

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

PROPOSED DECISION AND ORDER

**JANUARY 1, 2013 WORKERS' COMPENSATION CLAIMS COST
BENCHMARK AND PURE PREMIUM RATES**

FILE NUMBER REG-2012-00016

In the Matter of: Proposed adoption or amendment of the Insurance Commissioner's regulations pertaining to pure premium rates for workers' compensation insurance, California Workers' Compensation Uniform Statistical Reporting Plan—1995, Miscellaneous Regulations for the Recording and Reporting of Data, and the California Workers' Compensation Experience Rating Plan—1995. These regulations shall be effective on **January 1, 2013**, unless another effective date is specified.

SUMMARY OF PROCEEDINGS

A public hearing in the above captioned matter was held on November 16, 2012 at the time and place set forth in the Amended Notice of Proposed Action and Notice of Public Hearing, File Number REG 2012-00016 dated November 7, 2012, which is included in the record. At the conclusion of that hearing, additional time was granted for the WCIRB public members' actuary and for others to submit supplemental material. The hearing officer announced that the record would be kept open for additional written comment until 5:00 p.m. on Monday, November 19, 2012, and the record was closed at that date and time.

The record discloses the persons and entities to whom or which the Notices were disseminated. The Notice summarized the proposed changes and recited that a summary of the information submitted to the Insurance Commissioner in connection with the proposed changes was available to the public. In addition, the "Filing Letter" dated August 21, 2012 submitted by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) and related documents were available for inspection by the public at the Sacramento office of the California Department of Insurance (CDI) and were available online at the WCIRB website, www.wcirbonline.org.

The WCIRB's filings propose a change in the Workers' Compensation Claims Cost Benchmark and Pure Premium Rates (Benchmark) that reflect insurer loss costs and loss adjustment expenses and adjustments to the California Workers' Compensation Experience Rating Plan—1995 to conform to the proposed Pure Premium Rates. In addition, the WCIRB has proposed amendments to the California Workers' Compensation Uniform Statistical Reporting Plan—1995, Miscellaneous Regulations for the Recording and Reporting of Data, and California Workers' Compensation Experience Rating Plan—1995.

The initial filing of the WCIRB requested that the Commissioner adopt a set of pure premium rates for each classification to be effective January 1, 2013, due to loss and Loss Adjustment Expense (LAE) experience. On average, these pure premium rates would be at \$2.68 per \$100 of employer payroll, which is 12.6% greater than the average filed pure premium rate of \$2.38 per \$100 of employer payroll as of July 1, 2012. It was noted by the WCIRB that its filing did not include any provision in the costs for reforms that were proposed before the California Legislature.

On October 1, 2012, the WCIRB submitted an amended filing as a result of the passage of Senate Bill 863 (SB 863) that included an extensive analysis of the effect of SB 863 on California's workers' compensation system. The amended filing proposed the Commissioner adopt a pure premium rate level, or Claims Cost Benchmark, at \$2.38 per \$100 of employer payroll, which was the average pure premium rate level of what insurers had filed with the Department as of July 1, 2012. However, the actuarial analysis of the WCIRB in its October 1, 2012 filing supports a pure premium rate level of \$2.61.

Testimony was received at a hearing in Sacramento on November 16, 2012, and filed documents and exhibits were received into the record. The time period to receive additional written comment was extended by the hearing panel to 5 PM on November 19, 2012, to allow those presenting testimony to provide supplemental material. Additional documentation requested by the hearing panel was submitted prior to the close of the time period to receive written comment along with correspondence and documents submitted by the public. The matter was submitted for decision at the conclusion of the period to receive written comment on November 19, 2012. The matter having been duly heard and considered, the following review, analysis, and Proposed Decision and Proposed Order are hereby made.

REVIEW OF WORKERS' COMPENSATION CLAIMS COST BENCHMARK AND PURE PREMIUM RATES FILING

Subdivision (b) of California Insurance Code Section 11750 states that the Insurance Commissioner shall hold a public hearing within 60 days of receiving an advisory pure premium rate filing made by a rating organization pursuant to subdivision (b) of Insurance Code Section 11750.3 and either approve, disapprove, or modify the proposed rate. Subdivision (b) of Section 11750.3 states that a licensed rating organization, such as the WCIRB, shall collect and tabulate information and statistics for the purpose of

developing pure premium rates for its insurance company members to be submitted to the Commissioner. Pure premium rates are the cost of workers' compensation benefits and the expense to provide those benefits.

The pure premium rates approved by the Commissioner as a result of this process are only advisory. Insurers are free to accept or ignore the Commissioner's advice and make their own determination on the pure premium rates each insurer will use.

Chief Actuary Ron Dahlquist, with the assistance of Senior Casualty Actuary Giovanni Muzzarelli, provides below in the Actuarial Recommendation a review and analysis based upon the record in this matter. This review is similar to previous reviews CDI conducted on pure premium rate filings, and, as was noted in prior Proposed Decisions, the pure premium rate process is important as a gauge or benchmark of the costs in the workers' compensation system but must reflect the reality of insurer rate filings and the premiums being charged to employers. The pure premium rate process does not address insurance rates but only estimates the costs of benefits and adjusting expenses for the upcoming policy period beginning January 1, 2013. The term "rate" can be confusing to the public in the pure premium rate context since it is a measurement of cost per hundred dollars of employer payroll rather than the rates insurers may charge employers. This difference cannot be emphasized enough.

In this filing, the Commissioner is presented with a recommendation from the WCIRB, at the direction of its Governing Committee, to approve a Benchmark that is not supported either by the WCIRB's data or actuarial analysis. As noted above, the Commissioner holds a public hearing and either approves, disapproves, or modifies the proposed Benchmark. The code does not directly state the basis for approval, disapproval or modification. However, pure premium rates are to be used by the member insurers of the WCIRB in the insurer rate filings, and the Insurance Code does provide guidance on how the Benchmark and pure premium rates are to be evaluated.

A rating organization, such as the WCIRB, is required to carry out several functions under its license as set forth in Section 11750.3, such as collecting and tabulating information and statistics for the purpose of developing pure premium rates to be submitted to the Commissioner for issuance or approval. Pure premium rates are defined as that portion of the rate which represents the loss per unit of exposure, including loss adjustment expenses.¹ If insurers are to use the pure premium rates of the WCIRB, those pure premium rates must meet the same standards as the rates for which they are to be used.

Workers' compensation insurance rates are required to be adequate to cover an insurer's losses and expenses and shall not be unfairly discriminatory.² In considering whether rates meet these requirements, the Commissioner may consider factors such as past and prospective loss and expense experience within this state, catastrophe hazards and contingencies, events or trends within this state, and actual and anticipated expense

¹ Insurance Code Section 11730(f)

² See Insurance Code Sections 11732 and 11732.5.

experience.³ These requirements for insurer rate compliance, by extension, must also apply to pure premium rates used by insurers for their filed rates. Therefore, the Commissioner may review pure premium rates filed by the WCIRB on a similar basis. In addition, the general requirements that rates be reasonable and actuarially sound apply to pure premium rates. That is the basis of the actuarial review and recommendation to the Commissioner as set forth below.

DETERMINATION OF WORKERS' COMPENSATION CLAIMS COST BENCHMARK BASED UPON CURRENT FILING

It is the determination of this Hearing Officer that the Insurance Commissioner adopt the Benchmark at an average pure premium rate level of \$2.56 per \$100 of payroll to be effective with respect to new and renewal policies as of the first anniversary rating date of a risk on or after January 1, 2013. Pure premium rates for individual classifications shall be adjusted based upon the classification relativities reflected in the WCIRB's filings in accordance with the adjustment of the Benchmark. The change in the Benchmark determined herein is based upon the hearing testimony and an examination of all materials submitted in the record as well as the Actuarial Recommendation set forth below by CDI Chief Actuary Ron Dahlquist and Senior Casualty Actuary Giovanni Muzzarelli.

It is clear from the Actuarial Recommendation that the WCIRB Governing Committee's recommendation for the pure premium rate level is insufficient to provide an adequate basis for insurer rate filings and, therefore, is rejected. The WCIRB has failed to adhere to its own actuarial analysis and failed to provide any additional support or analysis based upon the factors under which insurer rates would be reviewed and determined to be reasonable and actuarially sound. Also, little time was spent by the Governing Committee developing a proper rationale for its decision, rather than leaving to the WCIRB staff to determine how it could be done.

Additionally, while the Public Members' actuary provided significant written and oral testimony, the fact that he provided a range of possible pure premium rates without providing a recommended point estimate limits the usefulness of that testimony. In setting the pure premium rate benchmark for the coming year, we must of necessity choose one single point. His range of reasonable estimates is fairly wide, given the uncertainties surrounding the impact of SB 863's provisions; anything from a decrease of 2.6% relative to the now outdated \$2.38 average filed pure premium rate to an increase of 19.7% from that level falls within his range. It would be much more useful if we had the benefit of his professional opinion as to which point within that wide range was his preferred choice.

CDI has been presented with a similar problem in the past, albeit as a result of the exact opposite issue. The WCIRB previously would provide a pure premium rate recommendation with out giving a range or alternative outcomes in its analysis. The WCIRB modified its methods and now provides a recommendation with a variety of

³ Insurance Code Section 11733.

alternative calculations that could be considered to constitute a range. The Public Members' actuary has provided us with a range but no recommendation, despite having arrived at a mid-range point that is in line with the WCIRB's actuarial analysis. We encourage the Public Members' actuary to exercise his own expert opinion and provide an actuarially supported point estimate of the indicated pure premium rate level to the Commissioner in future filing reviews.

Actuarial Recommendation

The WCIRB has proposed an average pure premium rate level of \$2.38 per \$100 of payroll in its January 1, 2013 rate filing. The filing also includes an actuarially indicated average pure premium rate level of \$2.61. CDI staff actuaries' analysis results in an average pure premium rate level of \$2.56 per \$100 of payroll for reasons set forth in the "Actuarial Evaluation" section that follows. The current industry average level of pure premium rates filed by insurers with the Department is currently \$2.49 per \$100 of payroll as of November 9, 2012. (The \$2.38 average filed pure premium rate referenced by the WCIRB Governing Committee was valued as of July 1, 2012 but has become outdated due to some significant recent filing activity.) While the indicated pure premium rate level represents our central estimate, and thus our recommendation, we note that both the WCIRB pure premium rate proposal and the middle estimate from the Public Actuary are within a reasonable actuarial range, as is the industry average filed pure premium rate level of \$2.49 per \$100 of payroll.

This WCIRB filing compares its proposed average pure premium rate level to the average industry filed pure premium level. We believe this comparison is useful. It provides an appropriate basis for assessing both the industry's ability to adapt to the proposed pure premium rate level and the size of the potential market impact of such an adjustment. Given that the proposed pure premium rate level is reasonably consistent with the industry's current average filed pure premium rate level, there should be little difficulty for the market to adapt to the proposed pure premium rates if individual insurers so desire. It is also likely that little market impact would result from their adoption. We note that the WCIRB proposed pure premium rates are advisory, and insurers are free to make their own decisions as to what pure premium rates they will use in their rate filings. Insurers have proven their willingness over time to exercise their own independent judgment, and we cannot predict the decisions insurers will make with respect to their rate and price levels.

We note that the market currently utilizes a substantial level of schedule credits, averaging something on the order of 20% of manual premium. Collected premiums at actual charged rates in 2011 were on average approximately 3.7% less than the WCIRB's July 1, 2012 recommended advisory pure premium rates, suggesting a high level of competition in the market. Our review of the California workers' compensation insurance industry's profitability indicates that the pricing environment is benefiting from substantial investment income relating to substantially higher premiums in prior years and associated reserves, resulting in an average market price level that is below what would be sustainable without this underlying level of support.

Actuarial Evaluation

The actuarial evaluation will focus on four main components of the analysis: 1) Loss Development, 2) Loss trends, 3) LAE (Loss Adjustment Expense) provision, and 4) the impact of Senate Bill 863. We will consider the first three components prior to consideration of the impact of SB 863, and then following the assessment of SB 863's impacts, will review the indicated pure premium rates net of SB 863.

1. Loss Development

The WCIRB utilizes a range of actuarial methods to develop estimates of the medical and indemnity components of ultimate loss. For the January 1, 2013 filing, these various methodologies produced a range from \$2.40 per \$100 payroll to \$3.17 per \$100 payroll, relative to the WCIRB's actuarially indicated rate of \$2.73 excluding the impact of SB 863.

As shown in Table 1, these methods can be categorized into two main types: paid methods and incurred methods. The paid methods reflect historical payments by accident year, with the various alternative indications reflecting the latest year paid development versus the most recent 3-year average, with and without adjustments for changes in insurer mix, and with and without adjustments for reform and for changes in claim settlement rate. Generally the paid methods have performed the best in terms of stability and accuracy.

Incurred methods reflect historical loss payments plus associated case reserves. Due to changes in case reserving practices over time within a given insurer and changes in insurer mix, the incurred methods generally do not produce results that are as stable or accurate as those produced by the paid methods, and thus are not given any weight in the selection process. These methods include a review of latest year versus the most recent 3-year average, and with and without adjustments for changes in insurer mix and changes in case reserve adequacy.

The CDI and the Public Members' actuaries agree with the indications developed by each of the methodologies. However, the Public Members' actuary's selected point estimate reflects a weighted average of the paid and incurred methods, whereas the WCIRB selected as its loss development assumption the "latest year paid, adjusted for reform" method. While the CDI staff shares the Public Members' actuary's concern regarding the recent history of adverse loss development, we support the use of the paid methodology by the WCIRB due to the aforementioned relative historical stability and accuracy.

Also shown in Table 1 is a comparison of the ranges of the various methods from the 7/1/12 filing versus the current filing. There is an increase across all the methods, driven by continued adverse loss development for both indemnity and medical losses as shown in Tables 2 and 3.

The indicated indemnity loss ratio for Accident Year 2010 has increased from 29.6% to 30.6% between the December 2011 valuation date of the prior filing and the June 2012 valuation date of the current filing, an increase of 1.0 points. The comparable change for the medical loss ratio for AY 2010 is an increase from 56.9% to 60.9%, an increase of 4.0 points.

Issues impacting the observed increase in indemnity and medical loss ratios will be discussed in more detail in the trend section of this report. However, leading indicators for loss development suggest that this pattern of increasing development may be peaking.

Table 1

| 7/1/2012 Rate Filing Evaluated at December 2011 | | 1/1/2013 Rate Filing Evaluated at June 2012 ex/ SB 863 | |
|--|--------------|---|--------------|
| paid methods | \$2.54 | paid methods | \$2.96 |
| incurred methods | \$2.62 | incurred methods | \$3.17 |
| \$2.33 | \$2.51 WCIRB | \$2.77 | \$2.73 WCIRB |
| | | \$2.40 | |

Notes:

- The 1/1/13 filing reflects data through 2q2012, versus the 7/1/12 filing which reflects data through 4q2011.
- Both paid and incurred methods produce higher indications for the 1/1/13 filing vs the 7/1/12 filing.

Table 2

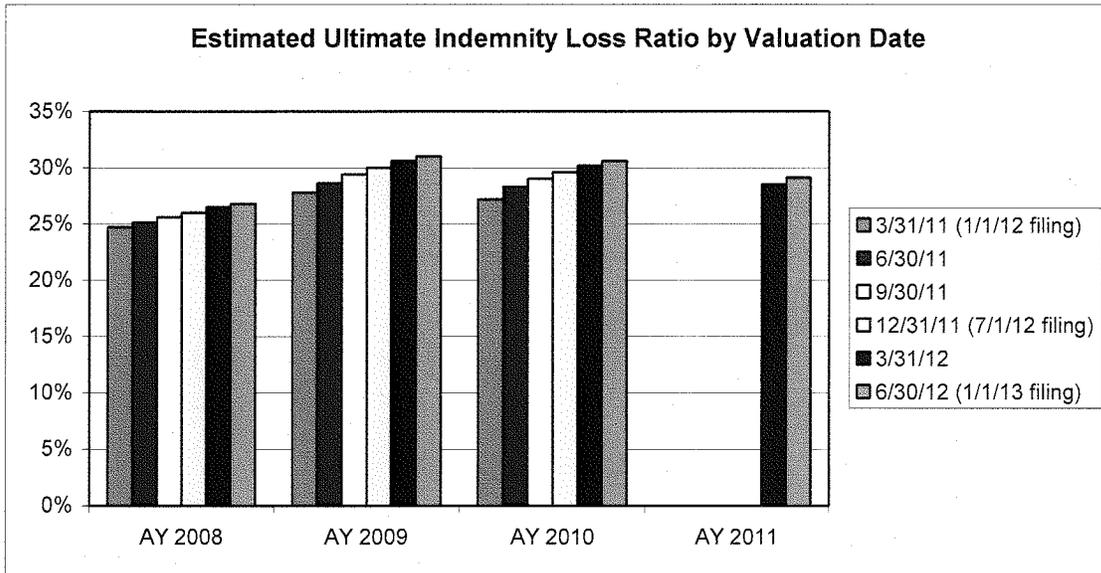
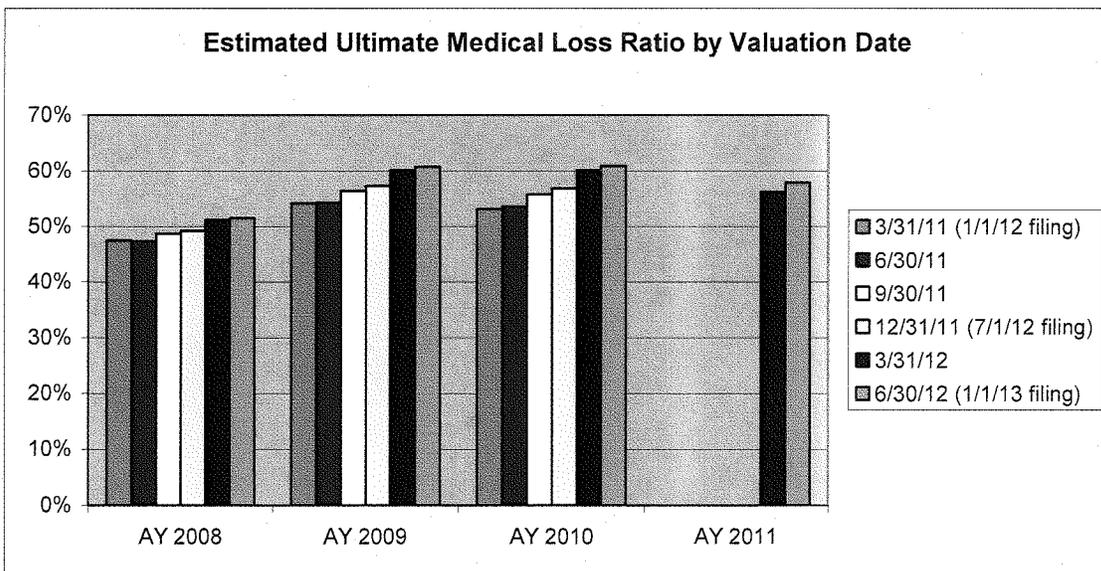


Table 3



2. Loss Trends

The WCIRB utilizes a range of trending assumptions to roll-forward the estimates of ultimate loss developed above to the time period reflected in the filing.

The various trend assumptions vary in terms of 1) the particular historical time period used to determine severity and frequency trends, and 2) the point in time at which these trends are applied to roll forward to the future time period of the filing.

As shown in tables 4 and 5, indemnity and medical severity trends over the more recent time frame (2005-2011) have decreased relative to longer-term historical averages(1991-2003), especially over the past two years (discussed further following the severity and frequency slides).

The resulting selected trends by the WCIRB for both the 7/1/2011 and 1/1/2013 filings are several points lower than the 1/1/11 filing and more consistent with the CDI's and Public Members' Actuaries' recommendations from the 2011 review. CDI believes that the higher 1991-2003 trends are not appropriate since that time period is heavily impacted by the run-away inflation in medical costs of the pre-reform years.

Table 4

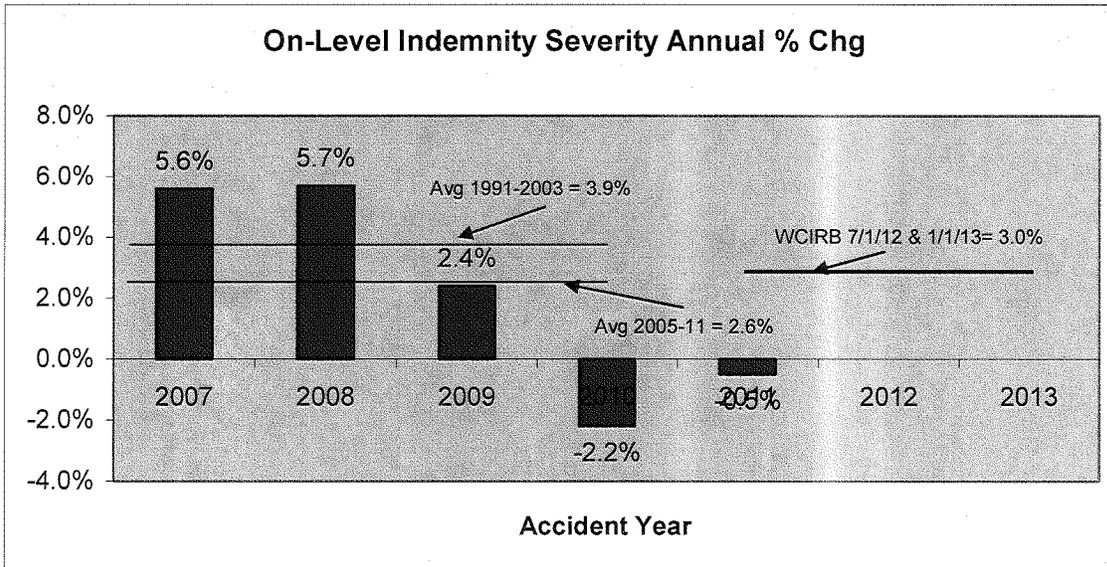


Table 5

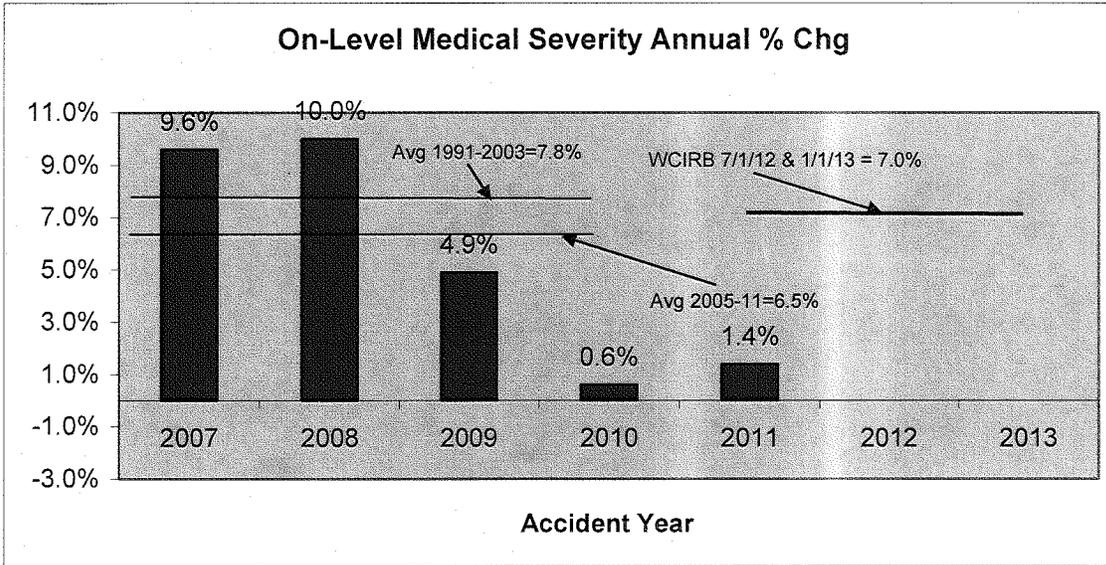
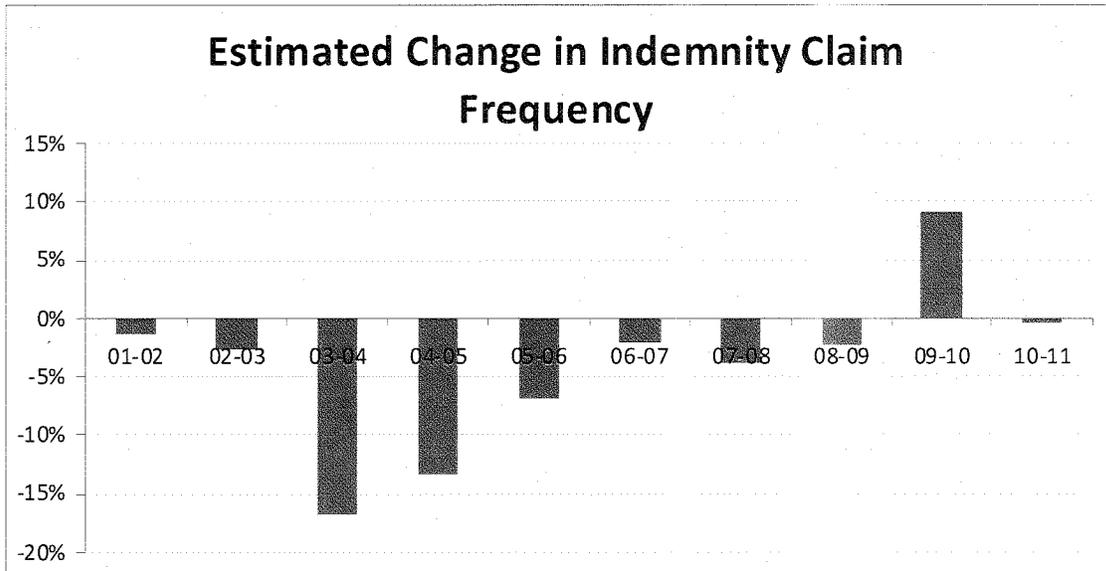


Table 6



We note that the negative severity changes indicated for accident year 2010 are driven by the unusual 9% increase in frequency shown in Table 6 above. The WCIRB is performing ongoing analysis to help determine the driver(s) of this frequency increase, with one possible explanation that this is a result of an increase in small claims that previously were medical-only claims, possibly connected to the state of the economy.

The National Council on Compensation Insurance (NCCI), which provides data collection and rate development for approximately 35 states and performs a role similar to the WCIRB in California, has noted this increase in frequency nationwide. A second driver may be an observed increase in cumulative injury claims, where claims are made with multiple body parts and can include a psychiatric component. We note that claim frequency for AY 2011 thus far appears to be consistent with the higher AY 2010 base level, with the change in frequency versus 2010 less negative than had been observed prior to AY 2010.

The main difference of opinion on the trend issue between the Public Members' actuary and the WCIRB is the use of separate indemnity and frequency trends versus a combined pure premium trend. The WCIRB applies separate trends as previously described, whereas the Public Members' Actuary suggests using a combined trend to limit the impact of the increased frequency of small claims in recent AY's. As shown in tables 7 and 8 below, the result of the separate trends is a very reasonable continuation of the loss ratio trend for both indemnity and medical, and CDI concurs with the WCIRB approach.

While we agree with the Public Members' Actuary that stability is desired and that his approach is more stable, we are concerned that we are in a period of change in which responsiveness to changing conditions is of greater than usual importance. The separate severity and frequency trends are telling us that the environment is changing, and while we do not yet have a full understanding of the changes that are happening, the separate analysis of frequency and severity provides information that the combined trend seems to smooth and to mask.

Table 7

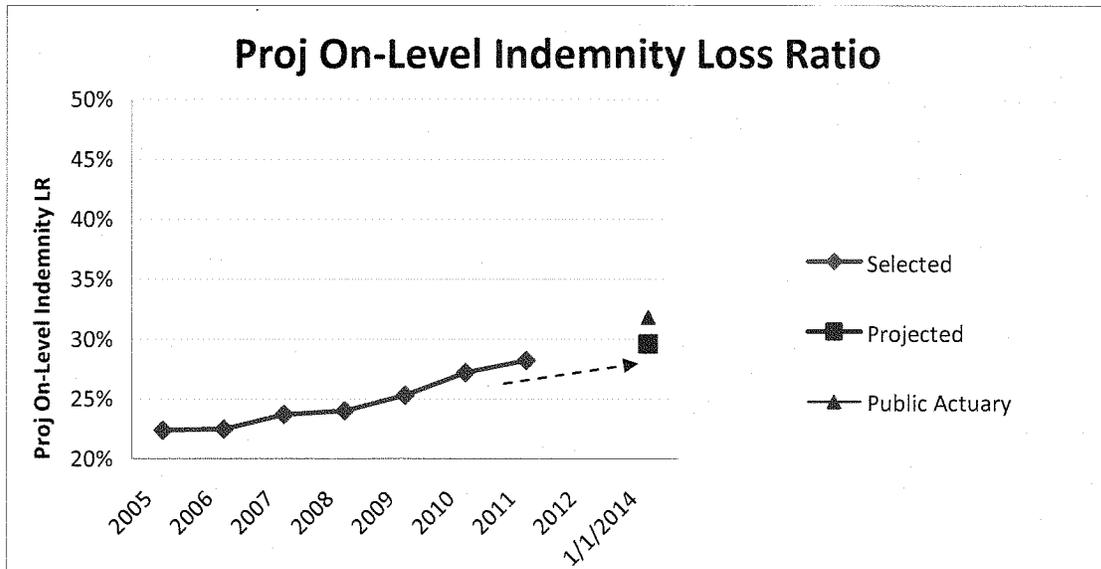
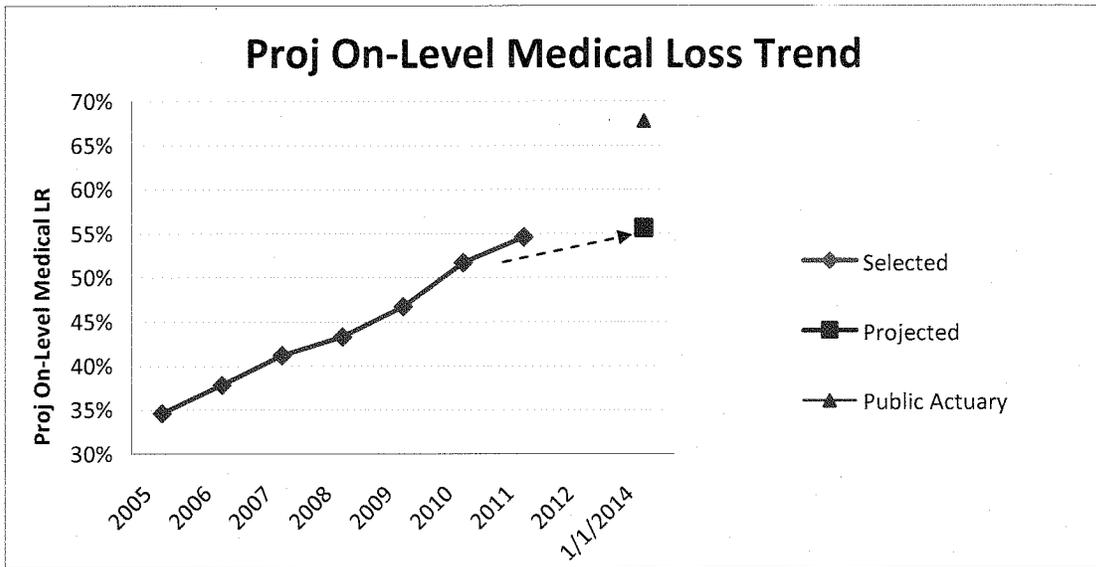


Table 8



3. Loss Adjustment Expenses

In its determination of the provision for loss adjustment expenses (LAE) in the proposed rates, the WCIRB developed separate indications for the allocated loss adjustment expense (ALAE) and unallocated loss adjustment expense (ULAE). In doing so, the WCIRB considered the historical ALAE and ULAE experience of all companies in the market, including the State Compensation Insurance Fund (SCIF).

CDI staff actuaries believe that the WCIRB's methods for determining ALAE and ULAE are generally reasonable, and we accept them with the exceptions noted in the following discussion. There are two main issues to be discussed for LAE: 1) the appropriateness of using SCIF experience for the development of the LAE provision in the rates, and 2) the appropriateness of the trend assumptions underlying the ALAE provision.

While ALAE ratios to loss are reasonably consistent between private carriers and SCIF, the ULAE indication for SCIF is much higher than for private carriers. The WCIRB addresses this issue by tempering the weight applied to SCIF (its market share) by 50%. The result of the tempering is a ULAE ratio to loss of 7.5% versus 6.1% for private carriers (see table 9). SCIF's LAE ratios include a significant component of excess expense, and CDI staff actuaries believe this excess expense should not be included in a prospective estimate of industry average costs required to settle claims in the future. The Public Members' actuary concurs with CDI on this issue. The impact of excluding SCIF experience from both the ALAE and ULAE is a modest reduction in the indicated average pure premium rate from \$2.61 to \$2.59.

Table 9

| LAE Provision Underlying 1/1/2013 Rate Filing | | | |
|---|-----------------|---------------------|-------------------|
| | All Carriers | Private Carriers | WCIRB Selected |
| ALAE/Loss | 15.4% | 16.5% | 16.2% |
| ULAE/Loss | 9.7% | 6.1% | 7.5% |
| Total ALE/Loss | 25.1% | 22.6% | 23.7% |
| Indicated Rate | | CDI* \$2.59 | WCIRB \$2.61 |

* CDI indicated rate is based on private carrier LAE/loss % (SCIF excluded because expense levels are excessive.)

With regard to the trend assumption underlying the ALAE provision, the WCIRB reviews a number of different methods and considers various trend periods as well as trend bases. The trend underlying the selected method is a 7% change in ALAE dollars per indemnity claim per year, consistent with the prior filing.

4. Impact of Senate Bill 863

In developing its actuarially indicated pure premium rates, the WCIRB included its estimate of the effect of SB 863. The net impact of SB 863 as calculated by the WCIRB and included in the actuarially indicated pure premium rates is a reduction in pure premium rate of 4.4%, or \$0.12, resulting in the net filed pure premium of \$2.61.

This estimated effect was the result of an effort that solicited input and participation from a number of individuals and groups from the industry, government, and the academic community including the Commission on Health, Safety, and Workers Compensation (CHSWC); the California Workers Compensation Institute (CWCI); Bickmore Risk Services (BRS); and the CDI. This effort began as the bill was in its developmental stages and took place over a period of several months. The WCIRB's final actuarially indicated estimates of the effect of SB 863 are the result of this collaborative effort.

Mark Priven of BRS, in his role as consulting actuary for the Public Members, made a particularly significant contribution to this effort. The WCIRB has adopted a number of Mr. Priven's estimates of individual components of SB 863 as its own estimates, and has adopted his methodology in large part for other components. Mr. Priven has also provided extensive written testimony as to his conclusions about the effects of SB 863 and its components, and also testified in the public hearing held on the WCIRB pure premium rate filing.

The following is an item-by-item discussion of the WCIRB's evaluation of each reform element, the corresponding BRS evaluation, and our conclusions. We note that the net SB 863 impact of \$0.12 decrease in pure premium rate can be broken out as an increase of \$0.09 due to higher permanent disability benefits, offset by a decrease of \$0.21 due to system savings from various components as described below.

Permanent Disability:

General:

The WCIRB and BRS are in close agreement in their estimates of the impact of most of the various changes affecting permanent disability benefits. This includes increases to the minimum and maximum benefits as well as the elimination of the future earning capacity (FEC) factors, the substitution of a 1.4 multiplier to the PD rating, the elimination of the three-tiered system of benefits depending on the injured worker's return-to-work status, and a number of other relatively minor changes. Both the WCIRB and BRS reflect a significant utilization impact in their PD estimate. The primary difference in their estimates of the impact of the changes to permanent disability benefits is a difference of opinion over the size of the utilization impact. This will be discussed below.

Changes to Permanent Disability Benefits:

Weekly Minimum and Maximum Benefits:

SB 863 increases the minimum and maximum weekly permanent disability benefits in two stages.

For accidents occurring in 2013, the minimum benefit is increased substantially across the board, while the maximum benefit is increased only for the more severely injured workers, those whose disability rating is 55% or higher. The maximum benefit is not increased at all in 2013 for permanent disability claimants with ratings below 55%, which constitute the great majority, so the effect of these changes in 2013 is small.

In 2014, the maximum benefit is made equal for all injured workers with permanent partial disability, regardless of disability rating. This results in significant increases in maximum benefits for injured workers with permanent disability ratings less than 55%, and causes most of the effect of the increases in minimum and maximum benefits to be felt in 2014.

Future Earning Capacity (FEC): Uniform 1.4 Multiplier:

SB 863 eliminates the differences in permanent disability ratings based on assessed differences in future earning capacity that are part of the existing Permanent Disability Rating Schedule, and substitutes a uniform 40% increase in all permanent disability ratings to make up for elimination of the FEC factors.

Add-ons for Psychological, Sexual, and Sleep Impairments:

SB 863 eliminates these as add-ons to disability ratings when there is a compensable physical injury. Medical treatment is to be provided for these conditions.

Elimination of the Three-Tiered Benefit Levels Depending on Injured Worker's Return-to-work Status:

Existing law prior to the passage of SB 863 provided for a decreased level of benefits to be paid when an injured worker has received a qualified offer of return to work, and an increased level of benefits when such a qualified offer has not been made. SB 863 eliminated both the increased and decreased benefits.

Other Changes:

A supplemental job displacement benefit of \$6,000 will be provided.

The burial allowance is doubled from \$5,000 to \$10,000.

Analysis of WCIRB and BRS Evaluations

Evaluation of Permanent Disability Evaluations Generally

The underlying basis for both the WCIRB and BRS evaluations of SB 863's changes to permanent disability benefits is a data set of 23,227 disability ratings obtained from the Disability Evaluation Unit of the Division of Workers Compensation. The ratings in the data set were performed by the DEU between June 2011 and March 2012.

Both BRS and the WCIRB evaluated all the PD changes together, recognizing the interdependence of the effects of the changes. BRS provided separate estimated effects for each reform element, while the WCIRB only provided separate effects for the 2014 effect of the change in maximum benefits and for the elimination of the three-tiered permanent disability benefit system based on return-to-work status. Both provided overall total effects.

Based on the description of the data sources and the general methodology used to evaluate the various changes to permanent disability benefits, we believe the estimates have a sound basis.

Evaluation of Impact of Increases to Minimum and Maximum Weekly Benefits

The evaluation of the increases in minimum and maximum benefits appears to be straightforward. The changes are simple. Wage and disability rating information is needed for each injured worker in the data set in order to complete the evaluation. It is our understanding that both disability rating and wage information are present in the record. Once this information is available, the calculations should be straightforward.

Evaluation of elimination of the Three-Tiered PD system

The WCIRB Permanent Disability Survey appears to provide adequate data to assess the impact of eliminating the three-tiered permanent disability benefit structure based on return-to-work status. This effect should be considered solid because the data is substantial and the calculation of the effect is a simple one.

It should be noted that the WCIRB and BRS use different utilization assumptions. The WCIRB assumes losses will increase by 60% due to increased utilization of the workers compensation system after a benefit increase. This is based on a detailed model that the WCIRB has used in past evaluations of prior changes in benefit levels. BRS agrees with the concept that losses will increase beyond the calculated impact based on current claimant loss distributions, but believes that in this case, the AMA Guides that heavily influence how permanent disability ratings are determined will have a limiting effect on the utilization impact. As a result, BRS assumes a 45% utilization effect.

Liens

Changes to Liens:

SB 863 reflects a number of provisions related to liens. Labor Code Section 4903.5 is added to the Labor Code and provides that every lien claimant is required to file its lien with the WCAB using an approved form and be charged a filing fee of \$150. Prior to the passage of SB 863, no filing fee was required.

In addition, the amendments to Labor Code Section 4903.5 provide that no liens may be filed more than three years from the date of service for liens filed before July 1, 2013 or 18 months from the date of service for liens filed on or after July 1, 2013. Prior to the passage of SB 863, there was no statute of limitations with respect to filing liens.

WCIRB and BRS Evaluations

There is relatively limited information available on the cost impact of liens. A 2011 report published by the CHWSC indicated that the number of medical lien filings has increased sharply since 2005. The report suggested that approximately \$1.5 billion per year is claimed in lien disputes, and the average cost of defending and settling a lien is approximately \$1,000.

Rather than performing a completely separate analysis, the WCIRB reviewed the method and estimated impact developed by BRS and substituted alternative assumptions. Estimates were developed separately for the establishment of the lien filing fee and the imposition of the statute of limitations. While the WCIRB and BRS selected significantly different assumptions as to percentages of liens avoided, average lien amount, average lien settlement rate, and average administrative cost, the end result of both the WCIRB and BRS analyses were within 5% of each other.

We believe both estimates are reasonable, and accept the WCIRB estimate. We are not overly concerned with the significant differences in the WCIRB and BRS assumptions, but consider that these differences merely illustrate the difficulty in estimating the potential impact of these changes. It should also be clear from this that the actual effect of these changes could turn out to be significantly different from this estimate.

In that light, we note that a large fraction of the projected savings from liens is due to the imposition of a statute of limitations. It is unclear to what extent lien filers will be able to modify their behavior and potentially accelerate filings to beat the proposed deadline. These savings could turn out to be less than estimated, perhaps significantly less, if efforts to accelerate filings are consistently successful.

Independent Medical Review (IMR)

SB 863 provides for a newly-created process of independent medical review (IMR). The impact of the proposed provisions are difficult to evaluate inasmuch as their ultimate impact is dependent upon the regulatory structure used in its implementation, any judicial interpretations of the new review process, and the practices and procedures used by the parties involved.

The IMR changes account for the majority of the overall difference between the WCIRB's estimated effect of SB 863 and that of BRS. As a consequence, the following discussion of the differences will be fairly extensive.

There are three areas in which both the WCIRB and BRS agree there is potential for IMR to produce savings.

Both agree there will be savings in administrative and legal costs because some utilization review disputes and some qualified medical evaluations would be resolved by a less expensive IMR report, and both essentially agree on the estimated savings. Both estimate that IMR will reduce the costs of liens by \$60 million and the costs of QME reports by approximately \$25 million. These amounts are relatively minor, both in absolute terms and when compared to savings estimates in the other two areas.

Both also agree there will be savings in temporary disability benefit payments, but disagree significantly on the estimated amount of the savings.

In the third area, that of medical cost savings, BRS assumes significant savings. The WCIRB does not, basing their position on the premise that the impact of SB 863's IMR system is not clear at this time. The WCIRB cites uncertainty in how often utilization reviews are overturned under the current system, in how often IMR reviews will be overturned in the new system, in how often IMRs will be utilized, and how they might eventually affect treatment patterns.

We accept the WCIRB's estimated effect of the administrative and legal cost savings because the rationale appears reasonable and there is essential agreement with BRS. We will comment on the temporary disability and medical savings estimates later in this section.

We believe that the WCIRB's IMR savings estimates may be conservative overall because no medical savings are assumed, although we share their concern with the level of uncertainty in this area presently. To the extent the IMR process produces more conservative treatment decisions that are upheld by the system, savings of medical costs could be considerable. On the other hand, the new IMR process is perhaps the most likely reform element to be challenged in court, and if these challenges are successful the estimated savings may not be realized at all.

Temporary Disability

The WCIRB estimates that there will be temporary disability cost savings of approximately 4%, constituting a reversal of one fifth of the 20% increase in temporary disability duration that has occurred since 2004-2005. This produces a savings estimate of \$210 million system-wide.

The BRS middle estimate concludes that IMR will reduce temporary disability costs by \$404 million. This estimate depends on BRS's review and analysis of the Texas Department of Insurance 2010 report on the impacts of Texas workers' compensation reform legislation. BRS concludes that Texas temporary disability benefit costs per claim were reduced by 20% as a result of Texas HB 2600 which was passed in 2001. BRS assumes for the middle estimate that it is reasonable to attribute half of this decline- a 10% reduction- to HB 2600's IMR provisions.

The development of BRS's middle estimate is shown on Exhibit 8, Page 3 of the October 10, 2012 memorandum on the evaluation of SB 863. BRS bases their conclusion that Texas' average temporary disability costs per claim were reduced by 20% on their estimate that the rate of change in Texas TD severity was reduced by 20% due to the Texas reforms: from a 12% increase per year to an 8.3% decrease.

The premise that the rate of change in TD average claim cost was reduced by 20% seems to rest on the premises that average claim cost would have continued to increase at the pre-reform rate if not for the reform, and that the decreased cost in the reform period is not a statistical aberration. This would seem to also require that a stable pre-reform trend would need to be established, and that there would need to be a demonstration that the post-reform reduction in cost did not immediately reverse itself. It would seem that several data points before and after reform would be necessary to provide the statistical basis for the assertion.

In any event, we consider it more appropriate to determine what changes in actual cost levels have occurred, to separately evaluate what impact a system change might have on future trend rates, and to make changes in future trend assumptions as appropriate.

In the case of temporary disability, BRS's Exhibit 8, page 3 only shows data for injury years 2000-2004. This time period is insufficient to show a well-established pre-reform trend, and it is less than satisfactory to demonstrate that the post-reform reduction in cost has persisted. The five data points allow calculation of four yearly percentage changes in average temporary income payments. The percentage changes, in order, are +22.6%, +3.1%, -3.4%, and -13.0%. BRS averages the first two changes to produce a pre-reform cost change indication of +12.4%, and averages the last two changes to obtain a post-reform indication of -8.3%. Averaging +22.6% and +3.1% does not seem to provide comfort that the resulting +12.4% is a reliable indicator of pre-reform trend, however, and while the -13% cost change in 2004 is very significant, there is no data point following to inform us as to whether or not this reduction has been maintained in subsequent years. At best, this approach appears to be a very rough indicator.

If we examine the average cost levels themselves, we can see that the average cost in 2004 of \$2,156 is 15.2% lower than the \$2,564 average cost in 2002. It is not clear from the data presented in BRS's Exhibit 8, page 3, however, if the \$2,156 value for 2004 represents the new post-reform level or whether the values will fluctuate randomly from one year to the next. The lack of data points for 2005, 2006, and additional years prevents us from seeing whether the 2004 value represents the post-reform level.

When we examine the 2010 Texas Department of Insurance report on the impacts of Texas workers' compensation reform legislation, we find the data values for 2005 through 2008. There are no data points available for years prior to 2000, so the pre-reform trend rate on which the measurement is dependent cannot be validated. The average temporary disability severities are \$1,995 for 2005, \$1,924 for 2006, \$2,128 for 2007, and \$2,268 for 2008. The yearly changes are -7.5% for the 2004-2005 change, -3.6% for 2005-2006, +10.6% for 2006-2007, and +6.6% for 2007-2008. This appears to validate the -13.0% reduction as real. It also shows that the decreasing trend has been at least temporarily reversed. This would also seem to show that costs had been reduced by as much as 20% before beginning to trend upward again.

Another key consideration, however, is that the timing of the changes to average temporary disability payments does not line up well with the timing of the implementation of the IMR reforms. The IMR provisions of Texas HB 2600 were effective January 1, 2002, yet injury year 2002 shows the highest average cost of the years shown. A slight reduction in average cost occurred in 2003, but the 2003 average cost was roughly the same as the 2001 pre-reform average cost. The only dramatic cost reduction shown occurred in 2004. This calls into question the premise that IMR was responsible for lowering Texas temporary disability costs. At best it would seem that any impact was delayed by two years. This is a concern because the task before us is to estimate as well as we can what cost levels will prevail during the period claims will be incurred and paid on policies issued using the January 1, 2013 advisory pure premiums in the determination of their rates. This will only include accidents occurring in 2013 and 2014, so any reform impacts that have a two-year delay would lower temporary disability costs only in 2015 and beyond, and will not benefit the 2013 advisory pure premiums.

BRS also shows on the same exhibit that Texas' average duration of temporary disability was 12.5% lower than California's for the year of injury running from October 2008 through September 2009. What is not known is whether this difference was smaller, larger or the same prior to the Texas reforms of 2001, or whether Texas' rate is now lower as a result of its reforms or because of some other basic difference in the two systems. As a result, this comparison is perhaps useful as an indication of a potential for savings, but it is not a demonstration that such savings have occurred in Texas or will be achieved in California.

Medical Cost

As previously stated, the WCIRB does not attribute any savings in medical costs to IMR, citing a number of important uncertainties.

The BRS middle estimate concludes that IMR will reduce medical costs by \$436 million. BRS presents support for their medical cost reduction due to IMR on Exhibit 8, page 4. The same approach is used here as was used for the temporary disability estimate. Yearly changes in average medical cost per claim taken from the Texas report are observed, both a "pre-reform" and a "post-reform" average rate of change are calculated, the difference in the two rates of change is calculated, and the result is called the "impact of reform". This time two more years are shown: injury years 1998 and 1999. The data still ends with injury year 2004.

The addition of the earlier years does allow the conclusion to be drawn that average medical costs were increasing at a double-digit rate prior to reform. BRS calculates a pre-reform average trend rate of +12.3%, and this seems reasonable based on the three percentage changes shown for the 1998-2001 period.

There is a large reduction in medical cost in 2003, so two post-reform rates of change are available for examination, rather than just one. These two changes show a 13.8% reduction in 2003 followed by a 1.2% reduction in 2004. This seems to indicate either that the averages are fluctuating substantially or that cost levels may be stabilizing at or near the 2004 level. Again, the absence of data points past 2004 is a limiting factor in the analysis, but it does appear that a lower cost level has been reached.

Once again, examination of the 2010 Texas report shows the missing data points for injury years 2005, 2006, and 2007. The percentage changes in the medical severity values shown are -1.2% for 2005, -4.2% for 2006, and +2.5% for 2007. These values do support a conclusion that medical costs have been reduced significantly.

Looking at how the average medical claim cost has changed over time in Texas, we observe that the average for 2003 is 13.8% below the average for 2002, which is the highest point. The average for 2004 is 14.8% below the level of 2002. If we compare the average of the 2001 and 2002 average claim costs to the average of the 2003 and 2004 values, we find that the latter value is 13.2% below the former value. Based on these values, one might reasonably conclude that medical costs have been reduced by between

13% and 15%. While the missing data shows that further decreases occurred after 2004, it is important to note that additional reforms were included in Texas HB 7, which passed in 2005. Thus these further declines are likely to have been partly or wholly caused by these subsequent reforms.

Again, it is problematic that 2002, the first post-reform year, shows a cost increase, and the large decrease only occurs in 2003. This once again raises the question as to whether IMR has caused a significant portion of the observed decrease in 2003, or whether it is driven by some other cause. It also raises the same concerns as we have raised in the temporary disability discussion regarding the appropriateness of modifying the advisory pure premiums for reform effects that will not be seen in the first year or two post-reform, given the time period for which the 2013 advisory pure premium rates will be in effect.

A full explanation of the changes to the Texas workers' compensation system that have occurred because of the reform bills is not provided, but BRS does state that there were other changes in addition to IMR, and BRS does assume in their middle estimate that IMR will only reduce medical costs by 5%, or a quarter of the 20% overall reduction they have assumed took place in Texas. While we agree that such a cautious approach is warranted, we are concerned that we do not have enough information on what has actually caused Texas' medical costs to decline. We simply do not know how much of the observed cost decreases are due to IMR and how much are due to other causes.

Our IMR Conclusions

We do believe it is reasonable to expect that IMR, when implemented in California, will produce some reductions in both medical and temporary disability costs.

We note that the WCIRB actuarial analysis of IMR's effect on temporary disability makes a judgmental estimate similar to that of BRS but with a lesser magnitude. While its basis is as judgmental as that of BRS, it has the advantage of accepting a smaller savings estimate, given that it is based purely on judgment. Given the imprecision of the BRS temporary disability analysis and our concern with the potential for delay in IMR's impact on TD benefit costs, we conclude that the WCIRB estimate is the most reasonable, and we adopt it as our estimate.

For medical, given the concerns we have expressed, we conclude that 2.5% of medical costs is a reasonable estimate of the possible savings due to IMR. This produces a medical cost savings estimate of \$218 million due to IMR. We believe it is important to be cautious because of the lack of information and the resulting uncertainty.

We have been instrumental in calling on the WCIRB to do a study of how medical disputes are likely to be settled in California under the new IMR process, how this may be different from the past settlement process, and what cost savings if any are likely to occur as a result. This study is in progress, and we look forward to its results. We will also require that the WCIRB study the impact of IMR on actual claim settlements during

2013 and subsequent years. As we have done in the past, we will press for any observed savings to be included in reductions to the pure premium rates as soon as practically possible.

Duplicate Surgical Implant Costs

SB 863 repeals Labor Code Section 5318, which provided for separate reimbursement for implantable medical devices, hardware, and instrumentation.

Earlier this year the CWCI preliminarily estimated that the savings from eliminating the multiple reimbursements for spinal implant hardware in California workers compensation patients was approximately \$67 million. Based on the WCIRB's estimates of total insured medical costs paid in 2010 adjusted to reflect the total statewide system, this would equate to approximately 1% of total paid medical costs. The WCIRB estimates that the repeal of the separate reimbursement for spinal implant hardware would reduce medical costs by 1% and total system costs by 0.6% or \$110 million based on a total statewide estimate of \$19 billion loss and loss adjustment expense.

BRS develops its estimate using the CWCI savings estimate of \$67 million in 2010 from eliminating the multiple reimbursements. BRS then multiplies the \$67 million estimate by 1.37 to adjust it to a policy year 2013 basis, and multiplies again by a factor of 1.173 to load it for ALAE savings. BRS assumes no ULAE savings. The final BRS estimated savings in this category are \$108 million- virtually identical to the WCIRB estimate. We conclude that both the WCIRB and BRS estimates are reasonable, and thus accept the WCIRB estimate.

Ambulatory Surgical Center (ASC) Fees

SB 863 amendments to Labor Code Section 5307.1 (c) provide that the maximum facility fee for services performed in ASCs should not exceed 80% of the Medicare fee for the same service in a hospital outpatient department. ASC facility charges are currently at 120% of the Medicare rate for hospitals. As a result, these proposed amendments would result in a reduction of one-third in ASC facility fee payments if it is assumed that the change in the maximum fee schedule allowance would translate directly to ASC facility fee costs.

The WCIRB noted that many ASC fees are reimbursed according to contracts at levels significantly below the 120% maximum limit. Based on their review of a sample of contracts, the WCIRB estimated that only 20% savings would be achieved if current contracts remain in force and reimbursements occur at the lower of the contract rate and the new 80% maximum level. Their savings assumption was increased to 25%, assuming that some contracts would be renewed at rates lower than both current contract rates and the 80% maximum.

The CHSWC, based on information provided by the RAND Corporation, estimated that ASC facility fee payments in 2010 were \$187 million. A reduction of those fees by 25%

would generate savings of approximately \$50 million. This equates to approximately 0.8% of total medical costs based on the WCIRB's estimate of total insured medical costs paid in 2010 adjusted to reflect the total statewide system. As a result, the WCIRB estimates the reduction in ASC facility fees would reduce medical costs by 0.8% and total system costs by 0.4% or \$80 million.

BRS develops its estimate using a RAND savings estimate of \$70 million in 2010 (published in March 2010). BRS then multiplies the \$70 million estimate by 1.37 to adjust it to a policy year 2013 basis, and multiplies again by a factor of 1.173 to load it for ALAE savings. BRS assumes no ULAE savings. The final BRS estimated savings in this category are \$113 million.

We accept the WCIRB estimate. The rationale appears to be sound and straightforward, and is virtually the same as the BRS approach, with the exception of the refinement that takes into account the existence of contract rates below the pre-SB 863 maximum.

Elimination of Impact of Ogilvie Decision on Permanent Disability Rating Adjustments

The 2009 WCAB decision in Ogilvie v. City and County of San Francisco allowed for the PD rating to be adjusted based on a finding that the future earning capacity (FEC) component of the PD rating did not appropriately describe the loss of FEC. As discussed above in the section Changes to Permanent Disability Benefits, under SB 863 FEC would not be used as a basis to determine the permanent disability rating on injuries occurring on or after January 1, 2013 and, as a result, these ratings would not be subject to amendments based on the Ogilvie decision.

In 2009 the WCIRB estimated the combined impact of Ogilvie and Guzman on cost levels to be 5.8%. This impact on PD benefits was estimated to be 20% excluding the impact on claims frequency. The WCIRB has since reviewed a wide range of information on costs emerging subsequent to the WCAB decisions, indicating that the original estimate is not unreasonable. Based on WCIRB Claims Working Group and Actuarial Committee discussions that Ogilvie adjustments to PD are rarer than Guzman, the WCIRB judgmentally estimates that one-fifth of the increase in PD benefits attributed to both Ogilvie and Guzman is attributed to Ogilvie. Thus PD benefits on 2013 injuries are estimated to be reduced by 4% (one-fifth of 20%) by the effective elimination of the Ogilvie adjustments.

In the 2009 evaluation of impact of Ogilvie and Guzman, the WCIRB estimated that ALAE would increase by 9% due to the WCAB decisions. Although the impact of the WCAB decisions cannot be isolated from other factors impacting ALAE (e.g. liens), ALAE costs did escalate following the WCAB decisions. As noted earlier, Ogilvie adjustments are rarer than Guzman but do involve significant frictional costs. As a result the WCIRB judgmentally estimates that one-third of the 9% increase in ALAE costs is attributable to Ogilvie and thus ALAE is estimated to be reduced by 3% by the effective elimination of the Ogilvie adjustments.

In dollar terms, the WCIRB estimates are that permanent disability benefits will be reduced by \$70 million before adjusting for utilization, and by \$120 million after the adjustment. Loss adjustment expenses are estimated to be reduced by \$80 million before the utilization adjustment and by \$90 million after it. The total estimated reduction in costs is \$210 million.

The BRS approach accepts the WCIRB methodology and estimate, with one change. BRS tempers the WCIRB utilization effect by 30%. The BRS savings estimate is \$202 million. The difference of \$8 million would be larger but for a discrepancy of \$10 million between the WCIRB estimate provided in the filing and the WCIRB estimate quoted in the BRS study, which was taken from WCIRB Actuarial Committee agenda material issued prior to finalization of the filing.

We agree that the WCIRB methodology, while necessarily based on rough assumptions, is the best that can be done with limited information. We do not see the differences in the WCIRB and BRS estimates as material, so we accept the WCIRB estimate.

Provisions Relating to Medical Provider Networks (MPNs)/Valdez

SB 863 amends Labor Code Section 4605 to provide that reports prepared by a consulting or attending physician chosen by the injured worker and outside the MPN shall not be the sole basis of compensation. These amendments appear to address the Valdez decision, which relates to the admissibility of reports completed outside an MPN. In addition, Labor Code Section 4603.2 provides that the employer is not liable for treatment or the consequences of treatment obtained outside an MPN.

While it is difficult to estimate the cost impact of these provisions, the WCIRB believes that, in particular, the SB 863 amendments to Labor Code Section 4603.2 should strengthen the effectiveness of MPNs. However, like the IMR provisions, this reform element is very likely to face a legal challenge, so its estimated benefits may not be realized.

Recent CWCI analyses have shown that costs are impacted by the use of MPNs. The BRS analysis includes a projection of the impact of strengthening MPNs on medical costs and temporary disability benefits. The key assumptions are:

1. Based on WCIRB and CWCI data, it is estimated that 76% of PD claims are within network and 70% of claims are litigated.
2. One-fifth of in-network litigated PD claims will obtain medical services outside the networks.
3. Based on CWCI data on cost differences within and outside networks, medical costs procured outside of network are estimated to be 10.2% higher than in-network costs, temporary disability costs are estimated to be 13.7% higher and PD costs are estimated to be 22.6% higher.
4. Based on WCIRB data, 68% of medical costs are unpaid at 24 months and assumed to be affected by the changes related to MPNs.

Based on these assumptions, BRS estimates savings of approximately \$57 million in medical costs, \$50 million in TD costs and \$68 million in PD costs, for a total savings estimate of \$174 million after considering utilization impacts.

The WCIRB estimate borrows the BRS method and assumptions, with the exception of differences in utilization assumptions, and arrives at a slightly higher estimate of \$190 million in savings.

We consider both the BRS and WCIRB analyses to be reasonable and accept the WCIRB filing analysis and estimate.

The BRS Low Estimate

The BRS low estimate is based on a set of alternative assumptions in two general areas: the basic experience analysis and the analysis of the impacts of the SB 863 reforms. The BRS low estimate assumption for the experience evaluation is that the WCIRB actuarial analysis is correct. As we have agreed in the earlier discussion that the WCIRB analysis is reasonable, we agree that the BRS adoption of it as their low estimate of the indicated pure premium prior to consideration of the effects of SB 863 is also reasonable. We do not need to discuss this further, but will concentrate on the BRS low estimate assumptions with regard to SB 863.

BRS in a letter dated November 19, 2012 lists key assumption differences in five areas that cause the differences in the BRS low, middle, and high estimates. They are the PD utilization factor, the lien settlement rate, IMR temporary disability savings, IMR medical savings, and the percentage of injured workers who obtain medical reports out-of-network. We have determined that the total difference between the BRS low and middle estimates of SB 863 savings is 4.5% of total system costs, or \$760 million, and the difference attributable to the IMR assumptions alone is \$548 million, which is over 70% of the total. Accordingly, our discussion will concentrate on the IMR assumption differences.

As previously explained, we do not agree with the BRS central estimates for IMR savings. Our conclusion is that our point estimate of savings is \$194 million less for IMR for temporary disability and \$218 million less for medical, resulting in a total of \$412 million less in savings and a correspondingly higher indicated pure premium rate level. Briefly, our reasons for this conclusion are that the Texas experience BRS principally relies on for both their TD and medical IMR savings assumptions appear to have a delayed impact, and thus it is not clear that IMR's effects will be fully felt in California during policy year 2013, the period for which we are evaluating pure premium rate indications; and that we cannot be sure from the evidence presented what portion of the medical cost savings realized in Texas were due to IMR and not some other cause. Without better knowledge of the causes of the Texas savings, we believe it is not prudent to attribute substantial savings to IMR.

Having stated our concern with the BRS middle estimates of TD and medical savings associated with IMR, it should be clear why we cannot support the low estimates. While we agree there is considerable uncertainty as to what the impact of the various reform elements will be, it is our opinion that it is questionable at best whether the BRS low estimates should be considered part of a reasonable range of estimates.

Having expressed our concern with the reasonableness of BRS's low estimate IMR assumptions, it is important to examine their impact. BRS assumes that IMR will reduce temporary disability benefits by 10% in its middle estimate and by 12.5% in its low estimate. With respect to medical costs, BRS assumes a 5% reduction in its middle estimate and a 10% reduction in its low estimate. In dollar terms, the low estimate is \$112 million lower than the middle estimate for temporary disability and \$436 million for medical, for a total of \$548 million of increased savings due to the difference in IMR assumptions. The total IMR savings assumed in the BRS low estimate is \$1.388 billion, broken down as \$516 million in temporary disability and \$872 million in medical savings. We are concerned with the size of these effects, given that they do not have a solid base of support.

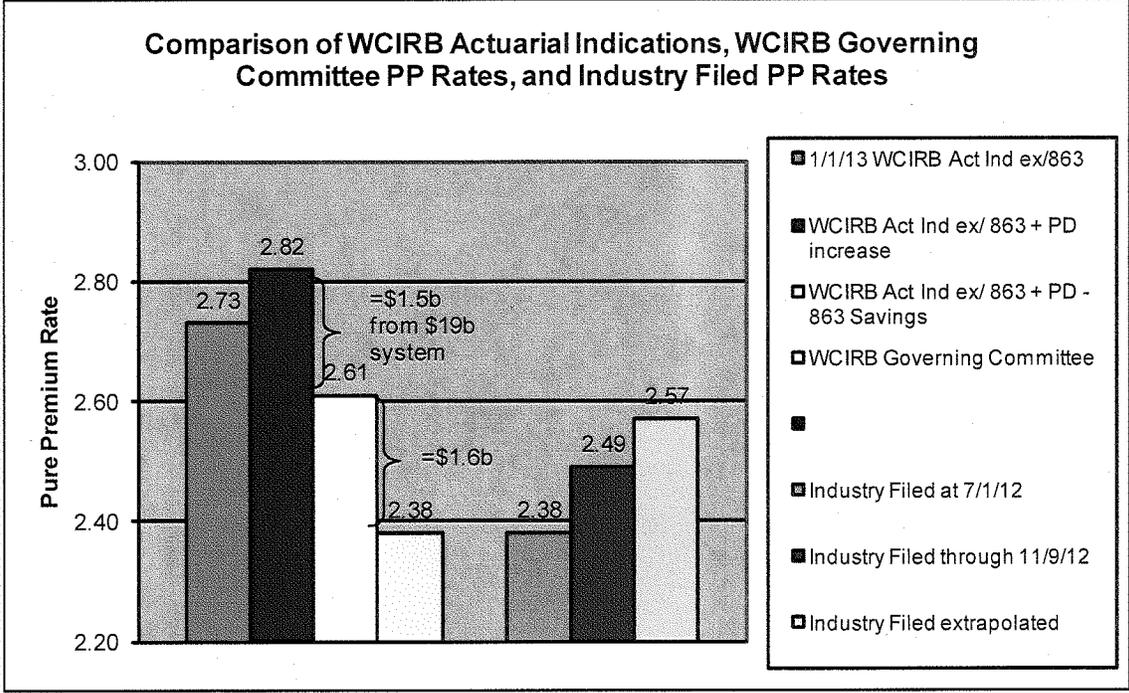
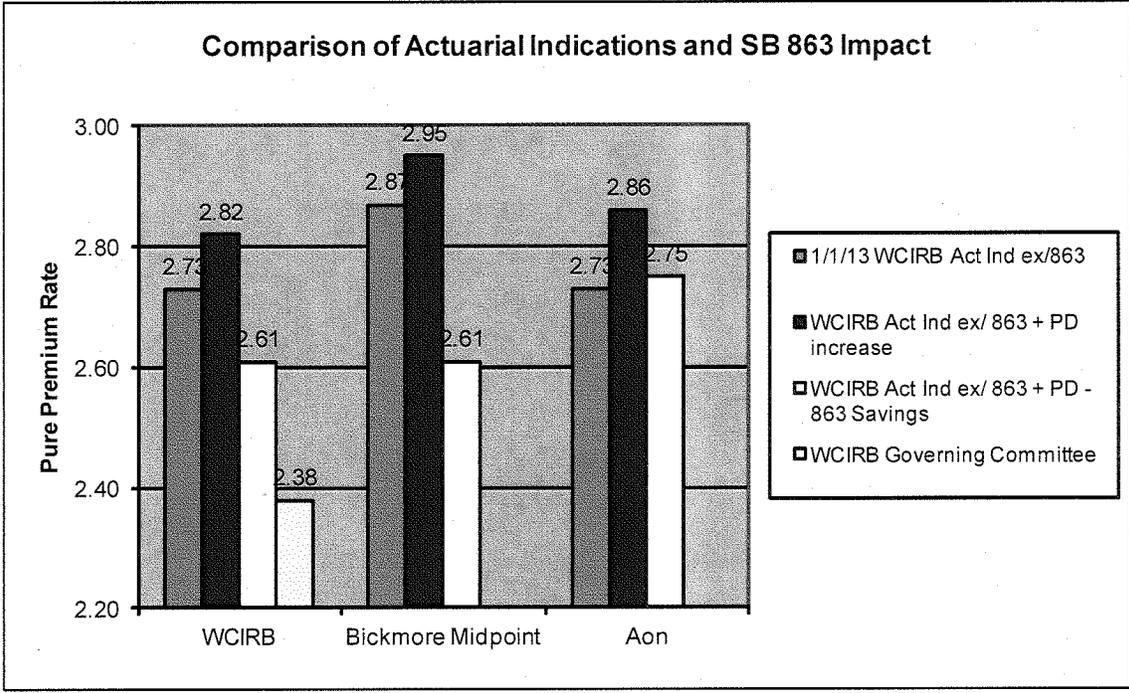
The total additional savings assumed in the BRS low estimate from all reform elements is \$760 million, bringing the total assumed savings due to SB 863 in the BRS low estimate to \$2.296 billion according to the BRS estimates of total system size.

5. Assessment of Pure Premium Rate Indication Net of SB 863

As shown in the first graph below, the WCIRB actuarially indicated pure premium rate is \$2.73 excluding the impact of SB 863 and \$2.61 net of the impact of SB 863. The midpoint estimate of BRS reflects a higher starting rate of \$2.87 excluding the impact of SB 863, but its higher assumed savings results in a consistent \$2.61 indication. We note that there is a range of opinion of the ultimate impacts both in regards to the permanent disability increases as well as the anticipated system savings. As one example, Aon brokerage recently published in their October 2012 newsletter that they believe permanent disability cost increases will be greater than reflected in the WCIRB calculation due to greater utilization of benefits, and that savings estimates are overly optimistic due to a number of factors. If we overlay Aon's estimates of PD increases and system savings onto the WCIRB's starting point of \$2.73 exclusive of SB 863, we get \$2.75 net of SB 863, as compared to the WCIRB's \$2.61.

As shown in the second graph below, the system savings assumed by the WCIRB actuarial indication of \$2.61 is \$1.5 billion relative to a total system of \$19 billion (per the WCIRB and reflecting self-insured exposures as well as the insured market). We note that the WCIRB filed pure premium rate of \$2.38 implies an additional \$1.6 billion of system savings, or a total of \$3.1 billion relative to the \$19 billion total system cost. Lastly, we note that the industry filed average rate level of \$2.49 as of November 10 reflects filings in the third and fourth quarters of 2012 of approximately 52% of the market in terms of direct premium volume. If the rest of the private market

(approximately 35% of premium volume) files for rate changes consistent in magnitude with the first 52% of the market, the average filed rate is projected to be \$2.57.



The BRS Range

The BRS report provides three estimates: low, middle, and high estimates. When questioned at the public hearing, Mr. Priven stated that the BRS middle estimate was based on cost elements that could be quantified, and that the low estimate was based on cost savings that could not be quantified but were expected to occur. He also stated clearly that BRS had provided a range, and not a point estimate.

Concerns with the Use of the BRS Range

While we agree that it is important to emphasize that future costs are uncertain, that they cannot be predicted with absolute precision, and that efforts should be made to quantify the range of that uncertainty, we are concerned that providing only a range can create difficulties. The assertion has often been made that the actuary's specification of a range implies that every point within the range is as valid as every other point. The problem with this is that it provides the temptation to choose the point within the range that is the most convenient to the reader of the actuary's report. This is often a point low in the actuary's range or even at the lowest point. In the case of this pure premium rate decision, the temptation is to assume that since the WCIRB's filed reduction in the average advisory pure premium rate to \$2.38 falls within the lower end of the BRS range, there is no harm in selecting that level as the appropriate level for the January 1, 2013 pure premium rate level, as the WCIRB Governing Committee has implicitly done.

Unfortunately, different choices within a reasonable range have different cost implications, so one must examine both what those different cost implications are as well as how likely each of them are to occur. As an outside example, if we assume the least costly scenario within the range will occur, and the most costly scenario is the one that actually occurs, there will clearly be a funding shortfall. If the range is a wide one, the shortfall will be a large one that may be difficult or impossible to manage. One would normally expect that if we choose the midpoint of the range, we will be assuming that there is a roughly equal likelihood that actual costs will turn out to be either higher or lower than our selection. If we choose a value near the low end of the range, we are instead implicitly assuming that there is a much higher likelihood that actual costs will be greater than our selected value than there will be that actual costs will turn out to be less. This approach would clearly seem to be less than prudent.

We now examine how this somewhat theoretical discussion applies to the matter at hand—the selection of the advisory pure premium rate level for policy year 2013.

The BRS middle estimate of the required average pure premium rate is \$2.61 per \$100 of payroll. The low estimate is \$2.32, while the high estimate is \$2.85. This ranges from an indicated decrease of 2.6% for the low estimate to an increase of 19.7% for the high estimate, with a middle estimate indicated increase of 9.6%. All of these percentages are relative to the now outdated \$2.38 average filed pure premium rate as of July 1, 2012.

Most notably, while the middle estimate is above the middle of this range, the Governing Committee's choice to file the pure premium rate level at the \$2.38 rate means that the filed rate is at a point 11% above the bottom of the range and 89% below the top of the range. If every point in the range were equally probable, this means that the Governing Committee's decision implicitly assumes that the probability would be 11% that the rate would be too high, and the probability that it would be too low would be 89%. If the BRS middle estimate were to subsequently prove to have been correct, the dollar impact of this mis-estimation would amount to a shortfall of \$1.6 billion. If the BRS high estimate were to prove correct, the shortfall would increase to \$3.3 billion. In contrast, if the low estimate were to prove correct, the benefit would be only \$437 million.

Conclusion with Respect to the Governing Committee Decision

We note that Mr. Bellusci, the WCIRB Chief Actuary, when asked at the public hearing for his best estimate of the appropriate average pure premium rate, testified that \$2.61 was that estimate. In answer to questioning, he also stated that the process of developing the SB 863 savings estimates that support the actuarially indicated rate of \$2.61 involved a number of individuals from a variety of organizations and took two to three months to complete. In contrast, it was established in other testimony that the Governing Committee made its decision in about 45 minutes of deliberation, without the benefit of any additional reports or substantive information. We conclude that there is no sound actuarial basis for the Governing Committee's decision. Based on the illustration above, we do not believe the decision was a prudent one, given the imbalance between the magnitude of the possible favorable and possible adverse consequences indicated by the position within the BRS range of the Governing Committee's selection of the \$2.38 average rate.

5. The Relationship of the Proposed Pure Premium Rates to Current Industry Filed Pure Premium Rates, Manual Rates, Final Charged Rates, and Insurer Profitability

Based on data developed by the WCIRB and updated by CDI to reflect filings through November 9, 2012, it appears that the industry average filed pure premium rate level of \$2.49 is 4.6% lower than the WCIRB actuarially indicated pure premium rate of \$2.61. Further, the average filed manual rate of \$3.65 indicates an average loading for expenses and underwriting profit (less investment income offset) of 46.4% of pure premiums or 31.7% of manual premium. Comparing it to final charged rate levels of \$2.45 in the first quarter of 2012 indicates a substantial use of schedule credits by the industry.

The average combined effect of all rating plan discounts is an average discount of about 31.7%. This appears to be a high level of discounting of insurers' manual rates; however, it should be noted that this average credit includes premium discount for at least one major insurer, and that insurer's average premium discount is about 10% of manual premium. It is reasonable to conclude that the industry wide average rating plan discount excluding premium discount is probably closer to 20%, although this must be considered approximate without detailed further analysis which is not practical for our current purposes.

We believe that the primary reason why insurers are willing and able to offer such discounts is due to the unusually high level of investment income arising from premiums and reserves associated with policies written in prior years at higher rate and loss levels during the pre-reform era. As indicated in WCIRB's Summary of December 31, 2011 Insurer Experience published September 4, 2012, the industry calendar year combined ratio, which reflects losses and expenses as booked by the industry in aggregate and excludes investment income, was 117% for 2010 and 122% for 2011. These results generated a return on net worth of approximately 5% in 2010. The industry reported investment income of approximately 25% of premium (pre-tax) in 2010 is 8 to 10 points higher than would be the case if reserves and associated assets were more in line with current premium volumes. Further, the WCIRB projects Loss and LAE ratios for Accident Year 2011 to be 20 points higher than what the industry has booked. As the industry's held loss and loss expense reserves now appear lower than WCIRB indications across all Accident Years in aggregate, current market pricing appears sustainable in the near-term due to investment income but is clearly not sustainable in the long-term.

OTHER MATTERS

Amendments to the California Workers' Compensation Uniform Statistical Reporting Plan—1995 ("USRP")

The WCIRB has proposed amendments to the USRP to be effective on January 1, 2013 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after January 1, 2013, except for one amendment involving audits of payroll that will be effective on January 1, 2014 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after January 1, 2014. Those amendments are contained in the WCIRB's filing and summarized in the Amended Notice of Proposed Action and the Amended Initial Statement of Reasons.

Amendments to the USRP contained in the filing have been reviewed, along with the trade group notices and other materials provided by the WCIRB. Comments were received concerning three USRP changes related to adjustment of the wage level for the following dual-wage classifications:

- Amend Classifications 5190/5140, *Electrical Wiring — within buildings*, to increase the hourly wage threshold from \$28.00 per hour to \$30.00 per hour based on the results of the WCIRB's 2011 wage level study.
- Amend Classifications 5183(1)/5187(1), *Plumbing — shop and outside*, to increase the hourly wage threshold from \$24.00 per hour to \$29.00 per hour based on the results of the WCIRB's 2011 wage level study.
- Amend Classifications 5538/5542, *Sheet Metal Work — erection, installation or repair*, to increase the hourly wage threshold from \$25.00 per hour to \$28.00 per hour based on the results of the WCIRB's 2011 wage level study.

Specifically, testimony and a subsequent letter were received from Pacific Advocacy Group (PAG) on behalf of contractor members of Western Electrical Contractors Association (WECA), Plumbing---Heating---Cooling Contractors Association of California (CAPHCC), and Air Conditioning Trade Association (ACTA). The major concern of these associations was over the increase in the wage level split as a result of the need to adjust for inflation. The associations contend that due to the economy their industries have not experienced wage inflation. Effectively, for employers that are paying employees at or close to the split wage level, this will require an increase in wages to employees to maintain the lower rated classification, thereby requiring cost increases to building trades employers.

According to the studies submitted by the WCIRB in support of the split-class wage level changes, there is need for adjustment both to keep up with wage inflation and to also make sure that each classification has an adequate distribution of risks between the higher-rated, lower wage classification and the lower-rated, higher wage classification. Additionally, the WCIRB points out that only 8 to 10% of the employers are within the split level and will generally be affected. There is both actuarial and practical support for the changes requested by the WCIRB.

PAG has provided practical business reasons for opposing the changes. This hearing officer, after reviewing the WCIRB reports, came away with the impression that the WCIRB has not fully analyzed the impact of its proposed changes in wage levels. In reviewing the tables on how risks will be distributed pre- and post-wage level change, there is a distinct possibility that employers will merely provide wage increases to their employees to continue to receive the lower rated classification. This will result in the re-distribution of the risks right back to where they currently are. In other words, the system will continue to reinforce the need to raise wages to both deal with wage inflation, possibly due in part to this very adjustment, and to make sure that the risks, based upon their loss histories, maintain adequate loss differentials to support the lower rated classification.

Based upon the reasons given by PAG and the concerns expressed herein regarding wage-level adjustments, this hearing officer agrees that the wage-level adjustments should be postponed and disapproves the rule amendments offered by the WCIRB concerning these three classifications. The WCIRB is directed to meet with PAG and the associations it represents to obtain additional information on how the wage-level adjustments will affect those employers with these classifications and attempt to reach an agreement on when and by how much an adjustment to the wage-level should occur.

The remaining amendments to the USRP, having been reviewed and having received no objections to the remaining amendments, are also approved as being reasonable and consistent with the purpose of the USRP.

Amendments to the Miscellaneous Regulations for the Recording and Reporting of Data

The WCIRB has proposed amendments to the Miscellaneous Regulations for the Recording and Reporting of Data to be effective on January 1, 2013 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after January 1, 2013. Those amendments are contained in the WCIRB's filing and summarized in the Amended Notice of Proposed Action and the Amended Initial Statement of Reasons. The amendments, having been reviewed and having received no objections, are approved as being reasonable and consistent with the purpose of these Miscellaneous Regulations for the Recording and Reporting of Data.

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

The WCIRB has proposed amendments to the ERP to be effective on January 1, 2013 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after January 1, 2013. Those amendments are contained in the WCIRB's filing and summarized in the Amended Notice of Proposed Action and the Amended Initial Statement of Reasons. The amendments to the ERP, having been reviewed and having received no objections, are approved as being reasonable and consistent with the purpose of the ERP. However, the WCIRB is directed to adjust the eligibility threshold in the ERP to reflect the Insurance Commissioner's adopted Claims Cost Benchmark in order to maintain approximately the same volume of experience rated employers.

PROPOSED ORDER

WHEREFORE, IT IS ORDERED, by virtue of the authority vested in the Insurance Commissioner of the State of California by California Insurance Code sections 11734, 11750, 11750.3, 11751.5, and 11751.8 that the advisory workers' compensation pure premium rates filed by the WCIRB and Sections 2318.6, 2353.1 and 2354 of Title 10 of the California Code of Regulations are hereby amended and modified in the respects specified herein;

IT IS FURTHER ORDERED that pure premium rates for individual classifications shall change based upon the classification relativities reflected in the WCIRB's filing to reflect the adjustment of the Workers' Compensation Claims Cost Benchmark and advisory pure premium rates as specified herein;

IT IS FURTHER ORDERED that the experience rating threshold be calculated to reflect the adjustment of the Workers' Compensation Claims Cost Benchmark and advisory pure premium rates; and

IT IS FURTHER ORDERED that these regulations shall be effective January 1, 2013 for all new and renewal policies with anniversary rating dates on or after that date, unless another effective date is specified.

I HEREBY CERTIFY that the foregoing constitutes my Proposed Decision and Proposed Order in the above entitled matter as a result of the hearing held before me as a Senior Staff Counsel of the Department of Insurance on November 16, 2012, and I hereby recommend its adoption as the Decision and Order of the Insurance Commissioner of the State of California.

NOVEMBER 30, 2012

A handwritten signature in black ink, appearing to read 'Christopher A. Citko', written over a horizontal line.

CHRISTOPHER A. CITKO
Senior Staff Counsel