

Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING

April 30, 2009

**Elihu M. Harris State Building
Oakland, California**

In Attendance

Chair Sean McNally

Commissioners Catherine Aguilar, Kristen Schwenkmeyer, Darrel "Shorty" Thacker and Angie Wei

Absent: Robert Steinberg

Executive Officer Christine Baker

Call to Order

Sean McNally, 2009 CHSWC Chair, called the meeting to order at 10:05 a.m.

Minutes from the March 5, 2008 CHSWC Meeting

Chair McNally requested a vote on the Minutes of the March 5, 2009 meeting.

CHSWC Vote

Commissioner Thacker moved to approve the Minutes of the March 5, 2009 meeting, and Commissioner Aguilar seconded. The motion passed unanimously.

Insolvent Workers' Compensation Insurance Carrier Study, Senate Bill 316 (2007)

Lloyd Dixon, Senior Economist, RAND

Bill Barbagallo, Navigant Consulting

Jim MacDonald, Senior Associate, RAND

Bill Barbagallo stated that he would provide an update to the study in progress, including the findings to date and current suggested recommendations for any reforms that should be considered. He stated that it was important to review the past, which brought about trouble in the insurance market in California.

Mr. Barbagallo stated that looking at the past 15 years, legislation deregulating workers' compensation rates which was passed in 1993 went into effect in 1995. As a result of deregulation, prices dropped dramatically, and various carriers who tried to maintain market share and remain competitive began to reduce their rates. Over 30 insurers owned by 18 insurance groups went insolvent from 1997 for a number of reasons. He stated that the researchers would discuss some of those reasons and similarities and conclusions that could be

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

drawn from that group of companies. He stated that market share of the State Compensation Insurance Fund (SCIF) rose from 20% to 50% at its peak and then declined. Industry losses occurred after 1995, then moved to large profits after the 2003 and 2004 reforms. However, there appears to be an indication that those profits are changing and declining, again for a number of reasons.

Mr. Barbagallo stated that insurers with a higher exposure in California were more likely to fail. Looking at the companies whose percentage of business, that is, whose percentage of premium of overall writings, were from California workers' compensation are classified as one group – at less than 20% of overall writings (107 companies) – 6% of that group failed. In other words, if the predominant writings were something other than workers' compensation, only 6% of those companies failed. For the middle tier of companies whose percentages of premium of California workers' compensation was between 20-60% (17 groups), the percentage of failures increases. Finally, for the last group whose writings were in excess of 60% for California's workers' compensation, the percentage that failed was 50%. Even further, of the California monoline companies that only wrote workers' compensation in California, with 80% or more of their business in California workers' compensation, 75% of those companies failed. Clearly, those companies with a concentration in workers' compensation had significant problems.

Mr. Barbagallo stated that insolvencies have been costly to surviving insurers. A California Insurance Guarantee Association (CIGA) chart shows the cost to insurers, policyholders and taxpayers. The numbers in the chart are relative to CIGA only, and CIGA may not handle all the losses from a carrier because some losses or types of business do not come under CIGA's purview. He stated, however, that CIGA will be handling the majority of losses coming out of these insolvencies. That gives an idea of the payments made, the outstanding reserves and the expected cost.

Mr. Barbagallo stated that the legislature wanted to review why so many companies failed. Over the years, other national reports have studied this issue. The insurance industry is cyclical, but the study found that California was exceptional to some degree. The key questions include: was the California Department of Insurance (CDI) doing its job of oversight? were changes in regulation needed? were they in fact enforcing the regulations? did policies and procedures within the Department need changing in order to ensure oversight? and were there already adequate policies and procedures in place that were not implemented? Other questions include: how can the performance of the insurance market be improved? how can the regulatory approach, that is, the specific wording of the regulation, be improved? is there enough teeth in the regulations to actually make a difference to control the industry? and what kind of incentives do the private sector parties have to improve the outcomes? He stated that a host of issues related to how private industry is doing its job, range from pricing questions to how the losses are laid off on the reinsurance market to the Rating Bureau involvement and guidance, and scheduled credits.

Mr. Barbagallo stated that recent events have raised concern that a new wave of insolvencies could occur in the near future. That concern was broader than the property and casualty industry, as the life insurance industry is also under scrutiny. The life insurance industry has not escaped the workers' compensation exposure because many life insurers own workers' compensation

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

companies and have substantial interest in various workers' compensation companies.

Mr. Barbagallo stated that the study approach began by selecting 16 groups for analysis, putting them in different buckets: groups generating less than \$30 million in premium and, of those carriers, how many were writing workers' compensation business predominantly in California those that were writing workers' compensation but not as a predominant business' the larger writers of workers' compensation in California; the middle premium national carriers; and the larger national carriers.

Mr. Barbagallo stated that to do the study adequately, a wide range of resources and data that are publicly available were used, including annual reports of the insurance companies, rating agency reports and materials from CDI, the liquidation bureau, the California Insurance Guarantee Association (CIGA), the State Compensation Insurance Fund (SCIF), and the Workers' Compensation Insurance Rating Bureau (WCIRB). He stated that they have spoken with all of those bodies, as well as numerous key players in the workers' compensation market, including current and former insurance company executives, personnel at CDI and other state agencies, and knowledgeable brokers and agents who have been involved in the California workers' compensation market for some time. Contacts with several solvent insurer contacts will be made. He stated that it is important to look at not just what went wrong but also what went right. To that end, they are speaking to insolvent insurers to understand how they prevailed and what they did differently from those who went insolvent.

Mr. Barbagallo stated that with regard to the overall goals, workers' compensation should be available to all businesses, with prices that are not discriminatory and that are not excessive; it should be balanced, competitive, fair, and available. Insurers should be able to pay benefits required by coverage, meaning the laws themselves should be fair; there should be balance and not skewed to injured workers or to employers or to carriers or to investors. He stated that the market should encourage innovation in terms of service and efficiency, with adequate resources and a forum to conduct business efficiently, effectively and profitably.

Mr. Barbagallo stated that examination of the past events leading up to the various insolvencies in consideration of possible recommended reforms reveals a pattern. For the most part, underestimated costs are a common element, as are pricing below estimated cost and revenues that are less than the true cost. He stated that the reserving decisions made by the insurers and their actuaries, in terms of appropriate decisions and accurate methodologies and data, can all lead to inadequate reserves if not handled correctly. He stated that once inadequate reserving is discovered, reserves are often increased; however, the questions are whether that increase in reserves is too late and whether the increase in reserves far exceeds what is in the surplus (leading to inadequate surplus), which could lead to insolvency.

Mr. Barbagallo stated that a wide range of reforms is being considered in the study. The objective is to reduce the likelihood of insolvency while preserving a competitive and innovative insurance market. The goal is not necessarily zero insolvencies, as there are numerous reasons for insolvencies, such as governmental regulation and the economic environment, and that not everything can be controlled. Specifics of each company may lead them to an insolvent path, and that may have not have anything to do with reforms, regulations or government oversight.

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

Lloyd Dixon stated that he would comment on initial findings and initial suggestions for reform and would look forward to feedback on the presentation. He stated that underestimated costs were a problem. The ratio of costs expected (projected by WCIRB) for the period is compared to the actual losses from the claims. From 1979 to 1994, prior to open rating, the estimates were plus or minus 20% accurate. After open rating and with the Minnear decision in 1996, WCIRB under-predicted costs by about 40%, so that their predictions were only 60% of the costs. After the 2003-2004 reforms, WCIRB seriously over-projected costs. He stated that this raises concerns about the performance of this aspect of the insurance market.

Commissioner Wei asked about the Minnear decision. Mr. Dixon responded that in 1996, the decision allowed for the treating physician presumption in the provision of care; it was an extension of the interpretation of legislation that was passed in 1993. He stated that it escalated the costs of providing coverage. One of the themes was that it took several years to figure out what was going on with costs to the system. He stated that there were many factors responsible for the poor performance of WCIRB including the Minnear decision and the court-ordered changes in benefits that took several years to understand what was going on and was applied retroactively to claims. There was also a slowdown of claims resolution due to a number of factors. WCIRB had limitations in methods and data that they used so that there was a heavy emphasis on extrapolating past trends, so that when the system changed, WCIRB was slow in picking up the implications of those changes.

Mr. Dixon stated that in speaking with WCIRB, the researchers have been impressed with the progress that has been made in learning from that period and making changes. The Bureau is now using a variety of actuarial methods in projecting costs and is starting off with more of a blank slate each year and not simply extrapolating past trends. Also, it is looking at what has really changed since the last projection. He stated that the Bureau now reconsiders the basic assumptions in its model. Also, it has established a claims subcommittee to identify more rapidly changes in claim payments patterns. From the researchers' perspective, WCIRB has made substantial advances that would reduce the likelihood of the same kind of problems occurring again.

Commissioner Wei asked about the ratio graph presented earlier in the presentation and the post-1995 period. Mr. Dixon responded that 1995 was the start of open rating and that each year, the Bureau would come up with expected loss costs and loss adjustment expenses for claims. Years later, it reviews what the costs actually ended up being for those claims. In 1999, WCIRB made a projection of claims costs that turned out to be 40% lower than the ultimate total claims costs. He stated that the question is why the Bureau was so far off. Some of the reasons were the fundamental changes in the unanticipated, poorly understood changes in benefits payments due to the Minnear decisions and some other factors that were going on at the time. Commissioner Wei asked whether that means that California got stuck with the 2004 reforms because the Rating Bureau was totally wrong. Mr. Dixon responded that that was one way to think about it. Commissioner Wei asked whether the Rating Bureau got it completely wrong. Mr. Dixon stated that the Bureau did not see how quickly the claims costs were going up. Mr. Barbagallo stated that basing future rates on past performance when there are changes going on does not help anymore. Commissioner Wei stated that that may be the explanation for why the Bureau got it

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

wrong, but the fact of the matter is that they got it wrong. She stated that the Rating Bureau mispriced, costs were skyrocketing between 2000 and 2004, and California got stuck with serious problems in 2004 as a result. Mr. Dixon stated that the case is that costs were escalating very rapidly in the 1995 to 2000 period; the fact that the line on the graph drops means the Bureau missed that. He stated that from the point of view of insurance insolvencies, what that means is that insurers were under-pricing their policies and not collecting enough premium to cover the costs that ultimately resulted. Mr. Barbagallo stated that it was not only the Bureau that misread the situation; when you look at the different companies, their actuaries also missed it. Commissioner Wei stated that the actuaries are the Bureau and that the Bureau is made up of the insurance companies. Mr. Barbagallo clarified that both in-house actuaries and the outside actuaries the Bureau contracted with to issue independent decisions got it wrong. Mr. Dixon stated that no one, including CDI, was on top of the situation of escalating costs.

Mr. Dixon stated that some of the reforms that might improve the accuracy of cost projections, and that might prevent similar situations from occurring are:

- First, provide transactional-level data to WCIRB, that is, data on the actual number of physician visits by claim. Currently, WCIRB does not receive that information, while other organizations like the California Workers' Compensation Institute (CWCI) do receive such information. He stated that perhaps WCIRB could benefit from that information.
- During this period, a number of insurers were not providing complete information to WCIRB, and an option is to increase the penalties for failure to provide that kind of information.
- Finally, the question related to the delay in understanding the implications of the Minnear decision and the court interpretations of the Minnear decision is whether there is a way to quicken the appeals process so that the ramifications of key court decisions can become evident more quickly.

Mr. Dixon stated that these are some of the reforms that should be considered and further explored. He stated that the study is still a work in progress and there may be changes to the recommendations about reforms.

Mr. Dixon stated that the issue of how insurers price is a second important area of consideration. Projected, expected costs were too low, but even given that, insurers were pricing lower than those expected costs. He stated that a chart in the presentation shows the ratio of the charged premium to the expected loss at the time. For example, in 1999, insurers were charging roughly 95% of the costs that were expected at the time. Another chart shows that those expected costs were already 40% too low, and insurers were charging below that. He stated the 1.25 is a sensible ratio of final premium to expected loss that includes other insureds' underwriting expenses and other things. He stated that during this period, insurers were pricing very low in a very competitive market; that is what some refer to as "reckless pricing." After the 2002 and 2004 reforms, prices returned to a more sustainable level. A number of factors may have contributed to this low pricing, including the regulatory process at CDI, the reinsurance market, and the role of SCIF.

Mr. Dixon stated that the researchers have been impressed with the attention that CDI paid to the workers' compensation market following open rating. CDI established a special workers'

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

compensation task force, conducted a number of market conduct and financial exams of the troubled companies in the 1997-2000 period, identified loose underwriting practices at Fremont and Superior, and were in regular contact with the management of the troubled companies. He stated that CDI was watching the market closely. According to the people the researchers spoke with, CDI realized that pricing for many of these companies was at unsustainable levels. However, actions that reversed inadequate pricing during this period were not taken. CDI did not challenge the rate filings for being too low, and while it did encourage some firms to raise rates, subsequent to examination reports, it did not enforce those rate increases.

Mr. Dixon stated several reasons for the situation described. One was that in the rate filing process, workers' compensation rates are evaluated using a less structured methodology than for lines requiring prior approval, which involves a very systematic process that the CDI rate regulation branch goes through in evaluating rates. Workers' compensation is different; it is an open rating system, and there is not as thorough examination as there is in other lines. He stated that it also was perceived by CDI that it was difficult to convince a hearing officer, who hears challenges brought by insurers, that rates are too low if the company's surplus looked adequate and there were reasonable loss ratios. Up to the time of a year or so before the companies became insolvent, their surplus and loss ratio (losses to premium) looked all right. In the second half of the 1990s, there was a free market philosophy at CDI and political pressures to keep rates low. All of these factors limited the ability of CDI to act. Today, if rates are too low, if CDI does not do anything right away, it will subsequently watch companies closely, and if it looks like the companies are getting into trouble, it will start to take action.

Mr. Dixon stated that there are many challenges to ensuring adequate pricing with open rating. In an open rating system, companies are allowed to set their prices. There are a lot of ways companies can act to charge whatever rates they want; they can set up multiple companies and shift policies across companies with different rate structures, and it is very difficult to monitor the extent of proper assignment of policies. Companies can also offer large scheduled credits, which means particular credits for an individual company to reduce its rates, and it is difficult to determine whether those rates are warranted or not. He stated that controlling rates in an open rating environment is difficult.

Mr. Dixon stated that the researchers are considering several reforms in this area including:

- Implementing a set of reforms around the rate filing process by insurers. This would involve limiting the scheduled credits to 25%. Currently, there is a rule of thumb that 25% is reasonable, but it is not an official CDI regulation and it is not always applied. Currently, there is no requirement that when insurers file rates, there is a certification that the rates are adequate; perhaps this requires an actuary to certify that rates are adequate at the time of the filing to cover claims costs.
- CDI could use the same template to evaluate rates in workers' compensation as it does for prior approval in other lines. It might require insurers to explain how the rates incorporate recent court decisions or legislative action. CDI should provide an explicit, upfront and clear example of how the rates deal with the uncertainty of costs as is the Minnear decision.
- Better oversight of implementation of rating plans is needed. What CDI does now is

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

conduct market conduct exams of insurers. The lags in scheduling those exams could be reduced, and penalties for violations discovered in market conduct exams could be increased. Currently, penalties are \$250 per violation, which is not a large sum.

- Require insurance underwriters to have some kind of professional certification. Currently, there are no requirements for professional training to approve rates. He stated that something like the Certified Professional Casualty Underwriter (CPCU) certification might make sense.

Commissioner Wei asked about one of the reform areas skipped in the presentation, and Mr. Dixon responded that insurers are currently allowed to do loss rating for even very small employers. They can look at past claims experience and set the rates. He stated that 95% of small employers will not have a claim in any particular year, but it would be misleading to say that because there are no claims over the past three years, those employers should get a very low rate. He stated that it might make sense to prohibit that type of experience rating for employers below a certain size; this is one way to allow insurers to price however they want.

Commissioner Wei asked about setting a minimum loss ratio, and Mr. Barbagallo responded that that cannot be done because there is no control over the losses. Commissioner Wei stated that on the health insurance side, there has been talk about setting a minimum medical loss rate ratio, where for every dollar of premium, a certain amount has to go out in treatment. Mr. Dixon responded that that would be similar to a minimum rate law, and Commissioner Wei stated that it would be between indemnity and medical payments, for every dollar of premium you have to pay out a certain amount. Mr. Dixon stated that prior to 1995, CDI set a minimum rate below which you could not charge; projections were that you would have to pay 75% or more in claims.

Mr. Dixon stated that the researchers are still in discussion with CDI and they would run the recommendations by them to see if they are reasonable. Commissioner Wei asked who the Insurance Commissioner was at the time, and Mr. Dixon responded that it was Chuck Quackenbush between 1995 and 2000.

Mr. Dixon stated that SCIF is, and was, a big player in the market and blamed by many in the industry for contributing to under-pricing. SCIF is both the market of last resort for employers who cannot get insurance elsewhere and a writer in a competitive market; it is free to write whatever coverage it wants. Critics argue that SCIF aggressively pursued rate reductions, and market share peaked during this period. SCIF did start paying broker commissions around 2000. Once Superior went insolvent, SCIF aggressively pursued its customers by sending out blast faxes to brokers saying to bring that business to SCIF, that it would match whatever prices Superior charged. He stated that that allegedly aggressive behavior drove down prices more than would have happened otherwise and contributed to the subsequent insolvencies. Defenders, on the other hand, countered that SCIF's market share only rose once the insolvencies occurred. Mr. Dixon stated that the researchers' analysis finds that the latter conclusion is the case. SCIF's market share charted from 1993 to 2007 demonstrates that it was not until the bulk of the insolvencies began in 2000 that SCIF's market share rose. He stated that the Golden Eagle conservation occurred in 1997, but that did not have much of an impact for SCIF. The SCIF chart, combined with some studies done by others, suggests that SCIF was pricing above the market during the second half of the 1990s and leads the researchers to suggest that it is not valid

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

to blame SCIF. He stated that the researchers have seen that SCIF provides useful discipline to the market, and they do not see any need to restrain SCIF's competitive efforts as long as its rates are adequate. It is almost as if it is a regulatory approach to have SCIF in the market as a competitive provider, providing discipline in the market.

Mr. Dixon stated that the researchers did have some adjustments to suggest. He stated that SCIF appears to have an implicit 20% market share target prior to 2001 and is coming back to 20% again. The researchers did not see any reason to have an implicit market share target, particularly in a soft market. One of the reasons SCIF might do that is the trouble it has adjusting its staff levels. A useful recommendation for further exploration is how SCIF could increase the flexibility of its staffing levels so that it is not stuck with the sense that it has to have 20% market share to cover its current staffing.

Mr. Dixon stated that there was another factor on the demand side, the people who purchase workers' compensation insurance. The researchers believe that the purchasers of workers' compensation bear some of the blame for the unsustainable pricing during this period. Employers and insurance brokers have little incentive to consider insurers' ability to pay. CIGA guarantees that workers' compensation claims will be paid, so an employer feels that it does not have to be too concerned about the stability of the insurer it buys coverage from. He stated that the researchers believe that it would be useful to modify some incentives to improve market performance on the demand side. Putting a lot of burden on employers does not seem the right target because of their limited information. It may make sense to require brokers to retain some liability if one of the insurers goes insolvent. He stated that that is an area which is controversial, and that it would be a major change to the system, but requiring brokers to retain some liability may make sense. He stated that such arrangements of residual liability do exist in other states.

Mr. Dixon stated that reserving decisions by insurers, or putting up money needed to pay the expected costs over the life of the claim, appear to have broken down. What is supposed to happen is that when an insurer files its annual statements, there will be an actuarial opinion that will state that the reserves that have been posted by the insurer are adequate to cover the costs. He stated that there are very few "qualified" actuarial opinions where the actuary raised an issue with the size of the reserves. He stated that under-reserving is discovered through a financial examination by CDI. An entire mechanism in the private sector exists to validate reserves, and it simply did not work, or at least there were short-comings in that process. He stated that the researchers believe that it is likely that the situation has improved in recent years with more strict professional standards for actuaries, and actuaries have a greater sense of managerial responsibility due to Sarbanes-Oxley. He stated that other reforms might come to mind, like having CDI appoint the actuary and pay for it. The actuary would be beholden to CDI rather than the private insurer, yet CDI does not want to get in the business of approving actuaries, which could become a bureaucratic mess. Other possibilities include continued enhancement of professional standards and ethics to encourage actuarial societies to continue to improve the standards in the profession. Still another possibility is to have quicker and more frequent reserve examinations by CDI. Currently, reserve examinations are done as part of the financial examination process, which is a large and lengthy process.

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

Mr. Barbagallo stated that there is an age-old phrase about there being good data and bad data, and that actuaries base their information on the data that come from the computer system which is capturing loss medical dollars, the total incurred dollar. Those dollars come from the underlying payments; if claims departments are not accurately paying those benefits and if policies and procedures are not in place to ensure that the cases are being evaluated accurately and in a timely manner, the data going to the actuaries would be skewed or invalid. He stated that then it is not just a matter of an actuarial evaluation but a matter of ensuring that the underlying claims payments are accurate.

Mr. Dixon stated that on the surplus side, insurers went insolvent, meaning they did not have adequate assets to cover their liabilities. He stated that in principle, insurers are supposed to hold a policyholder surplus in addition to reserves, which serves as a cushion for unforeseen events. In the second half of the 1990s, it is clear that the surplus was not adequate, and it was not just one or two companies that went insolvent; it was a large number of companies. He stated that this raises the issue of the required surplus not being adequate, given the uncertainty and the situation during that period. The risk-based capital (RBC) system is the primary surplus monitoring tool; it sets targets for the capital and surplus that a company needs to have, and it defines thresholds for regulatory intervention. When a surplus falls below a certain level, CDI can intervene. The RBC system was introduced into workers' compensation during this period around 1997, and it was thought to be an advance from the previous method of monitoring, but it seems clear that the minimum levels required were insufficient following open rating.

Mr. Dixon stated that it would be difficult to have CDI control rates. One philosophy of addressing the issue of insolvencies says to disregard rates, that they cannot be controlled so control should not be attempted. Perhaps what should be done is to focus on making sure there is enough surplus. One focus of the researchers' recommendations is the type of enhancements could be made in the RBC system to have a more appropriate cushion. The RBC method looks at the last ten years of experience in the industry and in the company to determine the right amount of capital. That seems short. For example, in a few years, the Minnear decision will drop out of the historical window that is used to calculate RBC. He stated that perhaps extending it would be appropriate; however, that is a national system run by the National Association of Insurance Commissioners (NAIC). He stated that there is company-specific data and national line data, but not state-specific data; incorporating that in the system might better explain exposures, particularly in California. He stated that there is also not a good way to adjust for under-pricing that is observed quickly in terms of how the final rates in a year compare with the expected costs in the year, and that there is no need to wait three years to have loss ratios show under-pricing. He stated that there needs to be quicker response when the industry is beginning to under-price. He also stated that finally, there are issues with reinsurance contracts, which should be the subject of another discussion.

Jim MacDonald stated that the discussion would not be complete without mention of reinsurance; there is no doubt it played a role in the insolvencies. The Government Accountability Office (GAO) did a report on the Unicover program where life insurers entered the reinsurance business and offered what proved to be a naïve and short-lived capacity that definitely contributed to the reckless competition in the market. He stated that one of the issues the Request for Proposal (RFP) asked to be looked at is access to capital. One of the insurance

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

companies that the researchers looked at, Paula, in 1997 had a successful initial public offering (IPO) at a time when the market was competitive. He stated that in addition to reinsurance, which is best understood as a form of synthetic capital in and of itself, there was capital available. Superior National's purchase of Business Insurance Group was financed by a combination of debt and equity in December 1998. Managing general agents are frequently mentioned in the last decade as a source of insolvencies of the Imperials, Nationals, Missions, etc. The researchers' findings are that managing general agents are generally not considered to have contributed materially to these insolvencies. He stated that the researchers did find one case where an insurer got into workers' compensation in the late 1990s through a managing general agent. He stated that another factor thought to explain why WCIRB was not able to correctly predict upcoming loss costs was the large deductible, introduced in 1995, but it was not found to be a significant contributor to instability. He stated that the deductible product took off in 2000, when the market started to harden. It was, however, a contributor to the data quality problems, partly because the large deductible was frequently unbundled at third-party administrator (TPA) firms, and this contributed to increasing the lag time of claims reporting.

Mr. MacDonald stated that some developments are less obvious, and there are new issues on the horizon. There are fewer insurance companies today than ten years ago, as well as fewer reinsurers, and there is a notable expatriation of capital from the business to foreign locations. He stated that the last company he worked for, which was Ace, just moved from Bermuda to Switzerland. There is a tremendous amount of capital outside the U.S., and systemic risk is implicit in the consolidation that has taken place.

Mr. MacDonald stated that there are ways to easily improve the situation by improving the transparency in financial reports. He stated that if one visited The Harford website, one could download statutorily required annual reports; on the other hand, on other websites, none of that information will be found. Making it easier to give people information like the Schedule P, loss development information, would decrease reliance on opinions from players like AM Best and would improve the ability of the private sector to understand and form opinions about these companies. He stated that this is an obvious opportunity for short-term improvement.

Mr. Dixon stated that the researchers expect to have a draft report in July, and the final report will be out in the fall.

Questions from Commissioners

Chair McNally asked whether there is a competency issue with regulators at CDI, or whether or not there was something deliberate in the inappropriate pricing. Mr. Dixon responded that they were planning to do an assessment of the qualifications of the personnel in CDI in the work scope, but it is a huge, difficult task to do an organizational and capability assessment. He stated that he has been impressed with the knowledge and awareness of those working at CDI. He was surprised to learn of the number of times staff met with the management of some of these companies. This situation was not a case of lack of awareness. The political difficulty of complaining that rates are too low was mentioned repeatedly; he believes that there is pressure on staff that makes it difficult for staff to raise that issue. The researchers have also heard from some people that the Insurance Commissioner should be appointed, but he is not certain that that

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

will make any difference. He stated that CDI's policy was to let the market set the rates, leaving insolvency regulation to ensure adequate surplus. Therefore, it may make sense not to focus on regulating rates but on insolvency regulation looking at RBC issues that ensures there is enough capital. Chair McNally stated that this seemed to be what CDI was assessing, and Mr. Dixon agreed. Mr. MacDonald stated that he had been through a market conduct examination and he thought that the examiner did a great job. Nevertheless, he stated that he thought it would be important to get some diversity in the workforce, that is, hire people who have worked in the private sector; all of the people (with one exception) that the researchers met with have been long-term CDI employees with accounting and financial backgrounds. Hiring a few people who have actually underwritten a business some time in their career is not a bad idea and could help in the examination process.

Chair McNally stated that when considering recommendations, a recommendation could be to move more towards insolvency regulations but make sure that regulators understand what they are looking at. Mr. Barbargallo stated that he felt that it was not an issue of doing something intentionally (i.e., not adequately regulating the industry). More can be done to look at underlying data to see what kind of impact the Minnear decision had. This would involve a sampling of files, not necessarily an extensive examination process.

Commissioner Wei stated in regard to intention and competency, that there is the basic issue of authority, i.e., what authority CDI has to do regulation. Mr. Barbargallo stated that a key issue is reinsurance and the lack of authority to get to the issue of reinsurance and reinsurance set-off. These issues could have a significant impact on a company's solvency. For example, if 90% of the costs are being laid off and they are structured in an unusual way, that begs the question of whether or not the company is on the wrong path. CDI does not really get involved there, as it is not within their purview or authority. Authority is therefore a key issue. Mr. Dixon stated that the researcher are still trying to understand the level of authority that CDI has in the area of reinsurance. Mr. Dixon stated that on the rate side, CDI has lots of authority in rate setting; the key issue is that rates have to be set right. He stated that inadequate rates were not a problem after 2000, but that might be a problem in the current period.

Commissioner Wei stated that she appreciates the discussion and that she is more and more convinced that the volatility of the workers' compensation insurance market is what is driving everything. It has a huge impact on the business climate and a huge impact on the benefits for workers. She stated that she believes California is again headed into another volatile situation. She stated that she would like to think about the Commission making more legislative presentations on the findings of this report, especially since the State has invested significant resources in this report. She stated that she would like to see the Commission invite some oversight or informational hearings in the legislature to occur in the fall in order to share the findings of the report.

Mr. Barbargallo stated that the issue does not exist in a vacuum. He reminded the Commissioners that the 1990s period was the dot-com boom with lots of investment and a time when the focus was not on rates, unlike the current climate which is recessionary. Mr. MacDonald stated that the current issue is capital management; up until now, the focus has been on the right hand of the balance sheet, yet new issues, asset management issues, are on the left side of the balance sheet,

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

and they can wipe out a surplus too, not just under-pricing. He stated that a more holistic viewpoint, not the narrow view as in the past, is clearly what is needed.

Commissioner Aguilar stated that she is interested in hearing what more is to come. She stated that she was thinking about the issue of not wanting insurers not to make the rates so high. Mr. MacDonald said that there are three big court decisions that could affect the benefits payments in workers' compensation and undermine the impact of reforms. He stated that medical inflation is trending back to double digit inflation rates and medical is increasing, taking over from indemnity. He stated that there is rampant competition, though not as reckless as in the past, as reinsurers are more constrained. He stated that although it is not as bad as in the past, there are lots of reasons for concern. One green flag is the more responsible long-term carriers, and one should note who is growing and who is getting smaller over the past three years. He stated that the focus should be on a metric for insolvency which identifies if companies are growing at double-digit rates in the midst of increasing competition. If there are no large parent companies or other sources of revenue outside of the state, those companies should be looked at closely.

Commissioner Wei asked if that was happening now, and Mr. MacDonald responded that it was, arguably, though he cannot prove it. History would show that growth in the midst of rampant competition is very difficult unless there are other lines or sources of revenue. Commissioner Wei asked how Zenith was growing, and Mr. MacDonald responded that Zenith has been getting smaller. Mr. Barbagallo interjected that it is difficult to comment on specific companies, especially public companies, as that would potentially impact their stock price. Mr. MacDonald then stated that a number of companies have gotten smaller while others have grown.

Commissioner Aguilar stated that she did not want to act too slowly in learning the lessons of the past. Mr. MacDonald stated that based on his experience, timing is more important than talent.

Public Comment

Linda Atcherley of the California Applicants' Attorneys Association (CAAA) asked about the 60% under-prediction of costs following the Minnear decision, which was really a statutory change in the treating physician assumption, and then the huge over-projection of costs in 2003-2004. She asked whether the researchers had looked at removing that under-prediction and removing the Minnear decision and estimating what the over-projection would have been then absent any reform. Mr. Barbagallo responded that they did not. Mr. Barbagallo also stated that recommendations about rates have to have a good understanding about what will affect rates in the future, not just look at past behavior. Ms. Atcherley stated the treating physician presumption also drove medical costs, not just permanent disability, because the cost of treatment increased. She stated that the time frame being looked at is not specific enough and not picking up minute changes, resulting in large under-projections of costs, which is very serious. Mr. Dixon stated that he agreed that factors other than the Minnear decision are important and that WCIRB and others needed to look at past trends and understand them sooner.

Ms. Atcherley stated that declining claims frequency also has an effect on overall profitability regardless of premium rate. Mr. Dixon stated that because claims were maturing more slowly, it took actuaries longer to see the trends change than in earlier periods. He stated that the main

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

reason for the slower maturation of claims that the researchers have heard is the increasing number of visits and potentially, more cases of contested treatment. Ms. Atcherley asked whether recommendations about the RBC would be enacted at the federal or state level, or at the insurance industry level. Mr. Dixon responded that while there will be many identified areas that need to be addressed, the study will not get into the detailed implementation of many of them. RBC is part of NAIC standards, and NAIC has a set of committees examining RBC all the time. Mr. MacDonald stated that NAIC would have to intervene in that process. Some states vary from the NAIC approach, and individual companies do too. For example, Standards and Poor has its own capital adequacy models. He stated that capital adequacy models are evolving and improving, and that they need to continue to evolve. He stated that some people think that they are lagging indicators and that it is too late by the time of mandatory control. He stated that there may be a need for more forward-looking indicators. Mr. Dixon stated that some states can modify RBC and do modify it for their particular situation, so California could think of that. Currently, CDI does not do that; it just uses the NAIC template.

Michael Nolan from CWCI stated that on the issue of under-projecting in Minnear, you have to keep in mind the cycle of the claim; most of the costs are on the back end, so it takes longer to develop, and you have to factor that in. He stated that on the issue of over-projecting cost, you have to distinguish between cost and frequency.

A member of the public asked about technology and transparency. Mr. Dixon responded that WCIRB does not get transaction-level data. WCIRB works closely with CWCI to do analyses of transaction-level data, but WCIRB has indicated that it would be useful for them to have the data and do their own analyses. He stated that that is one example of using data to achieve a finer data and level of analysis of trends. Mr. MacDonald stated that the availability of Yellow Books would help with transparency; they should be made more available to the public, making them downloadable, and some companies are already doing this. Instead of using premium as a measure of exposure, one could do the actuarial analysis with payroll information by class. The power of information technology could allow for more detailed analysis. All too often, actuaries have to rely on past years' data on premium and use models to assume loss ratios, and it takes years before that assumption can be tested for correctness. Mr. MacDonald stated that the point of using firms like CWCI for trends is that actuaries are not magicians, that empirical data frequently are not predictive of the future, and you need to look at trends within the trends, and that is the kind of work that CWCI does on return-to-work trends, both within states and within classes within states. He stated that leading companies are investing in that kind of analysis.

Chair McNally thanked the presenters for an interesting update on the study and discussion and stated that the Commission looks forward to their next presentation.

Draft Report on Self Insurance Groups

Lachlan Taylor, CHSWC Staff

Judge Taylor stated the Commission was asked to evaluate the stability of self insurance groups in California in view of the problems in New York State and other states. He stated that in New York State, the majority of self insurance groups are under-funded now and a number are insolvent. He stated that the challenge is to get the benefits of self insurance groups, such as flexibility and innovation and efficiency, and still have stability for employers.

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

Judge Taylor stated that he wished to acknowledge the valuable assistance of many people involved with the self insurance debate. The findings of the report include the following key points. California is in much better shape than New York. The first self insurance group in California began in 2002. From the beginning, California has required higher confidence levels for the reserving, and California has required a security deposit. California has not allowed the group administrator to be the claims administrator which allowed for an opportunity to manipulate the books. The key is if there is enough money in the self insurance group. In California, the Director's Office of Self Insurance Plans (OSIP) reviews the groups but may not have the talent, the skills and the motivation to second guess these entities. Therefore, one of the most controversial issues raised in the report is who should have oversight of self insurance groups. Some in the insurance industry would advocate complete transparency, so that the public can scrutinize what self insurance groups are doing and their financial status, but that would need to be weighed against the flexibility of self insurance groups to operate and serve the needs of their employers and employees.

Judge Taylor stated that the best interests of California employers and employees would be served if the Self Insurers' Security Fund (SISF) provided oversight, as SISF has its assets at risk if a self insurance group fails. There is some argument that insurers should have access to the information, but it is not the interest of insurers to protect employers and self insurance groups against the failure of the group; insurers have lost over half of their income stream because of reforms, and it is in the interest of insurers to eliminate the competition. Judge Taylor stated that the report concludes that it is neither in the best interest of self insurance groups to ensure the stability of their groups to expose their financials to the public, nor it is in their best interest to have only the Department of Insurance second guess what the status of self insurance groups is. The appropriate balance appears to be to have SISF be able to review and critique the stability of self insurance groups. Judge Taylor stated that the report also includes other minor recommendations.

Public Comment

Joe Burgess, CHSI, stated that he wanted to tell the Commission that he and other administrators appreciate the process followed in the report. The report is very well balanced and thoughtful with a number of positives for self insurance groups to go forward. He also stated that self insurance groups have an opportunity to be stronger. The RAND study on insurers encourages him to keep going forward with what self insurance groups have been doing and are planning to do. Judge Taylor stated that fully insured employers have no incentive to look out for solvency of their insurer because there is a back stop. In self insurance groups, the members do have that incentive. The report urges full disclosure of financials to members of a self insurance group. There is variation in the degree of disclosure across self insurance groups.

Commissioner Wei asked what the current law is, and Judge Taylor responded that the current law specifies that financial disclosure is required if a member asks. Self insurance groups handle this differently. Joe Burgess stated that the provision is in the indemnity agreement, and one of the concerns of self insurance groups is to maintain control over access to financials. He also stated that the meeting in April of administrators was productive.

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

Sam Sorich, California Association of Insurance Companies, stated that if he understood the report correctly, the recommendation is that the financial reports of the groups should not be made available to the public but to SISF. Judge Taylor responded that that was correct, that disclosure to the public would not enhance the stability of self insurance groups. Mr. Sorich stated that based on the RAND presentation, the argument about the value of making the financials of insurers available to the public should be the same for self insurance groups. Information made available would be about the self insurance group, not the individual employers participating in a group. This would allow the public to determine how OSIP is doing its job, just as disclosure of financial reports of insurance companies allows the public to determine how the CDI is doing its job. He stated that there is value in making the general financial information of for self insurance groups available to the public.

Chair McNally asked Mr. Sorich if that would apply to private self-insured entities also in SISF. Mr. Sorich responded that he has not focused on those groups. Chair McNally then stated that the report did not find any value in distinguishing between the self insurance groups and the individual entities as the analysis was done. He stated that he appreciated Mr. Sorich's comments.

Commissioner Wei asked about the two pieces of legislation pending in the Legislature on this topic and whether neither of them contains a recommendation about disclosure. Judge Taylor responded that those two pieces of legislation have been described as placeholders awaiting amendment, which may depend in part upon the report recommendations. Some of the simpler legislative recommendations in the report have been put into potential legislative language, such as the possibility that SISF may create separate accounts for groups and for stand-alones, much like CIGA has for different lines. There is also a recommendation for disclosure of information to SISF. However, there is no language drafted for a couple of the other recommendations, including what should be made public and what should not, as that would require more input than could be done at this time. He stated that there is also a question about whether the self insurance groups are compliant with the Corporations Code prohibition about distributions, and this could be cleared up with the right expertise.

Commissioner Wei asked what the next step would be and whether the report would be forwarded to the Assembly Insurance Committee, and Judge Taylor responded that that was so. Commissioner Wei stated that she would ask that there be a briefing along with the report. Judge Taylor responded that there is the intention to make amendments to both bills and that the discussion will continue in Sacramento.

CHSWC Vote

Commissioner Aguilar moved to approve the Draft Report on Self Insurance Groups to submit to Assembly Member Coto's office and for circulation and comment and to post within a month if no comments are made, and Commissioner Wei seconded. The motion passed unanimously.

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

Update on Quality-of-Care Indicators: A Demonstration Project

Teryl Nuckols, RAND Corporation and David Geffen School of Medicine at UCLA

Dr. Teryl Nuckols stated that she would like to recognize co-investigators and colleagues on the study of quality-of-care indicators in workers' compensation settings, particularly co-investigator Steven Asch who could not be present. She stated that a great deal of research shows that medical care provided in the U.S. is not very high-quality. Only 55% of medical care provided is consistent with recommendations based on published literature and the opinions of experts. For the most common conditions in workers' compensation, i.e., back, shoulder and knee problems, only 56 to 67 % of the right care is provided. This study included all settings, including workers' compensation settings. She stated that no one has looked systematically at the quality of care provided in workers' compensation settings.

Dr. Nuckols stated that improving the quality of medical care in workers' compensation settings would benefit both injured workers and employers. For injured workers, better care can improve recoveries and reduce temporary and permanent disability which would decrease economic losses. For employers, lack of recovery can create a need for medical care in the long run, and reducing temporary and permanent disability would decrease economic losses. One rigorous study, done in Spain, focused on guidelines and appropriate activities for injured workers: better care reduced time on temporary disability by 37%; better care reduced the number of temporarily disabled workers who became permanently disabled by 50%; and better care reduced medical and disability costs by 37%, a return of \$11 on each one dollar invested.

Dr. Nuckols stated that to measure quality in workers' compensation settings, specific quality-of-care measures are needed. The purpose of measurable standards is to permit objective evaluations of practice and indicate the extent to which current practice meets standards, and to ensure that results can be compared fairly among organizations or providers. Attributes of quality measure standards for care include that they are: relevant, scientifically sound, and feasible for measurement; described in detail so they can be applied in an objective manner; and have supporting information that explains qualifying terms, time frames, patient eligibility for the different measures, etc.

Dr. Nuckols stated that quality-of-care measures are related to but different from medical treatment guidelines. Quality-of-care measures are quantitative tools that: indicate performance related to a specific process or outcome; measure the quality of medical care; and have language that provides specific criteria for which practices are "right" and "wrong." In terms of complexity, there are simplistic algorithms that provide clear scoring instructions for process that can be measured practically. Measures are used in accountability systems, as there are assigned penalties or rewards based on performance applied in an objective manner. In contrast, Dr. Nuckols stated, guidelines are sources of recommendation to be applied prudently based on clinical experience. They consolidate information to reduce gaps between scientific knowledge and clinical practice. They are flexible in that they acknowledge the "gray zone" of uncertain appropriateness. In addition, they acknowledge medical complexity and patient preferences.

Dr. Nuckols stated that the goal of the study was to demonstrate quality measurement in workers' compensation. The objectives were to: develop quality-of-care measures for carpal

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

tunnel syndrome (CTS); pilot test the measure in workers' compensation provider and payor organizations; place measures and supporting tools in the public domain; and use the measures to assess quality of care for a larger population of patients.

Dr. Nuckols stated that public-private partnerships made the project possible. Funding support was provided by the Commission and Zenith Insurance. The Commission also provided essential assistance in developing the project. Partners-in-kind included Kaiser Permanente Northern California Regional Occupational Health and SCIF, which have been involved in pilot testing.

Dr. Nuckols stated that the research approach of the project was to develop quality measures for CTS included the following steps: Step 1-- a multidisciplinary research team developed draft measures from guidelines and literature; Step 2 -- a multidisciplinary panel of 11 national experts in CTS rated the measures for validity and feasibility; Step 3 -- the RAND/UCLA team created a tool that explains how the measures should be used; and Step 4 -- Kaiser Permanent Northern California Regional Occupational Health and SCIF pilot tested the measures.

Dr. Nuckols stated that 77 measures were developed: 31 measures address diagnosis and non-operative management of CTS including history and physical examination, medications, splints, activity modification and return-to-work planning; 6 measures address the use of electrodiagnostic tests; 18 measures are for indications for carpal tunnel surgery including when surgery is necessary and when it is inappropriate; and 22 measures address care before, during and after surgery.

Dr. Nuckols stated that in a Washington state study of CTS claims, half of the claims were initially filed for other conditions; in 20% of the claims, CTS was not diagnosed until more than three months after initiation of the workers' compensation. Dr. Nuckols stated that the longer the delay until the CTS diagnosis, the longer the disability tended to be. One measure therefore specifically addresses delays in recognizing CTS symptoms. New symptoms characteristic of CTS should lead to suspicion: if a patient complains of any of the following symptoms highly characteristic of CTS – paresthesias, numbness, or tingling on the first to third fingers or palm -- then a suspicion of CTS should be documented in the medical record at the initial evaluation of those systems, because early diagnosis of CTS can lead to earlier intervention.

Dr. Nuckols stated that many clinicians use the wrong examination techniques to check for CTS. Phalen's and Tinel's maneuvers, taught in medical residencies, are the wrong techniques. If the progress notes document that CTS is suspected, then the right technique should involve at least one of the following physical examination maneuvers that should be documented at the initial evaluation: testing for sensory abnormalities in median nerve distribution; testing for thenar muscle weakness; and examination for thenar muscle atrophy. Dr. Nuckols also stated that splints are often positioned poorly, which actually worsens symptoms. The wrong technique is that many splints come out of the box in a position of 20-30 degrees of wrist extension, and use of a wrist splint in extension worsens CTS. The right technique is for splints to be placed in a neutral position; if a patient with CTS is prescribed a splint, then the chart should document that the splint was positioned so that the wrist is neutral (neither extension >10 degrees or flexed).

Dr. Nuckols stated that several measures address work-relatedness, activity, and return-to-work

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

planning. She stated that measure titles are: New CTS diagnosis requires detailed occupational history; new CTS diagnosis requires assessment of occupational factors; new CTS diagnosis requires assessment of non-occupational factors; exacerbating activities should be identified when CTS limits functioning; rationale for work-association should be documented; patients diagnosed with CTS should be educated about the condition; exposures to vibration, force and repetition should be minimized; work-associated CTS symptoms should require prompt follow-up; work status should be monitored when CTS appears work-associated; return to work after CTS-related disability should require follow-up assessment; and prolonged CTS-related disability should trigger evaluation.

Dr. Nuckols stated that the measures for electrodiagnostic tests appear to be the first in that field. One measure indicates that people should be tested when anyone who has work-associated CTS may be a candidate to undergo surgery. There are essential examination components to test for CTS, including measuring and correcting skin temperature. Interpreting findings should be based on criteria for calling a result consistent with CTS. Although electrodiagnostic test results are one important consideration in determining when surgery is appropriate, the severity and pattern of symptoms, as well physical examination findings, are more important. The decision to operate should not just be based on electrodiagnostic test results.

Commissioner Wei asked what electrodiagnostic tests are, and Dr. Nuckols responded that they are nerve conduction studies that measure conduction across the carpal tunnel nerve. Commissioner Wei asked if this is an invasive process, and Dr. Nuckols stated that there is some discomfort from shocking the nerve, but nerve conduction studies are not very invasive. Commissioner Wei asked why if it is not the right test for CTS and it is not the right way to pre-screen for surgery, payors relying on it as a pre-screen for surgery. Dr. Nuckols responded that the reasons to take someone to surgery are complicated. Electrodiagnostic tests are helpful but not the main reason to operate, as there can be false positives. The test, however, can be helpful in confirming the impression of CTS.

Dr. Nuckols stated that indications for surgery have two uses. First, there are quality measures to examine prior care. For example, if a patient has mild CTS present for up to 12 months and all of the following criteria are met – conservative therapy has not been attempted or has adequately resolved the patient’s symptoms; the presentation is less than “high probability” and an electrodiagnostic test is positive for CTS – then the patient should not undergo carpal tunnel surgery. The study also created an algorithm to determine appropriateness of future surgery which considers symptoms, examination findings, conservative therapy and electrodiagnostic tests, and it could supplement the current American College of Occupational and Environmental Medicine (ACOEM) *Guidelines* in utilization review and help determine whether and when there should be surgery. A part of the algorithm looks at whether there are ongoing symptoms. The algorithm determines whether the surgery is inappropriate, optional or necessary. Prior studies that have developed similar algorithms have shown improved quality of life among people for whom surgery was consistent with recommendations.

Dr. Nuckols stated that manuscripts based on the study have been submitted to medical journals: *Journal of Occupational and Environmental Medicine*; *Muscle and Nerve*; and *Plastic and Reconstructive Surgery*. A tool, the RAND/UCLA Quality of Care-Measures for Carpal Tunnel

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

Syndrome: Data Collection Tools, which will include the algorithm, will be posted online when finished in the next few months.

Dr. Nuckols stated that there are some observations from developing the tool and pilot testing the measures regarding requirements for use have been noted. A complete record for prior care is important, so usually medical records are needed. First, users must accurately identify patients with CTS; usually administrative (i.e., claims) databases are used but they generally do not indicate the medical examination. Current Procedural Terminology (CPT) and International Classification of Diseases, 9th Revision (ICD-9) codes, should be used when possible. Second, assessing adherence to the measures requires a complete record of the care provided for CTS: the claims databases do not provide the necessary information; DFS and PR-2s may suffice if they are easily obtained and contain all information that is in the medical record, but usually, medical records are required. Third, staff with appropriate skill levels is needed; most measures can be rated by nurses and other providers particularly if they have a claims-review background, but some measures addressing electrodiagnostic tests and how surgery is performed require physicians in those fields.

Dr. Nuckols stated that providers could use these measures in their practices. The measures provide advantages for many workers' compensation payors that are interested in selecting high-quality providers for their medical networks. They are rigorously developed by physicians, based on the latest guidelines and developed by national experts in the care of CTS. They are also adaptable, as providers can select the measures they consider important and choose how to apply them. In addition, they are easy to use on a trial basis, as no special technology or expertise needed for most of the measures. Finally, they are inexpensive, as measures are free and start-up costs include training staff. These measures will become more useful if widely adopted and ultimately, report cards could compare provider organizations. It would be feasible in the workers' compensation setting to reduce the burden on the utilization review process.

Dr. Nuckols stated that the results of the study lay the groundwork for a comprehensive study of quality for CTS. The U.S. Agency for Healthcare Research & Quality has awarded a grant to develop projects and expertise addressing the relationship between quality and costs. The work on this project was instrumental in securing this grant. In addition, RAND and Kaiser Permanente Regional Occupational Health are partnering to do a study examining the quality of care among workers' compensation patients with CTS, as well as the relationship of quality care to workers' clinical outcomes and the costs to major stakeholders. A grant will be submitted to the U.S. Agency for Healthcare Research & Quality. At the same time, Kaiser Permanente will use the measures to develop an internal quality assurance program.

Dr. Nuckols stated that conclusions based on the study include that quality of care is important in workers' compensation settings and quality measures are needed. Low-quality care impedes recovery and increases cost to everybody. CTS is a good place to start. Also, provider organizations can use the CTS measures and tools developed by the study to monitor quality of care. For payors, it may be more feasible to encourage providers to monitor quality than to assess quality directly. In addition, payors could assess the appropriateness of future surgeries for CTS using the algorithm developed in the study.

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

Comments from Commissioners

Commissioner Aguilar stated that she thought it was a great study.

Public Comment

Michael Nolan, from the Workers' Compensation Research Institute (WCRI), stated that one of the goals of the study was to track under- and over-utilization. Dr. Nuckols responded that most of the measures address under-use because there are not many situations where doing something produces a negative result. There are several measures that address the use of medication and other treatments for CTS and indicate which are inappropriate, such as ibuprofen and opiates, and that low-level laser treatment should not be used. For surgical appropriateness situations, the measures are very clear for when there should not be surgery.

Julius Young, applicants' attorney, stated that in his practice, he has found cases in which CTS was diagnosed and later there was neck surgery. He stated that specialty providers seem to look at separate body parts and not the whole person, and as a result, carriers pay out a huge amount of money for medical treatment. Dr. Nuckols responded that the targeted measures for the physical examination and testing should improve this situation. In addition, electrodiagnostic tests should be instrumental if performed properly. Finally, the tool developed from the study will suggest that if there is suspicion that the problem is related to another body part, e.g., the neck, then that body part should be evaluated thoroughly.

Commissioner Aguilar stated that she has seen cases of mis-diagnosis and the sad results from that. She stated that she hopes that the measures and tool will help improve this situation beyond ACOEM *Guidelines*. Claims adjusters will also need to be better educated to handle diagnoses so that delays in treatment do not occur.

Commissioner Wei stated that at the beginning of this project, she did not really understand what the end result would be, but she feels that the study results will be very helpful. She thanked Dr. Nuckols for her work.

Update on the Worker Occupational Safety and Health Training and Education Program (WOSHEP); WOSHTEP and California Partnership for Young Worker Health and Safety Contracts

Robin Dewey, Labor Occupational Health Program, University of California (UC), Berkeley

Robin Dewey stated that she was representing WOSHTEP staff and would present an overview of WOSHTEP, which was established by workers' compensation reform in 2002 and is funded by insurance carriers authorized to write workers' compensation in California. The statewide program is administered by the Commission through three Resource Centers: UC Berkeley, UC Davis and UCLA. The goal of the program is to reduce injuries and illnesses among California workers and workers' compensation costs through worker involvement in prevention and promoting safety and health on the job. There are four major components with ongoing

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

activities: the Worker Occupational Safety and Health (WOSH) Specialist course, which teaches worker leaders how to become occupational safety and health specialists working with both management and workers on workplace health and safety issues; small business resources for the owners and managers of small businesses, including general materials applicable across industries and industry-specific materials for the restaurant and janitorial services industry, as well as materials and training in development for the dairy industry; young worker health and safety programs; and Resource Centers for helping WOSH Specialists and others.

Ms. Dewey stated that WOSHTEP materials either developed or in progress include: a Heat Stress Tailgate Guide in English and Spanish for crew supervisors to teach agricultural workers about health stress prevention; a Motor Vehicle Safety Programs Factsheet; a Workplace Violence Module for the WOSH Specialist Course; a Wellness Booklet focusing on integrating injury and illness prevention and wellness programs and promoting both of those; Fact sheets for high-risk industries and/or occupations; an English as a Second Language (ESL) curriculum teaching young farmworkers about health and safety at the same time that they are learning English; a dairy industry small business resource packet; and an Emergency Preparedness Module for the WOSH Specialist course.

Ms. Dewey stated that through a proposed three-year core contract, WOSHTEP will continue to: offer the WOSH Specialist Course by targeting workers in high hazard industries and occupations; deliver WOSH Specialist courses statewide; continue to identify and train WOSH Specialist Network Trainers; and maintain ongoing contact with Specialists and Trainers. In addition, WOSHTEP will continue to provide health and safety resources to small businesses by: continuing general small business, restaurant and janitorial trainings for small business owners/managers; and implementing a program for the dairy industry in the Central Valley. WOSHTEP will also continue to provide health and safety resources to young workers by: presenting two Young Worker Leadership Academies, one in Northern California and one in Southern California; providing ongoing follow-up with previous Academy graduates to keep them involved in safety and health activities, including participation in future Academies; and promoting the new Academy Guide nationally. Ms. Dewey also stated that WOSHTEP partners will continue to collaborate with community-based organizations to bring WOSHTEP resources and training to underserved workers, as mandated by the Labor Code. In addition, WOSHTEP will continue to maintain three Resource Centers, by: providing ongoing technical assistance and resources to WOSH Specialists and Trainers and others; and maintaining a multi-lingual resource guide which provides links to health and safety resources in over 23 languages.

Ms. Dewey stated that special projects proposed for a one-year WOSHTEP contract include: a Building Trades Project, working with the State Building Construction Trades Council (SBTC) to develop and incorporate injury prevention modules and case studies into the apprenticeship programs in Northern and Southern California; a Small Business Resource and Training Packet for Small Farms, providing a small business resource packet and pilot trainings for owners/managers of small farms; a Heat Illness Prevention Program For Farm Workers, promoting heat stress awareness through promotora networks using the Heat Hazards in Agriculture tailgate guide to teach farmworkers; an Indoor Heat Stress Prevention Project, developing short activities and materials in English and Spanish on indoor heat illness prevention across multiple industries; and a Health and Safety Resources and Training Materials Program

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

for people with severe developmental disabilities working in hazardous environments across several industries to be delivered in sheltered workshops.

Commissioner Aguilar stated that this is a great program and she offered her congratulations on its success.

Ms. Baker stated that the program is well established and the three-year core contract would allow for hiring and keeping staff for at least three years. This includes the funding for special projects expected to be included each year. The California Partnership for Young Worker Health and Safety contract would also provide funding for a three-year period. Contracts are funded by special funds that have to be dedicated to this program.

CHSWC Vote

Commissioner Wei moved to approve the WOSHTEP and California Partnership for Young Worker Health and Safety contracts, and Commissioner Schwenkmeyer seconded. The motion passed unanimously.

Executive Officer Report

Christine Baker, CHSWC

Ms. Baker stated that staff has been actively working on several projects. The Report on Self Insurance Groups and the Return-to-work Report Recommendations are some of the final documents that staff has been preparing.

Ms. Baker stated that Commission staff are also initiating two safety projects and are preparing the necessary memoranda of understanding and data requests. The projects include the impact of workers' compensation experience modification and firm age on safety behavior and an evaluation of the effectiveness of California's injury and illness prevention program. The Director's office has asked if an analysis of firms with apprentices can be included to determine if they might be safer and thus should have better premium costs.

Ms. Baker stated that along with the Report on the Return-to-Work Program, possible improvements to the program are being submitted. Juliann Sum, University of California (UC), Berkeley has been instrumental on assisting on this project. The Acting Administrative Director would like the report as a stand alone and the details of the recommendations as a separate document.

CHSWC Vote

MINUTES OF CHSWC MEETING
April 30, 2009 Oakland, California

Commissioner Thacker moved to approve for final posting and submission to the Acting Chief Deputy Administrative Director of the Division of Workers' Compensation (DWC) the Draft Report on the Return-to-Work Program Established in Labor Code Section 139.48 and a separate document with expanded recommendations, and Commissioner Aguilar seconded. The motion passed unanimously.

Other Business

None.

Adjournment

Commissioner McNally stated that the next CHSWC meeting is scheduled for August 27, 2009, in Oakland, at 10:00 a.m.

Approved:

Sean McNally, Chair

Date

Respectfully submitted:

Christine Baker, Executive Officer

Date