of the computation.

Our filing, which was submitted on August 22nd, fully, described the data, methodologies, and assumptions that underlie the discussions. Of course, we can address any questions the panel may have in the filing.

As discussed in the filing, the $2.33 per $100 of payroll represents deterioration from the last filing we made to be effective January 1, 2011. This was a result of several factors. These are summarized on page 3 of the handout.

First, there's been a significant increase in

frictional costs, particularly, allocated loss adjustment expenses, over the last several years. That's largely the result of increases in the number of medical liens, a by-product of the 2009 WCAB decisions on permanent disability rules, specifically, Ogilvie and Almaraz-Guzman, and increase in rates of the representation.

Second, there's been continued adverse loss development over the last year. We believe that's primarily attributable to slowing the claims settlement process, as well as the aforementioned WCAB decisions.

Third, for the first time in quite a few years, we saw a significant increase in indemnity claim frequency in 2010. Since this increase parallels what's happened in many other states, we think it could, in large part, be related to the economy and the recent recession. We're continuing to analyze this, and will in subsequent months, but, what the data we've seen so far suggests is that there's been a rise in cumulative injury claims over the last year. That could, in part, be claims that were not filed during the depths of the recession due to job worries.

Secondly, we've seen an increase in small indemnity claims that, in the past, may have been medical-only claims. As I mentioned, we're continuing to analyze the

causes of this increase.

Finally, since Pure Premium Rates are expressed per $100 of payroll, projected growth and losses and loss adjustment expense can be offset, at least in part, by growth and average wage levels.

Since we all know, since the time of last year's filing, in the summer of 2010, most economists have become increasingly pessimistic about the strength of the economic recovery in California; as a result, wage level growth forecasts that are reflected in our filing for 2011, 2012 and 2013 have decreased from a year ago.

While, despite modest reductions in average cost of medical and indemnity over the last year or so, to a large extent, what's driven the $2.33 per $100 of payroll average Pure Premium Rate we're proposing are trends in severity costs over the last five years -- really, since the reforms were fully implemented.

Page 4 of our handout shows estimated medical severities per lost time or indemnity claim. The average medical, we estimate, for 2010, per lost time claim of almost $41,000, is almost $12,000, or, about 40 percent higher, than it was in 2005 when the reforms were fully implemented.

Our filing cites a number of factors that have been documented as to driving some of those increases we've

seen over the last five years.

That includes, increases in medical treatment levels;

Items such as the number of visits per claim;

The number of procedures per visit;

The complexity of the procedures;

An increase in the volume of medical liens;

Increasing pharmaceutical costs, particularly, in areas such as compound drugs and opioids;

The cost of Medicare-related issues related to Medicare set-aside;

And, finally, increases over the last five years in both the cost of medical-legal and in the cost of medical costs containment.

As shown in page 6 of our handout, indemnity severities have also increased since the reforms were fully implemented in 2005. Our estimate of almost $22,000 of indemnity loss per indemnity claim for accident year 2010 is $5,000 more, or, about 31 percent higher, than it was in 2005.

As we discussed in the filing, our analysis of permanent disability ratings issued by the State Disability Evaluation Unit indicates that there was a significant creep in permanent disability ratings over the last several years; and those increases accelerated

following the WCAB decisions in 2009.

In addition, other data from the Division of Workers' Comp suggests there's been an increase in claims settlement.

And data from our own system, as well as other sources, suggest that temporary disability duration has increased over the last couple of years.

Finally, as shown on page 8 of the handout, allocated loss adjustment expenses has also increased, significantly, over the last five years. These are the costs of handling Workers' Compensation claims in California that can be assigned to an individual claim file. The average cost in 2010 is estimated at almost $11,000; that's $4,000 higher, or, 55 percent higher, than the 2005 figure.

As I mentioned, earlier, some of the factors we believe that are leading to this increase include increased liens, the WCAB decisions on permanent disability, as well as the increases in the rate of representation.

Okay, let me now just give a very high level summary of our filing, and the Pure Premium Rates that are proposed.

Our filing has two components:

Part A is the component that addresses the proposed

2012 Pure Premium Rates; that's based on March 31, 2011 loss and loss adjustment expense experience. It reflects methodologies that are very similar to the January 1, 2011 filing.

In addition, it reflects updated classification relativities that pertain to the Pure Premium Rates for the individual 500 industry classifications that Commissioner Jones, previously, referred to. That reflects the most recently available loss and payroll data by classification.

Part A of our filing also includes a wide range of alternative projections under different assumptions regarding loss development trending and loss adjustment expense.

Part B of our filing includes the proposed changes to the Commissioner's regulations.

Primarily, those are included in the Uniform Statistical Reporting Plan and in the Experience Rating Plan. And the core data used to compute the average Pure Premium Rate per $100 of payroll is provided by over 100 insurer groups that comprise 100 percent of the market and -- as I mentioned -- reflects experience as of March 31, 2011.

The data reported to the Worker's Compensation Insurance Rating Bureau is subject to a rigorous

validation process involving a series of automated data checks review by Worker's Compensation Insurance Rating Bureau actuarial staff, certification by insurer actuaries and officers, as well as an annual attestation by an independent auditor to each insurer's data submission.

The historical data is then summarized and compiled and forms the basis of our projections of policy year 2012 cost levels. There are three principal components of our projection:

First, the paid losses for each historical year through 2010 are projected or developed to an ultimate cost level;

Second, these developed losses by year, as well as the year-end premium, are adjusted to current common level;

Finally, the developed and undeveloped historical losses to premium ratios are trended forward to reflect inflation and other factors for that policy year 2012 basis.

As I mentioned, the actuarial loss and loss adjustment expense projection methodologies are very similar to the -- what was reflected in the last filing. There are a few refinements in how we reflected loss development, the impact of the recession on premiums, and

the application of frequency and severity trends that are highlighted, prominently, in the filing.

I can address any question on these methodologies, refinement, or any other aspect of our filing. That concludes our summary presentation. We can address any questions you may have.

MR. DAHLQUIST: Dave, the first question I would have is, you referred to the $2.33 average Pure Premium Rate in this filing as being deterioration from the previous filing.

Do you have either a percentage increase over the indicated rate or the actual average rate from the previous filing?

MR. BELLUSCI: Yes, Mr. Dahlquist. The deterioration from the January 1, 2011 filing, which was made last summer, is approximately 8 percent or, roughly, ten percentage points --

MR. DAHLQUIST: Wait a minute.

8 percent or ten percent?

I'm --

MR. BELLUSCI: -- depending if it's multiplied or added -- let's just say ten percentage points -- approximately.

MR. DAHLQUIST: All right.

I'm, particularly, interested in what's going on

with your 2010 relative to the prior years.

If we just looked at what's going on with severity, particularly, the medical severity -- and the rate of increase seems to have declined -- and it's, actually, gone negative in 2010 -- and, yet, at the same time, you've got -- you're showing a frequency increase of almost 7 percent.

In your comments, I believe you attributed this frequency increase, possibly, to a rise in cumulative injury claims and increase in small indemnity claims.

Did I miss something in the filing material?

Is there, you know, actual data supporting that, or, is this, basically, conjecture at this point, or, can you provide some background on that?

MR. BELLUSCI: Yes, I, certainly can.

As I mentioned, this was a very atypical change in claim frequency. We really had a 40-year history in California, as in many other states, of consistently -- consistent declines in claim frequency.

2010 was, clearly, an aberration, as it became clear to us that we did have a significant increase in claims frequency. We have begun our analysis of the causes for that increase. And some of that information wasn't included in the filing, but, was presented to the Actuarial Committee at their September 8th meeting -- and

we will provide it, for the record, but -- the two key fees that we focused on, so far, as you mentioned, were a rise in cumulative injury claims.

What cumulative injury claims are are claim filings that are for injury over an extended time period, as opposed to triggered by a specific event. We have seen some clear evidence of fairly sharp increase over the last year in those claims.

Secondly, what we've seen is that the rate of transition has changed. Claims that were, initially -- the rate of claims that were, initially, established as a lost time claim, and then transitioned to a medical-only claim, has shown a significant decline over the last two years.

So, we think, to a large extent, what we're seeing is smaller indemnity claims, that are causing the claim frequency for 2010 to go up; but, at the same time, causing that moderation and severity trend -- because you have more smaller lost time claims that are driving the severities down in 2010 -- and we can provide the details of that information that was presented to the Actuarial Committee -- for the record.

MR. DAHLQUIST: I guess I'm not clear what the basic source of the data is for this.

MR. BELLUSCI: The source -- both of that

information, the source would be Unit statistical information, where claims are categorized rather as either specific or cumulative in the Statistical Report; and, similarly, we're looking at the rate of claims that are transitioning.

MR. DAHLQUIST: So, accident year 2010 -- or -- policy year -- you must be getting -- most of this must be coming from policy year 2009 then?

MR. BELLUSCI: We've continued -- we've looked through policy year 2009, which, as you know, looks at 2010 injuries; but, these aren't necessarily specific. This is a shift in the trend that was starting to show up even prior to 2010, and appears to be continuing and accelerating into 2010.

MR. DAHLQUIST: Okay, I'll look forward to reviewing that information.

You know, I guess, related to this, there's two areas that come to mind:

One is that, you know, okay, I guess the underlying question is, the data source here is the Unit statistical, but, once the effort to get the detailed transaction level data is complete, won't that be a more timely source for this?

And then, the follow-up to that is, remind us what the current status is of your efforts in that -- in that

direction.

MR. BELLUSCI: Certainly.

As to the first point, I think that type of information will assist us, as it does tend to be very contemporaneously -- we'll be collecting all the transactions that occur -- all the medical transactions that occurred -- during the prior quarter, so, it will be very timely; that should help in understanding these issues.

More importantly, I think it will help in understanding medical issues. But, I think there could be some residual impact on even addressing issues like frequency to understand better what some of the new claims -- what some of the medical patterns on new claims that occurred within the last several months are; so, yes, I think it will help.

As to the second part of your question, our time frames, we are proceeding well in accordance with the schedule we have laid out for the Department over the last several months and years. We are in the process of developing that system. We are scheduled to begin to collect medical transactional data on, virtually, every claim in California. There's tens of millions of transactions a year -- in the latter part of next year -- and that project is proceeding in accordance with

schedule.

MR. DAHLQUIST: Okay, thank you.

Finally, you refer in the filing to the CWCI's latest study; yet, didn't actually provide that study in the filing. I'm wondering if that could be introduced into the record as part of our consideration.

MR. BELLUSCI: Certainly, we will provide it prior to the -- copy of it prior to the close of record.

MR. DAHLQUIST: Okay.

I think that's it for my questions for the moment.

THE COMMISSIONER: Welcome and thanks for your presentation.

I wanted to ask if you could unpack a little bit the information you provided with regard to what's happening in the increase in medical loss.

I think your presentation indicated that medical severities are up 40 percent since 2005; and you walked through five drivers of that.

What I wanted to make sure I understood is that you're not saying that the cost per medical service, itself, is going up; are you?

I mean, in terms of the actual per unit cost of medical service, that figure is not increasing significantly; is it?

MR. BELLUSCI: That is correct.

I mean, in a few areas, there have been some fee schedule changes that -- in the last year -- medical-legal -- and where there have been some very significant fee schedule -- but those have been more the exceptions rather than the rule. It's really only been a few areas that had significant increases in the fee schedule, which would imply significant increase in the cost per procedure.

THE COMMISSIONER: So, if it's not being driven by cost per procedure, I think, earlier, you said that one of the drivers is -- actually, you describe as medical treatment levels, but -- another way of saying that is utilization?

MR. BELLUSCI: Yes, that is correct.

THE COMMISSIONER: Could you tell us us a little bit more about what is happening with regard to that driver?

MR. BELLUSCI: Yes, I can.

The report that Mr. Dahlquist referred to, as well, gives a little bit more detail, but, let me summarize what we've looked at in that area.

Essentially, the report which we work with, California Workers' Comp Institute -- who has a medical transactional database that allows to kind of dig down and say, well, not only are costs going up, but, what's driving the costs -- and what that report has shown is

that, since -- while there were significant reductions in medical utilization during the reform period, as reforms were implemented in 2003, 2004 and 2005, we saw a significant reduction in utilization.

What we've seen, since 2005, is a steady, moderate and -- I mean, probably, not surprising -- given the world we live in -- a very inflationary medical environment -- kind of a steady, moderate rising in a number of utilization measures.

Focusing on the treatment, exclusive of pharmaceuticals, what we've seen is increases in the number of visits per claim, number of procedures for visits -- some transition to somewhat more complicated procedures has shown in the data -- in addition, on an area like pharmaceuticals, we have seen large increases in certain areas, as I mentioned in my testimony, specifically, compound drugs is one, and the utilization of opioids and others that are all evident in the CWCI analysis of the medical transactional data.

THE COMMISSIONER: It causes me to wonder because, at the same time during this period that you've described, we've had a dramatic escalation in the pricing of private insurance, either in the individual or large group market; and a concomitant increase in the number of Californians who can't afford health insurance; and a

concomitant increase in the number of employers no longer providing health insurance outside of the Workers' Compensation context.

And I wonder whether a part of what we're seeing is that, as people lose access to the healthcare system, otherwise, the intensity of their utilization -- appropriate utilization -- of the Workers' Compensation system increases because they have no other access to healthcare. I don't know if you have any thoughts on that.

But, it just strikes me that what you've described occurring in the Work Comp system with regard to utilization is happening at the same time there's a whole set of phenomena occurring, more broadly speaking, in the health insurance market.

MR. BELLUSCI: Yeah, I think that is very true. And though we haven't studied it, or seen a study on the relationship between the two, we do attempt to measure -- I'll call it inflation in Workers' Comp medical -- and compare it to inflation in, for example, group health premiums in California -- and, in fact, they've moved pretty closely -- in fact, over the last decade, the group health premiums have grown at even quicker rate than the Workers' Comp medical costs per claim.

THE COMMISSIONER: But, I'm not pointing to the cost

per units because I think you've indicated that the medical costs per unit, by and large, has been relatively stable in the Work Comp system --

MR. BELLUSCI: Yes.

THE COMMISSIONER: -- but, rather, the concomitant, significant increase in premium costs, outside the system, for private health insurance, either in the individual market, or in the large market, or in the small group market, and the associated increase in the number of Californians without insurance -- which could mean that the kinds of things that they might seek treatment for associated with an injury and -- may or may not go and seek repeated visits to address that -- they might be motivated to make really, really sure that they fully utilize the medical system under the Work Comp system because they've got nothing else outside.

That's what I'm wondering. I know you haven't studied it per se, but, it -- just your presentation caused me to reflect on that a little bit.

And then the other major drivers are the liens, pharmaceutical costs, which includes compounding, as well as the opioid issue; and then the Medicare set-aside issue.

Can you elaborate a little bit on the Medicare set-aside issue? Because I know that this is also being

broadcast, more generally, and, I think it's useful to educate the public a little bit about that issue.

MR. BELLUSCI: Certainly -- and this is a fairly recent phenomena that started to arise over the last five years and has become increasingly significant -- a significant portion of the claims process in California has, historically, been involved closing -- providing a payment for the injured worker's future medical -- ultimately -- or -- recently -- or -- over the last five or so years, Medicare has become increasingly concerned about that, and has issued some guidelines -- not regulations, but, guidelines -- that says, before -- in certain circumstances, particularly, for an older worker -- or a worker that is likely to move into Social Security fairly quickly -- that they need to be involved in approval or review of any settlement of the future medical component.

That's increased frictional costs in terms of getting Medicare involved and saying -- having evaluations of what that future medical is, preparing a report to Medicare, working with Medicare to determine, is it the appropriate amount that's set aside for an injured worker.

So, what we've seen is increases, both in terms of the cost of medical -- because the Medicare set-asides

can be very costly in many cases, but -- slows down the claims process -- in fact, claims may have been closed with settlement of future medical -- known as a compromise and release -- staying open to some extent -- and having an impact on the Workers' Comp system.

There was a recent study by U.C. -- by Mr. Neuhauser at U.C. -- on behalf of the Commission that suggested that these costs are as much as -- the cost of Medicare set-asides are as much as four or five percent of total medical -- so, it's becoming increasingly significant -- and, as I mentioned -- not only impact the the cost of the medical, but, also the claims settlement process, as well.

THE COMMISSIONER: Do I understand, correctly, though, that, fundamentally, what's occurring is, the administers of the Medicare system are saying to the carriers for an individual that may be approaching Medicare eligibility that the carrier needs to set aside sufficient funds to, essentially, reimburse Medicare for payouts it might make to an injured worker associated with the provision of Medicare?

MR. BELLUSCI: That's correct -- for medical treatment that's related to the worker's injury.

THE COMMISSIONER: To the actually injury? Okay.

MR. BELLUSCI: Yes.

THE COMMISSIONER: Would it be fair to say that, given all the fervor around cost containment at the national level, that we might -- and, in particularly, cost containment as associated with the Medicare program -- that we might see, potentially, increased activity by the federal government associated with trying to make sure that these Medicare set-asides are sufficiently large and sufficiently protected as they struggle to contain costs for the federal program?

MR. BELLUSCI: I think that's quite likely; and, in fact, there has been some recent activity with some new data reporting requirements on Workers' Comp claims to CMS -- the agency that administers Medicare for -- which allows them to report information on medical pay-offs -- it allows them to kind of go back to even older claims, and to review claims settlements to make sure that their interests have been protected -- so, I think that's a very fair assessment that this -- this is, most likely, to be a significantly growing phenomena.

THE COMMISSIONER: Okay, and then, last question, the liens issues -- can you explain what that issue is?

MR. BELLUSCI: Yes -- and this is fairly -- as I understand it is a -- fairly unique to California.

California has had a growing issue with the number of liens, most of which -- though, not all -- have

pertained to medical treatment disputes over -- billing disputes over -- reimbursement levels and so forth.

That, ultimately, the process in California is, these disputes over medical bills, some of them very small -- sometimes these bill disputes are only hundreds of dollars -- and go through an administrative process through the WCAB and the Appeals Board -- and in many offices -- WCAB offices -- these have really slowed down the claims process. They're overwhelmed.

Again the Health and Safety Commission has, recently, done a study on medical liens; and, as I recall, their estimates are somewhere in the neighborhood of about 350,000 liens -- not all of which are medical, but -- the majority are medical -- per year; and that phenomena has grown quite dramatically over the last three or four years.

THE COMMISSIONER: So, these are, essentially, medical providers who assert that they have provided some service associated with an injured worker in the Workers' Compensation system, and they're placing a lien on the carrier, essentially, for procedures associated with what the medical providers asserts was their cost of providing the care for which they've not yet been compensated?

MR. BELLUSCI: Or not yet been compensated to the extent they've been, partially, paid or -- yes.

THE COMMISSIONER: Okay, and, is there any Statute of Limitations associated with these liens, that you're aware of?

MR. BELLUSCI: I'm not an expert.

I know there was some legislation that was proposed, last year, to address the Statute of Limitations; it did not go forward this year. I think it's been pushed forward for next year; so, there was no legislation that was enacted at the session this year.

But, it has been a subject of potential legislation to try to address the Statute of Limitation on liens, which should reduce -- many of these liens have been filed years after the services were provided, so -- what the Statute attempted to do was put a time frame related to the date the service was provided when these liens can be filed.

THE COMMISSIONER: Okay, and, when they're filed -- the carriers, obviously, receive notice of the filing -- and they have to make provision -- because they now have exposure -- they don't know how it's going to turn out or -- in the assertion of the -- whether the claimed amount they're going to be required to pay or not -- or the consequences -- for their pricing of their product, because they've got to make accommodations for the potential that these liens will be perfected, I take it?

MR. BELLUSCI: Yes.

And, not only the cost of the liens, themselves, but, the recent Health and Safety Commission study that I referenced estimated that the costs in terms of defending one of these liens for the process is about $1,000.

So, in some of these cases, the insurer -- the employer -- could be incurring costs to defend a lien of $1,000, even though the lien, itself, may only be for a few hundred dollars.

THE COMMISSIONER: I also understand that there are some entities that have come into the marketplace to purchase these liens from the medical providers, perhaps, at a discount, and then bundle them together and assert the lien for -- attempt to assert the lien --

MR. BELLUSCI: That's my understanding.

There's a cottage industry of these third party organizations that have done exactly that.

THE COMMISSIONER: Okay, thank you.

MR. CITKO: I do have some questions, but, I wanted to clarify, first, that, when you spoke of the study by Mr. Neuhauser, that's Frank Neuhauser over, at the University of California, and those were studies for the Commission on Health Safety and Workers' Compensation; is that correct?

MR. BELLUSCI: That is correct.

MR. CITKO: Okay, and, you also -- that was both for the study on the Medicare and also the lien study?

MR. BELLUSCI: Yes. I don't think Mr. Neuhauser was involved in the lien study. I think the lien study was done by the Health and Safety Commission; but, Mr. Neuhauser was involved in the study that pertained to Medicare set-asides.

MR. CITKO: Was that a RAND study?

MR. BELLUSCI: No, it was just a study by the Commission.

MR. CITKO: Just by the Commission?

MR. BELLUSCI: Yes.

MR. CITKO: Okay.

Also, I just wanted to ask you some questions concerning your earlier presentation.

I note, in looking at the charts for both medical loss for indemnity claim and indemnity loss per indemnity claim, there have been increases over the years; but, there seems to be a moderation, or, even a slight decrease from 2009 to 2010.

Is that indicative of any change that you perceive in decreasing costs, or, how would you characterize what's happening here?

MR. BELLUSCI: Yes, that's a very good question.

We think, to a large extent, it's indicative of what

we talked about on claim frequency -- to the extent you're getting more indemnity claims that are relatively small -- some of those would have been medical-only claim -- these are going to deflate your average, so -- you have more small claims, so -- your coverage severity goes down.

So, I guess the good news is, the new claims tend to appear to be small; the bad news is, there's more of them.

So, that's one of the issues, I think, what lends us to think that this, essentially, is related to the economy.

The NCCI -- National Council on Compensation Insurance -- who directs information, like us, for, approximately, 35 states, has seen a very similar trend, where there was significant moderation of claims severity growth in 2010, and, atypical increase in the number of claims.

So, we're not -- that's -- for other states like ours -- for -- California is -- both of those phenomena, you know, are largely driven by more smaller lost time claims -- but, it is an area, you know, where we're continuing to analyze.

MR. DAHLQUIST: If I can just, briefly, interject?

I imagine it's early in the process of trying to get

to the bottom of this, but, is there any concern, you know, with regards to the medical utilization controls that were put in -- you know -- as far as these -- you know -- this frequency surge -- is there anything going on -- is there any concern that the utilization controls are not functioning properly?

MR. BELLUSCI: The utilization controls pertaining to claim frequency?

I'm not sure I fully understand the question, Mr. Dahlquist.

MR. DAHLQUIST: Well, something is going on and it -- well, I'm not quite sure either.

Okay, just withdraw the question then.

MR. BELLUSCI: As I said, it's an area we're continuing to look into; and we think there is this interrelationship between frequency and severity that, you know, we want to continue to analyze.

MR. CITKO: Also, with regard to medical costs containment, we had, previously, directed the Rating Bureau to remove that from medical.

I do note that in the -- in your list of medical severity, you talk about medical costs containment.

Where are you at in that process?

And I know that, previously, the rule required that medical cost containment be included in medical. We

changed that rule so that insurers are now reporting to the medical cost containment as an expense.

But, there is that lag time between getting the data the old way and getting the data the new way and having adequate data to reflect in each of the buckets of medical versus expense.

So, where are you at in that?

MR. BELLUSCI: Yes.

As you recall, the Commissioner adopted a rule a year ago that stated that, beginning with policies incepting after July 1, 2010, the cost of medical costs containment, which is quite significant, should be reported as allocated loss adjustment expense, rather than included in loss.

So, we have gone forward and we've begun to collect that data for policies incepting after July 1, 2010 in the allocated loss adjustment expense bucket.

However, since that's a small piece of our -- to make sure we have apples-to-apples comparison -- and we can't take out the old information -- we put -- for basis of comparison, we've moved that portion that reported an allocated loss adjustment expense back into medical, so that, when we look, over time, we have a consistent trend.

Eventually, as we have more and more, we build more

and more data in allocated loss adjustment expense, we'll kind of remove it and look at it in the calculated adjustment expense component rather than the medical.

But, again, at this point, for us to allow us to have consistent apples-to-apples comparison, over time, we've included all the medical cost containment costs as part of the medical.

MR. CITKO: Do you have an estimate as to how many years, or, how long down the road you'll be able to then separate these out?

MR. BELLUSCI: I think it will really depend on the type of analysis. We'll start to look at that. I don't have an estimate, definitely, but, I think, by next year, we may have a little bit more.

And, depending, maybe, on the time frame we're focused on, if we're looking at short term trends, we may be able to get a better picture of it within a year or two; some of the long-term trends, it may be more than a couple of years.

MR. CITKO: Do you have the ability, based on the prior data received -- and you may have gotten some of the data reported to you as medical cost containment -- be able to go back and, as we go through this transition, to be able to report it both ways?

MR. BELLUSCI: We don't on what's been reported

prior to July 1, 2010.

Beginning with the new rules, we'll know, exactly, how much has been allocated, and, exactly, how much of the payments for next year are in medical.

But, unfortunately, our historical database doesn't -- that's not broken out; it's just included in the medical.

But, we don't have a precise estimate, by accident year, of how much medical cost containment is. Now, ultimately, we, probably, have other sources that -- I think that -- allow us to make a reasonable estimate -- and we may do that at some point -- and just estimate how much of the past data we should take out; but, we don't have a precise estimate.

MR. CITKO: When can you start giving us that estimate?

MR. BELLUSCI: As I said, at this point, we've collected two quarters, so, we're, you know, a few years from that; but, you know, we can, certainly, work with you to get some early indications.

And we do include -- you know, we can provide you how much is in which piece of the calendar year payments, so -- again -- current -- we do know, in terms of the current year's payments, how much is in the medical and how much is calculated; it's just the historical that we

are unable to precisely isolate.

MR. CITKO: Okay.

I'd like us to work together, maybe, by the next filing, if, at least, some information, if you have an estimate, and we can start making some transition towards that presented in your filing. Let's see how that works with the next filing.

MR. BELLUSCI: Okay, we can do that.

MR. CITKO: The other thing I wanted to point out is the changes in indemnity they incorporate in the Cost of Living adjustments that have been announced by the Division of Workers' Compensation. I know that, each year, they take a look at that, and, do your projections include those increases in there?

MR. BELLUSCI: Yes, they do.

Each year, the Department of Industrial Relations' analysis of -- sort of a measure of what wage inflation was in the prior year, and the Statutory Benefits Schedule for both temporary disability and permanent, total disability, include a Cost of Living adjustment; and we do price that and reflect that in our filing.

MR. CITKO: Okay, all right. Thank you.

THE COMMISSIONER: Just a follow-up. I'm confused about something you said.

The order required that you move the medical costs

containment analysis from the analysis of medical severities over the analysis of, I guess, essentially, the adjusted loss --

MR. CITKO: Expense.

THE COMMISSIONER: Expense analysis -- and you've said, but, we only started collecting that information in the wake of the order for the last two quarters.

The part I'm confused about, though, is that, medical costs containment has been a component of the medical severity analysis for some time; has it not?

MR. BELLUSCI: It has.

THE COMMISSIONER: And, so, if that's the case, then, you must have some analysis in prior years -- prior to July 2010 -- with regard to what the medical costs containment component was -- the overall medical severity cost driver, if you will in those prior years.

So, why couldn't you draw upon that prior analysis, and, at the very least, provide us with a filing that, essentially, reports both?

As Mr. Citko pointed out, I understand, for comparative purposes, why you want to continue for some time to roll it into severity, comparing apples-to-apples over time.

But, the prior Commissioner's order, which I supported, was to pull it out, put it into this other

pot, if you will.

And you're saying, well, we've only just begun to collect information to do that.

And my confusion is, well, but, you must have been collecting information about it before in order to be able to analyze what share of the medical severity cost driver was associated with medical cost containment.

So, why can't we just go back and take that information out and use it and provide the filing the Department has asked you --

MR. BELLUSCI: Let me clarify --

THE COMMISSIONER: Okay, I appreciate that.

MR. BELLUSCI: -- I can see where there's some confusion.

Essentially, core data, which I was referring to, where we use -- to develop losses and trends -- is an aggregate accident year analysis -- so, that doesn't have that detail.

Where we have tried to dig down and say, what's driving the increases in medical costs? We've worked with organizations, like California Workers' Comp Institute that do have medical transactional data, and, using that data source, we can segregate how many of insurers' medical payments went to medical cost containment, related costs as opposed to medical

treatment as opposed to medical-legal; and that's the source we have.

Now, for a shorter term trend, we have that, probably, going back to, maybe, 2003. So, for a relatively short trend, we could do exactly like that; and we can work to do that -- to focus on the more short term trends -- to try to approximate how much of the ultimate medical is medical cost containment -- and show an analysis with medical trends, at least for the shorter period, over the seven or 8 years that that information is available.

THE COMMISSIONER: Okay, so, let's do that.

And, can you amend this filing to do that?

MR. BELLUSCI: Well, what we can do is, we will provide that information prior to -- we will provide an estimate prior to the close of the record that reflect that analysis.

THE COMMISSIONER: Okay, that would be very helpful.

And let's talk, substantively, what's happening with regard to medical costs containment.

Can you elaborate a little bit more with regard to what trends you have seen, say, since 2005, in the costs associated with medical management and cost containment?

MR. BELLUSCI: Yeah, it's been an area of very significant growth. I don't have the precise estimate,

but, it's been, if not the most rapidly growing, certainly, one of the most rapidly growing components of medical costs over the last five years -- since 2005 -- again, not surprising.

When you look at it, there were significant number of new tools created by the reforms where things like Utilization Review, which was done fairly infrequently prior to the reforms, it is done much more significantly now; so, there were some new cost tools that were created by the reforms.

Now, implementation of those tools were very, very effective in reducing costs. We saw a dramatic decline in medical costs during that period. So, while those tools were effective in, initially, reducing costs very dramatically, the cost of doing things like Utilization Review are significant; and we saw a big spike, immediately, after the reforms, and, that has continued to grow at a fairly healthy rate since.

THE COMMISSIONER: And the information I have available to me indicates that, for data associated with 24 months from date of injury, the average annual increase from 2005 to 2008 is 24 percent;

And, for 27 months from date of injury, the average annual increase from 2005 to 2009 is 23 percent;

And these are percentage increases associated with

medical management and cost containment.

So, they're fairly significant increases in that cost; and, yet, at the same time, you're indicating to us the utilization is going up at the same time.

And so it causes me to wonder whether or not the resources that are going into medical management cost containment are really well spent, because it's a significant cost driver with regard to medical severity, overall.

I just don't know -- I don't know what benefit we're, necessarily, getting out of that.

MR. MIKE: Commissioner, if I can try to respond to that.

As we've seen in the past, once reforms come into place, the participants implementing those reforms are pretty effective in achieving the objectives.

But, over time, the various constituencies, whether they be doctors, lawyers, whatever, find ways to get around those reg's -- not in an illegal way, but, in a lawful way -- to try to provide more care -- in this case to the injured worker -- and, as that occurs, you will see greater utilization.

You may also see greater utilization of the tools that insurers and self-insurers have to kind of control that increased utilization.

So, to me, it's not apparent that you couldn't see both an increase of utilization of these services going along with an increase in the cost of trying to manage the delivery of that care.

MR. DAHLQUIST: Is there an implication here that -- you know, it occurred to me, in looking at this, in past filings, that, you know, these costs were going up at a higher rate than the actual medical treatment costs -- I'm not sure that's, necessarily, still the case, but -- it occurred that, you know, you're switching from the prior environment where the physicians -- the treating physicians -- you know -- had the presumption of correctness and, perhaps, it wasn't cost effective to, you know, put money into these areas, you know, where, now, it's all about utilization control, but -- this was a change from, you know, a past system to a new system, and, there ought to be a step up to a higher cost level, and then a smoothing out or a leveling off. There doesn't appear to be a leveling off here anytime soon.

Is there any expectation of a leveling off, or, are there reasons why we can anticipate this area of costs to continue to escalate at similar rates?

MR. BELLUSCI: These costs?

You're referring to the medical cost containment?

MR. DAHLQUIST: Correct, medical management and cost

containment, yes.

MR. BELLUSCI: Right, yeah.

You know, I think one might expect to see some leveling off. There was, clearly, a ramping up of the whole utilization reform system. You know, clearly, that happened. That drove medical cost containment. We haven't, you know, seen any indication of leveling off; it's continuing to grow.

Will it level off in the future? I'm not sure.

I mean, I think there is an open issue -- this has been, you know, raised in a recent RAND study on behalf of the Health and Safety Commission -- of kind of what the optimal level of Utilization Review is.

I, personally, don't think it's none, but, is it getting the right bank for the dollar?

I think that's an open question that still needs to be resolved.

What are the kinds of -- how frequently should treatment decisions be reviewed?

MR. DAHLQUIST: A couple of other questions come to mind.

I guess, first off, in comparing to the pre-reform era, it would be interesting -- I'm just thinking out loud -- have you really looked, yet, at what the inflation rates and the medical severity were in the

pre-reform era compared to what we're seeing today?

You know, how do they compare?

MR. BELLUSCI: We have the -- prior to the reforms, we had a very significant severity rate increase -- typically, about five or six years of between 10 to 15 percent a year. The reforms drove down medical utilization. So, not only did we see no inflation; we saw negative inflation.

For two to three years, immediately, after the reforms, we saw fairly large increases in medical severity -- again, driven by the utilization -- along the lines that, you know, Mr. Mike referred to -- perhaps the reasons why, probably, not quite at the pre-reform level, but, maybe, at a very low double digit number.

And, as we've discussed, previously, we've seen some moderation of those severity trends. Now, how much of that is due to moderation of utilization services and how much of it's due to this phenomena of smaller claims? We're not sure.

MR. MIKE: I guess what Mr. Bellusci was saying, we did see a higher rate of inflation -- prior to the reforms, we're seeing about a 10 to 15 percent per year.

MR. DAHLQUIST: All right, and, that era was characterized by -- and correct me if I'm wrong, but -- characterized by a very limited ability to exert any

control over those costs; right?

MR. BELLUSCI: I think that's a fair assessment.

MR. DAHLQUIST: So, one way of looking at things, now, is, you know, perhaps, the utilization controls are being as effective as one might like to see them be, but, it's not as bad as the previous environment?

MR. BELLUSCI: And I think you have to look at, you know, the environment we're in. I mean, medical costs, even on the group health side, where you have the types of controls you have in Workers' Comp, but, even more controls like co-pays and deductibles, that aren't in the Workers' Comp system, are seeing, you know, significant inflation in medical costs.

So, it's probably not realistic in this environment to think that we're not going to have any -- even with the cost controls that the reforms created -- that we're not going to see medical inflation.

MR. DAHLQUIST: With regards to these medical, you know, utilization controls, that was a RAND study -- am I correct -- that recently came out under the auspices of CHSWC -- I think it's referred to in the Public Actuary's testimony -- I think it's somewhere in your material, as well -- I'm not familiar enough with that yet.

Does that study address -- does it make observations as to the effectiveness of utilization controls, you

know, as in practice in the current environment?

MR. BELLUSCI: My recollection of it is, there are some specific issues that they recommend be addressed in terms of sort of the issue of the effecacy of Utilization Review and right level. It's more of a knowledge of an issue that should be studied, that really needs to be looked at in the future, as opposed to conclusion as to whether there's too much Utilization Review or not enough Utilization Review.

MR. CITKO: Could you get us a copy of that study?

MR. BELLUSCI: Certainly. We can provide it prior to the close of record.

MR. CITKO: Anymore questions?

Okay, well, thank you, very much.

I'm going to take as an exhibit your handout that you provided to us; so, I'll accept that, also, and put that into the record.

I'd like to ask the public members that had wished to testify to come forward. Please state your full name, for the record, and, we will hear from you regarding your submission.

MR. WICK: Commissioner Jones, thanks for having us. If you want, I'll introduce the parties.

Is that okay?

MR. CITKO: Please, go ahead.

MR. WICK: On my right is Mark Priven, Bickmore Risk Services. He's our public actuary.

Next is Mitch Seaman of California Labor Federation, one of the two labor representatives on the Governing Committee of the Worker's Compensation Insurance Rating Bureau.

I'm Bruce Wick of the California Professional Specialty Contractor Association. It's one of the two employer representatives on the Governing Committee of the Worker's Compensation Insurance Rating Bureau.

What we'd like to do is have Mitch and myself speak, first, and then turn it over to Mark, because I'm sure Mr. Dahlquist will have a few questions for Mark.

We do take our role seriously as public members and we appreciate the opportunity. We get together and we dialogue on a round table really, really well.

Between labor and employers, what we agree on -- or -- a couple of things -- one is, the system was designed to give benefits to employees -- that's its function -- and employers pay the entire cost of that system.

So, we think we're the two main stakeholders in this, and -- there are other stakeholders, but, we think we're the two main parties in this thing -- and we do believe that employees are entitled to timely delivery of

all benefits they negotiated in the Legislature; and employers are interested in the minimal cost it should take to provide those benefits.

And we are very concerned, both of us, with the amount of unnecessary cost drivers that are in this system today. And, Commissioner, I thank you and your staff for pursuing what are serious issues of concern, where costs are going into the system and no perceived benefit is derived by the employee from that cost. And those include the liens and MPN's and cost containment and those kinds of things. Mitch and Mark will talk more in detail about that.

So, Mark, as Mr. Citko said, did give his analysis of the rate filing; and we gave a letter, as public members, in response to Mark's analysis.

We believe because of our stakeholder position and the fact that Mark, in a very balanced way, in light of labor and employer representatives, it's one of the most objective analysis, I think, you'll find. So, we would like to say a couple of things:

One is, thank you for the new format of the Pure Premium Rate filing. I think it's very helpful to the overall process; it's very good. We spend less time in combat over what the Pure Premium Rate ought to be; and we talk about the things you're talking about, today,

which is, especially, the unnecessary cost drivers in the system.

And we hope, even though, as you said, this is advisory, insurers, you know, can file whatever rates they want, we think you can highlight some of these very important areas, that we can make real improvements on, based on the Committee's work study and so forth.

That being said, we do think we ought to look at the Pure Premium Rate proposed. And, while the public members did vote for the proposal, that was done in a very short time frame, for Mark to do an analysis of the total data.

And, since he has reviewed that more thoroughly, his middle case projection is that the rate filing is four percent overstated. And so we would believe we want to have the most accurate information out there; and the most appropriate number we think is four percent less than what the Rating Bureau's proposal is.

And then, as was stated earlier about competitiveness, employers want a very healthy, competitive Workers' Comp environment. And we think we're pretty close to it -- maybe optimal -- when carriers are filing manual rates of $3.27, on average, and their charged rate is $2.38, that's almost 25 percent discount off their filed manual rates. We think that's

very good competition.

And so we would like you just to keep your staff oversighting this competition. Potentially, could it get too overheated? We do remember in the late '90's what competition did. We had 20 carriers go insolvent and employers had huge value-to-premium increases; and there were some carriers that could not pay employee benefits on time. And so we just want to make sure that we want to provide the most aggressive, competitive posture we can, but, avoid some carriers, perhaps, over doing it and winding up in an insolvent situation.

So, unless there are any questions, I'll turn it over to Mitch.

MR. SEAMAN: Thank you, Commissioner Jones, members of the panel. Mitch Seaman from the California Labor Federation.

We, just to summarize, agree with everything that Bruce said. This is a system that exists to provide insurance relief to injured workers; and it does that. But, there are some concerning trends in the data that is before everyone today that we think need to be highlighted.

First and foremost, that, while we do have what are relatively expensive Workers' Compensation rates, the benefits to the workers remain relatively low. After

adjusting for differences in wages, we're in the bottom 20 percent in terms of the benefits offered to injured workers.

And so we believe that presents a pretty stark contrast there between being at the top fifth in terms of cost, but, in the bottom fifth in terms of benefit. It's an issue that desires serious and immediate attention.

And, as time goes on, and these costs have inflated -- as these costs inflate -- they're not accompanied by any kind of a corresponding improvement in benefits for injured workers.

An example of this, that was mentioned, was the increasing cost of prescription drug coverage.

For example, since 2005, we've seen a 16 percent average annual cost increase measured as the cost of a claim at 24 months following the date of injury; there's been a similar cost increase of 18% at 12 months from the date of injury.

Some more numbers that we think are worth pointing out, are that, for every dollar provided for injured workers, on average, over $2.00 are spent on medical care; so, that's a dollar in indemnity benefits.

And there's a similar number: For every dollar provided for injured workers, 80 cents is spent on claims adjustment. And so these, generally speaking, are the

cost of people who handle claims, setting case reserves, coordinating care, things like that -- and other services that we don't see as providing much in the way of tangible relief to workers that have been injured on the job.

And while all of this is happening, the money going to workers in terms of indemnity benefits is only very modestly increasing, each year, compared to some of these other unnecessary cost drivers -- these medical costs that we're looking at today.

And, according to the Rating Bureau's own projections, the differences between these two is, likely, to increase in the future.

So, I'd just like, briefly, talk about some of the proposed solutions we think that -- without getting too far down into the weeds of, exactly, which ones -- we might support -- which ones we think should be a top priority. Suffice to say that there are a lot of different ideas out there that we think should be looked at.

One of these are proposals that the Health and Safety Commission released in November 2009 -- and there are many areas within these proposals that we believe can limit costs without any kind of a negative impact -- or much of a negative impact -- for relief for injured

workers.

And the other is the 2011 Health and Safety Commission RAND Study that is full of all different sorts of cost reduction strategies that we believe are worthy of further examination. Some of these were things like physician services-based-incentives, providing medically appropriate care more efficiently, and other non-monetary incentives, providing better and more appropriate care.

We'd also like to see, generally speaking, increased accountability for conformance and compliance with data reporting requirements; and also efforts to facilitate the monitoring and oversight -- and, also, generally speaking, to expand the ongoing monitoring of system performance.

That concludes our comments, so, I'd like to turn it over to Mark.

MR. PRIVEN: Mark Priven. First of all, thank you for the opportunity to testify.

So, as was indicated, earlier, by the Rating Bureau, these rates represent an 8 to ten percent increase over the prior rates. And this has kind of become an annual thing where rates increase 8 percent, ten percent, five percent, when wages and general inflation are far lower.

So, I think what that really means is that, every year, a larger and larger percent of the California

economy gets sucked into Workers' Compensation. One of the problems, also, is that, even in 2010, before these indicated increases, California was already one of the highest cost states in the country.

My indications are, if we had just been an average state, over the last five to ten years, it would have saved billions and billions of dollars for California employers.

So, my plea is one that only an actuary would love -- is -- let's just be average.

So, I was sitting in the back of the room before, and I saw all these incredibly smart, knowledgeable, earnest people. And, with the help of the Department of Insurance, and, working together with the DIR and the Legislature and the Governor, I, firmly, believe that we can be average; so, that's my average speech.

Okay, getting more into the technical issues on the Pure Premium Rates, as Bruce mentioned, my indications are a little bit lower than the Rating Bureau. I'm at -5.8 versus -1.8 that the Bureau indicated.

First of all, last year, I indicated several things that I disagreed with on the Rating Bureau methodology. First of all, I believe the loss trends were too high; and I'm glad to see that, this year, they've been lowered quite a bit -- and I think that they're appropriate.

Last year, the Rating Bureau utilized a method that adjusted for claim closure rates; and they've stopped doing that this year -- which I concur with.

And so, really, my only issue with the Rating Bureau method, this year, is that the 2012 rates are using 2010 as a base, as opposed to using both 2009 and 2010 as a base; so, that's a change in method from prior years and I think it would be more appropriate to continue to trend from a two-year base as opposed to just 2010.

And a couple reasons for that, as was indicated in the testimony before, 2010 is kind of an outlier. There's some weird things happening with frequency and average claim size that, I don't think, we all have a handle on. It's -- when you look at it in relation to the prior years -- to 2007, '08 and '09 -- it appears to be, like I said, sort of an outlier; and so to use that as the sole basis for projecting 2012 doesn't seem like a good idea. It's also the most averaged we have the least information on -- 2010 versus 2009.

A couple other things, moving on from just the rates -- the total rates.

One of the things that I really appreciate about this filing is that it had rates by class, and it had a comparison of the suggested or proposed Rating Bureau rates by class to those that are filed by the industry.

And I did a little bit of work collapsing that to industry as opposed to by class, and some pretty big differences came out.

So, while the overall rates of the Rating Bureau are about 1.8 percent different from those of the -- that are filed by the industry -- for example, construction-agricultural sectors have, substantially, higher insurance company filed rates than the Rating Bureau's proposed rates; on the other hand, you have other industries, such as retail, where the insurance company filed rates are far lower than the Rating Bureau proposed rates.

So, it's hard to go just from filed rates to make conclusions about what's actually being charged out there. So, what I would like to see is, rather than just seeing file rates, I would, actually, like to see charged rates, by class, so that we can, actually, make some conclusions about how the industry is functioning -- the insurance industry is functioning -- in terms of charging individual classes or industry sectors.

I think that's all I have prepared to talk about now, so, any questions?

THE COMMISSIONER: I have a few.

One is, I'm wondering -- I think Mr. Citko asked, earlier, if the Workers' Compensation Insurance Rating

Bureau could put into the record the studies that were referenced in your testimony. I think you referenced the same studies --

MR. PRIVEN: Yeah.

THE COMMISSIONER: -- but, I'm not entirely sure you mentioned the RAND study -- I think you mentioned that in your testimony, as well, but -- you also mentioned the Health and Safety Commission, earlier, the 2009 one.

So, I guess, the bottom line here is, if you could provide us, also, with the studies that you've referenced in your testimony so we make sure we have a complete hearing record --

MR. PRIVEN: Sure.

THE COMMISSIONER: -- because I think they were the same, but, I wasn't able to track it.

MR. PRIVEN: I think they're the same too, but --

THE COMMISSIONER: Okay, just so we get them.

And, then, second, I appreciated your support for the methodology that we've asked and that the Worker's Compensation Insurance Rating Bureau has agreed to utilize going forward. As I said earlier, I do think it's going to demystify a lot of this.

You raised a concern, though, with regard to the methodology -- in particular, the utilization of 2010 as a basis as opposed to 2009 and 2010 -- and I did want to

give the Rating Bureau an opportunity to respond to that, because, I'm just curious as to what was your rationale for -- if I'm hearing correctly -- deviating from using two years of -- two prior years as a base. Now, you're using one year as a base.

MR. BELLUSCI: Yeah, let me address that. Thank you.

So, as we discussed in detail, you know, our -- historically, our trend projection has been based on applying separate estimates of frequency and severity growth to, normally, the latest two years of experience -- which, in this year, would have been the 2009 and the 2010 years -- and this was actually fairly similar.

Last year, we saw some similar analysis. What we saw in reviewing that is, in using the 2009 year, part of the method would say, well, I'm going to apply my assumption -- my model assumption -- about claim frequency, and my model assumption about severity, from the growth from 2009 to 2010, so, we would have been -- apologize for getting too many numbers -- I'll try to not get too bogged down in it --

THE COMMISSIONER: Keep going. I'm still with you.

MR. BELLUSCI: Okay.

So, we would have applied -- our projection would

have been five percent decline in claim frequency; and, for medical, a 7 percent increase in claims severity.

But, as we talked about, the changes in 2010 are very different from what, you know, we saw in -- instead a five percent decline in claim frequency, we saw significant increase in claim frequency in 2010; instead of going down, it went up.

Similarly, instead of seeing that kind of 7 percent growth in medical costs, and, maybe, three percent indemnity, the severity -- the average cost of claims came down for both medical and indemnity.

So, given this pretty radical divergence from what the actual change was in 2010 -- appeared to be given to what the models were forecasting -- rather than rely on this forecast, we ended up applying these trend rates to 2010 -- first point.

Second point is, when you look at applying a two-year trend, it produces an overall loss trend that is, actually, even a little bit negative for indemnity, and something around three-and-a-half percent for medical.

Well, when you look at what the historical trend rates have been since reform, they've been well in excess of the the medical -- over seven -- I think -- the indemnity was over three -- so, that kind of forecast

growth from 2010 based on applying the two years seemed out of line in what we've seen over the last five years in terms of overall loss trend.

And, thirdly -- and that was information that we didn't have at that point that, recently, became available; and we'll provide it prior to the close of record. When we look at September, we got some more data to look at, some Unit Statistical that allows us to kind of refine the model estimates, as well as June 30 aggregate loss experience; and, when we apply those two, kind of update the model forecast based on what, actually, emerged in the Unit Statistical.

When we -- recently, we had additional information that became available. We got the June 30 loss experience. We also have kind of the first look at a partial year from our Unit Statistical data of what the actual decline is in claim frequency of actual change. This claim frequency is for accident year 2010.

So, when we reflect all that new information in our model, and then apply it -- that new information as of June 30 -- and then apply it to kind of the two-year trend bases, using both the '09 and '10, we get something fairly close -- if we just apply it to the 2010 -- so, those are the three observations I wanted to make.

THE COMMISSIONER: Okay, fair enough.

But, I'm wondering, I guess, the third point maybe would answer the question that I'm about to pose, which is, the assertion from the public members' actuary is that 2010 is anomalous; not necessarily the precursor or representative of an emerging new trend.

And it sounds to me, from my vantage point, that you believe it's anomalous, but, it may actually reflect an emerging trends in terms of what's happening in this market; and that's borne out by this additional information that you've collected.

Is that a fair, non-actuarial lay person's reading between the lines?

MR. BELLUSCI: Yeah, I think that's kind of a fair assessment -- it is. I think, as Mr. Priven mentioned, particularly, the components are anomalous.

As I said, we hadn't seen a frequency increase in many years; and we had seen pretty standard severity increases and severity moderated; so, it is anomalous.

But, when you look at it all together, you look at the loss trend, because there isn't a *** between frequency and severity -- you know, the loss trend isn't anomalous -- and, in fact, everything we believe is that, probably, the losses are going to increase -- and, in fact, in June, they did -- they did go about another point -- of what the ultimate cost of 2010 are anomalous.

We feel pretty good about the overall estimate of overall costs in 2010, which is the basis to which we're applying the trend; and, if anything, you know, it appears that it might be low because, as we look -- our estimate changes a little bit each quarter, when we get an additional quarter of data, as it did with the June 30 data.

THE COMMISSIONER: Okay. I believe I understand. I need to think about what you both said; but, I think I understand where the difference lies.

MR. DAHLQUIST: Can I pick up that just a little bit?

THE COMMISSIONER: Certainly.

MR. DAHLQUIST: What you said, earlier, what appears to be going on with accident year 2010, an influx of small indemnity claims that, you know, normally, would have been medical-legal, is it fair to say that your assumption of trending from 2010 assumes that those are permanent changes -- that those types of claims will be in the same proportions in 2011 and 2012 and onward?

MR. BELLUSCI: Indirectly, to some extent, it does, because, what we assume is that the level of losses -- our trending point is really just what the losses came in; not -- we don't trend, individually, the claim frequency in 2010. We look at the overall level of

losses. So, what we're saying is that the overall level of losses are indicative of what we can expect in the future.

MR. DAHLQUIST: But, there is some implication that whatever changed in 2010, if you're using that as a basis to project forward, you're implicitly assuming that, you know, some form of that will continue.

MR. BELLUSCI: Well, not that it will continue; that we've reached -- that it's in a plateau because we're not -- our frequency forecast doesn't project as increase in 2011; in fact, it projects kind of a long-term rate -- a decrease of three percent in long-term frequency.

So, we're not projecting that we'll get more of those kind of phenomena that -- we are projecting that we're at a new plateau, and what will happen in the future.

And that seems to be being beared out by -- the data through six months is that we'll have a more normal rate of frequency growth, where there's about two to three percent per year, and a more normal rate of severity growth, which is about three percent for indemnity and about 7 percent for medical.

MR. DAHLQUIST: What I really meant was, more, that the influx of cumulative injury claims and smaller indemnity claims is going to stick. You're not going to

see decreases in those categories. It's an implicit assumption that those are -- those types of claims, that is -- that share that -- are not going to go away.

MR. BELLUSCI: Yes, I think that's a fair statement.

THE COMMISSIONER: And then this is for any of the -- or all of the public members. I have your letters, which are very helpful. And, as was noted by the Worker's Compensation Insurance Rating Bureau, earlier, medical utilization is a significant cost driver; and we had some colloquy about what's behind that.

And I'm just curious whether the public members, or the public members' actuary, have any thoughts on what's happening vis-a-vis utilization; because, at the same time, as we've noted, we've got increased expenses associated with medical cost containment.

So, many more resources are being put into containing these costs, but, at the same time, while the per-unit cost of medical care is not significantly going up in any way to manifest itself as a driver, utilization is, accompanied with some other things: Drugs, medical liens, medical set-asides -- I get that -- but, I'm wondering if you could speak as to what's happening vis-a-vis utilization.

MR. WICK: Thank you. That's a great question.

I do hear from self-insured employers in California; and, while I understand it's easier for them to set up an effective MPN than, perhaps, for an insurance company, the difference is pretty stark between how they conduct medical procedures and processes for employees, typically, than insured employers.

And it makes a real difference that self-insured employers tend to focus more on outcome-based medicine and not say to somebody, you're going to pay -- I'm going pay you medical fee schedule with a ten percent discount because I'm such a big volume party versus I will pay you enough to diagnose well from the start and we'll have a good outcome for the employee; and that will actually be less cost.

We have seen where, you know, medical providers are in business. They have, hopefully, you know, the oath to take care of people, but, they are a business, as well; and, if they're not, in their opinion, being compensated well, or, enough for doing things, they will -- they'll try and -- you know, more utilization, perhaps, as a way they can get enough money to compensate them for taking care of the employee.

And I'd rather have it be pretty clean in terms of, let's focus on; and I've even heard some consultants say, pay more than the medical fee schedule, in certain cases,

so you get the right diagnosis -- so you get the right party -- you get the right provider -- doing the job.

So I notice, you know, you were focusing a little earlier on employees or people, themselves, trying to over-utilize, you know, because they've loss health insurance or something like that.

I think, in some cases, you could have medical providers trying to find a way to get compensated for taking care of employees. We have had medical providers leave occupational medicine -- and that's pretty sad for me to see -- they didn't see a way of providing enough money for Workers' Comp medical care.

And I think this is important to look at because the self-insured employers, I think, don't spend nearly as much in medical cost containment because they aren't arguing so much with their medical providers about, what are you doing and how much am I going to pay for it? So, I think that's an important area to look at.

THE COMMISSIONER: Are the self-insurers using something akin kind of capitated rate, if you will. The analogy that comes to mind is HMO's; in other words, are they saying -- to a medical provider are they saying -- look, we've got this body of employees, here's the risk associated with them, here's our claims history, and they negotiate with the medical provider?

You know, we'll pay "X" dollars per person as opposed to a fee-for-service sort of model?

MR. WICK: I'm not aware that they're doing that.

What we've heard from self-insured employers is they take a great deal of time and effort to set up their medical provider network; and those medical providers know they're expected to do quality work, outcome-based -- good outcomes come from the employee -- and they will be compensated fairly for doing that job. You know, no matter if they get 12 injuries a year or, you know, 57 brought to them, they will be paid at some level according to the medical fee schedule -- and, at times, even above it -- because, in some -- especially outlying areas -- it may cost more to take care of the employee.

So, I do think -- I'm not aware that they're really doing the capitated costs. They're really focusing on, I know and trust you as a medical provider. We're going to have a long-term relationship; and, if you ever don't do the job, or, you ever don't take care of an employee, you will be off my list.

And I understand it's easier for self-insurers to set up these kinds of relationships than, perhaps, an insurer; but, I don't think it's impossible for insurers to get closer to that relationship.

THE COMMISSIONER: Any of the other public members want to talk about utilization?

MR. PRIVEN: Okay, well, first of all, when we talk about -- you had mentioned medical cost containment, so, there's really two drivers of the medical cost containment:

One is bill review; and one is utilization review.

And so I think, appropriately, we're talking, mostly, about utilization review. There's bill review, I wanted to point out, which is the other half, and that's been, pretty much, tabled over time, so, that is not what's driving up -- when we look at medical cost containment statistics, it's really the utilization review that's driving it up.

Also, I want to get back to a comment, I think, the Commissioner made about cost shifting -- potential cost shifting -- between health insurance and Workers' Compensation. I haven't seen any studies on this either; but, I would have expected that to impact frequency.

So, in other words, I would have expected new injured people who otherwise in the past would have been treated under health insurance would now be filing a Workers' Compensation claim; and, with the exception of 2010, we really haven't seen much of a change in the sort of long-term decline in claim frequency.

That could be part of what's happening in 2010; but, really, that's the only year where we've seen a change in frequency. So, unless it's happening in that year, my inclination is that that's not a big part of what's going on.

The last comment I have, you know, if we sort of step back and think about what we're doing here, and the role of the Rating Bureau, I think, largely, it's facilitating competition.

So, for example, having loss rates by class or experience modifiers, it allows small insurance companies, or new insurance companies, to come into the market and have a basis of, you know, what the cost is for the -- for the risks that they're looking at insuring.

And, as I think about medical cost containment, strictly in utilization review, I think there might be a similar role for the government to play in terms of facilitating insurance companies and self-insured to use utilization review -- I'm not sure that we have all the information that we need, particularly, for a smaller insurer.

We're looking to go into a new area of, how would they evaluate which doctors to include in their medical provider network and so forth? There really isn't that

information that's publicly available. So, I just want to throw that out as an idea. I think the State of Texas already does provides information along those lines.

MR. CITKO: Do you know if the State of the Texas provides information on the medical provider or how insureds or self-insureds are doing utilization review?

I guess I just wanted you to be more specific about that comment.

MR. PRIVEN: I should retract that comment because I don't know that much about it; but, I believe it's on the providers.

MR. CITKO: Okay.

One thing I do want to make clear, we're using initials along the way, and I know MPN was mentioned, and that means Medical Provider Network.

Anymore testimony from the public members?

Okay, the reporter has requested a break. And the reporter is the one that tells us when we need a break, so, let's take a 10-minute break.

(Recess taken)

MR. CITKO: I do have, in the back, a list, a sign-in list. If you wish to receive the decision in this matter, please make sure you put your information down on the list, if you haven't done so already.

I do have some of those sheets here, also, if you

wish to testify. It has one person that wishes to testify. If anybody else would like to, please mark yourself down. Okay?

With that, I believe Mr. Gerlach, with the Applicants' Attorneys' Association, would like to provide some comments. Thank you for coming.

MR. GERLACH: Thank you, Mr. Citko. Good afternoon, Commissioner.

MR. CITKO: Would you state your full, for the record?

MR. GERLACH: Yes, I will.

Mark Gerlach. G-E-R-L-A-C-H. I'm with the California Applicants' Attorneys Association.

First of all, I want to add my thanks to the Commissioner and to staff, also, who I'm sure had a big role in making sure that we have this new approach.

I think that many of the problems that have been evidenced over the past several years with the employer community up in arms about the possible increases in premiums were generated by the rather large Pure Premium requests that had been made over the past several years.

We didn't see any of that this year, and I think that that's evidence that this new approach is successful -- and already has been successful -- and I thank you for adopting that.

As I mentioned to Mr. Citko, I did submit some comments late last night by E-mail so, hopefully, you will have gotten those.

I'd like to cover a couple of issues that were mentioned in some of the discourse that the Commissioner had with the Rating Bureau:

One, dealing with liens, there is a Statue of Limitations on liens. The legislation that was introduced was to reduce or limit that Statue of Limitations; bring it down to, I believe, a year. So, there is a Statute of Limitations; but, the question is, can we get it to a more workable level?

One of the bigger problems with liens -- and we, the Applicants' Attorneys Association, certainly, joins in others in lamenting some of the problems that it's causing at many of the boards, particularly, down south -- one of the problems that is out there is with the so-called zombie liens, which the liens that haven't been acted on by the provider and are, eventually, bought up by somebody -- you may be interested or you may already be aware of the fact that the WCAB held public hearings about a month ago to change some of its rules dealing with liens -- the rules specifically will allow for dismissal of a lien for lack of prosecution, so that a lien where there has been no action and a DOR -- excuse

me -- declaration of Readiness -- has not been submitted on that case within a year after the lienholder becomes eligible to file that document, if no action is taken in that year, then, any party can petition the Court to dismiss the lien. So, hopefully that will be one means that could take care of these so-called zombie liens that are out there, and we won't have the problem of people coming in with 10 or 15 year-old liens saying, I want to collect on this.

Another point that was raised dealt with the question of Medicare set-asides. I totally agree with the Commissioner's assessment that, because of the budgetary problems that the federal government is having, that this is going to be an area where there is going to be more attention by the federal government on making certain that they are not paying for costs that are -- legitimately should be -- charged to the Workers' Compensation system. That's what this whole thing is about. The issue arose over the past four or five years, because the Medicare system is having its own financial problems, and they have become more and more vigilant about making certain that they are not paying for costs that should legitimately be paid under Workers' Compensation.

The bigger problem for the system, that is, I

believe, an issue that can be solved, though, is the delay that is being caused, currently, by the process. Medicare, in many cases -- it's actually the CMS -- the Center for Medicare and Medicaid Services -- actually, has a contractor that handles the process; and this contractor is the one who is responsible for doing approvals of these Medicare set-asides. That process can, in many cases, take months and even years to get through to a final approval; and, in the meantime, the case is staying open. If the case were closed, all of the benefits would be finalized for that insurance company, and the injured worker would know what he or she is due also; so, it's better for both parties to get these closed out sooner.

I'm raising this because there have been efforts made on a federal level to require a better process for approving Medicare set-asides, a more timely process for approving this. There is some legislation that has been introduced; it's really not going anywhere; but, it has an unusual alliance of just about everybody in the system -- the insurance companies, defense attorneys, applicant attorneys, employers -- who want to see this process speeded up.

There is -- currently, I believe that there is a change in the contractor who is handling this, and there

may be some changes coming in the process, but, I just mentioned this federal legislation as an issue that you might want to look into and, perhaps, weigh in on as Commissioner of Insurance in the State of California.

With regard to this filing, I'd like to make a couple comments on the graphs that are included in the Bureau's handout, because I think there's some interesting differences in those graphs.

For one thing, if you look at the three graphs, we have the:

Estimated Ultimate Medical Loss;

Estimated Ultimate Indemnity Loss;

And then the Estimated ALAE -- Allocated Loss Adjustment Expense.

You will notice that the claim costs have an upward trend, that is a reducing upward trend; and, finally, in the last year, is a downward trend.

If you look at those figures, it's a fairly -- if you look at them on the percentage basis from year to year, which I did in my submission to the Department, you will see that it's a fairly steady downward trend in that -- in other words, immediately after 2005, there was a fairly strong increase; it's been a lesser and lesser increase each year until, finally, in the last year, it's a decrease.

If you look at the Allocated Loss Adjustment Expense, you don't see any of that at all there. The trend is simply up, up, up; so we have a different factor here.

And, if you're looking at, where are the cost drivers in the Workers' Compensation system now? The major cost driver does appear to be loss adjustment expenses; in fact, if you look at some of the factors dealing with the average cost per claim of indemnity in medical, I find it rather interesting that the Bureau has now tied in the increase in 2010 frequency with the decrease in severity.

There has been no recognition, however, of the fact that, during the increase in severity, there was also a decrease in frequency; in other words, what we may be seeing now is, yes, an influx of smaller claims coming into the system, which reduces the severity. Over the past four or five years, what we've had is an outflow of those lower claims.

We had a decrease in total frequency over that period of almost 50 percent. Now, we didn't reduce injuries in the Workers' Compensation system by 50 percent. I don't have any basis for saying that other than that just doesn't happen; but, we reduced claims in the system by almost 50 percent. Why was that?

As Mr. Bellusci alluded to, perhaps, during that period, workers were unsure about their job status. They were not willing to be making claims that would single them out as an individual that could be subjected to the next layoff, perhaps; and we had an outflow of claims in the Workers' Compensation system.

Now, when you fall off of a roof and break your back, it's a little difficult not to claim that as a Workers' Compensation claim; so, a lot of them stayed in the system. So, what I'm saying is, part of this increase in medical loss per claim is simply because we have more severe claims during that period of time; it's not that we had the same claims coming in and they were costing more. It's that we have a different set of claims, and those claims are more severe injuries so they cost more.

Now, in 2010, at least, we had a period where, perhaps, as Mr. Bellusci pointed out, workers may be feeling a little more secure in their jobs, and they are filing for a cumulative injury.

I may point out, also, that a decision by the courts in which workers who have multiple injuries are awarded benefits based upon those individual injuries, rather than the combined injury disability, that has caused a change in claiming strategies by injured workers; so, you

may find an increase in cumulative trauma claims could be caused by that also. I just point that out.

In any case, as I say, I submitted some written comments, primarily, suggesting that, perhaps, the severity trends, for some of the reasons that I indicated, are a little high in this filing, and could be moderated somewhat.

Other than that, I'd be happy to answer any questions if you have any.

THE COMMISSIONER: Thank you.

MR. CITKO: Thank you, very much.

THE COMMISSIONER: Thank you, very much; appreciate it.

MR. CITKO: All right.

Any further public comment regarding the Pure Premium Rates?

All right, we also have some rule changes. The Rating Bureau submitted amendments to the California Workers' Compensation Uniform Statistical Reporting Plan, the Experience Rating Plan, and the regulations for the recording and reporting of data -- I have a hand in the back?

AUDIENCE MEMBER: I had a question about the Pure Premium Rate. I didn't have a chance to raise my hand.

MR. CITKO: If you could come forward, and, if you

have a question, you could state your name, for the record.

AUDIENCE MEMBER: I just have a question.

Do I have to testify to have a question?

MR. CITKO: Yes, you do.

THE COMMISSIONER: Yes.

MR. CITKO: Because, hopefully, we can answer your question on the record.

PARTIALLY IDENTIFIED SPEAKER (JOHN): My name is John with Wells Fargo Insurance Services. I'm just simply looking at the Pure Premium Rates for 2010 -- I'm sorry -- for 2011 -- the ones that are in place now -- that table compared to the proposed for 2012. The difference is pretty significant and I have not yet seen anybody mention that today.

MR. CITKO: Have you looked at what insurers are using as their Pure Premium Rates?

PARTIALL IDENTIFIED SPEAKER (JOHN): No, I'm just looking because most insurers they base their rates based on the 2011 Pure Premium Rate table, so, all I'm asking, just simply --

MR. CITKO: Just quickly, let me just explain. Insurers -- those rates you're, probably, looking at, that were last approved by the Commissioner, are only advisory. The insurers are not required to use those; as

a matter of fact, if you look on our website, we have available, based on what insurers have filed with us, what Pure Premium Rates they have selected; and then their rates will include how, in addition to that, they modify them. So, the advisory rates being advisory, and, as has been pointed out in the filing, really, bear no resemblance to what insurers are actually using when they're -- in their filed rates; so, that's the confusion that we talked about earlier that was being created with the prior process.

So you really to get an understanding of where Pure Premium Rates are, currently, you need to look at the rate filings.

And let me ask the Rating Bureau: Did you summarize -- you summarized on the average what insurers' Pure Premium Rate level is that they're using in their filings; is that correct?

MR. MIKE: That's correct.

MR. CITKO: Okay, but, you don't have it broken down by class -- or -- do you?

MR. MIKE: What we filed, yes --

MR. CITKO: Oh, so, you have --

MR. MIKE: -- on the Pure Premium, right.

MR. CITKO: Okay, so, if you look at the filing, you'll see what Pure Premium Rates are being used by

insurers.

PARTIALLY IDENTIFIED SPEAKER (JOHN): I understand that.

But, if you look at, all the insurance companies have a factor that they start with. I understand the Pure Premium Rates for 2011 are advisory. I understand that; however, if you just take the 2012 proposed Pure Premium Rates that are in the filing made to you, and you just compare it to the 2011, the increase is pretty significant. I understand they're just advisory.

But, in your filing, you have a 2012 proposed Pure Premium Rate, and I'm hearing numbers of -1.8 and Bickford said it's closer to 4 than -1.8. I understand all that.

But, I'm just saying, this is a look at 2011 Pure Premium, that it -- that's being used today -- and the 2012 rate that's in the filing, that was submitted to you, the increase by class is pretty significant.

MR. DAHLQUIST: May I?

That is correct; but, the point is that those -- the previous approved Pure Premium Rates are seriously outdated. No one is really relying on that anymore. They're having to apply substantial multipliers off of them. The market is using, essentially, on average, Pure Premium Rates that are marginally above what the Bureau

is proposing.

PARTIALLY IDENTIFIED SPEAKER (JOHN): I understand that.

I guess what I'm trying to say is this:

Say an insurance company has a factor of 2.0. Basically, they take the Pure Premium Rates for 2011 and increase them twice, if they take your file, whatever you approve, because the Commissioner -- and they take that as an advisory and don't adjust that factor -- and they use the 2012 Pure Premium Rates that are in the proposed filing that are significantly higher. You would have a significant increase higher than the 1.8 proposed in the filing.

MR. CITKO: They would have to make a new filing with the Department -- first of all, they would have to state what Pure Premium Rates they're going to use; and, if they do adopt what's proposed by the Rating Bureau, they would do that; then they would add the modifier at that time; and that would be their filed rate.

I think, at this point, we'll take your comment; and I don't know if there's anything more that we can really answer, but, we can take your comment in and we appreciate that.

PARTIALLY IDENTIFIED SPEAKER (JOHN): Okay, thank you.

MR. CITKO: Thank you.

MR. DAHLQUIST: Thank you.

THE COMMISSIONER: Thank you.

MR. CITKO: Any further public testimony?

Any testimony regarding the changes to the rules?

And, seeing none, I believe that will conclude the testimony that we have here today.

I do want to just point out that, if anybody would like a transcript of the proceedings, then, you can request that from the reporter here. I'm sure she will give you a card.

And, Commissioner, do you have any closing remarks?

THE COMMISSIONER: We may have skipped a step.

Did you want to do a summary of proposed rules for the record or is that not necessary?

MR. CITKO: Yeah, that's not necessary.

THE COMMISSIONER: Okay.

MR. CITKO: We just have amendments to those three plans. There are many items in each of those; mainly, just definition changes, some changes in classifications, but, basically, I've noted those amendments and --

THE COMMISSIONER: Okay, great -- and we've got no testimony on the rule change?

MR. CITKO: Correct.

THE COMMISSIONER: All right.

Any other interested parties who wish to testify at this point about the hearing?

Okay, I want to thank the Workers' Compensation Insurance Rating Bureau for their presentation and their responsiveness to questions by this panel, as well as questions raised by the public members of the Workers' Compensation Insurance Rating Bureau.

I want to thank the public members, as well, for their presentation.

I want to thank Mr. Gerlach of the Applicants' Attorneys, as well; and thank my colleagues on the panel.

I want to underscore what I said a moment ago at the start of the hearing, which is that the rate filing that we're considering is advisory -- and I want to underscore that because, in the past, there's been a significant misunderstanding in the broader public, amongst the media, even amongst those in the Workers' Compensation system, including lawyers and businesses, as to what this rate filing is about.

What this rate filing is about is, it's about the rating organization making an assessment with regard to what they believe is happening, and what they believe should happen, with regard to the components of the Workers' Compensation Insurance rate related to the actual payment of benefits and the costs associated with

those benefits.

It's an important filing because it tells us something about what's been happening in the market and what we might anticipate is happening in the market; but, it's not binding.

The Workers' Compensation insurance carriers, at the end of the day, can set their rates as they will and can either take into consideration or disregard the decision of the Commissioner, as well as the recommended Pure Premium Rate filing by the Worker's Compensation Insurance Rating Bureau; so, I think it's important to underscore that.

No. 2, I appreciate the acknowledgment from various stakeholders in the system with regard to the new approach that the Department has asked and that the Worker's Compensation Insurance Rating Bureau has pursued with regard to this rate filing. I believe that this new approach more closely aligns this whole process with what's happening in the market.

What had occurred was, we were, essentially, reviewing, each year, something that became increasingly detached from what was happening in the market, and what was happening in terms of what insurers were filing as their Pure Premium Rate.

And so we thought it important to try to have an

approach that's linked directly to the filed rates and what's happening in the market, itself, so we have better information being provided to the stakeholders in the market, whether it's businesses, employers, labor organizations, carriers, you name it.

So, I'm very appreciative of the fact that the Worker's Compensation Insurance Rating Bureau did come forward with the rate filing, as they have, and I think it's extremely helpful. I think it is important to note that, although there is some disagreement in the testimony that we've received with regard to the precise dollar per $100 of payroll associated with Pure Premium, that there wasn't a dramatic divergence in the testimony, I heard from various stakeholders from, that -- which has been presented by the Workers' Compensation Insurance Rating Bureau -- obviously, we're going to consider the testimony and the complete evidence put before us in making a decision.

I'll get a recommendation from the hearing officer and then I'll make a decision whether to approve, modify or reject the filing. But, I thought it is positive that the, by and large, with some disagreements, the variance in what was being proposed as Pure Premium by the public members and the Bureau was not dramatically, dramatically different.

I do think it's important to underscore that those watching this hearing, or recording this hearing, and those who have a direct interest in this system, not be misled by the Pure Premium filing by the Worker's Compensation Insurance Rating Bureau, which is a -1.8 percent, from what the filed Pure Premium Rates are.

I don't want people to glean from that that this means that Workers' Compensation rates are suddenly going to go down because, one, it's advisory, and so the carriers are going to set the rates that they think are necessary to recover their costs and make a profit;

And, two, as we heard from the Bureau and various stakeholders in the system, there are significant cost drivers that we need to be attentive to.

I'm very, very concerned about the fact -- and there seems to be no dispute about this -- that we are in the top fifth of the states in the nation with regard to costs in the system, and in the bottom fifth with regard to the benefits that are paid to injured workers.

That tells me that there are significant costs in this system that are associated with the system, but aren't actually providing a direct benefit to those that the system is designed to help, which are the injured workers; and we've had some discussion about what some of those costs are and what's happening with regard to those

costs.

I'm going to continue, as the Insurance Commissioner, to look at ways that we might be able to make the system more efficient. My predecessor also spent a lot of time on this issue, and I think it bears continued attention and vigilence.

I also think that there are significant policy conversations occurring, both within the Legislature and in the other arm of this system, which is that element of the system that oversees the actual adjudication of claims and establishment of rules with regard to benefits and claims with regard to ways that we can get at some of these cost drivers.

For example, there's been legislation that's been introduced to try and go at the medical lien issue by placing a more restrictive Statue of Limitations;

There's been legislation with regard to trying to deal with the drug compound issue;

And there's been other bills, as well.

One thing I think we need to be mindful of, as we look for ways to improve the system, is that we are at an interesting moment in the history of the system where there seems to be significant competition in the market, but, at the same time, some cost pressures.

And I think we do need to be careful as we are

considering ways to adjust or even improve the system that we're mindful of what either the costs or benefits are associated with those proposed changes, and that we have corresponding efficiencies or cost reductions to cover things that we might be doing to try improve the system that have cost implications. Because, at the end of the day, we need to be very, very careful that we don't end up in a situation like that which we were in in the '90's, where you had almost a perfect storm in this market, for a variety of reasons.

So, I look forward to reviewing all the testimony and the evidence that's been provided, and I want to, again, thank you all of you who have been so attentive here today, and all of you who took the time to testify.

And I think, with that, I would just conclude by saying that, as Commissioner, I will continue to be interested in the ideas and recommendations of the stakeholders of the Rating Bureau and other interested parties with regard to how we can improve this system.

So, thank you, very much, for your attention today.

MR. MIKE: I would like to, in view of the information, you know, we've agreed to submit, for the record, possibly, keep the record open for two or three additional days.

Would that be possible?

MR. CITKO: All right.

Do you have a specific date?

MR. MIKE: The Wednesday of the following -- you said September 30th, so, that would be October 5th, I believe.

MR. CITKO: I don't have a calendar in front of me.

MR. DAHLQUIST: October 5th is Wednesday.

MR. CITKO: Okay, so, based on your request, we will keep the record open until 5:00 p.m. on Wednesday, October 5th, 2011.

MR. MIKE: Thank you.

MR. CITKO: Thank you.

And, with that, that will conclude the proceedings here.

(Public Hearing ends at 12:44 p.m.)

REPORTER'S CERTIFICATE

I, MARYANN P. COSTA RPR, RMR, C.S.R. NO. 5820, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That statements made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

I further certify that I am not a relative or employee of any attorney of the parties, nor financially interested in the action.

I declare under penalty of perjury under the laws of California that the foregoing is true and correct.

Dated this 5th day of October, 2011.

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MARYANN P. COSTA RPR, RMR, C.S.R. NO. 5820