

Commission on Health and Safety and Workers' Compensation

**MINUTES OF MEETING
December 10, 2009
Elihu M. Harris State Building
Oakland, California**

In Attendance

Chair Sean McNally

Commissioners Catherine Aguilar, Faith Culbreath, Robert Steinberg, Darrel "Shorty" Thacker,
and Angie Wei

Absent

Commissioner Schwenkmeyer

Executive Officer Christine Baker

Call to Order

Chair Sean McNally called the meeting to order at 10:00 a.m.

Minutes from the October 22, 2009 CHSWC Meeting

Chair Sean McNally requested a vote on the Minutes of the October 22, 2009 meeting.

CHSWC Vote

Commissioner Wei moved to approve the Minutes of the October 22, 2009 meeting, and Commissioner Aguilar seconded. The motion passed unanimously.

Election of 2010 Chair

Commissioner Culbreath nominated Commissioner Wei for the position of 2010 Chair of the Commission, and Commissioner Aguilar seconded. The motion passed unanimously.

Report on the California's Volatile Workers' Compensation Insurance Market Study

William Barbagallo, Navigant Consulting

Lloyd Dixon, RAND

Jim Macdonald, RAND

Lloyd Dixon stated that interim findings from the study were provided in April 2009 and the final study would be presented today.

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Background

Mr. Dixon stated that the workers' compensation market has been volatile over the past 15 years. After the adoption of open rating in 1995, the pre-tax underwriting profits of California workers' compensation insurers were very low; they then rebounded to go to historically high levels in the 2006 period. The underwriting profits across the nation in the second half of the 1990s were soft, but they were far worse in California than the rest of the country. In addition, the average insurer rate for \$100 of premium was roughly \$2.00 per hundred dollars of payroll in the second half of the 1990s and nearly tripled to almost \$6.00 per hundred dollars of payroll in the 2003 period. Some of the largest insurers in the State were considered conserved, went insolvent, and subsequently they were taken over by the Department of Insurance (CDI). In 2000, roughly 15 insurers were conserved and taken over, and the numbers were substantial in the following years. In 1995-1996, the insurers that were to become insolvent wrote about one-third of the premium in the State.

Mr. Dixon stated that the insurers with the higher exposures in California were more likely to fail. Categorizing insurance groups by the percent of premium they wrote in the California market shows that about 7% of those who wrote less than 20% of workers' compensation premium failed following open rating and that rose to 43% for insurers that received more than 60% of their premium from California workers' compensation. This suggests that insolvencies were due in part to insurer exposure in California, which was therefore a good indicator of whether an insurer would survive. Mr. Dixon stated that the insolvencies have been costly to policyholders. The costs to the California Insurance Guaranty Association (CIGA) have been significant. When an insurer goes insolvent, CIGA will pay its claims. Total incurred costs of \$7 billion were paid by CIGA in the total amount put aside in reserves; the net incurred costs of \$5 billion are the amount recovered. Mr. Dixon then stated that these are not all the costs related to insolvencies, only claims payments costs.

Commissioner Wei asked if this means that CIGA paid out \$2 billion more than they collected, and Mr. Dixon responded that that was correct, and the difference billion would have to be assessed. Jim Macdonald stated that CIGA receives distributions from the insolvent carriers at about 10 or 15 cents on the dollar and that is a large portion of CIGA proceeds; in addition, there are the assessments on the carriers that also go into the CIGA fund. Commissioner Wei asked if that meant that there were \$5 billion assessed against all employers. Mr. Dixon responded that that was the case, and he stated that the total costs for CIGA may be higher than the costs of claims payments and reserves for those claims payments

Commissioner Wei asked if this was reflected in today's CIGA rates, and Mr. Dixon responded that CIGA will assess the insurers for those costs, and the insurers then pass on those costs as a percentage surcharge on the policy to the employer. Commissioner Wei asked if there is a line item about what is passed on or whether there is a fee and whether this is built into their actuarial. She asked if this charge can be seen. Mr. Mac Donald responded that that was the case and that a percentage of the premium, 2% in California, the maximum, is passed on to the employer. Commissioner Wei asked how much 2% raises, and Mr. MacDonald stated that the 2% and the distributions coming from the receiverships have not been enough to fund all the

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liabilities, so several years ago, there was a bond measure to assist CIGA with additional funding. The average for the industry across all states is usually 1%, but in California, it is 2%.

Commissioner Aguilar asked if that is also on excess insurance premiums for self-insurers, and Mr. Macdonald responded that it is not on self-insureds but on excess insurers. Michael Nolan, President of the California Workers' Compensation Institute (CWCI), stated that he could provide an explanation on excess insurance. Mr. Dixon stated that there are different types of excess insurance. Chair McNally asked if there is a surcharge on an excess insurance policy for self-insureds, and Mr. Dixon and Mr. Macdonald stated that they were not sure about this. Mr. Nolan stated that excess insurance which self-insureds buy is treated not as a workers' compensation product for CIGA purposes, but treated as general liability; that means that the assessment process and coverage are different for workers' compensation. Workers' compensation is the last dollar for CIGA purposes; general liability is the first. The workers' compensation assessment comes through the employer as a separate surcharge, which is no greater than 2%. Because the State issues bond for CIGA, CIGA has the right by law to make a separate assessment to pay off those bonds, but that has not been triggered as yet.

Purpose and Methodology of the Study

Mr. Dixon stated that the purpose of the study was to: identify the factors that contributed to the market volatility and the large number of insolvencies following price deregulation; and to suggest policy changes that can reduce the severity of these problems in the future. Sixteen insurance groups were selected for detailed analysis, eight solvent and eight insolvent. Sources of data included:

- Reports and other materials including rating agency reports and Annual Reports and materials from CDI. Rating agency reports were from the Collateralized Loan Obligation CLO, CIGA, the State Compensation Fund (State Fund), and the Workers' Compensation Insurance Rating Bureau (WCIRB).
- Interviews with key players in California workers' compensation market included insurance company executives, top staff in CDI, staff at WCIRB, CLO and CIGA, and knowledgeable brokers and agents.

Mr. Dixon stated that a set of goals for the workers' compensation insurance market which guided the analysis included that: workers' compensation coverage should be available to all businesses; workers' compensation prices should reflect the cost of providing the required benefits; the market should encourage innovation; insurer insolvencies should be rare because insurers write a premium with the promise to pay claims over time and that should be the norm not the exception; and the market should not be overly volatile because volatility makes it difficult for businesses to plan and makes California less attractive for business.

Mr. Dixon stated that six factors that contributed to volatility and insolvency were analyzed: inaccurate cost projections of the costs of claims; pricing by insurers that were below projected costs; reinsurance contracts; arrangements with managing general agents (MGAs) and third-party administrators (TPAs); under-reserving; and an inadequate surplus cushion to guard against adverse events.

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Mr. Dixon stated that WCIRB and CDI loss projections were inaccurate by wide margins following open rating. The ratio of projected costs to actual loss costs by WCIRB and CDI was about 40% below what costs turned out to be. Factors responsible for substantial projection errors included:

- Repeated major legislative and judicial changes in benefits, especially the Minnear decision in September 1996.
- Slowdown in claims resolution.
- Limitations in methods and data used by WCIRB including: heavy emphasis on extrapolating past trends; incomplete data on certain types of claims; and no direct access to transaction-level data that would allow analysis of trends and the particular types of medical visits.

Commissioner Wei asked whether there was any way to determine if insurance companies were adequately reserved before 1996, and Mr. Dixon responded that that would be discussed.

Mr. Dixon stated that WCIRB has made changes to address shortcomings and ensure greater reliability of cost projections during the past 15 years including:

- Conducted an assessment of the accuracy of rate filings.
- Retained an outside firm to review rate-making methodologies.
- Established a claims subcommittee to identify more rapidly changes in claim payment patterns.
- Currently planning to collect transaction-level data directly from insurers.

Recommendations to Make the Workers' Compensation System More Predictable

Mr. Dixon stated that a number of insurers emphasized the difficulties created by the system not being predictable about costs. Recommendations to make the system more predictable include:

Recommendation 1: Increase clarity of legislative intent and scope.

For the issues addressed in the Minnear decision to even arise, there had to be some uncertainty about what the Legislature intended when it passed the 1993 reforms pertaining to the presumption of the primary treating physician. Mr. Dixon stated that the Legislature could reduce uncertainty about the impact of reforms by using unambiguous language when writing legislation and making clear statements about the intent and scope of the legislation. While the language that ultimately ends up in a bill is often the result of lengthy negotiations, the Legislature should appreciate the potential for the potential of vague nature of the compromise language to cause trouble in the future.

Recommendation 2: Expeditiously release guidance and regulations on issues when there are important disagreements among stakeholders.

A number of insurers interviewed believed that the Department of Industrial Relations (DIR) could reduce uncertainty over the interpretation and impact of legislative reform by more expeditiously issuing regulations and statements on how legislation should be interpreted.

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Recommendation 3: Review the performance of the Workers' Compensation Appeals Board (WCAB).

Review should focus on the consistency of decisions across judges, as well as how consistently judges follow the law.

Recommendation 4: Explore the most appropriate way for WCIRB to take advantage of transaction-level data.

There are a number of ways that WCIRB might be able to access transaction-level data. It might proceed with current efforts to collect such data directly from insurers or work with CWCI or the Workers' Compensation Information System (WCIS) that is being managed by DIR. The advantages of the alternative approaches should be evaluated and the most appropriate way should be explored.

Recommendation 5: Increase comprehensiveness of data provided to WCIRB.

The cost and practicality of providing or improving the data available to WCIRB should be examined for three types of claims payments:

- Payments by CIGA on the claims of insolvent insurers. This information is not currently provided to WCIRB.
- Payments on claims by self-insured employers. WCIRB currently does not get this information.
- Payments on claims brought under large-deductible policies. It would be important to explore data quality of these claims.

Recommendation 6: Fast track analyses of the impact of important legislation and judicial opinions.

The Commission on Health and Safety and Workers' Compensation (CHSWC) and other groups have conducted analysis of important legislation and court decisions. Continuing the prompt commissioning of such studies could help WCRIB and CDI better anticipate the effects of changes in the system.

Commissioner Wei stated that these recommendations seem to suggest that underlying data are the problem for why the cost projections were so inaccurate, and she would welcome additional input from other stakeholders about recommendations on other factors. Mr. Macdonald responded that WCIRB is looking at historical information as are the independent actuaries and the actuaries employed by the carriers. In the case of the Minnear decision, the historical data do not help. Even give than some insurers might have been accurately reserved, the impact of legislation can work against that. He stated that these recommendations suggest that when the Legislature is looking at making changes in law, the impact of the changes should be evaluated, especially about how will this affect the dollars available to pay for the losses and how will this affect the increase in cost going forward.

Commissioner Wei stated that it would be important to identify some operational steps that could be taken. She also asked whether it made sense for more than one operating database to be collecting transaction-level data. Mr. Dixon responded that this was considered in Recommendation 4. He stated that recently, one of the WCIRB's committees passed a resolution to develop a plan to collect data directly from insurers, and he said that the question remains as

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to whether this is the best approach or whether that approach should be combined with other approaches.

Pricing Practices

Mr. Dixon stated that the pricing practices of insurers during the second half of the 1990s contributed to the surge of insolvencies. A number of factors drove the low pricing including:

- Concern that large, national insurance companies would gain market share.
- Lack of experience by some insurers with pricing in an open rating setting.
- Availability of unrealistically priced reinsurance.
- Entry of group health insurers into the workers' compensation market.
- Overly narrow focus of employers on price and less concern about whether the claims could be paid.
- Aggressive competition from the State Compensation Insurance Fund (State Fund).

Mr. Dixon stated that group health insurers believed that they could treat injured workers more cheaply in part by applying utilization review techniques that had been developed outside the workers' compensation system. It was not until later that group health insurers realized how little control they had over medical treatment in California's workers' compensation system. He also stated that because CIGA pays the claims on insolvent carriers without limit, employers can shop for insurance without a great deal of concern about whether claims will be paid, and this overly narrow focus on price can contribute to going with insurers that are not the most financially healthy. Finally, he stated that State Fund was competing aggressively on price for larger accounts. In 1995 in particular, the charge premium to the modified premium ratio was well above the underwriting breakeven point for profit; after 2002, it was also above that point. However, in 1998, the ratio was below even 1.0, particularly for the largest accounts. State Fund was not really competing on price. For small accounts throughout this time, the price ratio for State Fund was 1.4 compared to 1.0 in the private market.

Commissioner Wei asked if there are numbers on how many accounts were large and how many were small during this timeframe, and Mr. Dixon responded that that information is in the report. Commissioner Wei also asked if brokers were used, and Mr. Dixon responded that brokers were used and that also contributed to the situation. State Fund may not have realized that the brokers were very aggressive. Commissioner Wei then asked what the compensation structure for brokers was, whether it was a percentage of what they write, and Mr. Dixon responded that it was and was about 7%. Mr. Dixon stated that State Fund's market share rose after open rating. Based on book premium, the actual money that comes in to insurers, in 2003, State Fund's share of the total premium collected was over 50%. This created concern about a breakdown in the workers' compensation market in California.

Mr. Dixon stated further that CDI was aware of what was going on with pricing in 1998 and 1999, but that CDI's ability and willingness to increase rates were limited. With regard to ability, prior to 2002, CDI had to show that an insurer's pricing threatened its overall solvency before it could require rate increases. Also, there was a limited willingness to intervene with a free market

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philosophy during second half of 1990s and political pressures to keep rates low, and this limited CDI's willingness to act. This was due in part to the 1992 Rate Commission report that concluded the system of controlling rates was paternalistic and that insurers were rational profit maximizers. CDI did take aggressive action regarding State Fund, vigorously urging State Fund to increase its rates in 2001 and 2002.

Mr. Dixon stated that the study developed a number of recommendations related to the pricing issue. Some of the people interviewed during the study believed California should return to some form of minimum rate pricing regime; however, support for such a change was not widespread. Others supported prior CDI approval of workers' compensation rates, but given the pressure to protect employers from high rates rather than inadequate rates, requiring approval does not appear to be a dependable solution. CDI might use its existing authority to require workers' compensation rates to be adequate to cover insurer losses and expenses, but it is difficult to regulate rates in an open rating setting. Insurer pricing schedules are complex, and insurers can put together compelling arguments to support the rates they charge and the scheduled credits that are used on a particular account. Mr. Dixon stated that therefore, a better approach is to keep the competitive rating schedule in place but to emphasize solvency regulation.

Increasing Transparency of Pricing Decisions

Mr. Dixon stated that changes that would be useful to increase the pricing discipline in the market include increasing the transparency of pricing decisions, rather than tightening the price regulation on insurers, and making more information publicly available, while allowing the oversight by different investors to put pressure on companies to charge appropriate rates. Recommendations regarding pricing include:

Recommendation 7: Make WCIRB pricing reports public:

Every quarter, WCIRB provides CDI a report on each insurer and these reports should be made public.

Recommendation 8: Post insurers' annual and quarterly financial statements on the CDI website:

These are publicly available but not always easy to obtain.

Recommendation 9: Consider publicly releasing the results of CDI field rating and underwriting exams:

These exams evaluate whether the insurer has filed rates with CDI and is using those rates and whether the credits have been applied reasonably. Providing this information would indicate whether insurers have provided appropriate documentation for the rates they are charging.

Commissioner Wei asked whether CDI has existing authority once they do field rating and underwriting exams to require change, and Mr. Dixon responded that it does. One of the advantages of releasing the reports would allow more review of what CDI has done in response to those exams.

Recommendation 10: Impose penalties for violations in field rating and underwriting exams:

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There are no direct financial penalties that CDI can levy for violations in field rating and underwriting exams. CDI does not have direct authority to do that.

Recommendation 11: Improve training and professional standards for workers' compensation underwriters:

Currently, there are no licensing or certification requirements for people who negotiate rates or terms with potential employer policyholders. Attention should be put on improving the training and licensing requirements. Mr. Barbagallo stated that traditionally, there has been no training for underwriters; however, exams and licenses are required to be a producer or a claims adjuster or reinsurance broker; therefore, it may be time for regulators to make minimum standards for qualifications for underwriters.

Recommendation 12: Create a whistle-blower program to report excessively low rates:

Currently, there is no formal procedure for making complaints. Many insurers call CDI about practices of their competitors. A formal process should be put in place.

Recommendation 13: Explore ways to give insurance brokers and other intermediaries a greater stake in the financial soundness of the insurers with which they place policies:

This would better align the incentives on the demand side of the market and ensure that brokers or other intermediaries are more concerned about the financial soundness of insurers. CIGA might levy a surcharge on insurers that become insolvent.

Recommendation 14: Publicly release the State Fund's ratio of charged premium to modified pure premium by size of account:

This would allow for oversight of State Fund's pricing decisions.

Recommendation 15: Increase State Fund staffing flexibility:

This would allow State Fund to set a staffing level for low market share, e.g., 10%, and then use contractors when there is an increase in market share.

Reinsurance Contracts

Mr. Dixon stated that reinsurance contracts in the second half of the 1990s gave insurers insufficient stakes in the profitability of the policies they wrote. During this period, several large life insurers wrote reinsurance contracts with low retentions and low prices. The contracts created incentives for insurers to reduce prices, relax underwriting standards, and passively process claims. Subsequently, contract disputes left insurers with greater liability for claims costs than they expected when the policies were written. The study concludes that had the insurers retained a greater financial interest in the business they wrote, they might have taken more care for the pricing and underwriting decisions for which they were ultimately responsible.

Mr. Dixon stated that CDI tightened reinsurance requirements following the rash of insolvencies. CDI had authority to review some reinsurance contracts in the 1990s, but the particular contracts entered into by the soon-to-be insolvent insurers did not trigger review. In 2006, additional conditions on reinsurance contracts were adopted by CDI; now, insurers were required to retain at least 10% of direct written premium. However, limitations of the regulation raise concerns:

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10% is not particularly high (for example, the Hays study suggested 25%); there are no monetary penalties; and the regulation only applies to insurers domiciled in California and “volume insurers.”

Recommendations to Better Align Incentives Created by Insurance Contracts

Mr. Dixon stated that recommendations aimed at better aligning the incentives created by insurance contracts include:

Recommendation 16: The adequacy of the current retention requirements and enforcement mechanisms should be evaluated:

Policymakers and regulators should assess whether the current requirement that insurers retain at least 10% of the risk is adequate. Also, CDI should be provided with the authority to issue corrective orders to increase retentions and to impose fines when insurers fail to comply with corrective orders.

Recommendation 17: Require licensed insurers to obtain approval before entering the reinsurance business.

As seen in the early 1980s, a period of reckless underwriting, the problem involves the insurers that decided to get into the business in a competitive market. An ease-of-entry problem needs to be addressed; some restraint or procedure, at least a business plan, needs to be implemented and presented by insurers to CDI which would assess whether there should be entry into the reinsurance market.

Commissioner Culbreath asked if this would be another license, and Mr. Macdonald responded that if you are licensed as an insurer, you can become a reinsurer; a license might be a good requirement, but at least some procedures should be put in place. Mr. Dixon stated that CDI would have to review a plan before an insurer enters the reinsurance market. Commissioner Wei asked if it makes sense for an insurer to enter as a reinsurer, and Mr. Barbagallo stated that entry into reinsurance, even global reinsurance, can be automatic. He stated that insurers are looking for naïve reinsurers to assume business that is severely underpriced; this is similar to the subprime mortgage business. This is called “passing the trash.” Commissioner Wei asked how many reinsurers there are, and Mr. Barbagallo responded that there are three or four dozen professional reinsurers that dominate the market. In terms of insurers who do some amount of reinsurance, there are thousands. The Reinsurance Association of America (RAA) estimated that about 87% of premiums written in the U.S. go to reinsurers and then to as many as 3,000 off-shore or foreign underwriters, many of them in Bermuda. Commissioner Wei stated that those foreign underwriters do not pay U.S. taxes, and Mr. Barbagallo responded that they are subject to different jurisdiction, though frequently they are working through admitted companies in the U.S. Commissioner Wei asked if these reinsurers pay into CIGA or pay any of the socialized cost of insurance insolvency, and Mr. Barbagallo responded that they do not. With the exception of Lloyds, if there is a problem with a reinsurer, there is no guarantee fund. Commissioner Wei asked who assumes the cost and whether it is CIGA that eventually does, and Mr. Barbagallo responded that that was correct.

Mr. Macdonald stated that Recommendation 16 is an area which CDI has not concentrated on but kept at an arms-length distance from the review of reinsurers. The layoff can be substantial

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where the reinsurer is taking on 90% of the premium and then, arguably, 90% of the losses. However, the issue is whether the reinsurer is having financial problems. Mr. Macdonald stated that there should be some greater evaluation of the adequacy of the risk-retention requirement. There should be some examination by CDI of the reinsurance contracts and relationships and how quickly the reinsurers are responding to requests for reimbursements from insurers.

Commissioner Wei asked how much reinsurance contributed to the problems of the 1990s and whether it was part of the reason that WCIRB did not assess the situation accurately. Mr. Barbagallo responded that it was significant. If you look at some of the companies, reinsurance is part of their business structure. Some companies definitely went under insolvency because of reinsurance. Commissioner Wei asked if there is any standard or ratio for how much can be reinsured, and Mr. Macdonald responded that there was not any standard or ratio. Different states have passed different regulation. Mr. Barbagallo stated that some states have adopted “fronting,” the act of an insurer sending all or most of its insurance to a reinsurer. Mr. Macdonald stated that skillful reinsurance relationships have been established re. “layoff” or losses being shifted to reinsurers. In California, there is the 10% adopted in 2006, but there can be other relationships to cover that 10%. He also stated that there are different ways to structure a reinsurance program. Mr. Dixon stated that a lot of states do not have a requirement, but the question is whether 10% in California is sufficient, and he stated that this should be evaluated and reconsidered. Mr. Macdonald stated that the concept of reinsurance is that the risk is being spread and no one gets hurt too badly.

Role of Managing General Agents and Third-Party Administrators in the Insolvencies

Mr. Dixon stated that the incentives of insurers and MGAs are not always aligned. MGAs are often “given the pen” or authorized by an insurer to negotiate and buy insurance policies but are not required to invest in the insurer’s balance sheet or share in the ultimate profitability or losses of the claims. This is particularly an issue in workers’ compensation, because the profitability of the policies MGAs write is not clear for at least three or four years. This creates conflicts between the growth goals of MGAs and the profitability concerns of insurers and reinsurers. Many of the people interviewed for the study said that there were MGAs who have performed well. The report documents cases where the actions of some MGAs exacerbated volatile market conditions following open rating and contributed to some of the insolvencies. Some of the examples of this include Legion, Reliance, and Unicover.

Mr. Dixon stated that CDI has some authority over MGAs. In 1991, provisions were adopted that placed some limitations on contract terms between an MGA and an insurer; for example, interim profits cannot be paid to MGAs under certain circumstances until five years after premiums are earned; and insurers must conduct onsite review of underwriting and claims processing of their MGAs at least twice a year. However, there are some loopholes: the MGA definition in the legislation allows many MGAs to avoid being legally classified as an MGA, though they are taking on important insurance functions; and some insolvent insurers failed to regularly audit their MGAs. Also, some insolvent insurers failed to regulate their MGAs through regular auditing.

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Mr. Dixon stated that recommendations to increase the stake of MGAs in the profitability of the insurer include:

Recommendation 18: Develop a broader legal definition of MGAs to include firms taking on substantial roles in underwriting and paying insurance claims:

Doing so will make it more difficult for firms to gain the MGA definition.

Recommendation 19: Augment the requirements on MGA contracts to give MGAs more stake in the process:

Policymakers and regulators should assess whether the current language is sufficiently broad to apply to most circumstances in which insurers delegate important underwriting or claim-payment authority to outside firms.

Recommendation 20: CDI should monitor whether insurers are complying with the requirements for auditing MGAs and confirm that the audits meet minimum standards.

Under Reserving

Mr. Dixon stated that under reserving contributed to the problems following open rating. Data from WCIRB show the difference between insurer-reported losses and the estimated ultimate losses; for example, in 2000, losses reported by insurers were \$7.5 billion less than the amount of losses expected by CDI, indicating that insurers as a whole were under-reserved by \$7.5 billion. In the 2002 period, the amount was \$12 billion under-reserved. Currently, there is a surplus of \$5 billion process over-reserved.

Commissioner Wei asked if the reserve of \$5 billion today is adequate, or in other words, whether there should be \$5 billion over-reserved. There appear to be a pattern and practice of taking advantage of certain circumstances to under-reserve or over-reserve, and in either situation, insurers are making money. She stated that over-reserving cannot completely be blamed on WCAB decisions. Between 2004 and 2005, after the April 2004 reforms, \$10 billion were collected. Commissioner Wei stated that employers should be outraged. Mr. Barbagallo stated that these figures are calendar year information, which, in the insurance industry, is the sum of all prior accident years. The highly cyclical nature of the insurance business means that there is compensation for under-reserving or deficiencies in prior accident years. That does not show up in calendar year information so it may look that a given calendar year is more profitable than it actually is.

Commissioner Wei stated that it appears that those companies that survived are making up for their losses. Mr. Dixon stated that in a tough market, insurers were losing a lot of money; if they posted lower reserves, they would lose a little less money. This does not necessarily mean that insurers are making money in both situations. This indicates that in the 1990s, insurers did not set aside sufficient reserves to cover the cost of claims. CDI made insurers increase their reserves and this led to insolvencies. Mr. Dixon stated that insurers should not be allowed to grossly under-reserve. Commissioner Wei agreed and stated that the swings appear to cause a situation where someone could be taken advantage of. Mr. Barbagallo stated that in the insurance industry, especially in workers' compensation where it can take many years to pay out the claim, it has not been possible to determine with certainty the current medical costs. Mr. Macdonald

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stated that the insurance industry does not have control over what medical costs will be or what legislative decisions would be. He stated that if there were controlled, the confidence level would be higher and the industry would be less volatility.

Chair McNally stated that the statutes should be less vague, so that there would be less opportunity for judges and for people in the system to game the system and there would not be so much volatility. Commissioner Wei stated that the statute is unclear, and it is not right to blame the judges in an independent judicial system for a lack of consistency when the legislation is unclear. She also stated that the market is unpredictable and volatile; yet that time period is when insurers made historically record profits. Mr. Macdonald stated that the study does not state that judges should be blamed for the insurance industry crisis; that is only one element. Commissioner Wei stated again that she believes that the unpredictability cannot just be blamed on WCAB cases.

Mr. Dixon stated that the data indicate that there appears to have been a breakdown in private reserve-validation process during the second half of the 1990s. Actuaries submit an opinion once a year about the adequacy of reserve. Chair McNally stated that even an actuary cannot anticipate a Minnear decision or an Almaraz/Guzman decision, and Mr. Dixon agreed. Mr. Dixon stated that it was only after CDI examinations of several insurers that went insolvent, it found large reserve deficiencies. In addition, actuaries had previously confirmed that the reserves for the soon-to-be insolvent insurers were reasonable and they turned out not to be. Mr. Dixon stated that there is a conflict of interest here. The situation may have improved over the past five years with changes in actuarial standards and with Sarbanes/Oxley.

Recommendations to Increase the Independence and Objectivity of Actuarial Opinions

Mr. Dixon stated that recommendations to reduce the chance that actuaries will have incentives to give less-than-objective assessments include:

Recommendation 21. Require that actuarial opinions provide additional information:

Currently, the actuarial opinion states only that the reserves are reasonable. For example, more information might be required to: report a range of reserve projections using different actuarial methodologies; document the accuracy of past projections; and identify the actuary preparing the past opinions so there is some accountability for past work.

Recommendation 22: Require that actuarial opinions review reserves for a sample of claims:

Currently, actuaries typically do not check to see if reserving practices have changed. It would be valuable to have a direct audit by the actuary or someone hired by the actuary.

Recommendation 23: Consider requiring CDI to appoint and pay actuaries as opposed to the actuary or insurer:

This would help reduce potential conflicts of interest in the preparation of actuarial reports. The insurer would then be assessed to cover the costs of its actuarial opinion. CDI does that when it conducts financial examinations, so there is precedent for this change.

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Recommendation 24: Review CDI's prioritization scheme for financial examinations and consider a mandatory trigger for examinations.

There is currently no such trigger.

Recommendation 25: Impose penalties for under-reserving.

Currently, no penalties are assessed if a CDI exam reveals under-reserving.

The Risk-Based Capital System is the Primary Tool for Solvency Regulation

Mr. Dixon stated that how much surplus or capital that insurers hold is an important factor for ensuring the health of the insurance system. The primary system for solvency regulation now is the Risk-Based Capital (RBC) system, developed by the National Association of Insurance Commissioners (NAIC). The RBC system specifies how much surplus, or policyholder surplus, an insurer should hold. It also spells out what regulatory actions are appropriate should policyholder surplus fall below the target, with the first level of response being the Company Action Level, which required the insurer to identify the conditions contributing to the event and to file a corrective action plan within 45 days. Mr. Dixon stated that the RBC system in place today was not fully in place during the period leading up the insolvencies. The study examined what regulatory actions would have been indicated had the current RBC system been in place to get an idea of how well the current RBC system would have worked. The study determined that the RBC system would have provided little warning of the insolvencies in many cases. The study compared the date that the insurer was conserved compared with the date the Company Action Level was triggered, that is, when it was evident that the surplus was below the Company Action Level. For several insurers that went insolvent, there was no warning before the company was conserved and went insolvent, so there was no time to adjust the situation. For several other insurers, there was warning of about nine months, but that might not have been sufficient time to respond to a situation of low capital.

Recommendations Aimed at Improving the Efficacy of the RBC System

Mr. Dixon stated that the study made recommendations to improve the efficacy of the RBC system including:

Recommendation 26: The advantages and disadvantages of more stringent thresholds for the RBC ratio and the combined ratio should be explored:

NAIC should consider strengthening the trigger for the Company Action Level. California is the largest member of NAIC which sets out the RBC system and so California could play an important role in the deliberations.

Recommendation 27: The RBC formula should be modified to better reflect the risk of an insurer whose business is concentrated in states with a difficult workers' compensation market:

If a company does a lot of business in a volatile market, like California, more capital should be required to deal with the volatility.

Recommendation 28: Consider requiring insurers to submit RBC calculations more frequently:

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Calculations should be submitted twice a year or four times a year because the insurance system can change rapidly. Currently, calculations are submitted once a year.

Recommendation 29: Introduce systemic risk and enterprise-level “stress testing” into evaluations of the adequacy of insurer capital:

A shortcoming of the RBC approach is the implicit assumption that the past is reasonably predictive of the future. State regulators should consider plausible scenarios, such as economic downturns and other events, which could provide a stress test for workers’ compensation insurers and their reinsurers.

Conclusions

Mr. Dixon stated that many factors came together to produce the volatility and insolvencies that followed open rating. It may be that the particular confluence of events that followed open rating may not happen again. However, memories are short, and many of the same institutions and incentives that led to the problems in the last half of the 1990s remain in place: recent Ogilvie and Almaraz/Guzman decisions remind us that claims costs are subject to rapid and unanticipated change; MGAs and reinsurance caused problems in the 1980s and 1990s and could do so again; and the RBC system is not a panacea and cannot be fully relied on to alert regulators and create the safety cushion needed to avert insolvencies. Mr. Macdonald stated that any one element that created the insolvencies could lead to the same situation.

Mr. Dixon stated that several themes run through the recommendations including: increase predictability; enhance transparency; better align incentives of MGAs, brokers and reinsurers; and improve CDI oversight. He stated that it is important not to overreact and to develop recommendations that rely on market discipline and better aligning incentives rather than on more heavy-handed regulation. As the lack of predictability was repeatedly mentioned as a key driver of the volatility following open rating, providing more information would allow market participants to better monitor the actions of workers’ compensation insurers and could help curtail some of the excesses that can occur in an open-rating setting.

Suggested Next Steps

Mr. Dixon stated that suggested next steps include:

- Create a multi-agency working group to determine which recommendations can be implemented administratively and which require legislation.
- Engage legislators, CDI, insurers, and other stakeholders in discussion to determine which recommendations warrant prompt action and require further evaluation and refinement.
- Implement agreed-upon changes expeditiously.

Mr. Macdonald emphasized that almost all the recommendations include associated penalties in order to put consequences in place to help ensure accountability.

Chair McNally thanked the presenters for conducting a comprehensive and insightful study.

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Public Comments and Questions

Linda Atcherley of the California Applicants' Attorneys Association (CAAA) stated it is definitely true that a lack of legislative clarity exists and is one of the factors creating litigation. The consequences of a proposed piece of legislation need to be thought out carefully. She stated that the Minnear decision was based on an insurance company request that the treating presumption report and opinions be presumed correct. The Minnear decision enforced that strictly. The insurance industry did not take into account that they did not have control past 30 days; as a result, they could not rebut the treating physician opinion. The same thing can be said about utilization review which was put into law as an ability to promptly effectuate decisions on medical treatment and to provide cost containment. However, a dispute in the utilization review process results in a very lengthy qualified medical evaluator (QME)/agreed medical evaluator (AME) process. When utilization review and bill review were implemented, people did not understand the cost of doing that. The result of that cost has been to inflate the cost of medical treatment. The administrative cost of a law or benefit has to be taken into account. She also stated that the judges do a good job in a complex situation; they do the best they can to interpret laws that have no other interpretations.

Steve Zeltzer, Chair of the California Coalition for Workers' Memorial Day, stated that there are serious flaws in the study. He stated that there is no estimate or figures for the percentage of workers' compensation premiums that are going to pay for healthcare in California for injured workers. In fact, more and more of the money collected in premiums is not going to healthcare but administrative costs. That inefficiency is not addressed in the report. He stated that his organization is opposed to the insurance industry running workers' compensation and disagrees with the California AFL-CIO position of reforming the systemic fraud going on in the insurance industry. They believe that the insurance industry should be eliminated and the money collected should go directly to health care providers. It is a waste of time to consider how to improve the insurance companies. Mr. Zeltzer also stated that Cal/OSHA has eliminated all the doctors and injured workers are not getting proper treatment; they are put in a position of having to fight with doctors and insurance companies to get healthcare. He stated that injured workers are losing their homes, ending up homeless, even committing suicide, and this is a tragedy. The current system is profitable for insurance companies but not beneficial for injured workers in California who have had their permanent disability benefits cut by 50%. The utilization review system prevents injured workers from getting healthcare in a prompt fashion. He stated that his organization supports a single payer system.

Mr. Dixon responded that the California Legislature requested the study and its focus is insolvency. The issue of benefits to injured workers is outside the scope of the study. Mr. Dixon stated that in terms of a single payer system, the study suggests that it would be valuable to have a system with innovation, so the idea that State Fund should have a large market share was not considered the direction to take if innovation and competition in the market are important. He stated that it would be important to assess advantages and disadvantages of a single payer system vs. a competitive system.

Dina Padilla, injured worker and patient advocate, stated that she has worked in the insurance industry and medical insurance and medical field. She stated that she worked for Kaiser which

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has a third-party administrator (TPA) which makes determinations on whether or not claims will be filled. She stated that she was involved with a whistle blowing for Kaiser Permanente Medical Group (KPMG). The whistle blowing agency took the case on its own to the federal government, and KPMG was fined. She stated that she would finish her comments when the next Public Comment section comes on.

Sandi Trand, mother of an injured biotechnology worker, presented documentation to Chair McNally and stated that in June and September of 2009, she talked to the Department of Insurance Consumer Fraud Division Commission. She stated that when the District Attorneys are given more than ample evidence about crimes committed by the employer and the District Attorneys' office against an injured worker in the biotechnology company, they do nothing. She stated that her son's medical bills were over \$333,000, from 1995 through 2005; he was exposed to 19 different unknown types of bacteria and fungus at the company where he worked. Ms. Trand stated that she had presented information earlier to the Commission, which included her son's health history and medical bills. Ms. Trand stated that she does not understand what the Commission does or what the CDI Consumer Fraud Division Commission does. Ms. Trand then asked Commissioner Wei what "gaming" the system meant, and Commissioner Wei responded that it referred to playing games about where the money in the system is. Ms. Trend stated that people's lives, which are at stake, are not games; people are getting hurt. Chair McNally stated he appreciated her comments and that he would be available to talk to her later.

Theo Pahos, representing the Association of California Insurance Companies, stated that he would make written comments on the report at a later date. He stated that companies were under-reserved during the period discussed, the first "melt down," and did not expect costs to go so high so quickly. The Bureau and insurance companies could not raise rates quickly enough. He stated that there it is no possible or practical to increase reserves when there are double-digit increases. The under-reserving and under-pricing created a \$5 billion shortfall for the system. Insurance companies are now more strongly reserved. Mr. Pahos stated that he generally does not agree with Commissioner Wei; the only reason the report has been done and discussions are going on is that Commissioner Wei insisted on the insertion of the report into a bill that the Association was sponsoring. The Association took the amendment and that is why the report has been done and is being discussed today.

Commissioner Steinberg asked Mr. Pahos to clarify his last statement about what was inserted in the bill, and Mr. Pahos responded that the report was required by a bill, Senate Bill (SB) 316, by Senator Yee from San Francisco; the Association had asked that that bill be put forward and they sponsored it through the legislative process. However, to get consensus, they had to agree to take language required by labor to have the study conducted. So the accusations that not enough has been done to evaluate insurance practices is not accurate. Commissioner Steinberg stated that CHSWC commissioned the study, and Mr. Pahos responded that that was because of direction of SB 316. Commissioner Wei asked Mr. Pahos to clarify if this an instance where they agree, and Mr. Pahos stated that that was correct.

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Commissioner Wei asked if the report would be posted as a final report and if there would still be an opportunity for stakeholders to make comments. Ms. Baker stated that the report has been distributed via email. Commissioner Steinberg stated that he would like to defer action on the report. Commissioner Wei again asked if it could be posted and be open for comment. Chair McNally stated that that is what would be done; the report would be posted and would be discussed at the next meeting. Judge Taylor stated that the contract with RAND does not limit RAND's authority to release the report independently of Commission action. Commissioner Wei then asked if there is the possibility that RAND would finalize the report even if the Commission has not adopted it, and Judge Taylor stated that that was correct.

Report on Return to Work in California: Trends in Benefits and Replacement Rates

Seth A. Seabury, RAND Corporation

Seth Seabury stated that the specific numbers presented in the return-to-work study about trends in benefits and replacement rates are subject to change because the study has not gone through the RAND quality assurance process. However, Mr. Seabury stated that he is confident that the general conclusions will be unchanged.

Mr. Seabury stated that permanent disability in California is a controversial area with a number of problems. The system is costly for employers, and there is cost uncertainty, but despite the high costs, there are also poor outcomes for injured workers that include high earnings losses and comparatively low replacement rates. According to Mr. Seabury, there have been several dramatic reforms in recent years to the workers' compensation system, which included massive changes to the permanent disability system. There is continued uncertainty highlighted by recent court decisions such as Ogilvie/Almaraz, but even before these decisions, there was considerable debate about how well the system was working. Mr. Seabury stated that there is agreement that early return to work (RTW) is a beneficial outcome for everyone including employers who will get lower workers' compensation costs and workers who will benefit from having reduced earnings losses.

Mr. Seabury stated that improving RTW in California has become a higher priority due to the potential impact of the reforms on income replacement. In 2004, the State of California overhauled the permanent disability system, and these reforms led to large cuts in permanent disability benefits. The reforms also included, however, numerous provisions to reduce waste and improve RTW. If RTW improves, then people get back to work sooner, earnings losses fall, and there is a potential offset to an adverse impact in income replacement. In evaluating the effect of the policy, the question is whether RTW has improved and to what extent any improvements have offset the impact of the benefit cuts.

Mr. Seabury stated that the study evaluated RTW in California and addressed a number of research questions including:

- What is the effectiveness of employer efforts in promoting or improving return-to-work?
This is a critical issue because most policies focus on employers, specifically on how

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employers accommodate injured workers in returning them back to work. In the scientific literature, however, there is a lack of consensus on how effective employer initiatives in RTW are, and this study has evidence on supporting these types of programs.

- What are the trends in post-injury employment in recent years? This includes looking at how trends in RTW have changed over the years.
- How have these trends been influenced by the workers' compensation reforms?
- What has been the impact of reforms on income replacement?

Mr. Seabury started that the previous literature on the effectiveness of employer RTW programs is mixed at best. This study evaluated whether getting employers to adopt RTW programs will help in terms of improving RTW. Data for the study were taken from a survey of 40 large, private, self-insured employers. The study took data prior to reforms; it also collected detailed information about efforts to improve RTW and matched that data with data on outcomes for injured workers, including RTW. The study compared RTW outcomes at firms before and after program adoption and compared it to firms that do not have a program to review changes at the firm. This approach helped to overcome the problems that have plagued the literature and helped to identify a causal effect of the programs.

Mr. Seabury presented the central findings using an example of a hypothetical firm selected from the sample at random and that did not have an RTW program. The median lost-work-day case at this employer will involve about 8.9 weeks away from work. If the employer adopted an RTW program, and there is no change in the employer, then for the injured worker, the median weeks away from work will fall to 5.3 weeks. Therefore, there is a significant decline in the duration of injury-related absence associated with program adoption. The study also addressed the question as to whether these programs only affect the less severely injured workers, or if they also impact the RTW outcomes of more severe injuries, such as those involving permanent disabilities. Mr. Seabury explained that, indeed, there was an effect on permanently disabled workers. The study restricted the analysis to lost-work-day cases with a permanent disability. For these injured workers, the median number of weeks away from work is 35.5, but if the same experiment is conducted and the firm adopted an RTW program, then the median time out of work drops to 22.9 weeks. Mr. Seabury stated that these findings show that employer RTW programs can be very effective and provide an opportunity to improve RTW if more employers adopted the same RTW principles.

While the employer efforts can be effective, Mr. Seabury pointed out that the questions remains as to whether employers were adopting the programs and bringing the people back to work sooner in light of the reforms. To answer this question, the study used data from workers' compensation claimants from WCIRB and looked at workers with injury dates from the first quarter (Q1) 2000 through the second quarter (Q2) 2006, and then these were linked with earnings data from 1998 through Q2 2008. The study included injured workers from 2000 through 2006 and examined at their earnings path before and after injury. The study also matched the injured workers to uninjured controls; other workers who were working at the same

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firm as the injured workers (who were not injured) and had very similar pre-injury earnings were selected; these workers were called “control workers” because they had a similar expected earnings path but were not injured, so employment outcomes for the injured worker as if the disability had not occurred could be estimated and compared to the earnings of injured workers to earnings of uninjured “controls.”

Mr. Seabury stated that in the employment data from Unemployment Insurance (UI) records, the total earnings are available for a quarter but not hourly or weekly data; this evaluation takes place only if there are earnings in the quarter for the injured worker and the uninjured controls. The data do not indicate when or how often someone works. To evaluate the disability on the ability to work the relative employment ratio was calculated, which is the likelihood injured workers are working at some point after the injury compared to the likelihood that their uninjured “control workers” are working. This gives a measure to evaluate trends, overall and by different characteristics (such as disability severity). Mr. Seabury pointed out that comparing outcomes across different levels of disability severity is very important for understanding these trends and replacement rate results. He further stated that when measuring disability severity in the past, a disability rating is generally used; that is what the system uses to evaluate the severity of the disability and that is what has been used in past RAND work; however, for trends over time, a disability rating or average rating to rank people cannot be used anymore because the 2004 reforms completely changed the nature of the disability rating used. The study uses an alternative measure of disability severity where it ranks patients according to their medical costs in the quarter of injury; if an injured worker has very high medical costs relative to other workers injured in that same quarter, then that injured worker has a severe disability; if an injured worker is in the middle, that is a moderate disability, and if an injured worker is at the bottom, that is a slight disability. Because this is a novel measure of disability severity, Mr. Seabury presented some summary statistics to verify that it captures variation in disability severity. Someone who is working two years after injury has the least severe disability and will be working 62% of the time, compared to someone with the most severe disability who will be working 42% of the time. Mr. Seabury stated that this indicated the measure based on medical costs was a valid way to capture variation in disability severity.

Mr. Seabury noted that a 0.7 value of what they termed the *relative employment ratio* at two years can be interpreted as suggesting that an injured worker is 70% as likely as an uninjured control worker to be working in the quarter two years after the quarter of injury. Mr. Seabury presented a graph of the relative employment ratio by quarter of injury from 2000-20006; and is the graph included a comparison of the relative employment ratios one year after injury and two years after injury (two years is the longest period that is observed for all injured workers in the sample). Based on the data, there was a general decline in RTW early on in the series, so RTW was actually getting worse around the early 2000s, but around 2002, there was a sharp reversal, and post-injury employment for the injured worker started to improve relative to their controls. In the latter part of the sample, workers who were injured were doing better than workers who were injured in the early part of the series; the relative employment rose to 75% in the later part of the sample, compared to closer to 65% in 2002. He then showed a similar graph breaking the trends down by disability severity. For each level of severity there was a similar pattern: RTW declined early, but around mid-2002 it reversed and saw big gains. For the slight and moderate disability severity categories the trend was somewhat more moderate; however, it was very sharp

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for the most severely disabled. The most severely disabled appeared the most likely to benefit from improvements in RTW, as workers in the severe category improved from being 50% as likely to be working to 60% as likely to be working.

Mr. Seabury noted that for the trend towards improving RTW rates were beginning prior to the adoption of SB 899, which happened in 2004. He pointed out that this means that the gains in RTW cannot be attributed only to RTW policies that were implemented by the reforms; some other factors might have had an effect, including non-occupational disability policies, such as the Fair Employment and Housing Act (FEHA), and potentially the changes to the vocational rehabilitation system. That is not to say that the reforms had no effect, the study could not differentiate between all the different policies, but it appears that other factors had an effect as well.

Mr. Seabury stated that it remained unclear the extent to which the trends were influenced by changes in the behavior of employers. The goal of the reforms was, in part, to incentivize employers to adopt RTW policies; it was important to know if employer activities or attitudes towards RTW had changed. Therefore, they conducted a survey of firm RTW practices. Mr. Seabury stated that RAND sent out a small electronic survey that inquired about the use of RTW programs and how they have changed in the past five years. The survey included very large self-insured firms and small insured firms, so it covered both ends of the employer spectrum. There were 62 responses, about a 50-50 split between insured and self-insured employers. He acknowledged that the survey had a self-selected sample; the employers chose to respond, so it was not necessarily representative of all employers. He stated that, nonetheless, the study was useful to provide some context to the empirical findings in light of employer attitudes. The study used a web-based survey form, and provided definitions about the relevant information (such as, what was meant by RTW practices and what constituted “aggressive” RTW practices). About 50% of employers stated that they were doing the same as they were five years ago; a very small fraction said they were less aggressive, but about close to half stated that they were more aggressive and they were making a greater effort to bring disabled workers back to work than they were five years ago. Mr. Seabury stated that there was a series of questions in the study that focused on RTW issues, but the questions were consistent. Therefore, this small sample in this study showed that employers have been increasing their efforts to bring people back to work.

Mr. Seabury stated that they also wanted to determine to what extent the reforms were important in influencing employer decisions. Therefore, the study asked the question whether employers agreed or disagreed with the statement: “Recent reforms to ____ (*the blank could be filled with either “workers compensation” or “FEHA”*) have increased the firm’s willingness to bring disabled workers back.” (Mr. Seabury noted that this was paraphrasing the original question that was asked in the survey.) According to the responses submitted in this study, 35.5% of the employers agreed that the recent reforms to workers’ compensation had increased their willingness to bring the disabled workers back to work, but a larger percentage, 45%, agreed that the changes to FEHA, which strengthened the disability and anti-discrimination protection to disabled workers, were important. The study is not suggesting that FEHA is more important than workers’ compensation reforms in terms of driving employers’ decision-making, but it does suggest that FEHA is an important factor, and potentially *as* important a factor, as the workers’ compensation system in promoting employer incentives to bring workers back to work. Mr.

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Seabury pointed out that these findings are consistent with the idea that changes in employer behavior were an important part of the changes in RTW observed from 2000-2006, but also indicate that factors both inside and outside the workers' compensation system were important in motivating the employer behavior.

Mr. Seabury stated that the study also addressed what has happened to earnings loss and income replacement over this time period. Changes in income replacement can be driven both by changes in earnings losses and by changes in benefits. A number of reforms in recent years have affected the benefits paid to injured workers. There were benefit increases in laws such as Assembly Bill (AB) 749, and the replacement of injured workers' rehabilitation programs with job displacement vouchers. In addition, SB 899 adopted a new rating schedule which led to a cut in disability ratings and by extension a cut in disability benefits. Mr. Seabury stated that this study looked at the trend of earnings losses-in addition to the trends in RTW-and compared it with trends in benefits to evaluate the overall changes in replacement rates. The data used in the study compared the outcomes for disabled workers to the outcomes for the uninjured control workers using the same WCIRB data and injured worker sample as previously described. The workers injured were from Q1 2000 through Q2 2006, and then the earnings losses were compared to the indemnity benefits (this is how the study defined "income replacement"). This study projected five-year earnings losses, although earnings losses cannot yet be observed for someone injured five years later (for example, the data do not yet exist for someone injured in 2006). Mr. Seabury stated that in past work, replacement rates tended to decline over time because benefits are paid out over a finite period; in general, five years is the minimum period of time over which RAND preferred to evaluate the long-term replacement rates. To project five-year earnings losses, the study incorporates the actual RTW outcomes observed over two years for everyone, because it is then possible to incorporate the improvements in RTW into the projections.

Mr. Seabury summarized the methods used with a hypothetical example; the study calculated earnings losses and replacement rates by using the earnings for uninjured workers who are the "control." In the example, an uninjured "control" worker earned \$6,000 in the quarter, while the injured worker earned \$3,000 in the quarter, so the earnings loss for the quarter was \$3,000. The hypothetical workers' compensation benefits paid to injured workers in that quarter were \$2,000, so the hypothetical benefits divided by the hypothetical estimate of earnings loss implies a replacement rate of two-thirds in this example. Mr. Seabury stated that it was easy to imagine a scenario where benefits fell but the replacement of lost income actually improved; if earnings loss fell by more than benefits fell (say, because of a significant improvement in RTW), then there could be a decline in benefits but an overall increase in the replacement rate.

Mr. Seabury stated that it is this possible scenario that makes the *a priori* expected impact of the reforms on replacement rates ambiguous; even though it is known that benefits fell, it can't be known what happened to replacement rates without estimating the change in earnings losses. To provide an example of the earnings losses in the data, the earnings for the injured workers were matched to the earnings for the uninjured workers. The earnings were very similar for the injured and uninjured worker prior to the injury, but at the quarter of injury, there was a big and a persistent drop in the earnings, so there is about a \$2,000 difference per quarter between the injured and the un-injured worker. There is a \$2,000 per quarter earnings loss (Mr. Seabury

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noted that these are values were normalized to 2006 dollars, so they represent real dollar losses). The study reviewed the data over 20 quarters and pooled people with a full five years of data; to look at the trend, the losses need to be projected.

Mr. Seabury stated that the study looked at cumulative losses. This means that the study does not look at replacement rates at one point in time; instead, the study summed up losses and it reviewed total benefits over the period and compared what fraction of total losses were replaced by benefits (so the replacement rates are cumulative). When the study projected a five-year loss, RTW gains did lead to a fall in earnings losses, and the earnings losses were about on average a little over \$50,000 per year in 2006 dollars leading to up to 2003; once the improvement in RTW occurred in mid-2002, there was a general decline, and then earnings losses fell by a significant amount, to about \$42,000-\$45,000. Again, these are cumulative five-year losses for workers injured in this quarter. Mr. Seabury stated that the disability benefits fell even more sharply over this period. The real value of indemnity benefits paid out in this sample was going up slightly prior to 2003; then for injuries starting in 2004, it dropped off (the decline pre-dated the adoption of the new schedule partly due to the changes in the vocational rehabilitation system that also reduced benefits).

Mr. Seabury stated that when the estimates of the earnings losses were combined with the changes in disability benefits, there was a pretty sharp decline in the replacement rates of lost income; the replacement rates were relatively steady over this period at close to 50% overall, but in 2004, the study saw a sharp decline to closer to about 40%; in addition, there was a 10% drop in replacement rates; so starting from a base of 50%, there was a 20% drop overall. Mr. Seabury stated that this was a clear decline. He further discussed how RTW affected this change. The study projected losses using a statistical model based on RTW, and this allowed it to estimate what earnings replacement rates would have been had there not be improvements in RTW. The study estimated replacement rates using the previous methods, but instead of actual RTW observed for injured workers in the quarter, the study fixed RTW at a low 2002 level; at that point, the study reviewed what the trends in replacement rates would have looked like if RTW stayed in the bottomed-out level. The study found that the improvements in RTW did help offset some of the decline in the replacement rates but not all and not even most. When the study fixed RTW to low 2002 levels, replacement rates fell to about an estimated 35% as opposed to 40%; if one thinks about the difference between 50% and 40% versus the difference between 50% and 35%, then the improvements in RTW helped to offset about one-third of the potential decline in replacement rates over this period.

Mr. Seabury stated that the study also looked at how the changes to replacement rates differed across the levels of disability severity. When the study examined the least severely disabled, the benefit cuts and RTW changes had relatively little impact. One reason was that the replacement rates for less severe disabilities were already quite low, which is consistent with prior RAND studies. Mr. Seabury stated that the impact the policies had on the most severely disabled workers was much greater. The replacement rates for the most severely disabled are higher at about 70%; for the most severely disabled, in this study; prior to 2003, the replacement rate was two-thirds replacement rate overall, but after 2003, it dropped off more dramatically and fell to about 50% towards the end of the sample; thus, there is a 20-percentage point decline in income replacement rates, a significant drop. Even though the most severely disabled experienced the

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biggest gains in RTW, the potential decline in replacement rates over this period was larger than the estimated replacement rates which would have fallen closer to 40% had the gains in RTW not occurred (so the these gains offset only one-third of the potential decline).

Summary of Findings and Policy Implications

Mr. Seabury summarized that the results of the study indicate that the replacement rates have fallen substantially since the reforms, from 50% to 40% overall, and noted that this decline is more concentrated among the most severely disabled. He noted that it may seem odd to some that the severely disabled experienced the greatest decline in benefits. If one reviews the reforms, there is a built-in increase to benefits for workers with a very high disability rating; this is why it is important to note that this study ranks disability severity using a measure other than the disability rating. Mr. Seabury stated that if an injured worker has a high disability rating, then the workers probably will receive a higher replacement rate (due to the change in disability reforms). Because of the change in the schedule, however, the most severely disabled (by the alternative measure used by RAND) are much less likely to receive a higher disability rating than they were before. Therefore, there is a decline in replacement rates. Mr. Seabury stated that the study shows that the improvements in RTW offset a portion of this decline, about one-third of the potential decline in replacement rates.

Mr. Seabury noted that past RAND studies have questioned the adequacy and equity of permanent disability benefits in California. The results in this study suggest that the recent reforms have led to a decline in the level of income replacement. RTW did improve and it did offset some of the decline in benefits, but improvements in RTW were insufficient to offset the decline in benefits. He stated that according to the study, several reforms have been enacted to promote RTW and big improvements have been seen, but it is unclear how much of the improvement could be attributed to the workers' compensation reforms. Mr. Seabury stated that discussions with stakeholders have highlighted problems with the way the reforms have been implemented. RTW policies have been driven in part by employer activity, though employers may have been induced to make changes by other factors than the RTW incentives that were adopted. Mr. Seabury stated that, similarly, it did not appear that RTW changes were driven by benefit changes (the timing does not fit with the notion that disability benefits have dropped off dramatically and that is why people are going back to work) More generally, the timing of the RTW changes does not match that closely to the workers' compensation reforms.

Mr. Seabury stated that another implication of the study is to consider not only how workers' compensation can actively improve RTW, but also how the system can be reform to prevent it from discouraging of RTW. One of the ways to promote improvements in RTW is to continue efforts to minimize disputes between employers and injured workers; this will improve RTW or keep the gains of RTW. Other non-occupational disability policies have helped RTW, so it would also be important to better coordinate the workers' compensation system with other non-occupational disability programs to reduce the friction that can contribute to poor RTW outcomes.

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Public Comments and Questions

Chair McNally thanked Mr. Seabury. He opened the floor for comments that should be limited to three minutes and to this presentation.

Linda Atcherley of the California Applicants' Attorneys Association (CAAA) asked Mr. Seabury if the study omitted lower-wage people or if this study includes everyone. Mr. Seabury responded that this study included everyone, so the replacement rates include everyone. Ms. Atcherley stated that the study is a lot better in terms of inclusion. Mr. Seabury responded that the study was limited to people who were not affected by changes in temporary disability benefit levels to avoid incorporating their changes and any influence that had in RTW. The trends in RTW are essentially the same as if the study looked at a full sample of workers which is what the study does for the replacement rates. Ms. Atcherley asked if when the study looked at the replacement rate, the study kept the two-year temporary disability cap versus people who had no temporary disability cap, so the replacement rates included people who were injured in 2000 who did not have a two-year temporary disability cap and who did have the cap. Mr. Seabury responded affirmatively but stated that he did not think that had any effect on any of the trends reported in either analysis.

Commissioner Aguilar asked whether the data used in this study are from WCIRB, and Mr. Seabury responded that that was correct. Commissioner Aguilar asked if data from EDD were used to see if the workers received earnings and whether the study could differentiate if the worker went back to work for the same employer. Mr. Seabury responded that they used data from EDD; he noted that they could look at the trends in return for the at-injury employer, so they can identify who the injured worker was working for from EDD data, and the RTW trends were similar but more pronounced because of bigger gain in RTW at the at-injury employer. Commissioner Aguilar asked if there were other factors that might have encouraged employer RTW such as the Department of Fair Employment and Housing (DFEH) stating that the employer had not been an able to accommodate properly or the assessment was not done right, but they could not differentiate that or whether there are other factors, for example, if people chose not to go back to work or retired. Mr. Seabury stated that there were other factors and that this is why they had the uninjured controls, because some of that will happen whether or not certain policies are going on, and the same factors affect the control workers based on the policies that are in effect. If a worker is more likely or less likely to retire because of injury, then it will potentially affect the RTW trends. Commissioner Aguilar stated that that is definitely a factor because of population claimants like "baby boomers" who will be retired and will be a large piece of the population. Mr. Seabury stated that this was one of the challenges of doing an analysis in a dynamic environment like California where there are multiple reforms going on. Commissioner Aguilar asked whether the education of employers would be a factor too, for example, employers understanding what they are supposed to do in the interactive process. Mr. Seabury agreed that it would be. Commissioner Aguilar stated that this was very interesting.

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Report on Self Insurance Groups

Lachlan Taylor, CHSWC

Judge Lachlan Taylor stated that in April, CHSWC presented a draft report on self insurance groups. Public comment showed that it required revision, as CHSWC had missed some topics that they had been asked to look at. Revisions were made and a revised draft was posted for public comment ten days ago. Some feedback has been received and a few further revisions have been made. Judge Taylor stated that the current version of the report begins with references to the Corporations Code on page 27.

Judge Taylor stated that all employers in California must secure the payment of compensation either by insurance or self insurance, except for the State. Throughout the history of California workers' compensation until the past decade, self insurance meant stand-alone self insurance for large employers that had the financial capacity to absorb their own losses. Public entities were also allowed to form self insurance groups called Joint Powers Associations (JPAs). Beginning in 1993, private self insured employers were allowed to form self insurance groups (SIGs). In 2002, the first SIG was approved. Now, the first round of major rethinking of California's SIG programs is occurring, and in response to a request by then Chair of the Assembly Insurance Committee Joe Coto, Commission staff prepared this report.

Judge Taylor stated that some of the major differences between self insurance and insurance are that self insurance is under the jurisdiction of the Department of Industrial Relations (DIR) and insurance is under the jurisdiction of the Department of Insurance (CDI). SIGs have many of the characteristics of insurance, so DIR has to in some ways regulate them like it would insurance; however, self insurance companies are not exactly the same as those with insurance, so they become a unique regulatory puzzle.

Judge Taylor stated that some of the major recommendations of the report include

- DIR does not have all the resources in place to thoroughly regulate SIGs, and the report recommends "beefed up" regulatory resources.

- One of the large public disputes is whether SIGs should be subject to more public disclosure of their financial condition, comparable to the public disclosures of insurance companies. One argument is for government transparency, or an extra set of eyes to see who is watching the regulator. On the other hand, stand-alone self insureds do not have to expose their financial status to the public. It is not clear that public disclosure would even help.

Judge Taylor stated that the report recommends that the Self Insurers Security Fund (SISF) have full access to the financial resources of SIGs. The reason for this is that SISF is the entity which stands at risk if a SIG fails. There is CIGA, which stands at risk if an insurance carrier fails, but SISF, which also insures the big stand-alones like Boeing, Marriott, PG&E, also stands at risk if one of these SIGs were to fail. Commissioner

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Aguilar asked for clarification that financial information is a profit and loss statement or information related to claims and claim payments. Judge Taylor responded that it is financial information about the group, not the individual members. He stated that SIGs have annual CPA financial reports that are not currently public, nor is their actuarial analysis. The debate is about whether their programs would be more secure if this information were made public. He stated that SIGs do not get rated by Moody's or have investors or capital investment other than the resources of their members, so the recommendations in the report are that members and prospective members of SIGs should have access to financial statements and actuarial reports, and that SISF should have access to that information. He stated that there does not appear to be any added benefit to wider public exposure.

- Judge Taylor stated that another recommendation is to give SISF a greater level of involvement, in fact, to allow SISF to trigger action by DIR; the question remains whether this is proper delegation of government authority. The recommendation is not for SISF to pull a SIG's certificate of consent to self insure, not that SISF actually step into the role of the regulator, but that it merely set off warnings that would necessitate the regulator to take action. A SIG may still demonstrate to the regulator's satisfaction that the SIG is fine. SISF would not have the last word on anything, and that would attempt to preserve the proper role of the regulator while giving a more active role to SISF.
- Judge Taylor stated that another item, which is new since the April draft, is to ask DIR to exercise authority over the marketing of SIGs. Some representation and marketing pieces are cause for concern. If there is any misrepresentation to members, there could be a problem later when going after members for assessments. Unlike an insurance policy, if a SIG is unable to pay fully for the losses from the amounts collected from its members, it can go back to members and assess them.
- Judge Taylor stated that this raises another problem: it is important to assure that members are fully informed and cannot claim that they do not have to pay an assessment because of some defensive misrepresentation, but it is also important to look at what may happen if they actually have to do assessments. The question is whether hundreds of members in different counties of the state would have to be sued in order to collect assessments if they were disputed. There is a recommendation that the Legislature should adopt methods for the liquidation of groups (SIGs) to consolidate liquidation proceedings into one court/one proceeding, so that there are not unmanageable collection problems, if and when assessments on members of a failed group have to be dealt with.

Judge Taylor stated that those were the key points and that the Commissioners have received the public comments on the November 30th version of the report, which take issue with one of the

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recommendations that audits might be generalized to the entire book of business instead of having DIR conduct an audit and say that reserves have to be raised on a specific handful of cases. DIR has responded and will pilot the idea with one SIG which is closing down, where DIR will do a 100% audit of the SIG's claims and will compare the results with a sample audit which would then be extrapolated.

Public Comment

Mike Whitehurst, a Burger King franchisee who owns several restaurants between Oakland and Union City, stated that he was present to speak on the success of SIGs and why SIGs are so valuable to the State of California. He stated that he has been a founding member since 2005 of the California Restaurant Mutual Benefit Corporation which insures over 500 companies and 4,000 restaurants and over \$1.1 billion in payroll. In the five years prior to 2005, he spent around \$650,000 to standard insurance companies, and he created about \$50,000 in claims during that time. Since then, he has cut that amount in about half, about \$300,000 to \$325,000 in premiums, with the same amount in claims over the past five years. He stated that he received a return on investment (rather than "dividend") of excess payroll or excess premium of \$50,000. He stated that he appreciated the first presentation on insurance insolvency, as it demonstrated why SIGs are of such great value. He stated that they are required to have security deposits of 135% of expected future liabilities, they must meet an 80% confidence level of the actuary, and their investments of their funds are extremely limited, which the board supports. He stated that if the standard insurance companies had the same restrictions on the investment of their funds, they would all leave the State of California. He stated that their third-party administrator (TPA) works at the bequest of the Board of Directors, and the Board runs the company (SIG). He stated in conclusion that SIGs are a fabulous opportunity.

Commissioner Wei asked Mr. Whitehurst if, as a SIG, he would be open to being required to report data to a transactional database. Mr. Whitehurst asked if standard insurance companies do that, and Commissioner Wei responded that if it were uniform, would a SIG be ready to do that and be held accountable. She stated that this would be only a reporting of claims information and transactions to get data for the purposes of doing studies on the cost drivers and figure out policy recommendations. Judge Taylor stated that since SIGs are already required to report claims data to WCIS, it would be good to "put some teeth" into the requirement for reporting. He then stated that the answer to the question would likely be "yes" given the requirement already in place.

Judge Taylor added that there is some discrepancy in interpretation as to whether a SIG is allowed to return money to its members; some SIGs do and some do not. He stated that it would be useful for the DIR Director's Office to clarify that. He stated that it is a new field for California and that there are a lot of unanswered questions, but the report has called attention to the issues such as the return of surplus contributions and whether that violates the Corporations Code, as well as whether experience modifications are permissible, which is not clear.

Joe Burgess, CHSI, stated that they are the administrator of two SIGs. He stated that he first wanted to thank Judge Taylor for his work and for consulting with a large number of people. He

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stated that they were late to the table in submitting comments and that it would have been better to have more board members of more SIGs who would be able to talk about the report. He stated that Clay Jackson from Affinity sent in a letter that clarified some things that made it into the report. He stated that the view of CHSI is that SIGs meet the highest standards in the state now. He stated that the 80% confidence level is a critical factor and that SIGs have to be secure. He stated that they support the licensing of administrators, and they would even support some additional internal control audits. He stated that outside auditors, or independent insurance auditors, would be desirable. They have the ability to do a thorough operational audit. He stated that some of the recommendations on regulations might need to fit the balance between micro-managing and not micro-managing; some regulations can smother things, as noted on the Health Care Organization (HCO) front. He stated that members of SIGs are involved. He stated that next week, they are working on legislation for getting SISF more power legislatively as a partner. They are meeting with SISF next week to go over financials and start the process; it is a voluntary process and a good thing.

Commissioner Aguilar asked Mr. Burgess's opinion on the need to have a separate security fund for SIGs. He stated that it would be a good idea, since SIGs are pre-funding (they are pre-funding their losses at 80%), they also have mandates for excess insurance, and they have mandates that stand-alone self insureds do not have. He stated that SIGs need to be actively involved in SISF, and as the evolution goes forward, there should be a bigger presence and more activity by SIGs in the fund, however it is structured.

Lewis Lawrence of CHSI stated that he wanted to comment on some of the value that SIGs bring to the return-to-work process and the potential for small employers that are members of SIGs to do the things that they would not do if they were not a part of a group. He stated that he was interested in the earlier return-to-work presentation and noted that it was limited to insured employers and large self insureds. SIGs do not fall into either of those groups. He stated that as an administrator, they are able to bring to their members to bring some of those values to them that normally a small employer would not do. He stated that the members of SIGs are smart business people who are innovative and who are looking for ways to do the best they can with limited resources. He also stated that the member employers have a close relationship with their employees, which is not always the case with large employers. These employers work closely with their employees to bring them back to work. He stated that over-regulation of these SIGs would not be wise. He stated that SIGs need the freedom to work with their employees, whom they sometimes consider to be like family members, which something you do not see with a large employer.

Chair McNally stated that he agreed with Mr. Lawrence. He stated that in discussions on the return-to-work issue in California involving the interactive process and workers' compensation, one of the problems is that the insurance carriers write risk that does not include return-to-work considerations. A lot of small employers are not getting the support that they are accustomed to getting when that issue arises. They look to an insurance carrier, hoping for some advice and help, and that is an issue they are not getting support with. When small employers and SIGs are focused on this issue, it makes good public policy. He stated that he did not mean this to be a criticism of the insurance companies; it is just that they do not underwrite the risk, and so there is a gap. He stated again that the employers have that exposure and they are not getting support.

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Tom Sourci, an independent insurance broker, stated that he was one of the co-founding brokers of AdComp, one of the first approved SIGs in 2002. He stated it took 18 months to put the group together and get it approved. He stated that he was present to support the SIG business model. He has been an independent insurance broker for 30 years since 1978, and what has occurred since 1995 is that legislation that created open rating also allowed SIGs to form and self-insure. However, no one took advantage of that until 2002, although they actually began the process of approval in 2000. He stated that as presented by the RAND report, insurance rates skyrocketed and insurance companies at that time were predatory. He stated that he does not know if that has changed since then, but when there is a non-profit structure and a for-profit structure competing for business, it is important that the for-profit structure does not have an advantage. He stated that he was referring to the issue of disclosure. He stated that he always tries to present all the information that is relevant to prospects before they join the group so that they understand their exposure. As far as making financial information available, he stated that he believes it would give insurance companies an unfair advantage in marketing efforts.

Mr. Sourci stated that there is a fairly solid base of SIGs in California as an industry as a whole. They are gaining market share, and he believes that insurance companies would like to put SIGs out of business. He stated that his opinion is evidenced by the fact that he has been terminated by a couple of companies he used to represent, as they do not like the fact that he is marketing a SIG. He stated that related to "leveling the playing field," the 80% confidence level that is required of SIGs is a good thing, but since insurance companies do not have the same requirement, they have an advantage there. He stated that when insurance companies go out of business and cost everyone else money, that should be looked at in terms of oversight and funding levels. He stated that SIGs have a huge advantage because the employers are engaged and that is a benefit to employees; in fact, the whole system benefits. He also stated that the IRS only allows SIGs to deduct to a 70% confidence level, so disputes have arisen about having a non-profit organization collecting at an 80% confidence level and the IRS not allowing SIGs to write that off. He stated that he wished the State and the federal government could get together on that.

Commissioner McNally asked whether Mr. Sourci is at odds with the recommendation regarding financial disclosure. Mr. Sourci stated that it needed to be discussed and what needs to be considered is the negative impact that it will have on the SIG industry. Commissioner McNally asked for clarification on the type of disclosure, specifically public disclosure or disclosure to agencies and SISF, and Mr. Sourci stated that he is opposed to public disclosure, not disclosure to agencies.

Questions from Commissioners

Commissioner Steinberg stated that this report began by a request from Assembly Member Coto, which was prompted in turn by the experience in New York. He asked what was different with California. Judge Taylor responded that California did not have a department suing an administrator, which is happening in New York. California has maintained a separation between the program administrator and the claims administrator. California also has required a pre-funding of liabilities throughout. These are steps in the right direction. The question remains whether this is enough; he stated that it is not, but that it is a step in the right direction. He also

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stated that California has been requiring that each program year be separately funded and has clarified that each program year has to be carrying funds which are in 8 out of 10 times going to be enough. New York was not doing any of this. California learned from New York's experience even before getting started. He stated that a number of New York's painful experiences are reflected in the current report. California is not perfect but California has done better than New York from the beginning.

CHSWC Vote

Commissioner Steinberg moved to approve for final release and posting the Report on Self Insurance Groups, and Commissioner Wei seconded. The motion passed unanimously.

Ms. Baker stated that the report would be submitted to the Assembly Insurance Committee.

Executive Officer Report

Christine Baker, CHSWC

Ms. Baker stated that there are a number of products she would like to brief the Commissioners about. Every year, Commission staff prepares a report on selected indicators. Some of the indicators come from the Annual Report, so there is no new data, but this report puts all the statistics into one document that is posted on the CHSWC website. Workload data from the Division of Workers' Compensation and from the Division of Occupational Safety and Health are included. This report serves as a benchmark and can indicate whether things change for the better or for the worse over time.

CHSWC Vote

Commissioner Culbreath moved to approve for final release and posting CHSWC's Selected Indicators in Health and Safety and Workers' Compensation: 2009 Report Card for California, and Commissioner Aguilar seconded. The motion passed unanimously

Medical Study

Ms. Baker stated that the ongoing medical study has had a few hurdles due to contract freezes and other issues. Ms. Baker stated that the contract deadline is coming up and the contract needs to be amended for additional time and funds. If an amendment could not be moved through the bureaucracy, proceeding with a new Request for Proposal (RFP) would be advisable because Barbara Wynn is working with WCIS data. She stated that she is advising the Commissioners from a procedural standpoint about this need to extend the contract date or possible need to go back out and renew the contract, and she asked if there were any concerns about this.

Commissioner Wei requested that Ms. Baker keep the Commissioners informed as always about the action she would need to take.

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Lien Issues

Ms. Baker stated that there has been much discussion about liens. The Commission approved a study of liens. There continue to be questions about lien issues. Ms. Baker, Judge Taylor and Commission staff would like to go to Southern California to conduct a sample survey to look deeper into lien problems to determine that any remedy would meet the needs of the lien boards.

Commissioner Aguilar asked why there should be more of a problem with liens in Southern California than Northern California, and Ms. Baker responded that staff would find out why that is so. Commissioner Wei stated that if it is appropriate for Commissioners to go to a work group on this issue, Ms. Baker should let the Commissioners know.

Commission Accomplishments

Ms. Baker stated that since we are at the end of this year, accomplishments have included the following: the Labor Code Section 77 mandate of preparing an Annual Report has been met, and the Insurance Insolvency study, as mandated by Labor Code Section 77.7, has been finalized.

WOSHTEP

Ms. Baker stated that the 2009 WOSHTEP Advisory Board Report, mandated by Labor Code Section 6354.7 and prepared by the Advisory Board on the use and the impact of the programs developed for WOSHTEP, has been finalized for Commission approval.

Ms. Baker stated that WOSHTEP has been a very successful program. Accomplishments of the program include: expanded services to the Central Valley and the Inland Empire; developing materials in English and Spanish; materials on indoor heat illness have been developed and are in use; and adapting the WOSH Specialist curriculum for the agricultural industry to include training and resources on tractor and machinery safety, pesticide handling safety, and other farm-related issues. She stated that she would like the WOSHTEP team to report on the program in the new year. The team is a dedicated group of trainers and curriculum developers.

CHSWC Vote

Commissioner Culbreath moved to approve for final release and posting the 2009 WOSHTEP Advisory Board Annual Report, and Commissioner Aguilar seconded. The motion passed unanimously.

Commissioner Wei stated that two union members have died in 2008 and 2009 from indoor heat illness exposure in a warehouse and a Safeway Distribution Center. It has been identified that training might have saved one of the lives. Heat exposure and heat illness were not identified and the worker was sent home to go to the doctor. Commissioner Wei stated that she would like to provide a link for the WOSHTEP team to provide indoor heat illness training.

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Schools Action for Safety and Health Program

Ms. Baker stated that the Schools Action for Safety and Health (SASH) program funded with OSHA penalties has held advisory meetings and curriculum and materials are being drafted. Pilots will start in the next year. Ms. Baker also stated that Commissioner Aguilar has been active on this project.

Study of Self Insurance Groups

Ms. Baker stated that the legislatively requested study of self insurance groups has been completed.

Roundtables

Ms. Baker stated that numerous roundtables have been held to get feedback from the community on a number of issues such as first aid, return to work, and uninsured employers.

Labor-Management Proposal

Ms. Baker stated that the Labor-Management Proposal has been posted on the website a month early, and feedback has been coming in. She requested that the Commissioners indicate what the next steps should be. The Commissioners commented that they would advise encouraging public feedback through the regular channels for public feedback.

Ms. Baker stated that she and the staff are honored to serve the Commission and continue to look for ways to improve the system for workers and employers. Commissioner Aguilar thanked the staff for all their hard work. She asked Commissioner Wei to elaborate on how the Commission meets its statutory obligations. Commissioner Wei stated that there are statutory obligations in the Labor Code for different parts in the Labor Agency that produces its studies. She stated that the Commission is the only body that meets its statutory deadlines, possibly, if she were to look closer, the only one that attempts to meet its statutory deadlines. She thanked Commission staff for being hard-working, dedicated public servants.

Other Business

None.

Adjournment

The meeting was adjourned at 1:30 p.m.

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Approved:

Kristen Schwenkmeyer, Acting Chair

Date

Respectfully submitted:

Christine Baker, Executive Officer

Date