

V. EFFECTS OF REFORMS ON INSURANCE INDUSTRY SURPLUS AND SOLVENCY

Impact of Reforms on Insurance Company Surplus

In addition to reducing insurance rates, the reforms also decreased costs associated with claims incurred prior to the effective date of the legislation. The retroactive impact of the changes increased the surpluses of insurers with outstanding (unpaid) workers' compensation claims liabilities.

For example, there are currently many open insured claims associated with injuries which occurred in 2002. As of December 31, 2002, insurance companies estimated and expensed the full cost of the 2002 claims. The costs on the 2002 claims which had not yet been paid were booked as a liability. However, some of the provisions of the recent reforms reduced the expected future payments on open 2002 claims. This reduction in future costs resulted in a decrease in liabilities which, in turn, increased surplus.

In discussing the impact of the reforms on insurance company surplus, it is important to note that this impact is not necessarily reflected in insurance company "statutory surplus" which is filed with CDI. Statutory surplus of an insurance company is the surplus determined by the accounting treatment of both assets and liabilities established by state statute. It is important to keep in mind that statutory surplus reflects actuarial estimates of loss and loss adjustment expense liabilities. If the reforms reduce liabilities by five percent, but an insurance company's estimate only reflect a two percent reduction, then the company's statutory surplus will not reflect the true savings from the reform. In addition, there are many factors which affect statutory surplus, such as non-admitted assets and reinsurance recoverables, which are not directly related to savings from the reforms.

Impact of the Reforms on Prior Years' Surplus

While there are accurate methods for estimating the impact of changes to medical fees (out-patient, pharmacy, in-patient and physician fees), it is extremely difficult to predict in advance or separate the impact of a broad procedural change such as instituting the ACOEM Guidelines. Therefore, we will discuss each of these components separately. The following is a summary of our results.

Exhibit V.1. Impact of Reforms on Insurance Industry Reserves (2003 & Prior): (\$Billions)		
Reform	Savings Active Insurers	Savings All Insurers
Medical Fees	\$2.3-\$2.6	\$2.8-\$3.1
Evidence-Based Medicine	\$2.9-\$4.0	\$3.4-\$4.7
Permanent Disability	<u>\$0.2-\$2.8</u>	<u>\$0.2-\$2.9</u>
Total	\$5.4-\$9.4	\$6.4-\$10.7

It is important to note that while the reforms produced retroactive savings to the insurance industry, future changes could retroactively reduce or reverse those savings. For example, increasing benefits in the PD schedule could retroactively increase costs, depending on how the benefit changes are implemented. Similarly, court decisions could retroactively increase benefit to a level higher than what insurers thought they were when writing the policies.

How the Reforms Have Impacted Surplus

There are a few basic ways in which the reforms have impacted insurance company surplus.

Retroactive: Many aspects of the reforms are retroactive, meaning the changes apply to all claims which occurred prior to the enactment dates of the reforms, but have not yet been resolved. For example, medical fee schedules were changed as a result of SB 228. This means that prior to SB 228, which took effect January 1, 2004, insurance companies needed to reserve claims and state their liabilities using the old medical fee schedule. However, starting January 1, 2004, medical fees were on average reduced, thereby lowering insurance companies' expected future costs on existing claims. This reduction in liabilities results in an increase in insurance company surplus.

Prospective: Insurance company surplus can be expected to increase to the extent that post-reform premiums are greater than post-reform costs (after adjusting for investment income). We consider this to be an issue primarily related to how the insurance industry has priced the savings from the reforms, which is discussed in Section IV of this report.

Market Forces: There is substantial evidence that after the reforms the California workers' compensation market has attracted new capital during the post reform period. However, insurance companies are not required to report surplus and capital allocations by coverage and state. Given that most carriers write multiple lines of insurance in many different states, we are not able to quantify the amount of increased capital and surplus resulting from this consideration. In addition, the insurance companies that we interviewed differed in their opinion as to why competition is increasing in California. Some thought that the reforms were instrumental in making the market attractive, while others stated that the price increases leading up to the reforms were the primary cause of interest.

In discussing the impact of the reforms on insurance company surplus, it is important to note that this impact is not necessarily reflected in insurance company "statutory surplus" which is filed with the Department of Insurance. For example, SCIF filed ultimate cost projections for accident years 2002 and prior increased from December 31, 2003 to December 31, 2004, and also from December 31, 2004 to June 30, 2005. This may be because there were other factors that offset the savings anticipated from the reforms. In any case, the retroactive savings from the reforms has not resulted in a net decrease in SCIF's surplus for 2002 and prior.

Major Elements of the Reforms Retroactively Impacting Surplus

Overview

There are many elements of the reforms that apply to all existing claims and, thus, retroactively affect surplus. These include the following:

Out-Patient Facility Fees: SB 228 instituted a fee schedule for outpatient facilities based on Medicare's fee schedule. Fees were initially set at 120% of Medicare's schedule for hospital outpatient departments (APC) via emergency regulations which took effect as of January 2, 2005. The fees were increased to 122% of Medicare's APC rate as of July 1, 2004. These regulations have recently been updated to incorporate Medicare adjustments.

Pharmacy Fees: According to SB 228, the maximum allowable fee for all dispensers is 100% of the MediCal rate. This change applies to all drugs provided on or after January 1, 2004. In addition, SB 228 made the mandatory generic substitution requirement apply to all dispensers.

In-Patient Hospital Fee Schedule: Prior to SB 228 in-patient fees were already based on the Medicare system. SB 228 and emergency regulations effective January 2, 2005 made several changes to the fees and reimbursements.

Physician Fee Schedule: Reductions of up to 5% were introduced under SB 228 if the Official Medical Fee Schedule (OMFS) guidelines exceed those of Medicare. However, SB 228 did not change the OMFS itself.

ACOEM Guidelines: SB 228 requires that medical treatments be supported by medical evidence found in the ACOEM guidelines. This applies based on the date of medical treatment.

Permanent Disability Rating: SB 899 instituted many changes that affect permanent disability awards, including apportionment, the method of arriving at a PD rating, and the PD schedule.

Changes to Medical Fees

We have found three studies which either directly calculate the impact of the changes to medical fees on reserves or can be adjusted to provide an estimate. Two of the studies were performed by the WCIRB which were in turn were based heavily on work provided by the CWCI. The third estimate was performed by Frank Neuhauser of the University of California, Berkeley for CHSWC. In spite of the fact that these studies were performed at different time periods (one before SB 228, one just after SB 228 was implemented, and one very recently), the conclusions are remarkably similar and point to the potential for retroactive savings (e.g. increase in surplus) of \$2.8 - \$3.1 billion. The following exhibit summarizes the results of the various studies:

Exhibit V.2. Impact of Changes to Medical Fees on Insurance Industry Reserves		
(\$Billions)		
Basis for Estimate		Savings
WCIRB (12/1/05)		\$2.8
WCIRB (5/26/04)	Estimate #1	\$2.8
WCIRB (5/26/04)	Estimate #2	\$3.0
Neuhauser (4/22/03)		\$3.1
Selected		\$2.8-\$3.1

The above figures represent only the insured portion of California workers' compensation market. Self-insured risks are not included. The following is a discussion of the above estimates:

WCIRB December 1, 2005: At least once a quarter the WCIRB Actuarial Committee meets and reviews the latest workers' compensation loss experience related to active insurance companies in California. Insurers which have gone bankrupt are not included because they do not report losses to WCIRB. At the most recent meeting (December 1, 2005), the committee discussed activity through September 30, 2005.

Consistent with prior meetings, the December 1, 2005, actuarial committee meeting adjusts medical payments prior to January 1, 2004 to the levels that they would have been had SB 228 been in effect. This is an appropriate adjustment aimed at removing a potential distortion to the paid medical loss development patterns. Based on work performed by the CWCI, the adjustment was 9.4%, which represents about \$3.3B. Multiplying the paid loss development factors by the adjusted paid losses, the result is estimated ultimate medical losses of \$54.3B for accident years 1976 - 2003. This represents an estimate of what ultimate losses would have been if SB 228 had been in effect since 1976.

Since medical payments are reduced by approximately 9.4% to reflect SB 228, dividing the above \$54.3B by 90.6% (= 100% - 9.4%) equals estimated ultimate medical losses had SB 228 never taken effect. This equals \$59.9B for accident years 1976 - 2003.

These calculations suggest that SB 228 would have reduced costs associated with injuries occurring between 1976 and 2003 by \$5.6B if it had been implemented in 1976. However, the actual implementation date was January 1, 2004; though we anticipate a reduction in future payments associated with prior claims, there is no retroactive savings on payments that have all ready been made. The \$5.6B can be thought of as the sum of two pieces: actual payments made prior to January 1, 2004, plus payments made on or after January 1, 2004. As discussed above, the estimated impact that SB 228 would have had on pre- January 1, 2004, payments is \$3.3B. Therefore, the projected impact of SB 228 on payments on or after January 1, 2004, is \$2.3B (= \$5.6B minus \$3.3B). Since SB 228 took effect on January 1, 2004, the estimated savings due to medical fee changes in SB 228 is \$2.3B.

The \$2.3B we have just derived only represent the savings associated with active insurers. Savings associated with insurers that are inactive due to bankruptcy or receivership are not included because they do not report their losses to the WCIRB. In Appendix F page 1, we

adjust the savings by year to include estimated savings associated with inactive insurers. This adjustment brings the total savings up to \$2.8B.

WCIRB May 26, 2004: The May 26, 2004, WCIRB Actuarial Committee evaluated the 2003 and 2004 legislation, including the impact of AB 227, SB 228, and SB 899 on unpaid medical costs. High and low estimates were presented, with separate projections for changes to pharmacy fees, outpatient fees, inpatient fees, changing the assumption of correctness of the primary treating physician (SB 899) and the introduction of medical utilization guidelines (SB 899). (Refer to Appendix F pages 3 and 4.)

The savings associated with medical fee changes calculated by the WCIRB are all detailed in terms of loss ratio. To be consistent with step #1 above, we utilized earned premium as of September 30, 2005, in order to calculate the dollar savings. Using these premiums, the savings vary between \$2.3B and \$2.5B. As with step #1, the initial estimate of savings excludes inactive carriers. The adjustment to include inactive insurers results in a total estimated savings of \$2.8B to \$3.0B.

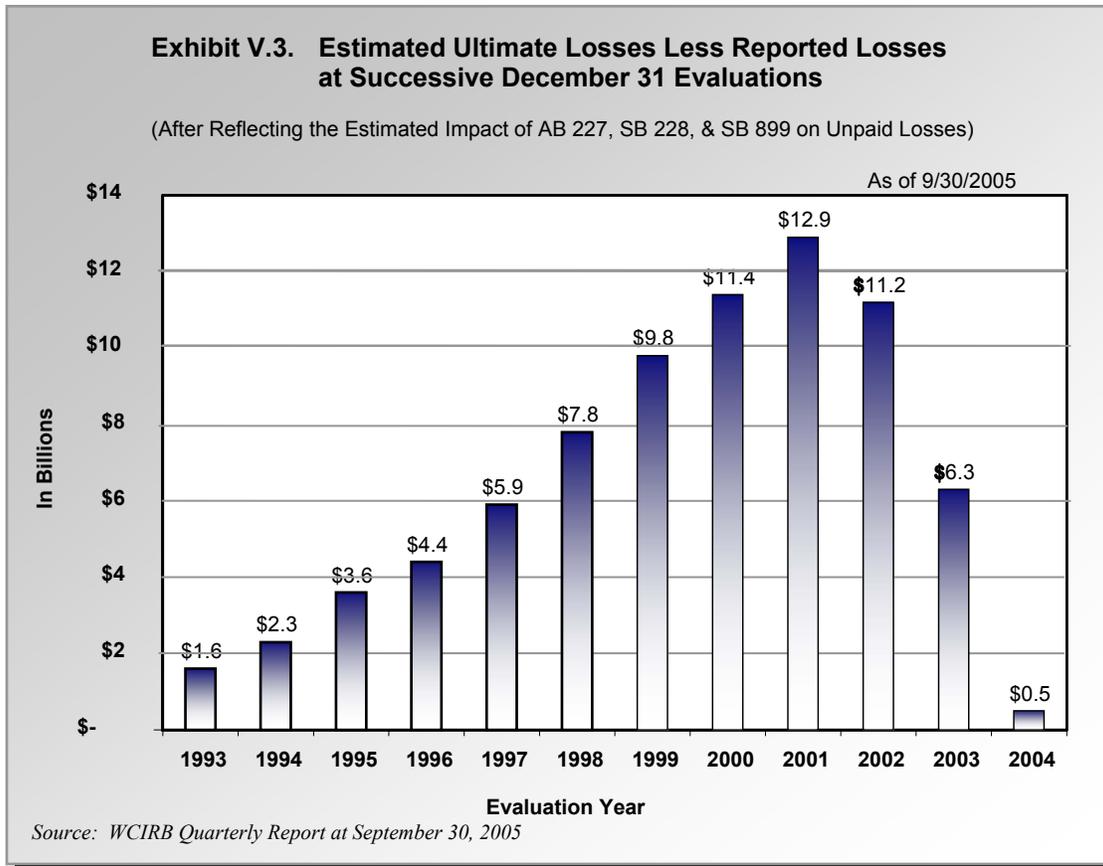
Neuhauser/CWCI: On April 22, 2003, Frank Neuhauser of UC Berkeley released a report for the purpose of giving guidance to CHSWC regarding the likely impact of various proposed regulations.¹ It is important to note that SB 228 had not yet been finalized, and so this report relied on assumptions of what changes would likely occur. We have only included the report's estimates of the impact of changes to the outpatient fee schedule and pharmacy fees, which total \$3.1B.² Changes to in-patient fees were not analyzed. The study also projected the impact of changing physician fees to a Resource-Based Relative Value Scale (RBRVS) which SB 288 did not implement. Given the limited amount of information available when this study was conducted, it is remarkably accurate regarding the scale of savings that would be realized by changing medical fees.³

Evidence-Based Medicine

Aside from changes to medical fees, the reforms introduced many other changes that retroactively altered costs. One particularly significant change was the introduction of evidence-based medicine through the ACOEM Guidelines.

More than a year has passed since evidence-based medicine was implemented. Actual loss emergence subsequent to April 2004, and the degree to which it has changed from prior levels can be used to generate an estimate of the impact of the legislation on costs. One method of estimating the impact of evidence-based medicine is to look at projections before and after its inception. Assuming that the methods used to create the projections are consistent and appropriately reflect changes resulting from the reforms, then the difference between the pre-reform and post-reform estimates can be assumed to be caused by the reforms.

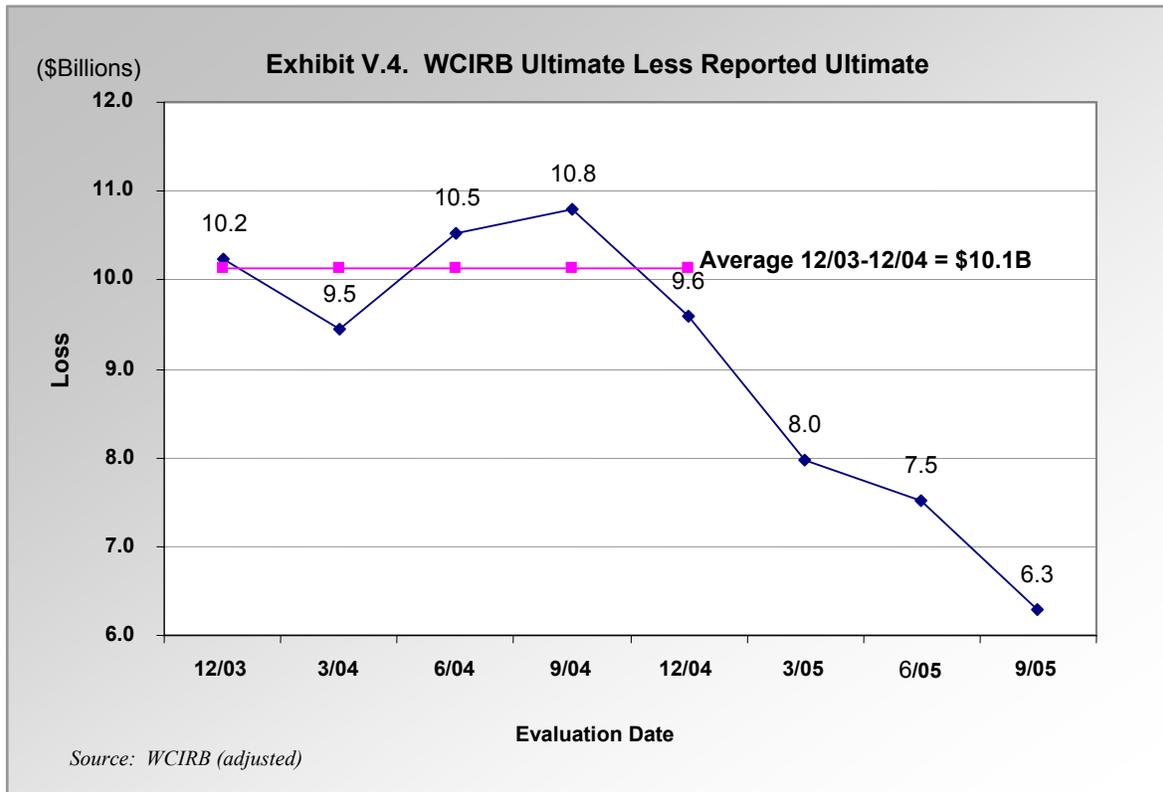
For the past few years the WCIRB has released a quarterly "Summary of Insurer Experience" which includes an exhibit showing estimated ultimate losses of projected by WCIRB minus those reported by insurance companies. The following exhibit is based upon the latest WCIRB quarterly report.⁴



Concentrating on evaluation year 2003, the above exhibit shows that the September 30, 2005, estimates of ultimate losses for accident years 2003 and prior are \$6.3B higher than the insurance company reported ultimate loss projections as of December 31, 2003. It is important to note that while this is indicative of insurance company reserving, the \$6.3B does not directly equate to insurance company deficiencies as of December 31, 2003, because it is gross of both deductibles and reinsurance.

By reviewing historical WCIRB quarterly summaries of insurer experience we can see the variability of the estimates over time. For example, the following exhibit shows the differences between the WCIRB and insurer ultimate losses for accident years 2003 and prior.

This exhibit shows that while the difference between the WCIRB and insurance company estimates was \$6.3B as of September 30, 2005, the difference was \$9.6B as of December 31, 2004. Since both of these figures are comparisons to insurance company reported information as December 31, 2003, then the change from \$9.6B to \$6.3B was due to a change in WCIRB estimates.



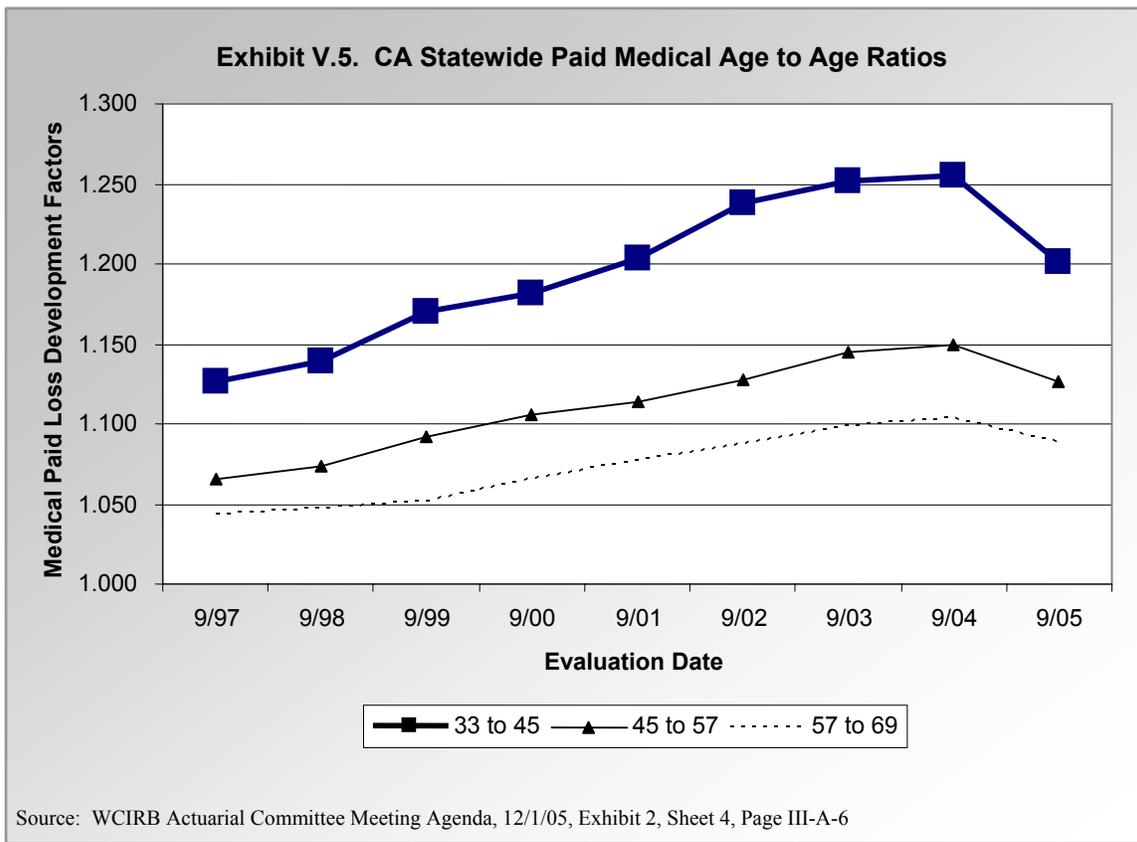
All of the WCIRB figures have already been adjusted for changes to the medical fees resulting from SB 228. However, beginning in December 31, 2004, the WCIRB partially changed their method reflecting these changes. In all valuations the most-recently valued losses were reduced to reflect the new fee schedules. In December 31, 2004, the WCIRB also began reducing the prior-year valuation losses in order to adjust the paid medical loss development factors. The figures on the above exhibit are adjusted to bring the pre December 31, 2004, estimates to the same basis as the as the post December 31, 2004, estimates.

The above figures are also adjusted for changes in which carriers have reported losses to the WCIRB. While almost all active carriers regularly report loss and premium information to the WCIRB, WCIRB estimates may change from one quarter to the next based on certain carriers becoming inactive due to late-reporting of an active carrier. The figures in the above exhibit adjust for this.

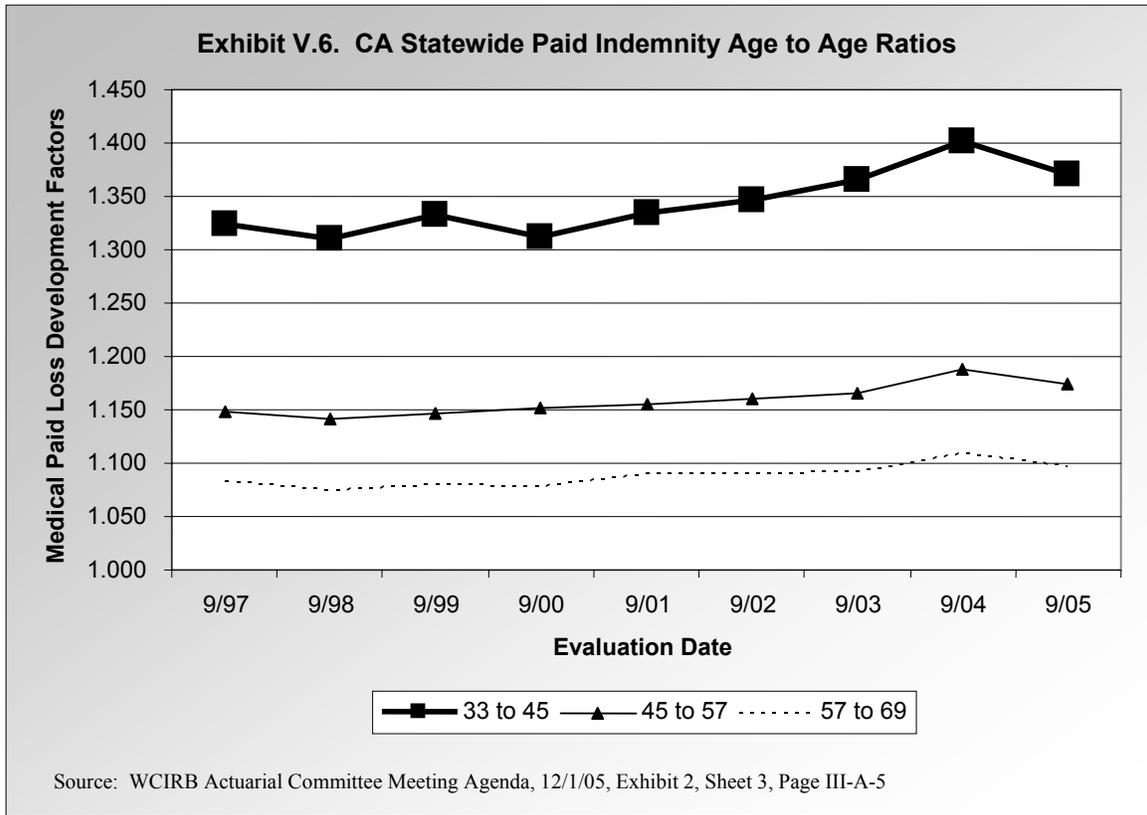
The WCIRB method of calculating ultimate loss requires at least one year of loss payments. Therefore, changes other than medical fees that took effect in April 30, 2004, were not fully

reflected in the WCIRB estimates until after December 31, 2004. Similarly, changes which took effect January 31, 2005, or later, have not yet been fully reflected in the WCIRB's September 30, 2005, results. Based on this we believe that the drop in WICRB estimates during 2005 is likely a result of the reforms.

The following exhibit shows the paid medical age to age ratios over the past several years. These development factors are a key element in reflecting the impact of the reforms on older years. This exhibit clearly shows that the age to age ratios were increasing for many years prior to the reforms. The decrease in age to age ratios, which we believe is due to the reforms, does not begin until the latest year. These factors are not adjusted for changes to the medical fees.



The indemnity age to age ratios are higher than the medical ratios, and they display a similar pattern. They increased for many years in a row leading up to the reforms. More recently they have started to decrease.



It is clear from the above exhibits that the impact of the reforms on historical loss development was most significant in 2005. While the WCIRB estimates of ultimate loss vary quite a bit from one evaluation date to the next, the 2005 projections are generally lower than the preceding estimates. The following exhibit compares the results:

Exhibit V.7. Comparison of 2004 versus 2005 Estimates of Ultimate Loss for 2003 & Prior (\$Billions)

Estimate	2004	2005	Difference
High	\$10.3	\$6.3	\$4.0
Average	10.2	6.8	3.4
Low	10.1	7.3	2.9
Selected			\$2.9-\$4.0

Based on the estimates presented above, we believe that it is reasonable to assume that the reforms reduced 2003 and prior losses by \$2.9B to \$4.0B for active insurers. This excludes the impact of medical fees. Medical fee savings were increased by about 19% to convert from active insurer savings to all insurer savings. A similar adjustment for the non-medical fee savings results in an estimated range of \$3.4B to \$4.7B.

PD Schedule

There is substantial uncertainty regarding the interpretation of SB 899 with respect to the retroactive impact of the new PD schedule on older claims. For example, it is not clear if SB 899 will be interpreted to allow the January 1, 2005, PD schedule to apply to claims with dates of injury prior to January 1, 2005. California Labor Code 4660(d) reads as follows:

The schedule shall promote consistency, uniformity, and objectivity. The schedule and any amendment thereto or revision thereof shall apply prospectively and shall apply to and govern only those permanent disabilities that result from compensable injuries received or occurring on and after the effective date of the adoption of the schedule, amendment or revision, as the fact may be. For compensable claims arising before January 1, 2005, the schedule as revised pursuant to changes made in legislation enacted during the 2003-04 Regular and Extraordinary Sessions shall apply to the determination of permanent disabilities when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by Section 4061 to the injured worker.

According to a recent ruling by Judge David Hettick’s regarding *Elizabeth Aldi vs. Carr, McClellan, Thompson & Horn and Republic Indemnity Co. of America, SF) 0485703*, the PD schedule implemented on January 1, 2005, only applies to injuries occurring on or after that date. If this interpretation prevails, then the retroactive savings associated with the new PD schedule will be limited to those pre-2005 claims in which there had already been final decision using the new schedule and which could not be appealed. The savings associated with these claims is very limited.

Even if the courts rule that the SB 899 PD schedule does apply to pre- January 1, 2005, claims, there are other legal issues to consider, such as the interpretation of “existing Order, Decision or Award of the Workers’ Compensation Appeals Board for determining those cases that could not have the provisions of SB 899 applied to ongoing determinations. These legal issues are discussed in detail in the legal analysis included in Appendix G of this report.

The following exhibit provides our estimates of retroactive savings related to changes to the PD schedule outlined in SB 899 and implemented January 1, 2005:

Exhibit V.8. Impact of Changes to PD System on Insurance Industry Reserves			
(\$Billions)			
	Low Savings	Middle Savings	High Savings
Active Insurers	\$0.2	\$1.2	\$2.8
All Insurers	\$0.2	\$1.2	\$2.9

The detailed calculations supporting the above projections are in Appendix G and are based on the following steps:

Ultimate Indemnity Loss: The estimates of ultimate indemnity losses by accident year as presented in the WCIRB Actuarial Committee meeting of December 10, 2005, serve as our starting point.

Ultimate PD Loss: We estimated ultimate PD losses by modifying total indemnity losses from step #1 by the anticipated relationship between PD and non-PD losses. The split between the two benefit types is based on data based on the revised January 2004 rate filing. We adjusted the underlying data to reflect the impact of AB 749 on the distribution of indemnity losses.

Percent of PD Claims Affected by Reforms: The total percent of claims affected was based on information proved by the CWCI related to the lag was allocated to various accident years based on the following:

- a. Data relating to the lag between when the date of injury and the last date in time period covered by a TD payment. Information relating to this was provided by CWCI.
- b. Consideration that 2004 medical determinations of PD may have sped up as an attempt to ensure that the PD benefit is based on the pre- January 1, 2005, schedule.
- c. Judge David Hettick's ruling regarding *Elizabeth Aldi vs. Carr, McClellan, Thompson & Horn and Republic Indemnity Co. of America, SF) 0485703*. As result of this ruling, it is questionable whether the January 1, 2005, PD schedule will apply to a substantial portion of pre- January 1, 2005, claims.

Percent of PD Costs Affected by Reforms: The claims with a greater lag between the date of injury and the time they become PD claims are on average larger than those claims with a shorter lag. We adjusted for this based on data provided by Frank Neuhauser of UCB.

Percent Savings of PD costs from Reforms: The percent savings associated with the PD costs was developed for the low, middle, and high scenarios in Section III.

Retrospective Savings: Our estimate of the retrospective savings is equal to the Ultimate PD costs (step #2) times the percent of PD costs affected by the reforms (step#4) times the percent savings of PD costs from the reforms (step #5).

The calculations associated with the above steps are outlined in Appendix G.

Chapter V Endnotes

¹ Frank Neuhauser to Christine Baker; Estimating the Impact of Changes to Medical Fee Schedules Insurers' and Self-Insured Employers Reserves, CHSWC, 4/22/03

² Frank Neuhauser to Christine Baker, 4/22/03, page 4

³ Frank Neuhauser to Christine Baker, 4/22/03

⁴ WCIRB Summary of September 30, 2005, Insurer Experience, December 9, 2005, page 9