

# WCIRB Actuarial Committee Meeting

Materials Presented at the WCIRB Actuarial Committee Meeting  
November 8, 2016

## Notice

The information provided in this presentation was developed by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) solely for the purpose of discussion during this presentation. The WCIRB shall not be liable for any damages, of any kind, whether direct, indirect, incidental, punitive or consequential, arising from the use, inability to use, or reliance upon information provided in this presentation.

© 2016 Workers' Compensation Insurance Rating Bureau of California. All rights reserved.

No part of this work may be reproduced or transmitted in any form or by any means, electronic or mechanical, including, without limitation, photocopying and recording, or by any information storage or retrieval system without the prior written permission of the Workers' Compensation Insurance Rating Bureau of California (WCIRB), unless such copying is expressly permitted by federal copyright law. No copyright is claimed in the text of statutes and regulations quoted within this work.

Workers' Compensation Insurance Rating Bureau of California, WCIRB, WCIRB California, WCIRB Connect, WCIRB Inquiry, X-Mod Direct, eSCAD and the WCIRB California logo (WCIRB Marks) are registered trademarks or service marks of the WCIRB. WCIRB Marks may not be displayed or used in any manner without the WCIRB's prior written permission. Any permitted copying of this work must maintain any and all trademarks and/or service marks on all copies.

To seek permission to use any of the WCIRB Marks or any copyrighted material, please contact the WCIRB at [customerservice@wcirb.com](mailto:customerservice@wcirb.com).

# SB 863 Cost Monitoring

WCIRB Actuarial Committee Meeting  
November 8, 2016

## WCIRB SB 863 Cost Monitoring

- Cost Monitoring Plan submitted to CDI in March 2013
- Identifies cost components to be measured, data elements and methodology, and scheduled timeframes
- Initial retrospective evaluation released in October 2013
- 2016 report to be released by mid-November

## PD Benefits – WCIRB Prior Estimates

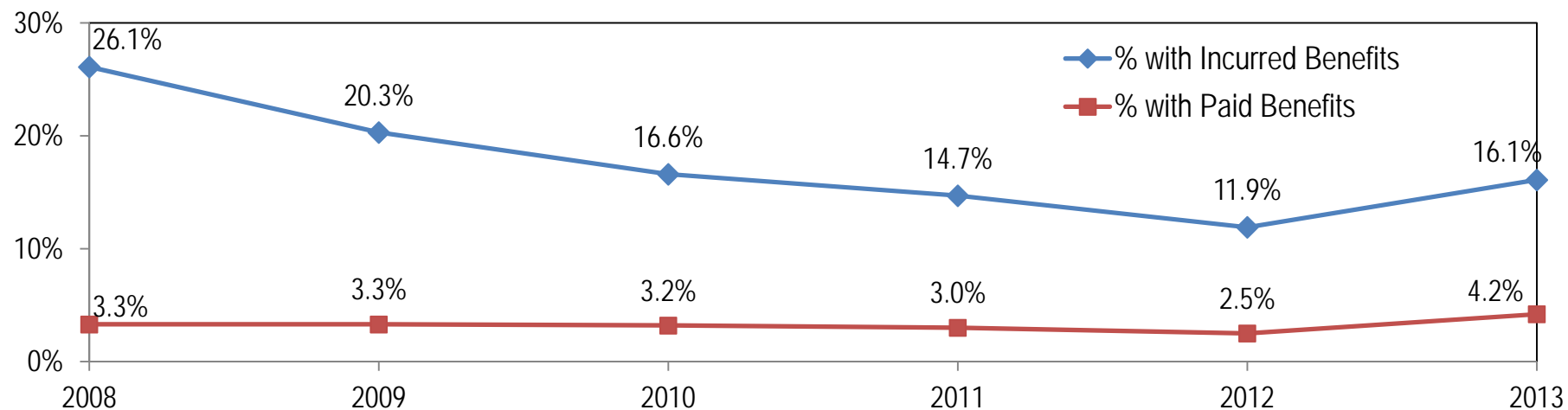
- 2013 Changes to PD Benefits estimated to increase costs by 0.3% (\$60M) (incl. frequency impact)
  - Includes increases to weekly PD benefit min. & max., increase in burial allowance, and changes to SJDB benefits
  - No estimate for DWC RTW program triggered by SJDB benefit (not in pure premiums)
  - Increase to PD minimums most significant component for 2013
- 2014 changes to PD maximums estimated to increase costs by 3.1% (\$590M) (incl. freq. impact)
- Estimates based on WCIRB Legislative Evaluation Model
  - Model reviewed by Committee in 2013

## PD Benefits – Summary of Current Information

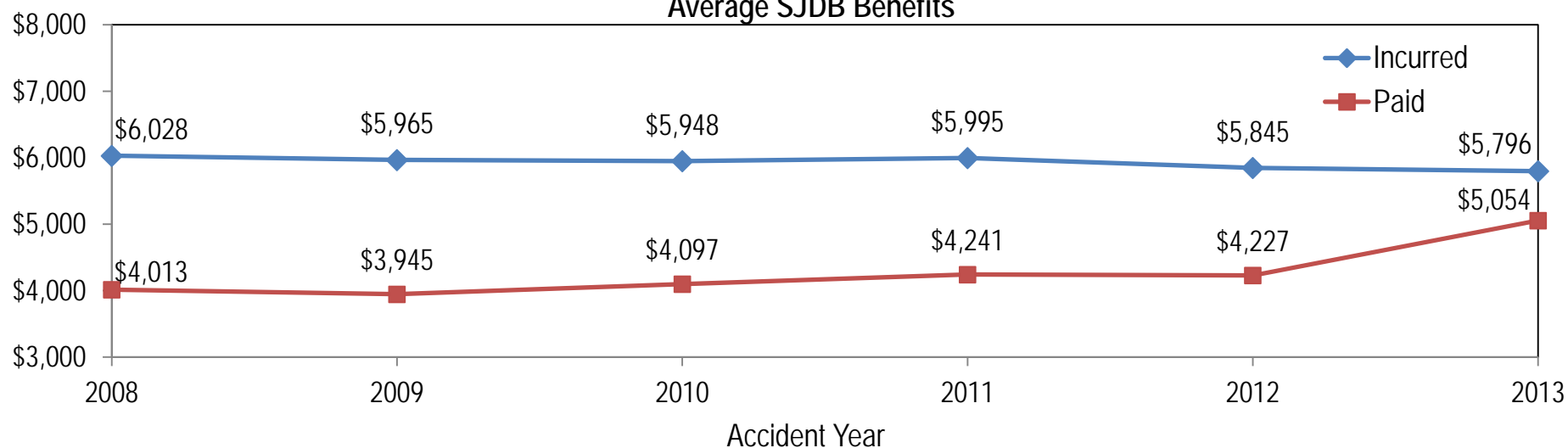
- Based on USR PD claims from AYs 2013 & 2014
- Estimated PD benefits calculated using old (2012 & prior) and new (2013 & 2014) min. & max.
  - Based on reported weekly wage and PD rating on USR
- Results were generally consistent with prior estimates

# Changes in SJDB Benefits

Percentage of PD Claims with SJDB Benefits



Average SJDB Benefits



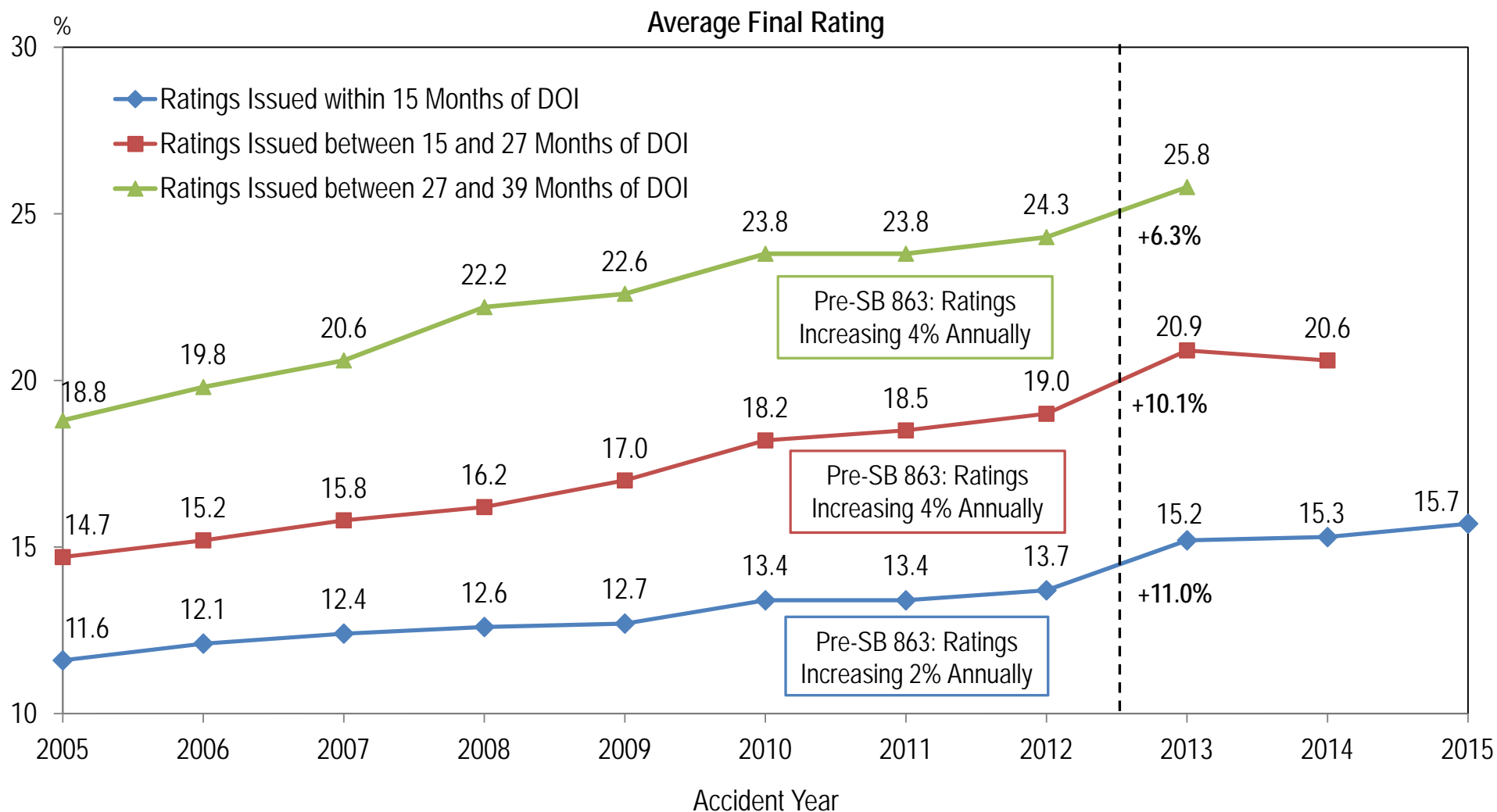
Source: WCIRB Permanent Disability Claim Survey at first survey level.

## PD Ratings – WCIRB Prior Estimates

- Elimination of FEC factor and addition of uniform 1.40 adjustment estimated to increase costs by 2.7% (\$510M) (incl. freq. impact)
- Elimination of PD rating add-ons estimated to decrease costs by 0.8% (\$160M) (incl. freq. impact)
  - 10% of psych add-ons assumed to remain as a result of catastrophic injuries or violent acts
- Estimates based on analysis of final ratings from DEU data
- Combined impact estimated at 6% increase in average PD rating
  - Does not reflect additional impact of eliminating Ogilvie (prospectively estimated at -1.1%; -\$210M impact on total costs)
  - Updated in 2015 to remove any frictional cost savings from Ogilvie (\$80M)

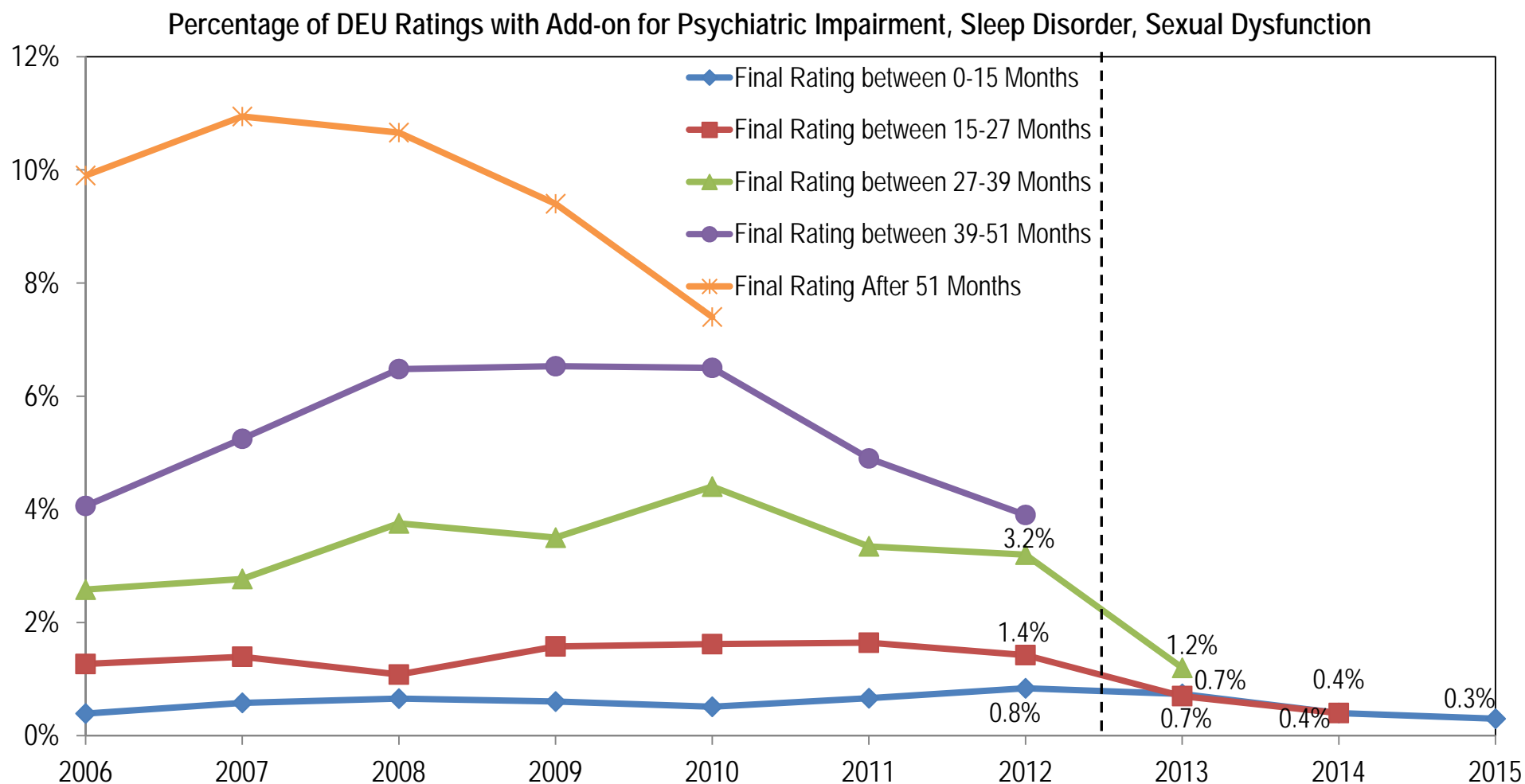


# Average PD Ratings Based on DEU Data



Source: Disability Evaluation Unit data.

# Prevalence of PD Add-ons Based on DEU Data



Source: Disability Evaluation Unit data.

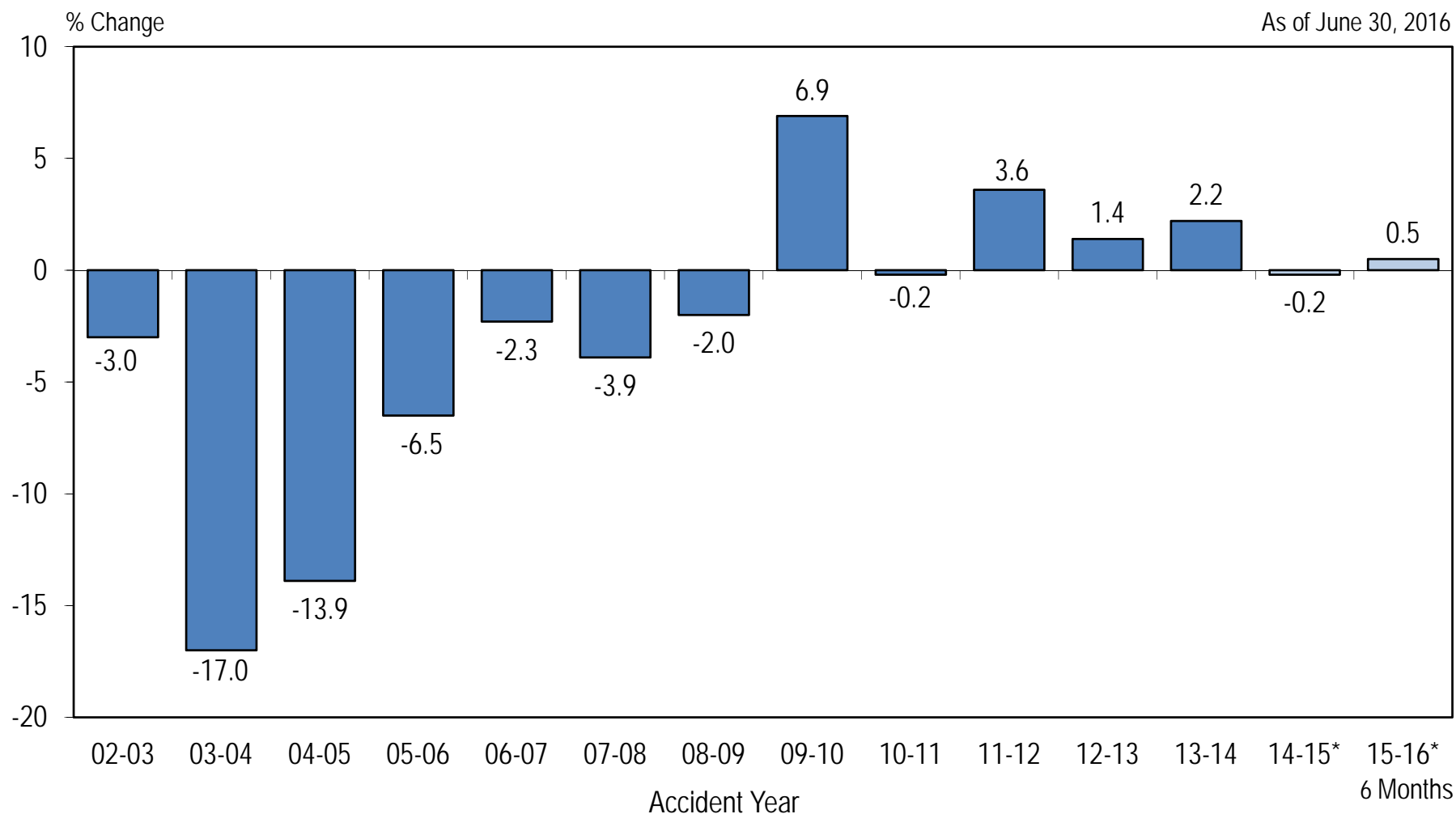
## PD Ratings – Summary of Current Information

- 2013 and 2014 PD ratings from DEU increasing consistent with projections & pre-reform trends
- Impact of FEC changes generally consistent with projections
- Add-ons significantly declining in more mature 2013 ratings
  - Prevalence also declining in older accident year ratings
  - No evidence of any new add-ons emerging
- Staff recommends no change from prior estimates

## Indemnity Claim Frequency – WCIRB Prior Estimates

- Total SB 863 impact on frequency estimated to increase costs by 1.1% (\$200M)
- Assumed frequency changes approx. 0.2% for every 1% change in indemnity benefits

# Estimated Change in Indemnity Claim Frequency

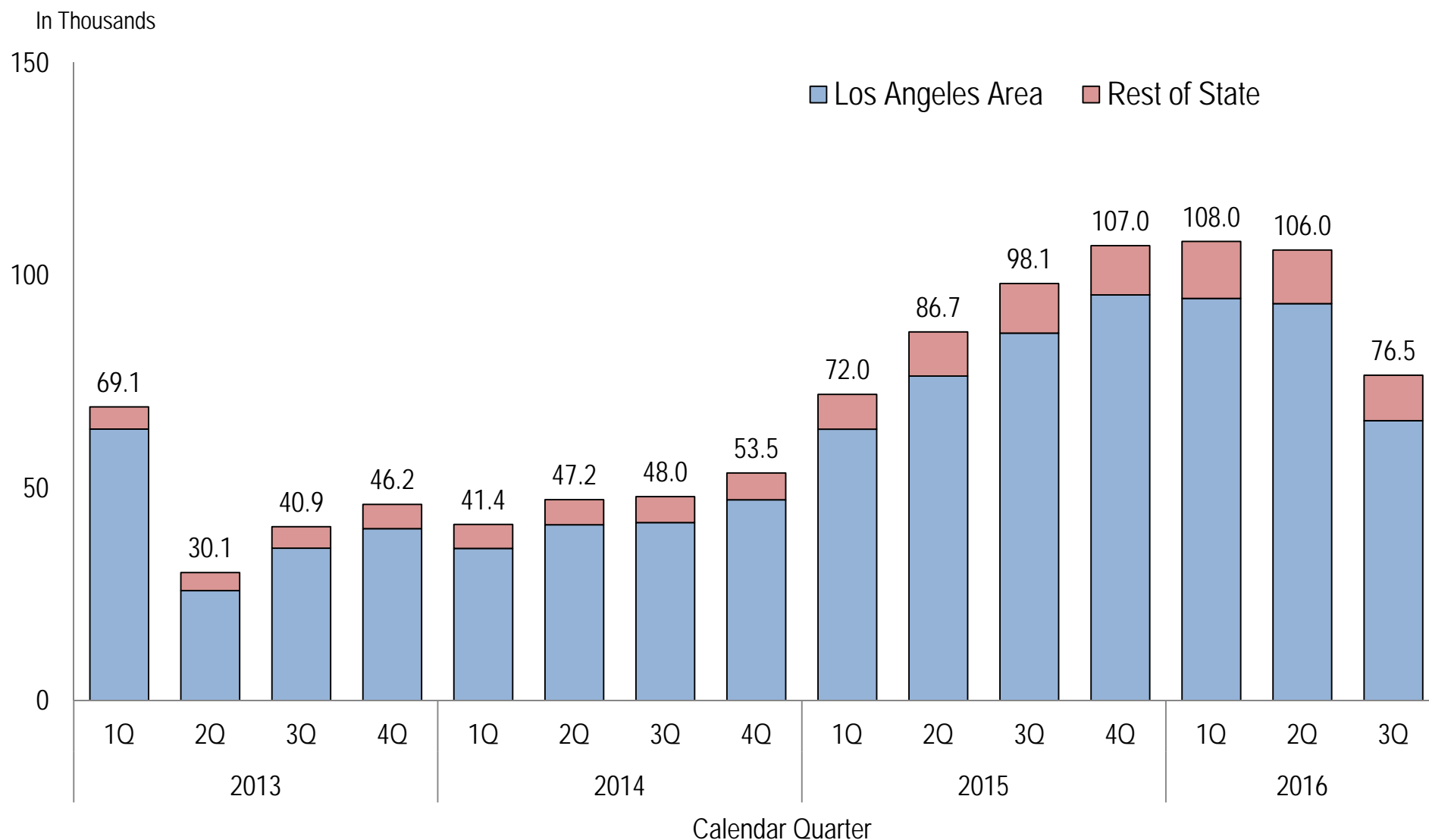


\* Based on changes in reported aggregate indemnity claim counts compared to changes in statewide employment. All other estimates based on unit statistical indemnity claims compared to reported insured payroll.

## Liens – WCIRB Prior Estimates

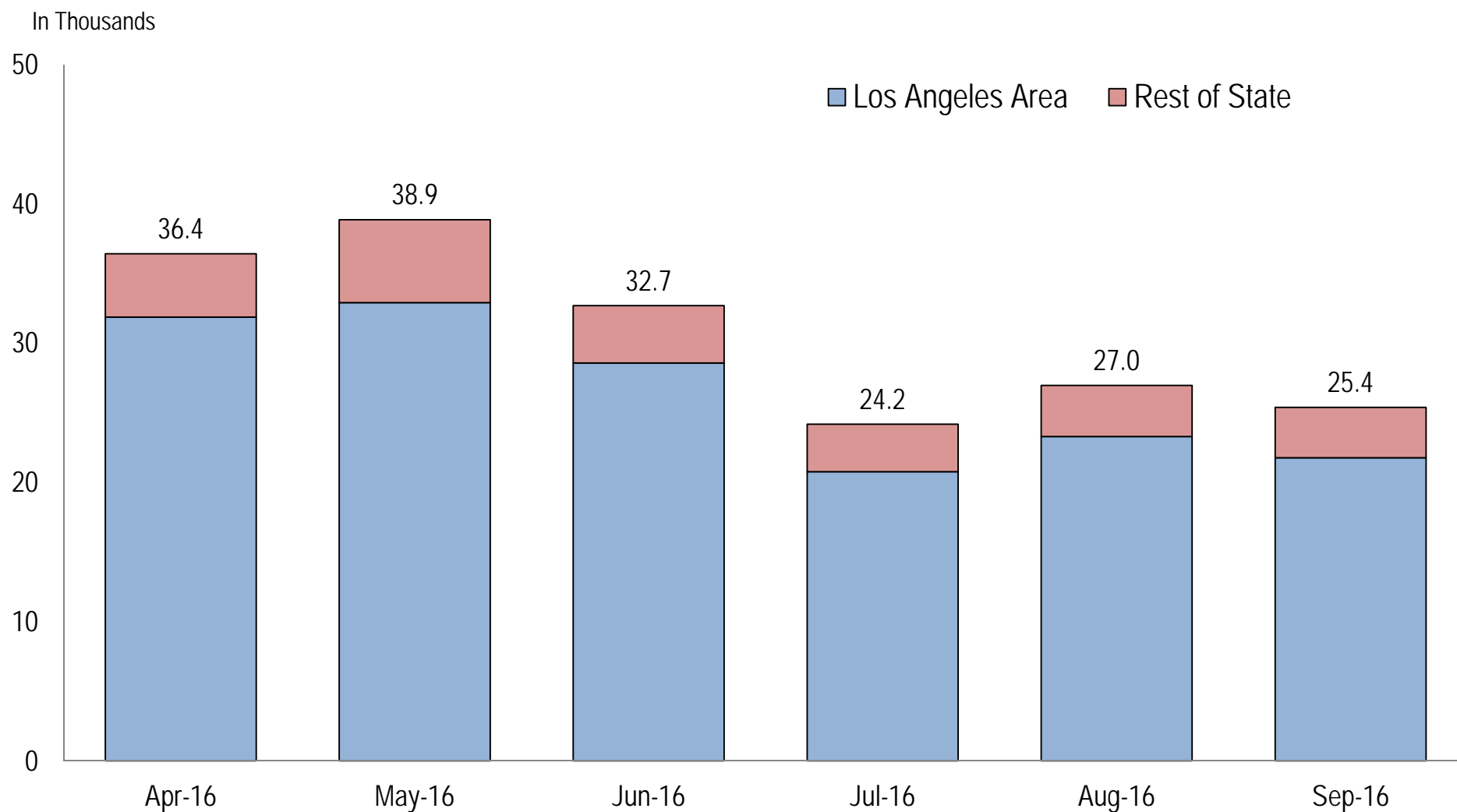
- Total impact of SB 863 lien provisions estimated to decrease costs by 2.5% (\$480M)
- Assumed 260,000 liens (41%) eliminated by filing fee and statute of limitations
- Relatively smaller liens impacted
- Significant savings in administrative costs
- Updated in 2015 due to concern over increased lien filings in 2015 compared to 2013 & 2014

# Quarterly Number of Liens Filed



Source: EAMS Liens Data

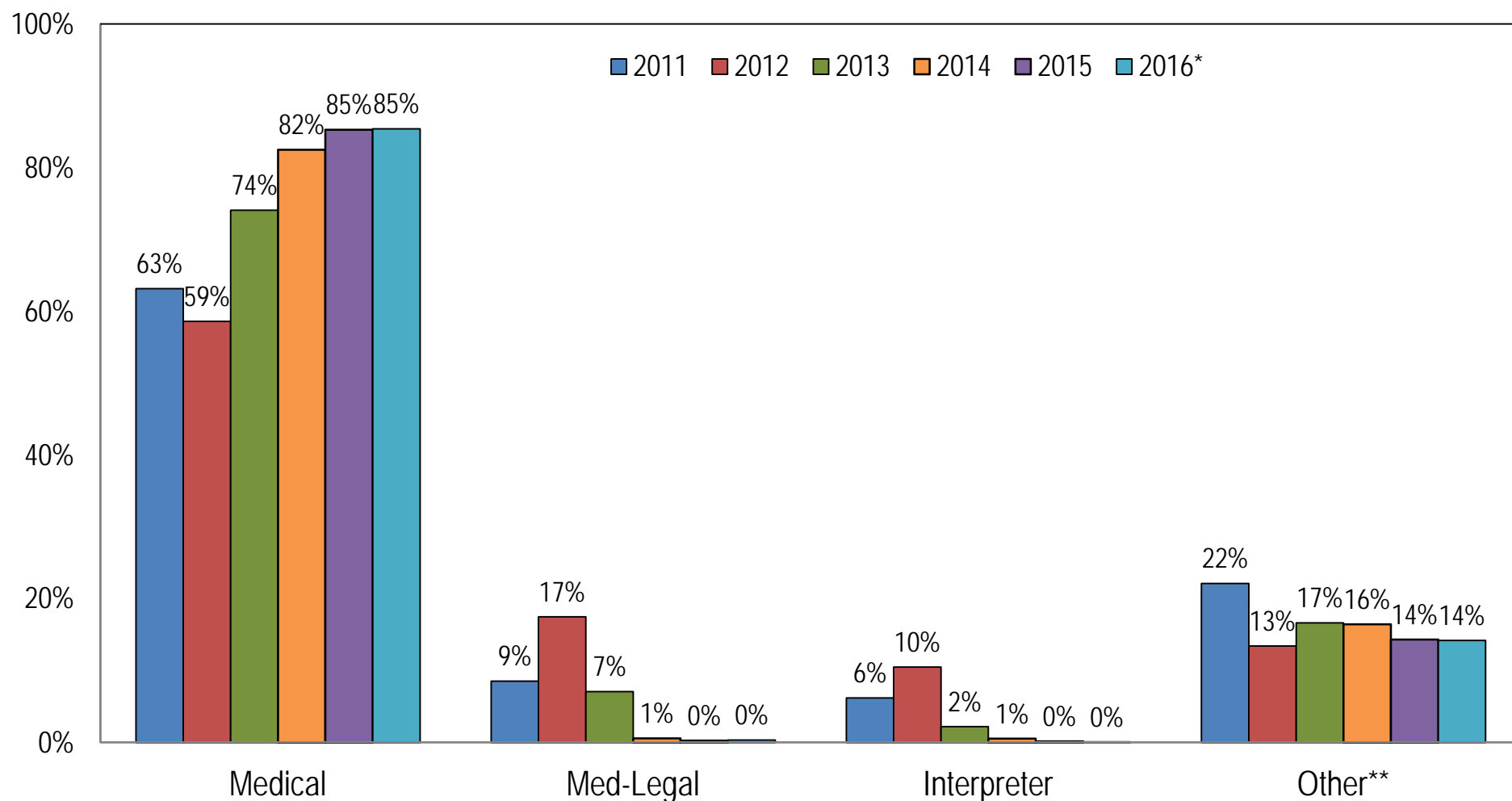
# Monthly Number of Liens Filed



Source: EAMS Liens Data



# Distribution of Liens Filed by Type



\* Based on the first 3 quarters.

\*\* Other includes Attorney Fees, Family Support, Living Expense, PFL, Transport, Wage Replacement, Copy Service

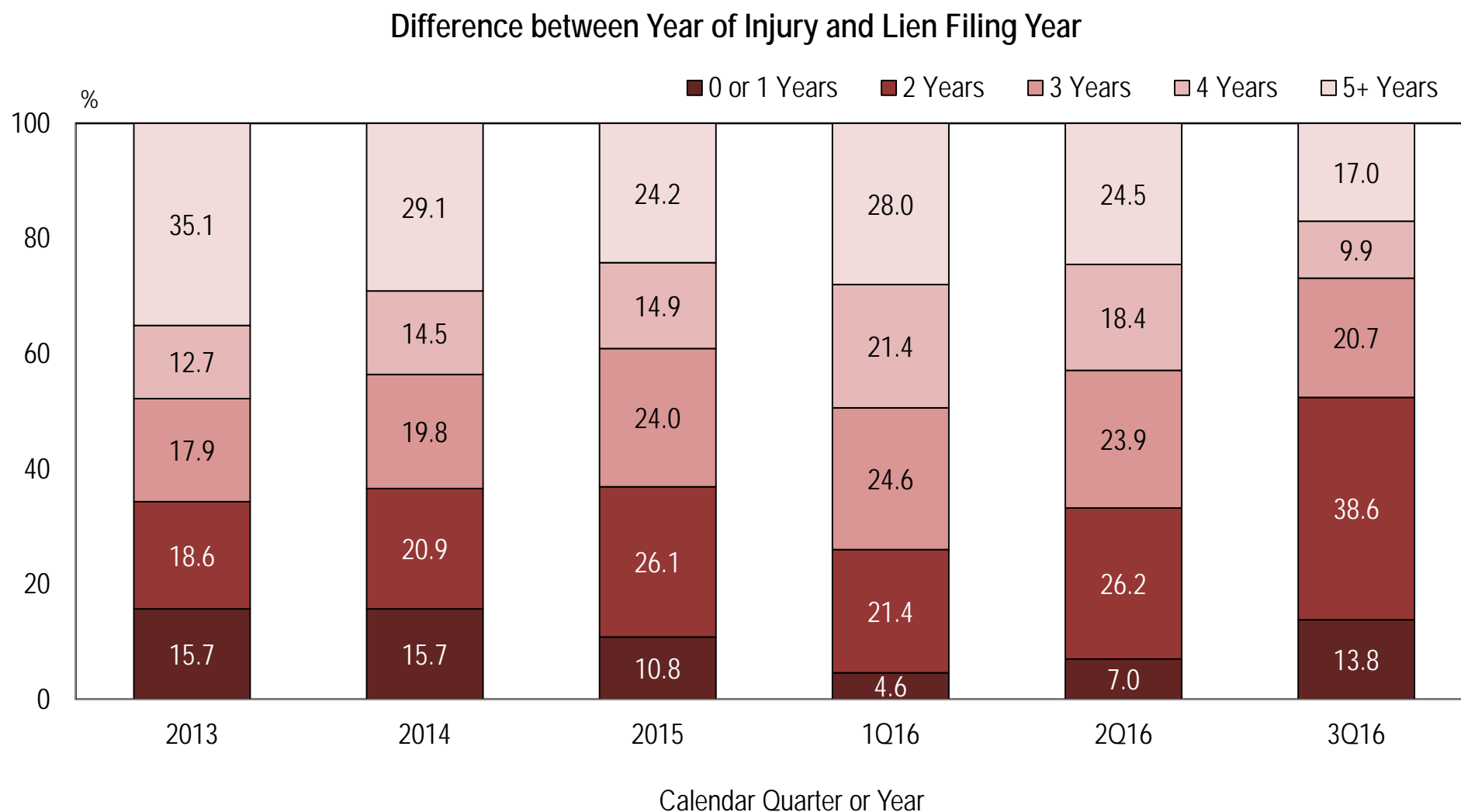
Source: EAMS Liens Data

# Liens Filed from Largest Lien Claimants



Source: EAMS Liens Data

# Distribution of Liens Filed by Date of Injury



Source: EAMS Liens Data

# Number of Liens Filed

Calendar Year	Number of All Liens (in Thousands)	Change from 2011	Number of Medical Liens (in Thousands)	Change from 2011
2011	463.9	---	293.0	---
2012	1,179.3	+154%	691.2	+136%
2013	186.3	-60%	138.0	-53%
2014	190.2	-59%	156.9	-46%
2015	363.9	-22%	310.3	+6%
2016 (proj. from first three quarters)	387.4	-18%	330.8	+13%
2016 (proj. from third quarter)	306.2	-34%	259.7	-11%
Prospective Estimate	---	-41%	---	---

Source: EAMS Liens Data

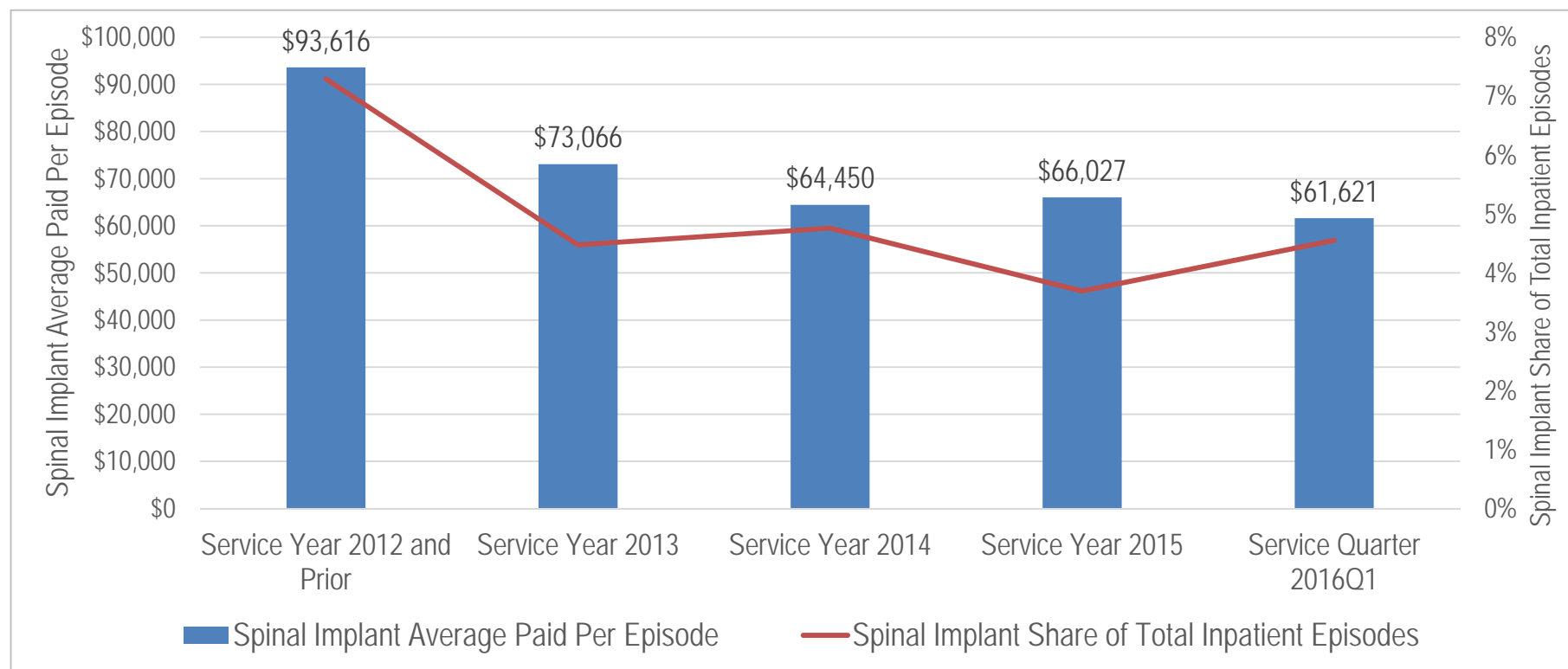
## Liens – Summary of Current Information

- Significant increase in lien filings in 2015 and 1Q & 2Q 2016
  - Both 36-month and 18-month statutes of limitations in effect
- Lien filings declined dramatically in starting July 2016
  - 36-month statute of limitations no longer applies
  - Age of lien consistent with change in statute of limitations
- 3Q 2016 liens much higher than 2013 & 2014 levels but generally consistent with prospective estimates on an annual basis
- Size of liens impacted (based on claim surveys) generally comparable to prospective estimates
- Staff recommends no change from most recent estimates
- Liens will be closely monitored in 2017 with SB 1160 in effect

## Surgical Implant Hardware – WCIRB Prior Estimates

- Elimination of separate reimbursements for implantable hardware prospectively estimated to decrease costs by 0.6% (\$110M)
- Estimate based on CWCI study of multiple reimbursements
  - Duplicate payments added \$20,000 to each procedure
- Updated in 2015 to reflect additional savings per procedure (\$30M additional savings)

# Surgical Implant Procedures – Updated Results



- Savings due to 40% decrease in utilization of spinal implants: Approximately \$40M.
- Savings due to 28% drop in average payment per episode: Approximately \$16M.

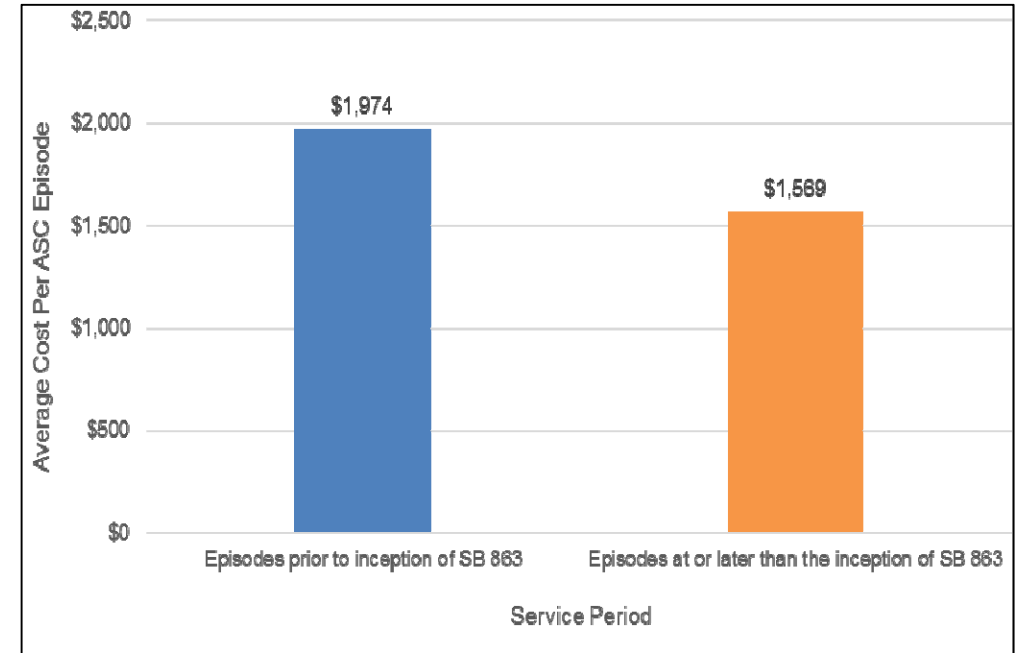
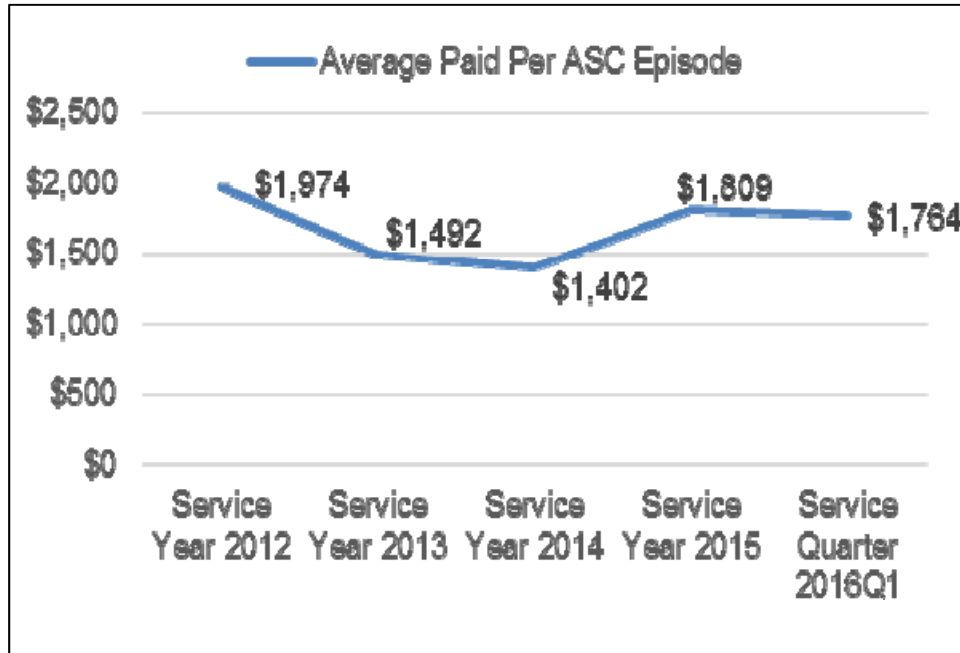
Source: WCIRB Medical Data Call

## Ambulatory Surgical Center Fees – WCIRB Prior Estimates

- Changes to ASC fees estimated to decrease costs by 0.4% (\$80M)
- Some ASC fees reimbursed under contract levels below current fee schedule
- Assumed reduction in ASC facility fees of 25%
  - Approximate average of savings if all fees are impacted (33%) and if no contract fees are impacted (20%)
- Assumed no shift of procedures from ASCs to outpatient hospitals as a result of SB 863



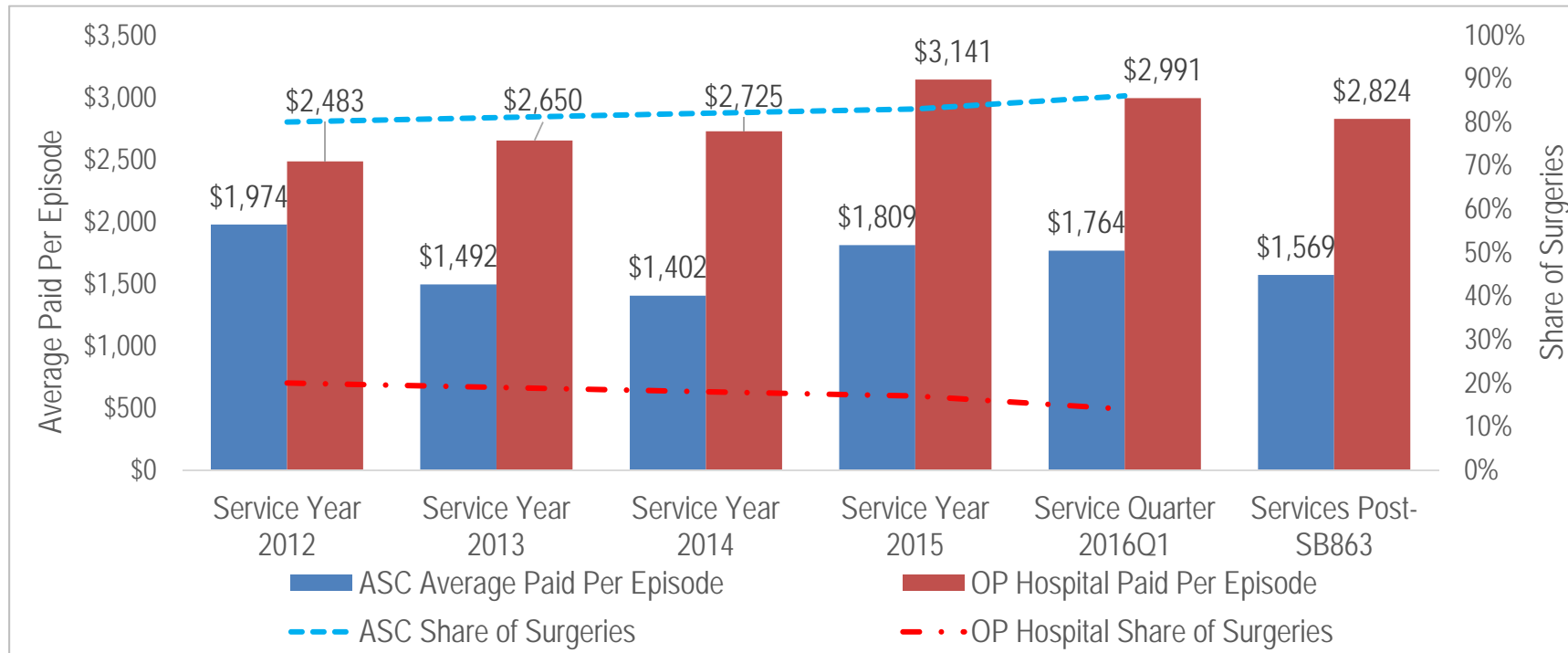
## ASC Episodes – Unit Cost Trends



- Result: Paid per ASC episode declined by a cumulative 21% since the introduction of SB 863 in Q1 2013
- Implication: Assuming no utilization changes, without adjusting for medical inflation, SB 863 generated a \$405 drop in cost per ASC episode

Source: WCIRB Medical Data Call

# ASC and Outpatient Hospital Episodes – Utilization Trends



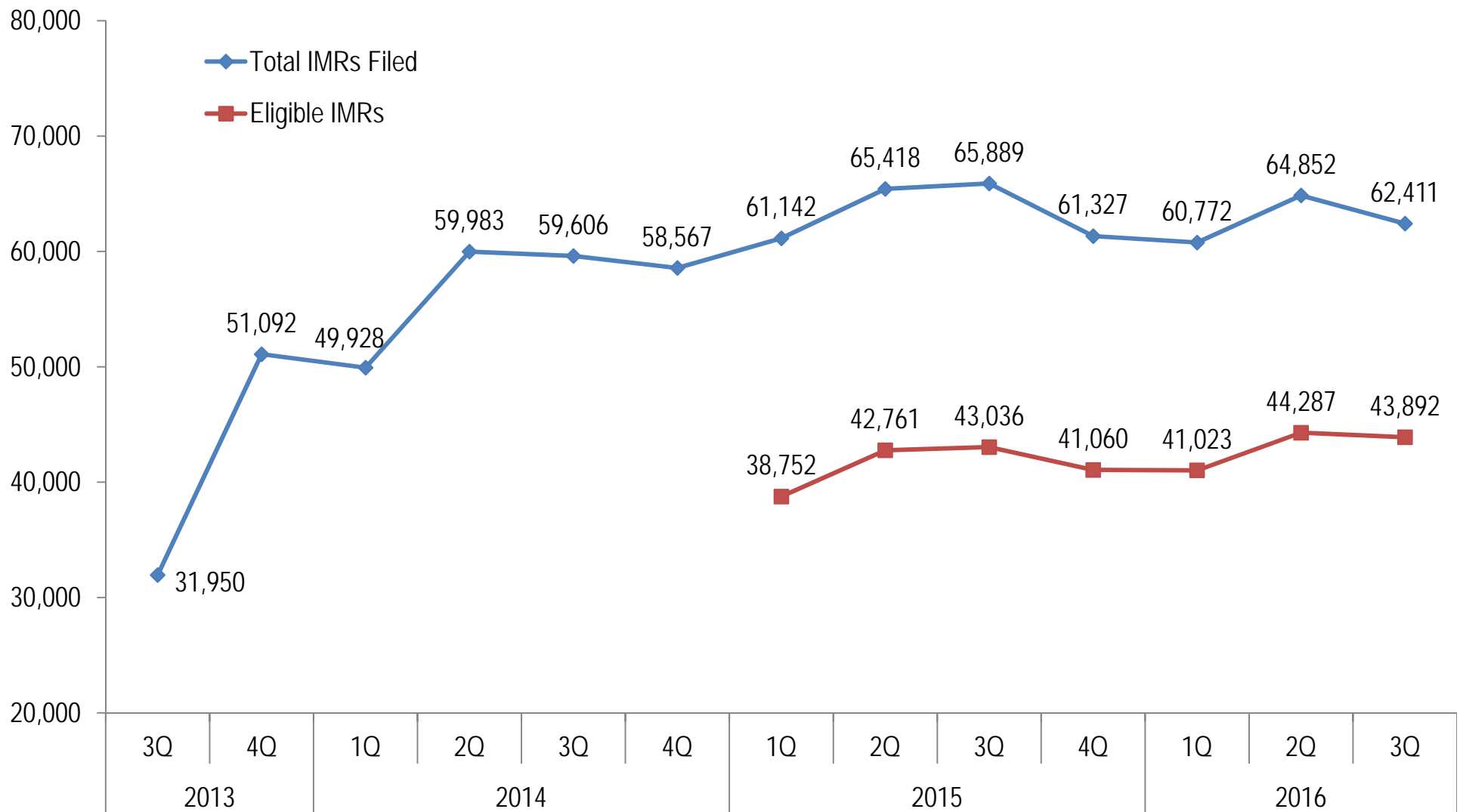
- Result 1: When comparing similar procedures at both settings, the share of outpatient hospital surgeries has not increased, but has dropped from Q3 2012 through Q1 2016
- Result 2: Without ASC-type cost controls, outpatient hospitals received an aggregate 80% higher payment per episode than ASCs

Source: WCIRB Medical Data Call

## Independent Medical Review – WCIRB Prior Estimates

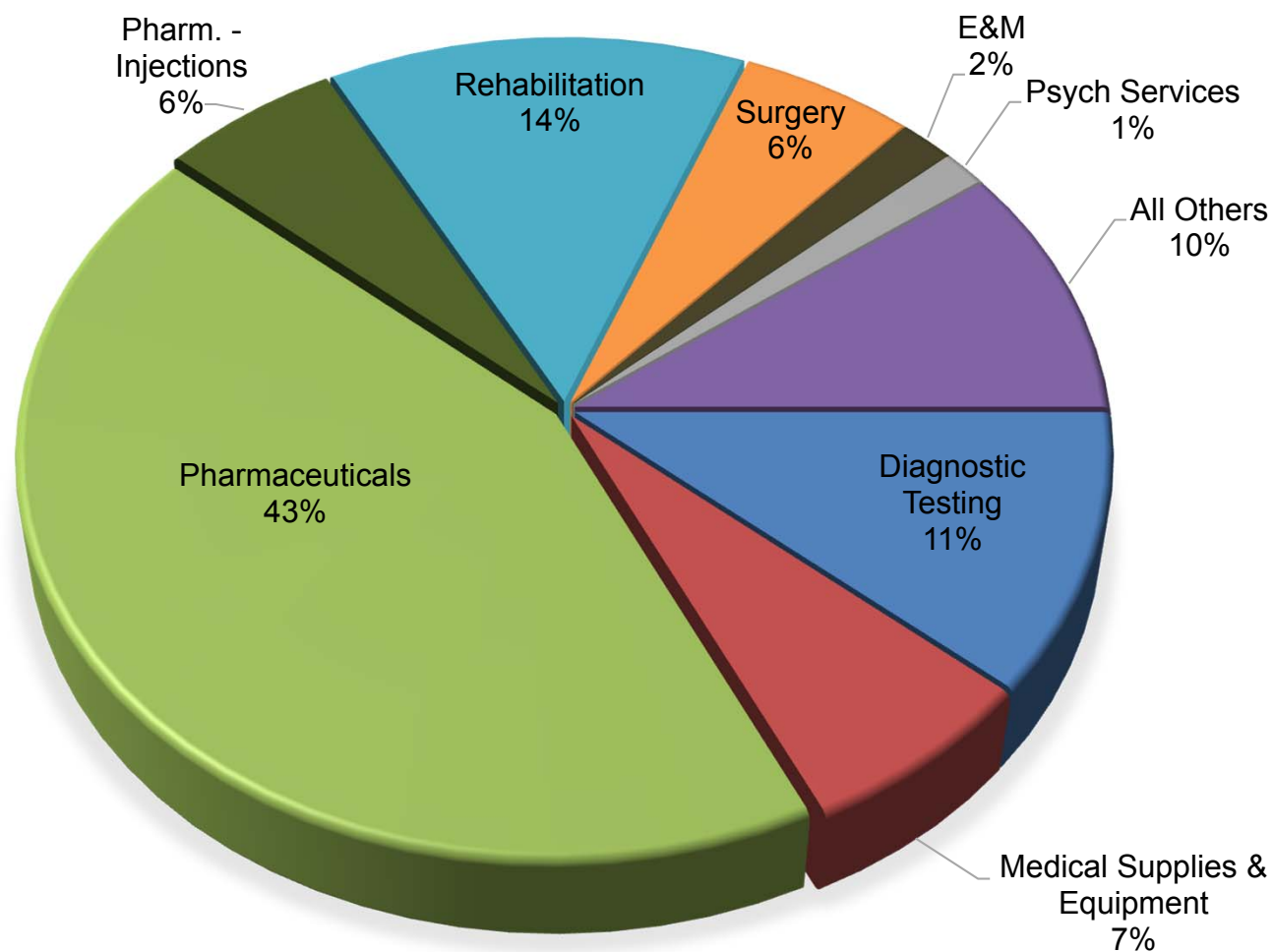
- Total quantifiable impact of SB 863 IMR provisions prospectively estimated to decrease costs by 2.1% (\$390M)
- Total of 51,000 IMRs per year prospectively estimated
  - Would result in reductions in “frictional costs”: liens related to UR disputes, QME reports and expedited hearings
- Reduced litigation related to medical treatment prospectively estimated to reduce ALAE costs by 2.4%
- Reduction in delays for medical treatment assumed to reduce TD duration by 4%
- Updated in 2014 to eliminate savings for “frictional”/litigation costs (\$180M)
- Updated in 2015 to reflect costs for greater-than-anticipated volume of IMRs (\$60M) and expedited hearings (\$10M)

## Number of IMR Requests by Quarter



Source: DWC from IMR vendor.

## Distribution of IMR Disputed Treatments



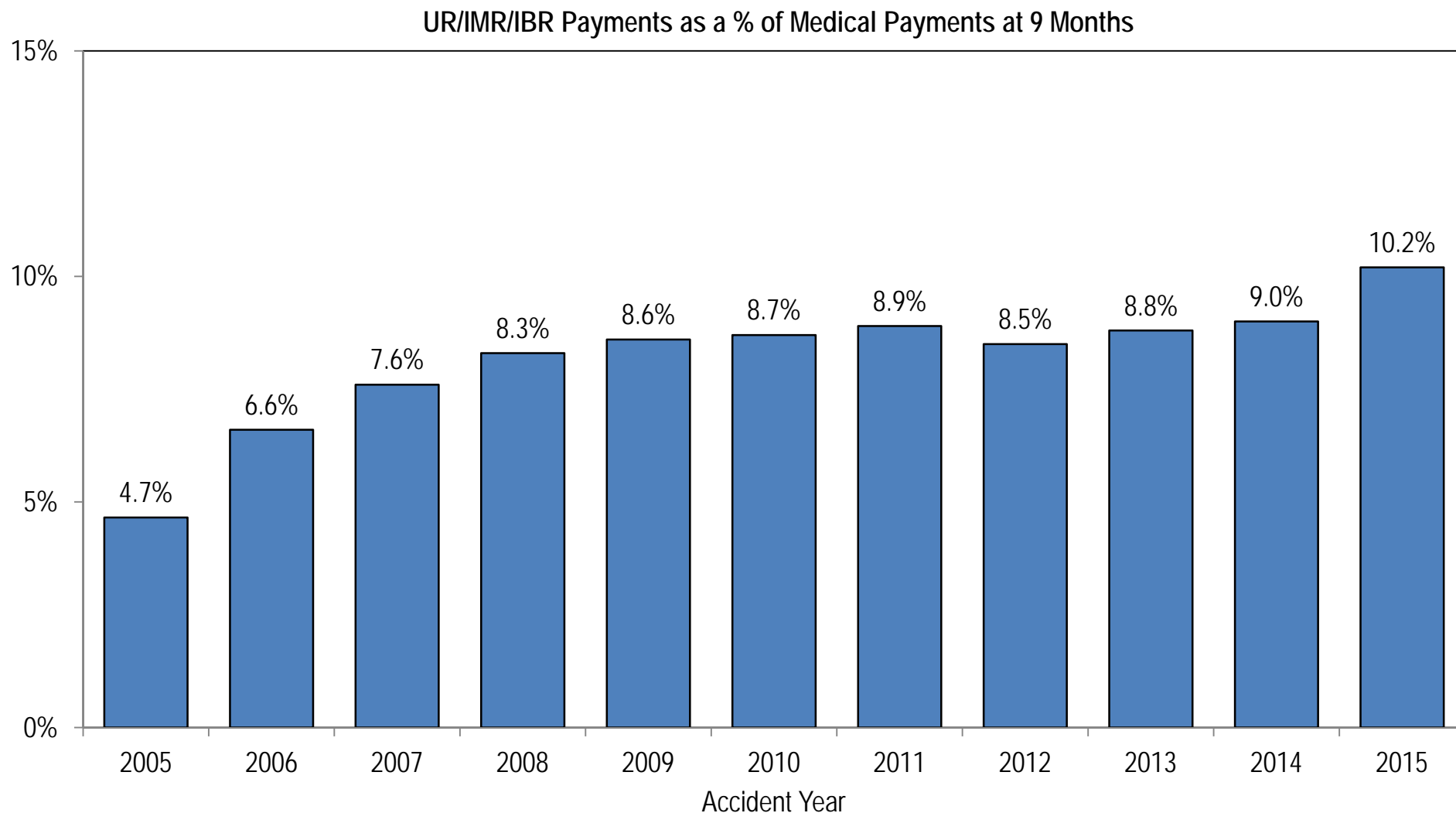
Source: DWC IMR decision database

## Results of IMR Decisions

IMR Filing Year	Number of IMR Decisions	% w/ UR Upheld	% w/ UR Overturned	% w/ UR Partially Overturned
2013	46,163	86.4%	6.9%	6.7%
2014	132,349	87.2%	6.7%	6.1%
2015	154,431	83.7%	8.9%	7.4%
2016	91,588	87.0%	8.9%	4.1%
Total	424,531	85.8%	8.0%	6.2%

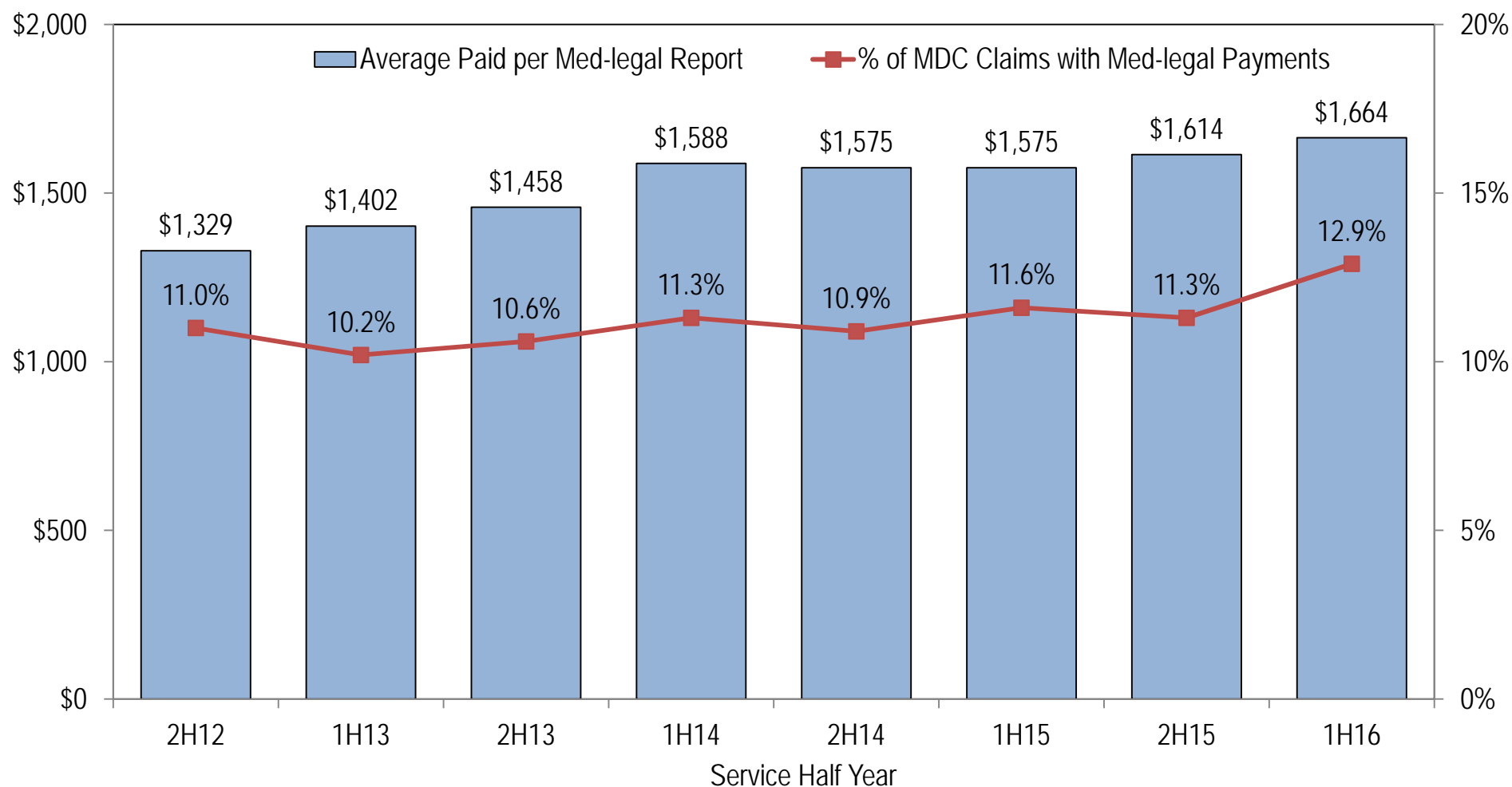
Source: DWC IMR decision database

# Payments for Utilization Review



Source: CWCI data. Estimated based on the percent of medical payments for Med Mgmt./MCC by accident year and the percent of UR/IMR/IBR payments for MCC by service year.

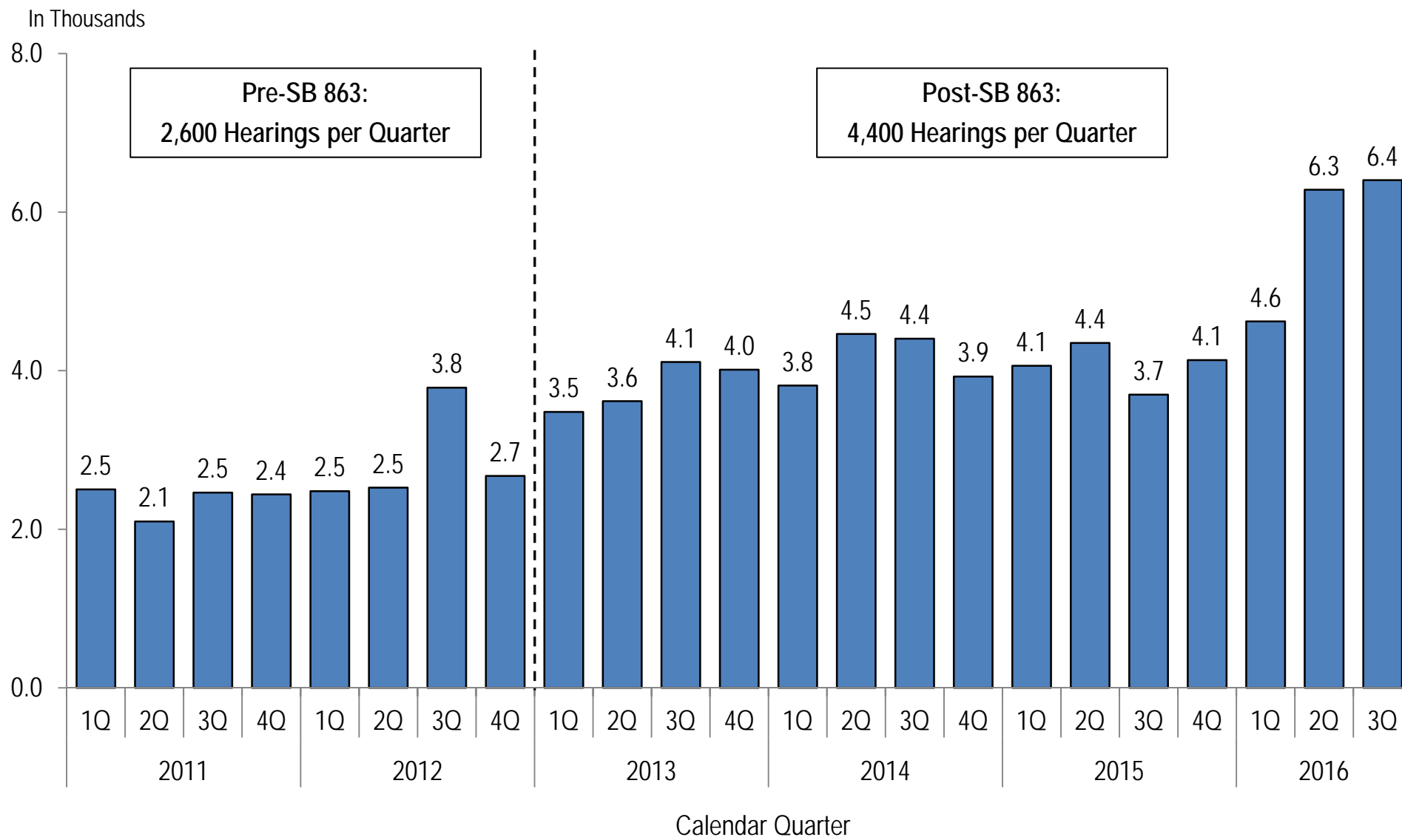
# Medical-Legal Costs



Source: WCIRB Medical Data Call. Data is based on transactions where the transaction half = service half.

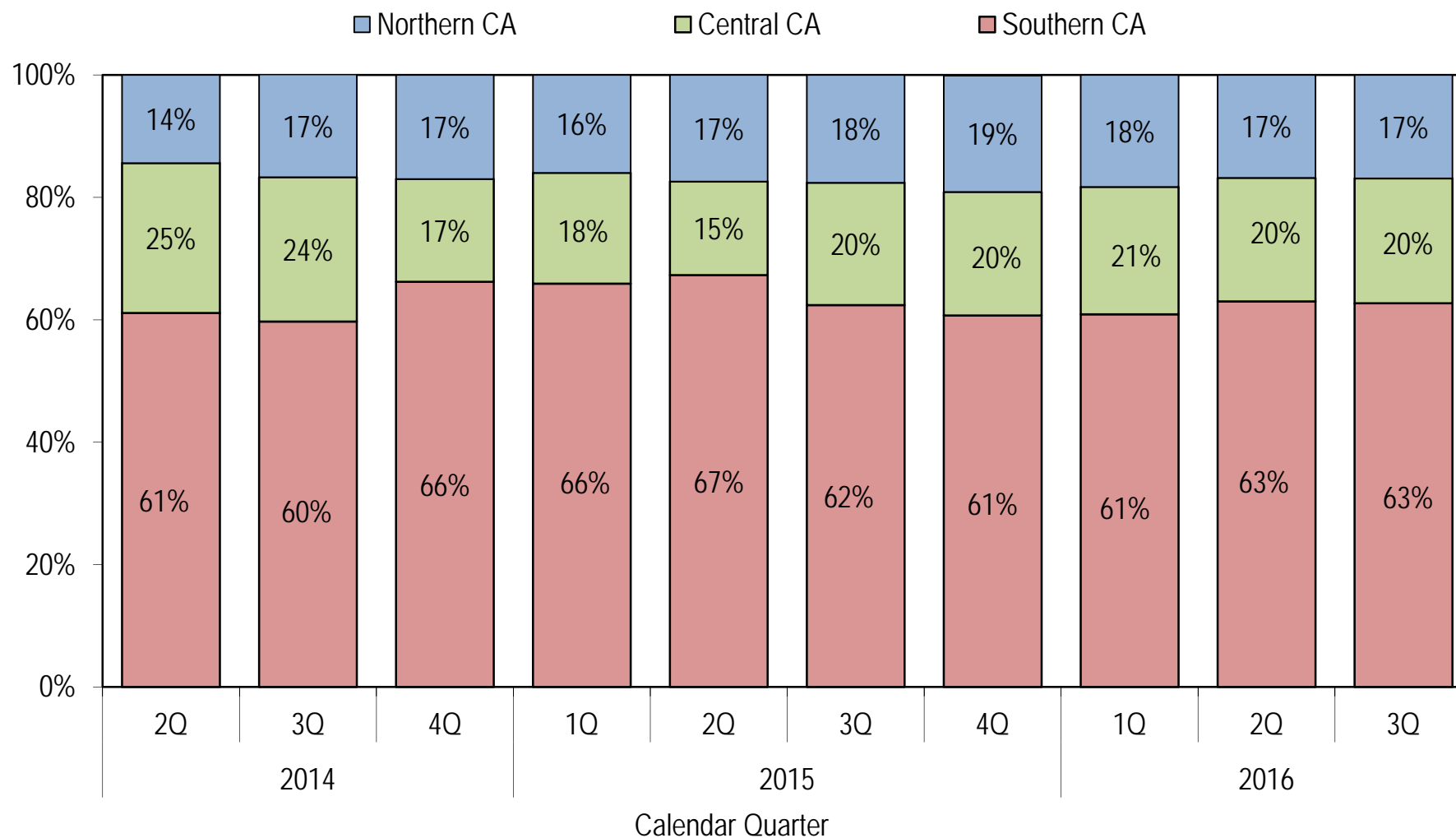


# Number of Expedited Hearings



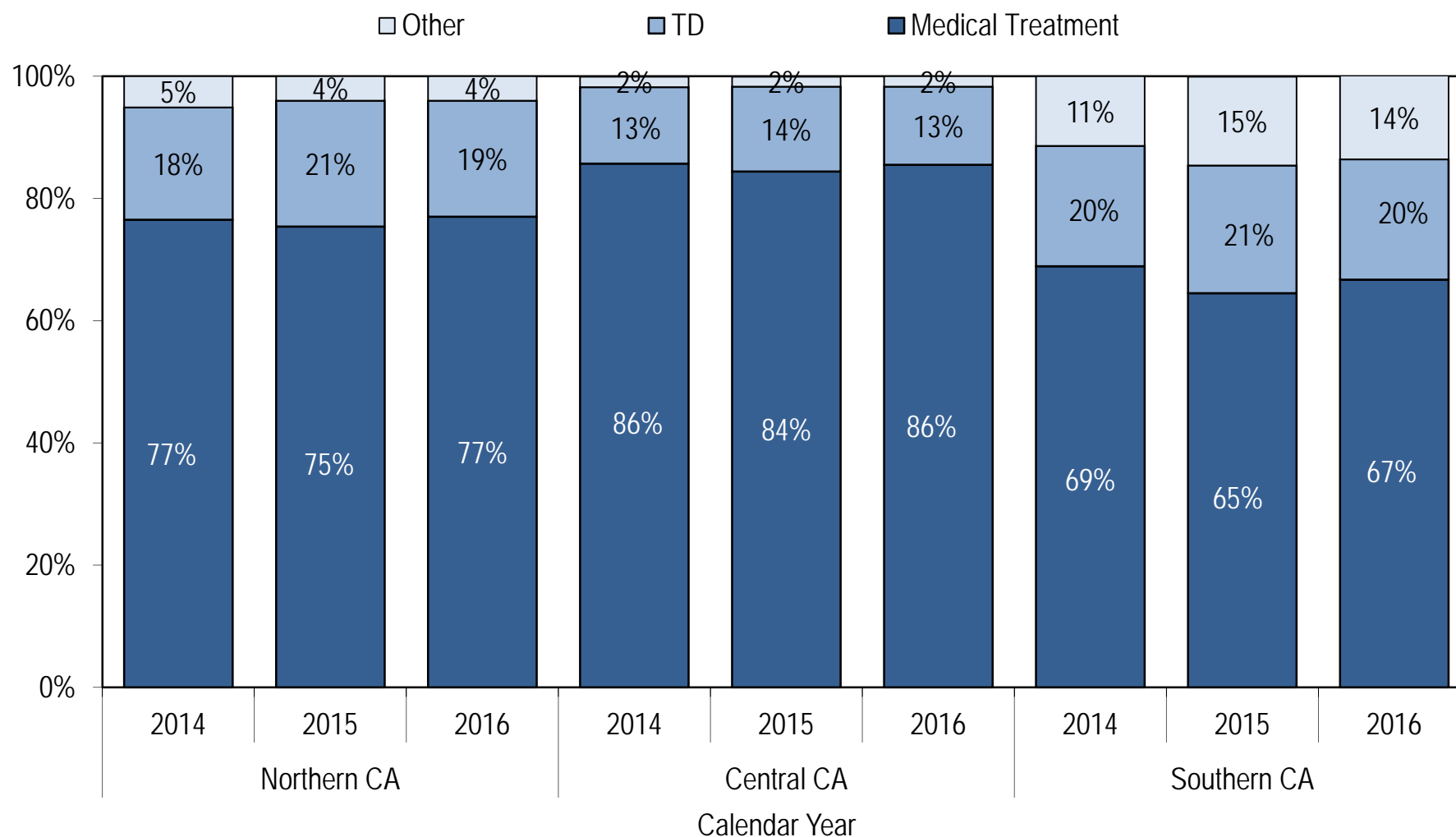
Source: DWC

# Distribution of Expedited Hearings by Region



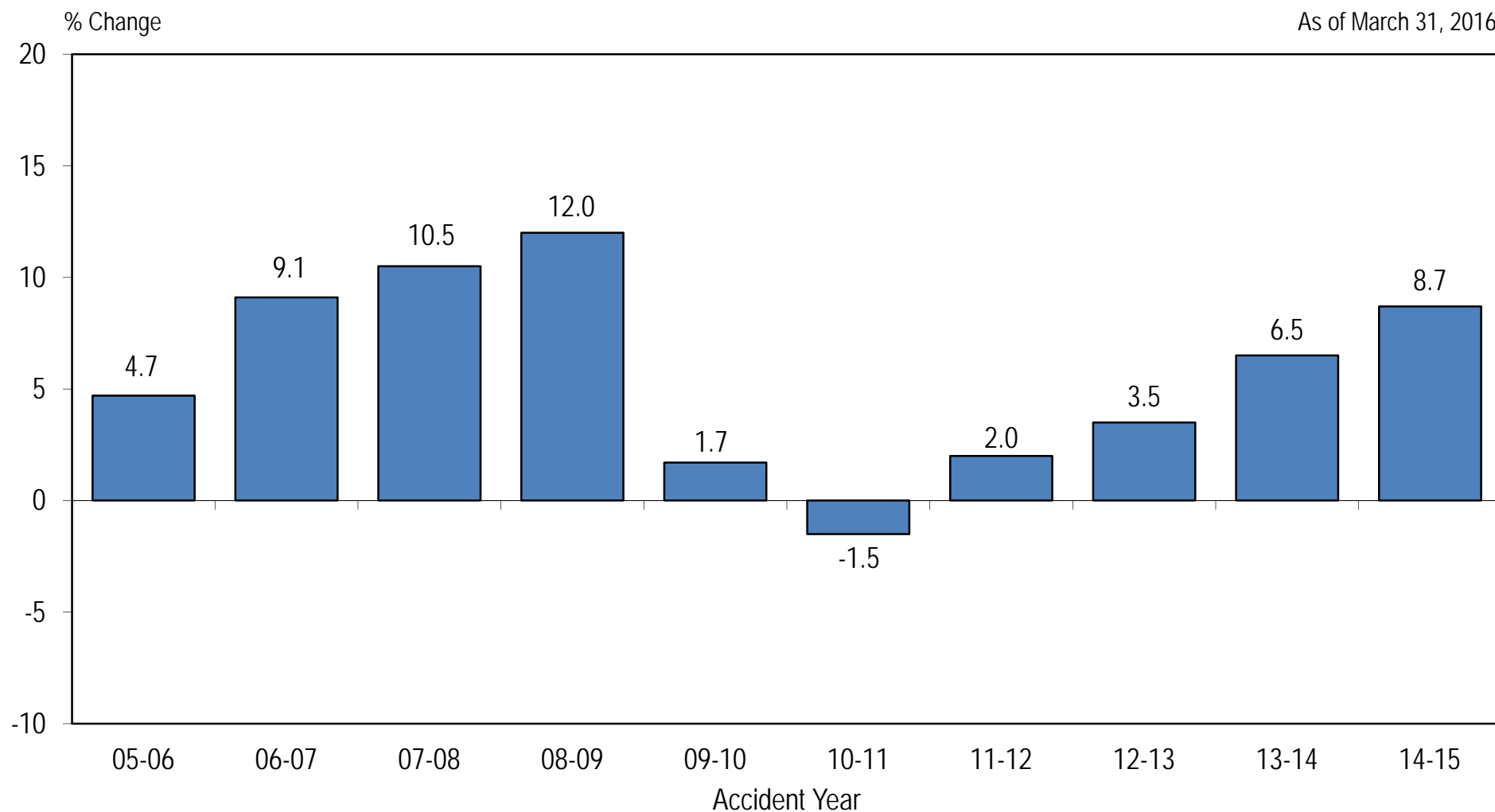
Source: DWC

# Distribution of Expedited Hearings by Type within Region



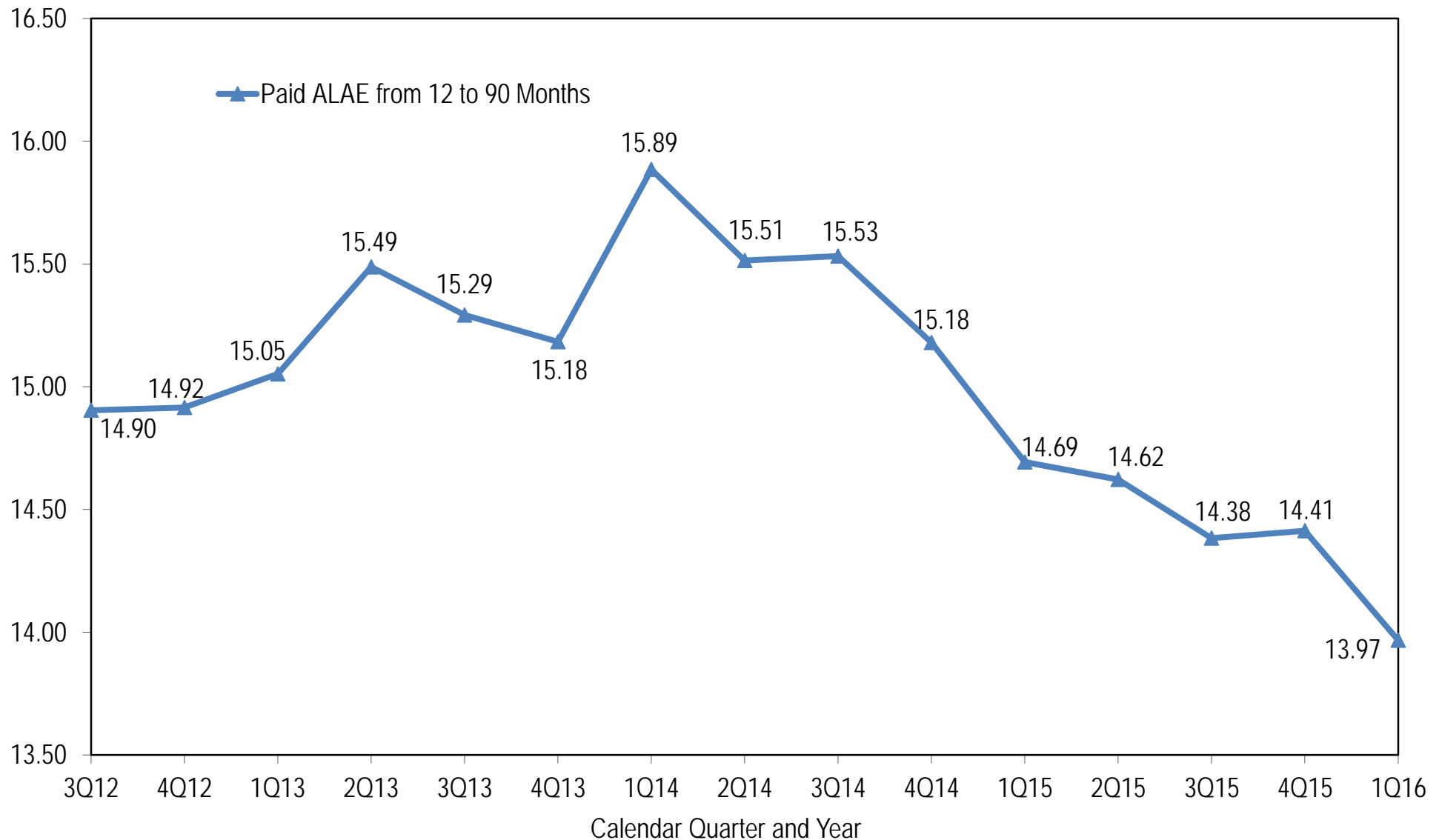
Source: DWC. 2014 is second through fourth quarters only. 2016 is first through third quarters only.

## Change in Ultimate ALAE Severity – Private Insurers

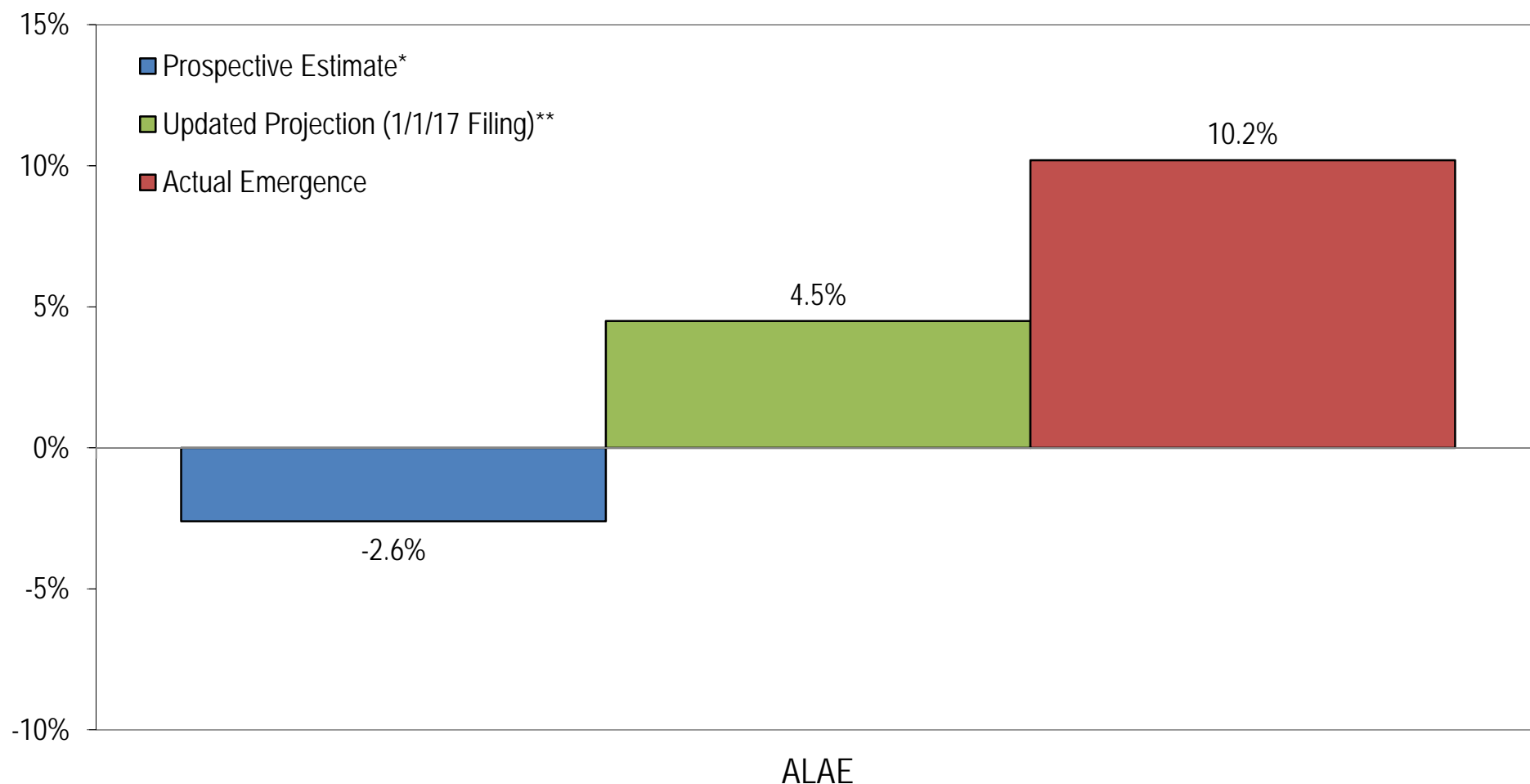


Source: WCIRB aggregate financial data and projections

## Cumulative Quarterly Paid ALAE Development – Private Insurers



# ALAE Cumulative 2013 & 2014 Severity Changes



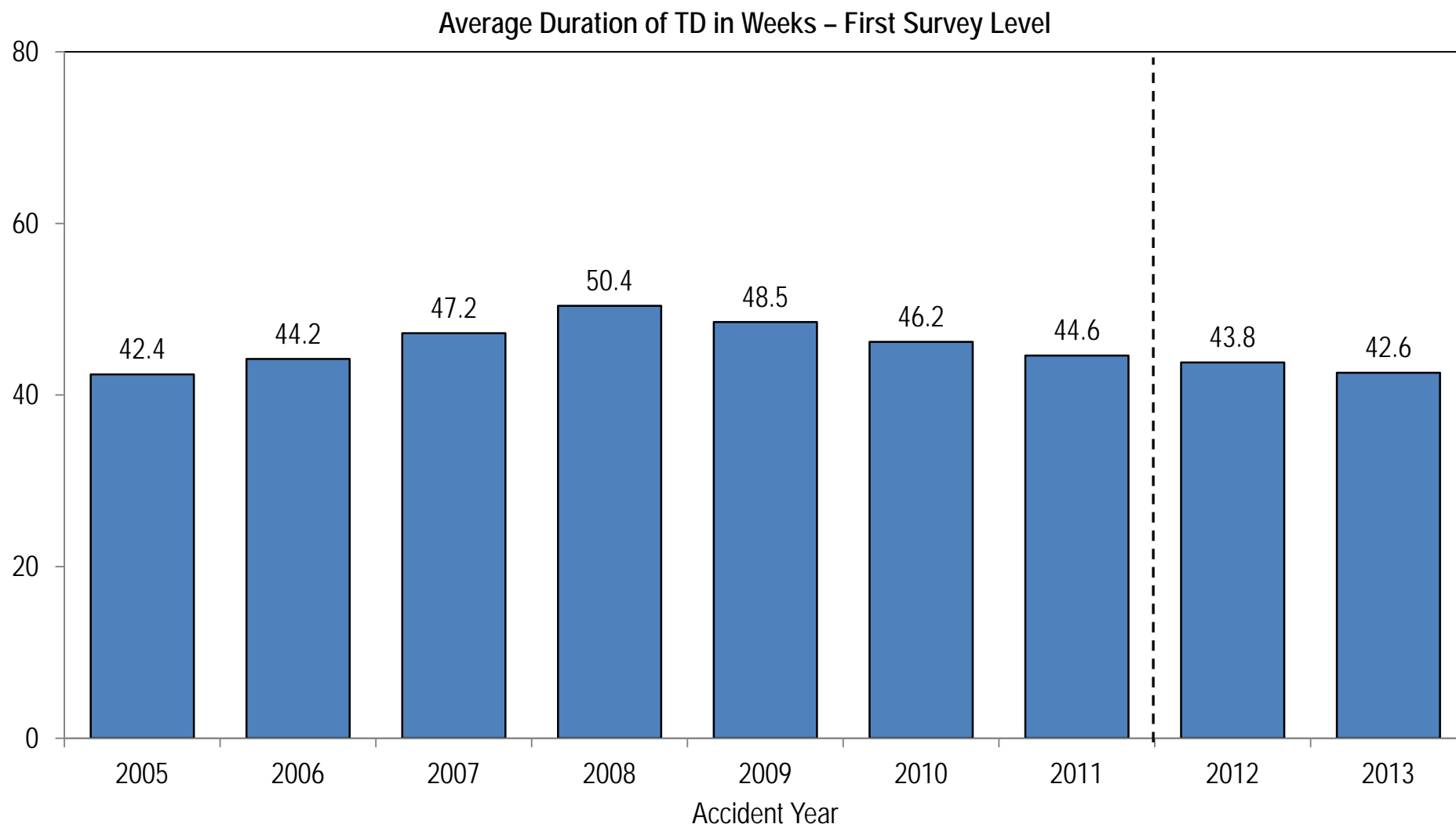
\* Includes the WCIRB's prospective estimates of the impact of SB 863 and projected severity trends from the 1/1/13 Filing.

\*\* Includes the WCIRB's most recent estimates of the impact of SB 863 and projected severity trends from the 1/1/17 Filing.

## Independent Medical Review – Summary of Current Information on “Frictional”/Litigation Costs

- IMRs continuing to be filed at high levels, though consistent with recent estimates
- Volume and average cost of med-legal reports increasing
- Number of expedited hearings increasing significantly in recent quarters on top of post-SB 863 highs
  - Most expedited hearings continue to be for medical treatment issues
- Average ALAE severities continuing to increase
- More in-depth study of ALAE in separate item
- Staff recommends continuing to not reflect “frictional”/litigation cost savings from IMR as well as modest increases from higher volume of IMRs & expedited hearings
- Staff recommends no adjustment for higher than anticipated ALAE costs since it is difficult to distinguish SB 863 impacts from other factors but continuing to monitor ALAE development

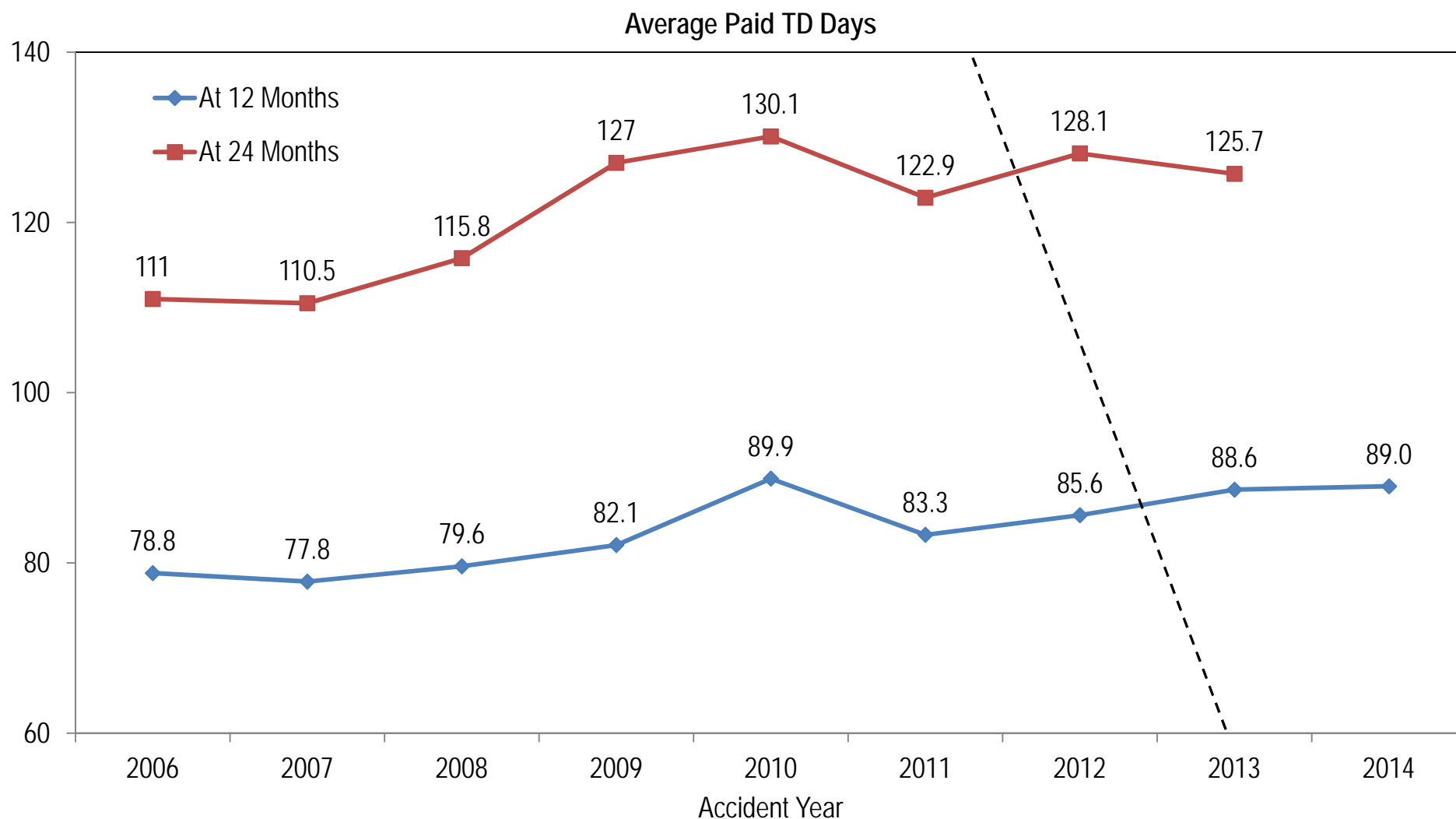
## Temporary Disability Duration – PD Survey Data



Source: WCIRB permanent disability claim survey. First survey level is approximately 28 months.

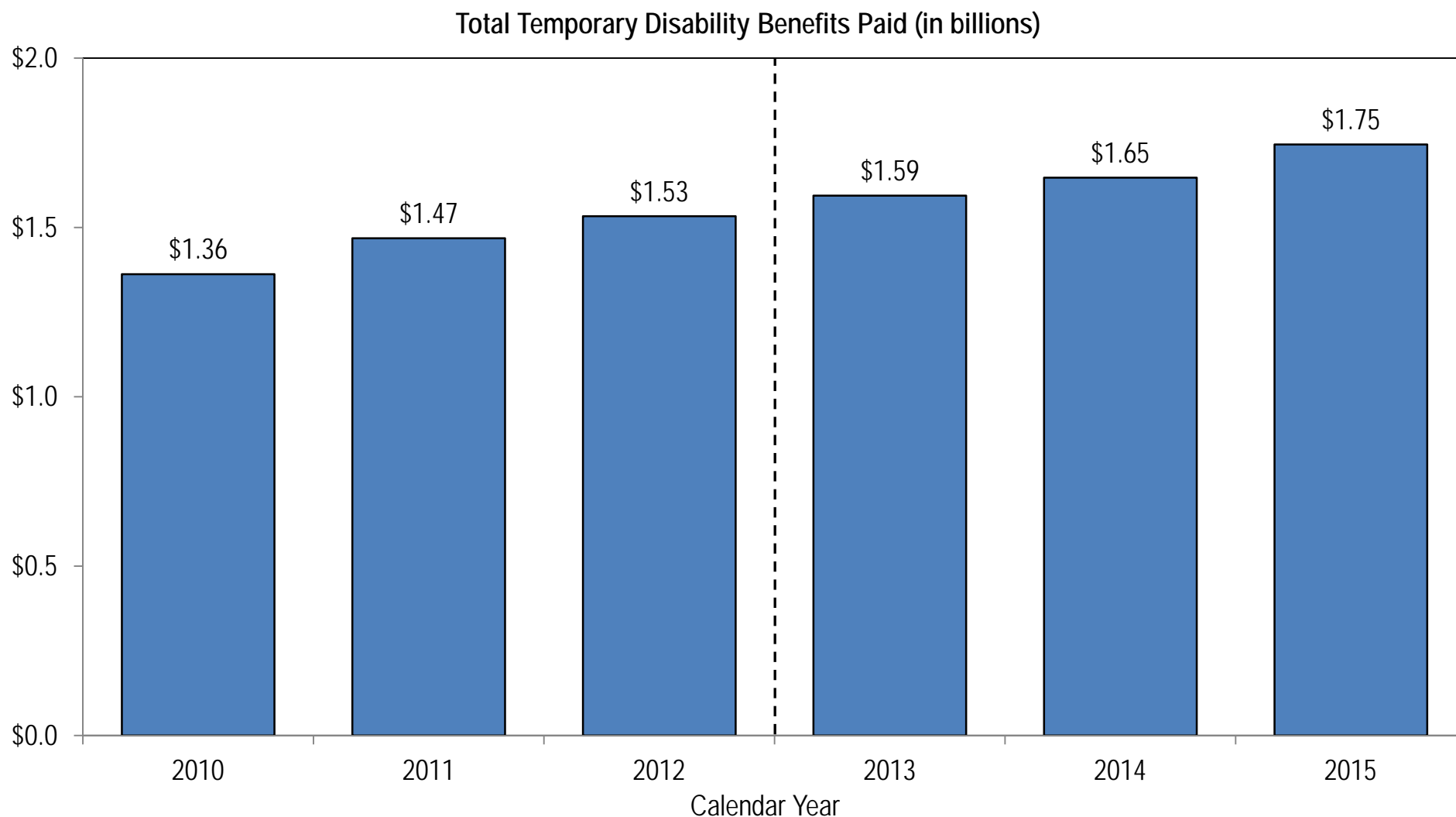


## Temporary Disability Duration – CWCI Data



Source: CWCI

# Temporary Disability Benefits Paid by Calendar Year



Source: WCIRB Annual Reports on Calendar Year Paid Losses and Expenses.

## Independent Medical Review – Summary of Current Information on TD Duration

- TD duration not declining in post-SB 863 years
  - PD Survey data shows years-long trend of declining TD duration moderating
  - CWCI data shows TD duration increasing 2%-4% in post-SB 863 period
  - No noticeable affect of SB 863 on total TD benefits paid by CY
- Staff recommends eliminating savings to TD duration from IMR process (1.1%; \$210M on total costs)

## MPN Strengthening – WCIRB Prior & Current Estimates

- Total quantifiable impact of SB 863 MPN changes estimated to decrease costs by 1.0% (\$190M)
  - Based on CWCI information on MPN usage & costs
- Latest CWCI data shows MPN utilization rates increasing moderately
- Staff recommends no change to prior estimate

## Copy Services Fee Schedule – WCIRB Prospective Estimate

- New copy services fee schedule pursuant to SB 863 effective 7/1/15
  - Intended to achieve consistency of reimbursement and minimize disputes
- WCIRB prospective estimate based on review of insurer aggregate payment information and Berkeley Research Group analysis of payments per copy service
  - Average reimbursement rate under new fee schedule is approximate average of rates already being paid
- No adjustment reflected in 1/1/16 Filing since impact assumed small

## Impact of New Copy Services Fee Schedule

- Copy Service Fee Schedule Payments:

Service Period	Paid Per Copy Service Set
2015 Q3	\$105
2015 Q4	\$100
2016 Q1	\$99
2016 Q2	\$98

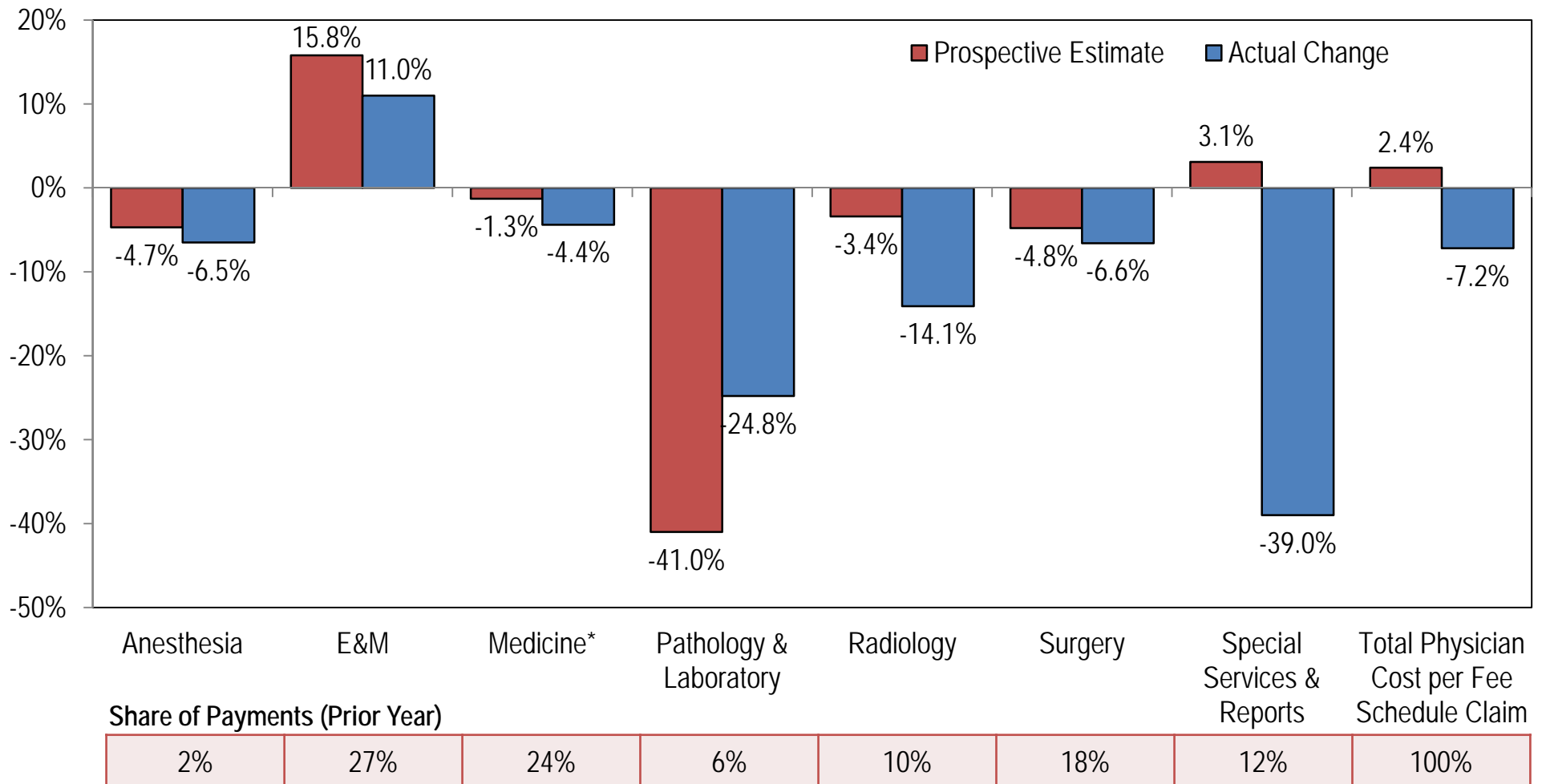
- Result: Based on first year of implementation of the copy service fee schedule, it appears to have achieved its purpose of creating consistent levels of copy service reimbursement. Recent data show a reduction in copy service liens since 2015.

Source: WCIRB Medical Data Call

## RBRVS – WCIRB Prior Estimates

- Evaluated in 1/1/14 Filing – prospectively estimated to increase total costs by \$340M
  - Impact on 2014 services = +2.4% on physician costs
  - Impact on 2015 services = +1.5% on physician costs
  - Impact on 2016 services = +2.1% on physician costs
  - No changes in utilization patterns assumed
- Updated for 1/1/17 Filing based on WCIRB MDC data
  - Impact on 2014 services = -4.8% (from +2.4%)
  - Impact on 2015 services = -2.5% (from +1.5%)
  - No change to prospective estimates for 2016 & 2017 service years

# Projected vs. Actual Change in Physician Fees – 2013 to 2014 Transactions through 2Q 2016 (30 Months)

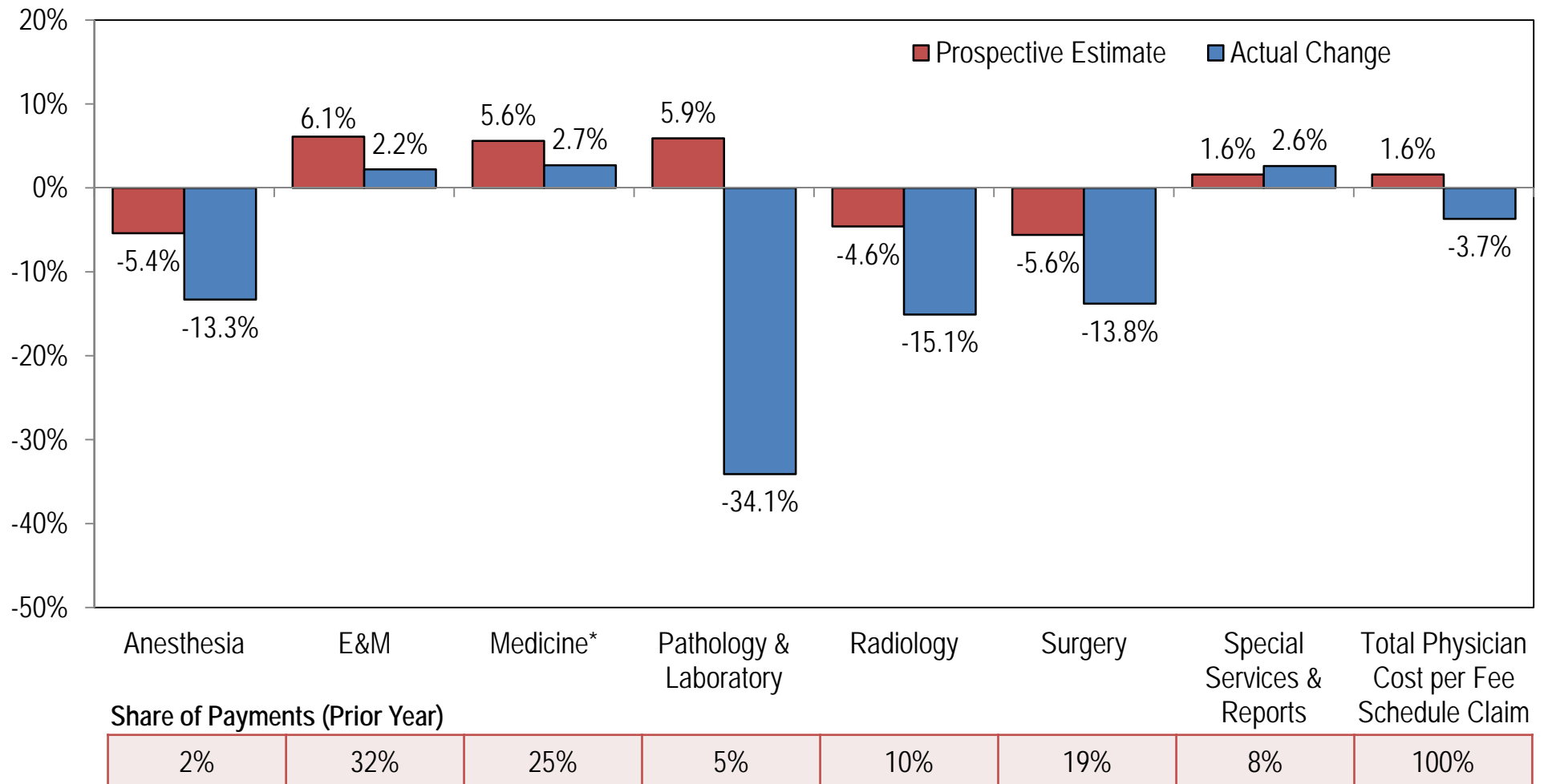


\* Includes Physical Medicine, Chiropractic and Acupuncture

Source: WCIRB Medical Data Call.



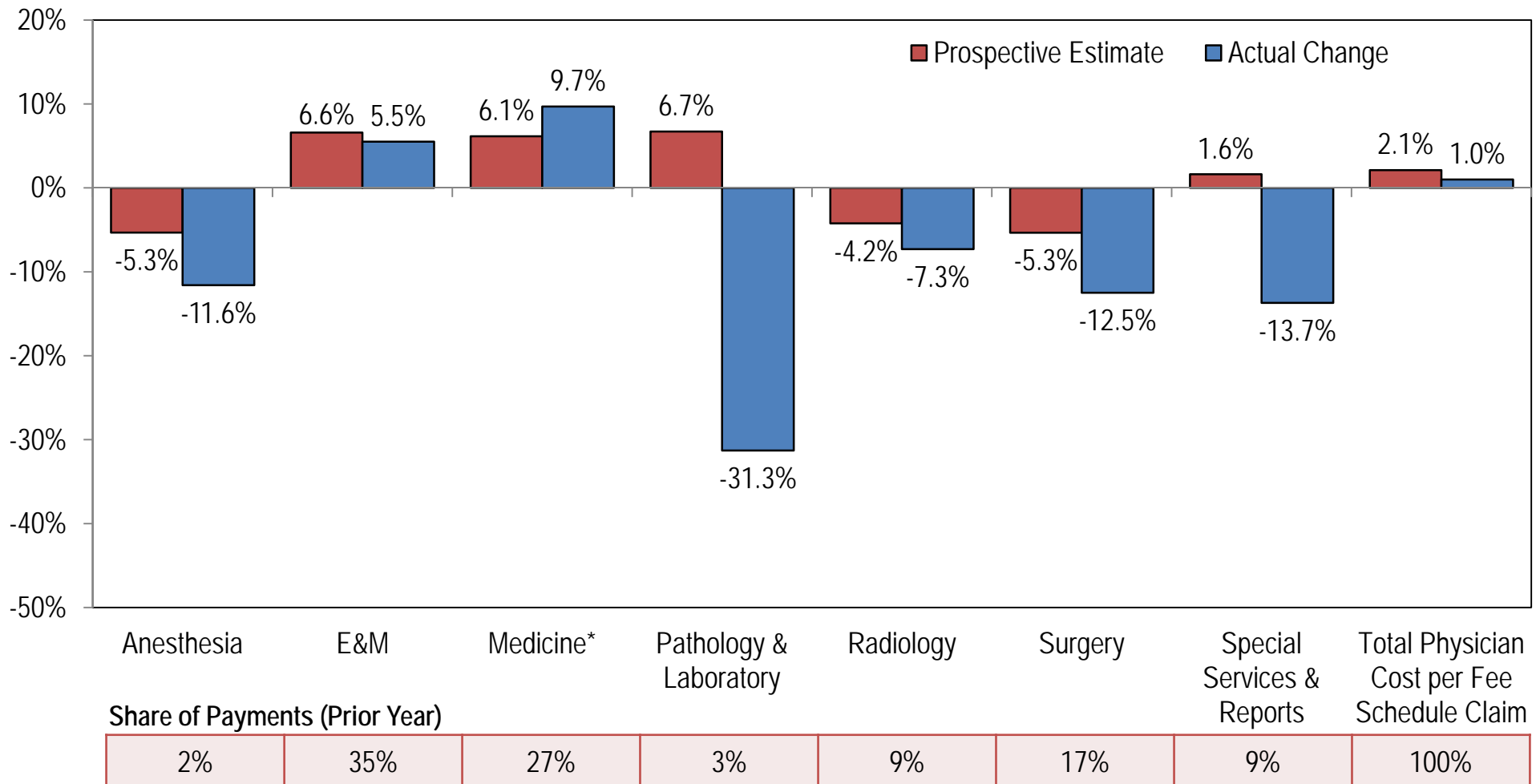
# Projected vs. Actual Change in Physician Fees – 2014 to 2015 Transactions through 2Q 2016 (18 Months)



\* Includes Physical Medicine, Chiropractic and Acupuncture

Source: WCIRB Medical Data Call.

# Projected vs. Actual Change in Physician Fees – 2015 to 2016 Transactions through 2Q 2016 (6 Months)



\* Includes Physical Medicine, Chiropractic and Acupuncture

Source: WCIRB Medical Data Call.

# Changes in Average Physician Costs per Claim Over Time

Change in Physician Payments per Fee Schedule Claim for  
Transactions through...

Service Year	6 Months	12 Months	18 Months	24 Months	30 Months
2014	-3.3%	-5.0%	-6.3%	-6.8%	-7.2%
2015	+2.9%	-2.8%	-3.7%		
2016	+1.0%				

Source: WCIRB Medical Data Call

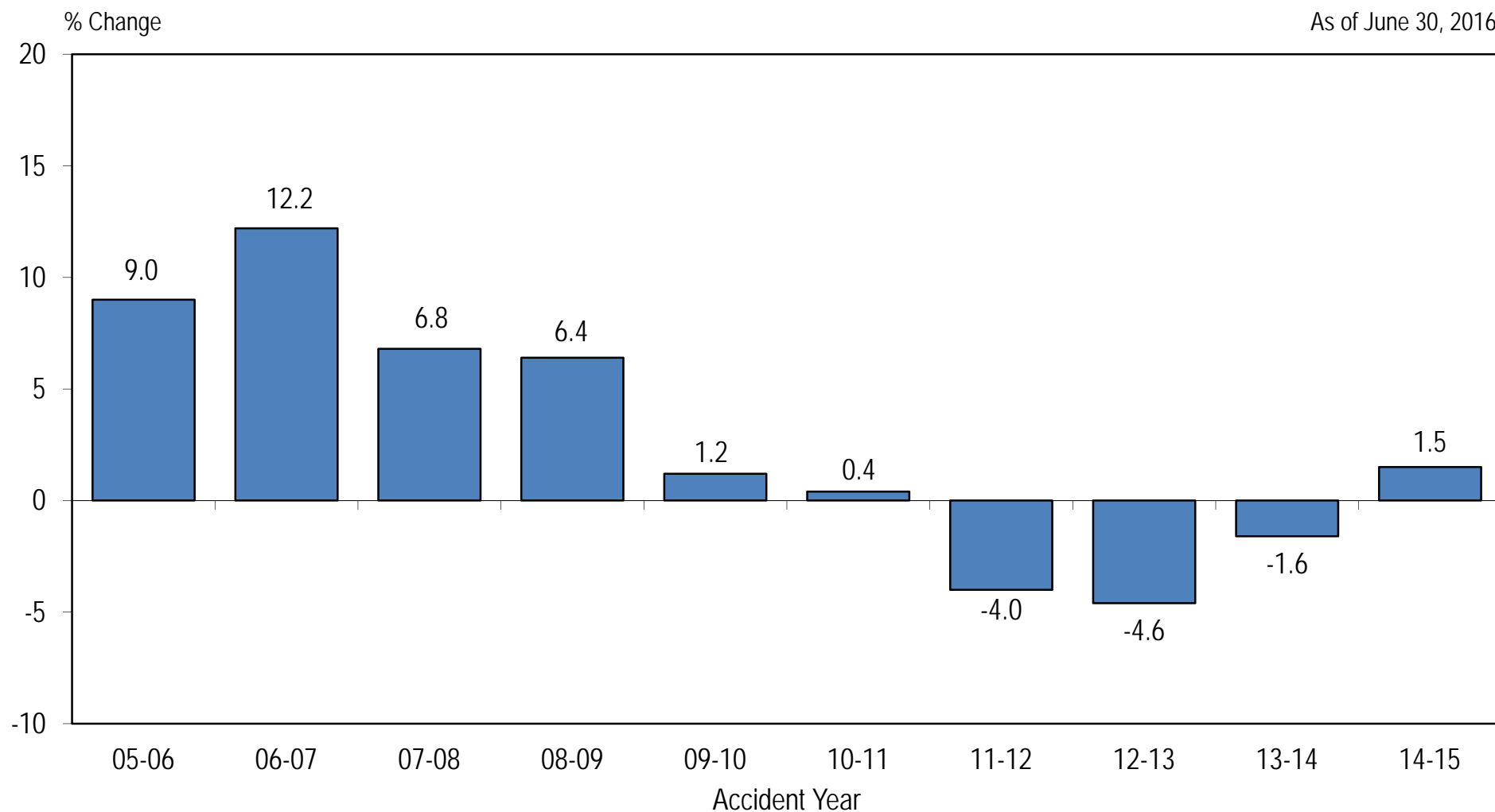
## RBRVS – Summary of Current Information

- Average physician payments for service years 2014 and 2015 continue to decline
  - Significant decreases in Special Services & Reports, Pathology & Laboratory categories
  - Decreases across all categories in number of transactions per claim
- Service year 2016 through six months emerging slightly lower than projection
  - Prior years had declined significantly from six month estimates
- Staff recommends updating service year 2014 and 2015 estimates with most recent data and eliminating cost increase for 2016

## Changes in Utilization of Medical Services – WCIRB Prior Estimates

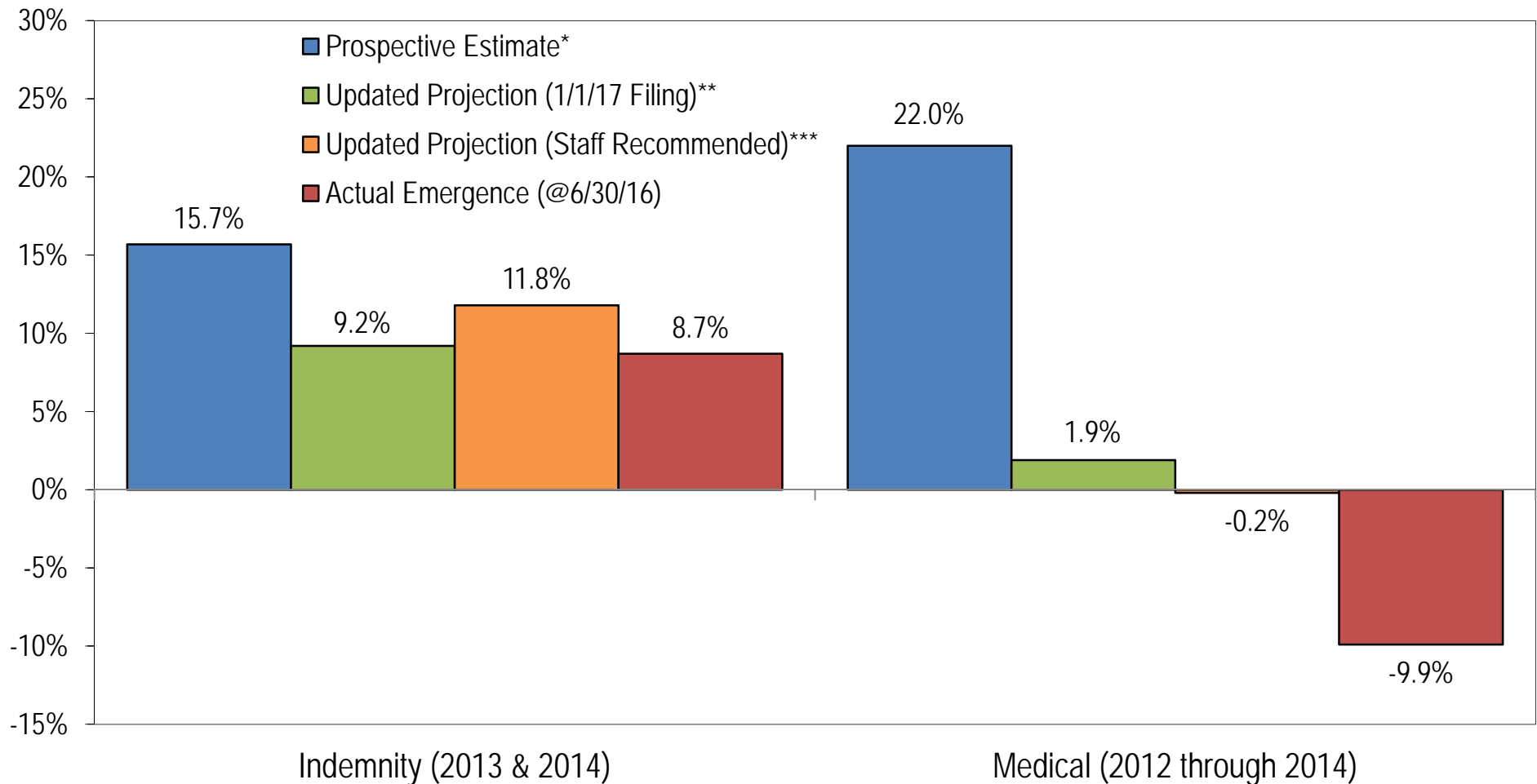
- WCIRB did not prospectively estimate any changes to utilization of medical services from SB 863 provisions related to IMR, IBR, MPNs, etc.
- Overall medical severities declined in 2012-2014 rather than increased at pre-reform trends
- Very difficult to segregate changes in medical utilization by specific SB 863 provisions
- 5% overall decrease in medical utilization reflected in 7/1/16 Filing
  - Updated to 10% decrease in 1/1/17 Filing
  - Spread across accident years 2012-2014 based on relative changes in paid medical development

## Change in Ultimate Medical Severity Excluding MCCP



Source: WCIRB aggregate financial data

# Indemnity & Medical Cumulative 2013 & 2014 Severity Changes



\* Includes the WCIRB's prospective estimates of the impact of SB 863 and projected severity trends from the 1/1/13 Filing.

\*\* Includes the WCIRB's most recent estimates of the impact of SB 863 and projected severity trends from the Amended 1/1/17 Filing.

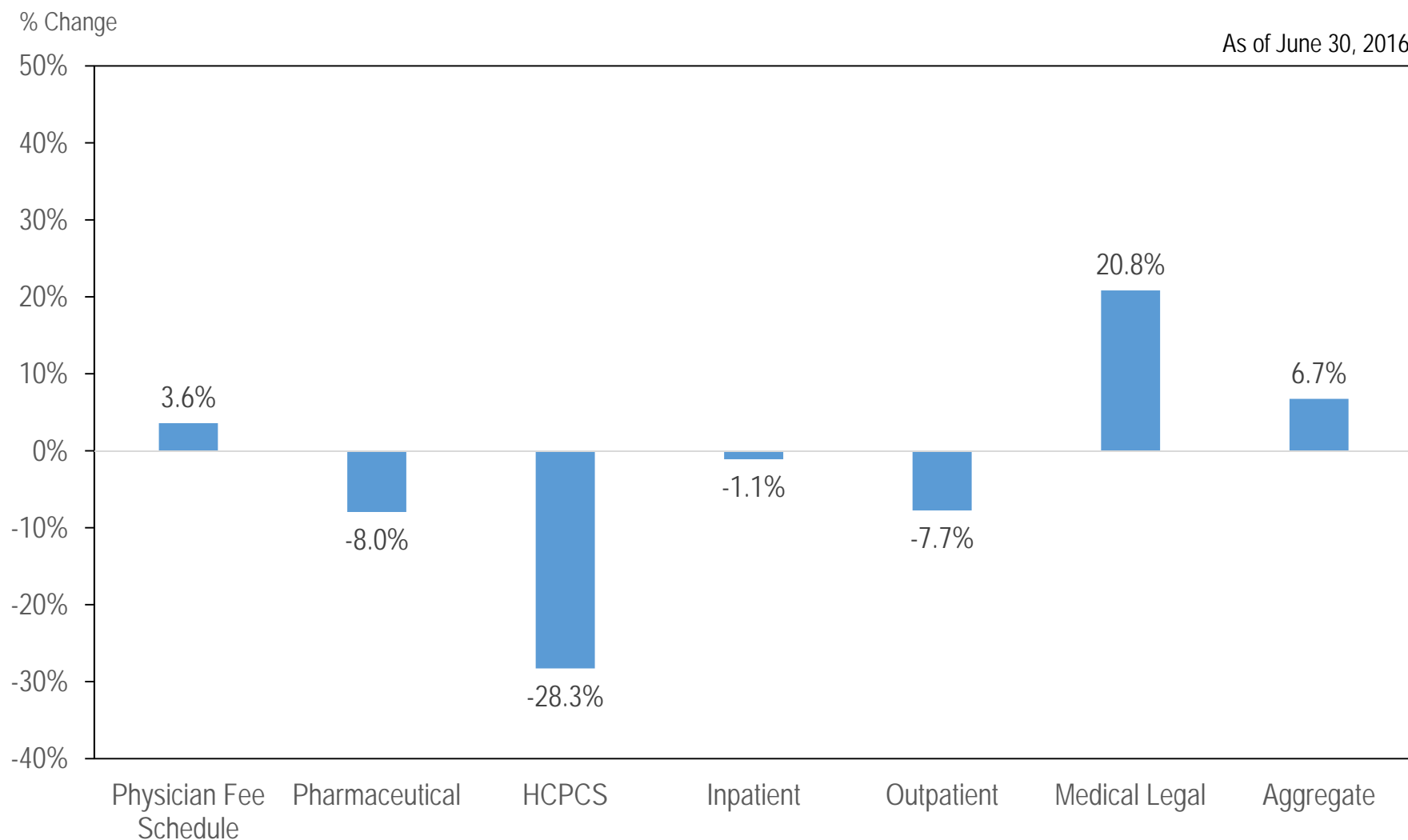
\*\*\* Includes elimination of TD duration savings from IMR and updated RBRVS estimates for 2014-2016 service years.

## Changes in Utilization of Medical Services – Summary of Current Information

- Overall medical utilization continuing to decrease
  - Paid transactions per claim decreased by 15.7% since the second half of 2012 and by 2.6% from the first half of 2015 to the first half of 2016
- Difference from SB 863 projected medical severity change to actual emergence still approximately -10%
- Staff recommends no change to overall adjustment for changes in medical utilization
  - Will review distribution of -10% across older AYs prior to next filing



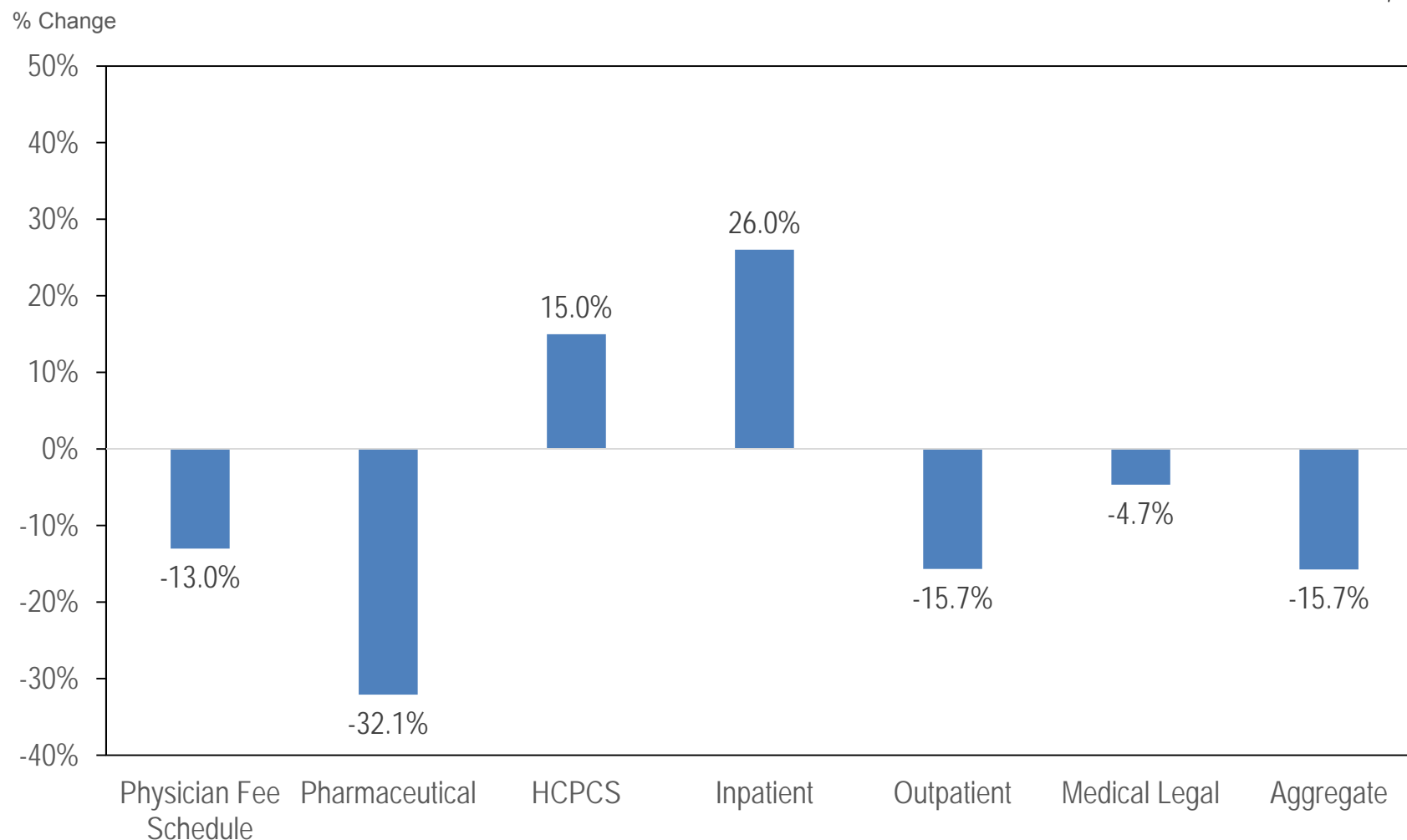
## Changes in Paid per Transaction – 2H 2012 to 1H 2016



Source: WCIRB Medical Data Call.

# Changes in Transactions per Claim – 2H 2012 to 1H 2016

As of June 30, 2016

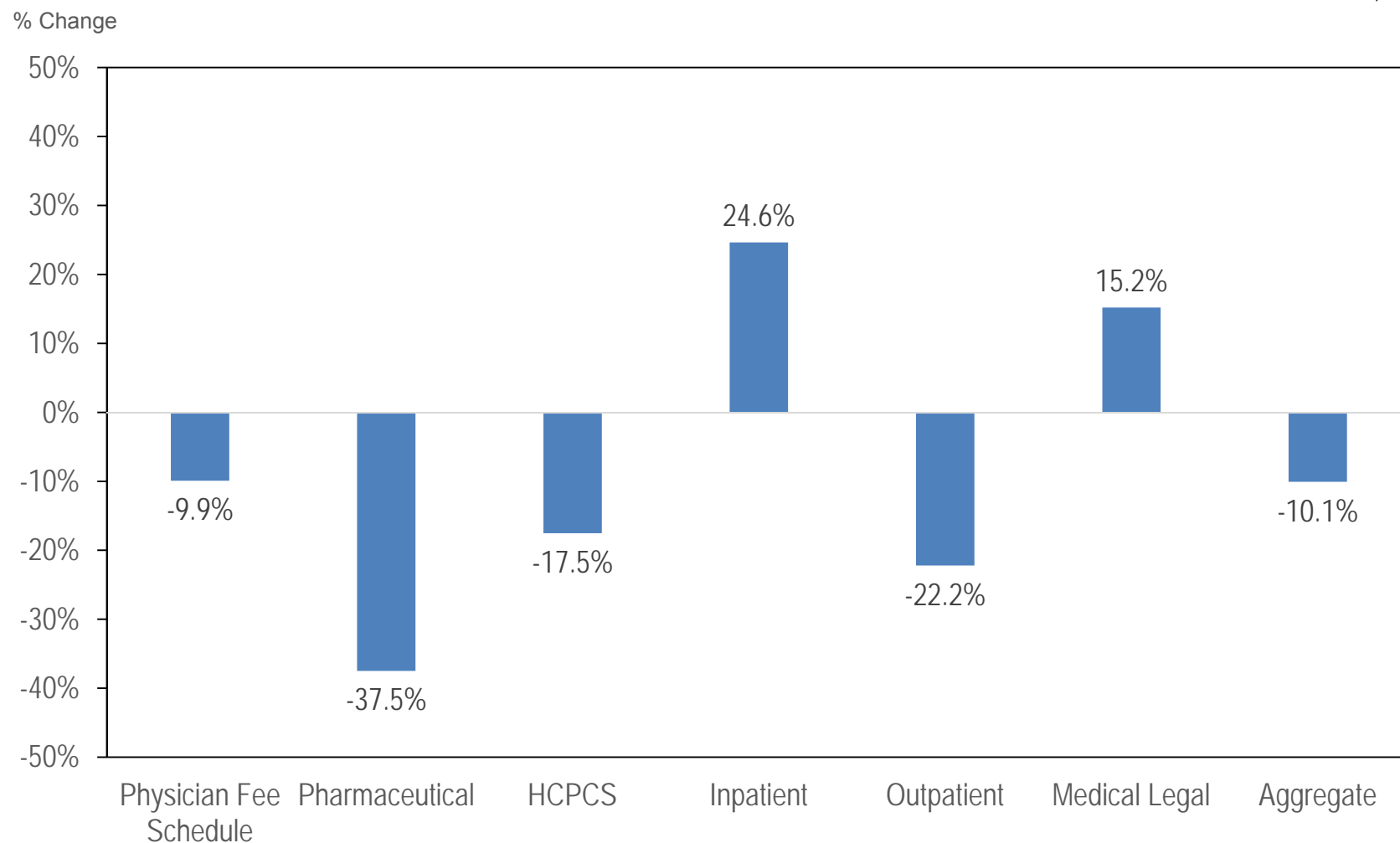


Source: WCIRB Medical Data Call

Claims for this purpose are counted if they have a paid transaction within that medical category. For example, the number of claims with an inpatient transaction have declined by 28% from the second half of 2012.

# Changes in Paid per Claim – 2H 2012 to 1H 2016








As of June 30, 2016













Source: Medical data call,

Claims for this purpose are counted if they have a paid transaction within that medical category. For example, the number of claims with an inpatient transaction have declined by 28% from the second half of 2012.

# WCIRB SB 863 Cost Monitoring – Indemnity Reforms

SB 863 Provisions	WCIRB Original Cost Estimates (\$s in billions)	Current Monitoring Results Impact on Net SB 863 Savings	Updated Estimates (\$s in billions)
Changes to Weekly PD Benefits	+\$0.6		+\$0.6
Replacement of FEC Factor	+\$0.6		+\$0.6
Elimination of PD Add-ons	(\$0.2)		(\$0.2)
Three-Tiered Weekly PD Benefits	(\$0.1)		(\$0.1)
<u>Ogilvie</u> Decision	(\$0.2)		(\$0.1)
Indemnity Claim Frequency	Small Increase		---
Indemnity Severity	Significant Increase		---
<b>Total Indemnity Reforms</b>	<b>+\$0.7</b>	---	<b>+\$0.8</b>

# WCIRB SB 863 Cost Monitoring – Medical & LAE Reforms

SB 863 Provisions	WCIRB Original Cost Estimates (\$s in billions)	Current Monitoring Results Impact on Net SB 863 Savings	Updated Estimates (\$s in billions)
Liens	(\$0.5)		(\$0.5)
Surgical Implant Hardware	(\$0.1)		(\$0.1)
ASC Fees	(\$0.1)		(\$0.1)
IMR – Impact on Frictional Costs	(\$0.2)		+\$0.1
IMR – Impact on TD Duration	(\$0.2)		\$0.0
MPN Strengthening	(\$0.2)		(\$0.2)
RBRVS Fee Schedule	+\$0.3		(\$0.4)
Copy Services Fee Schedule	\$0.0		\$0.0
Medical Severities	No Impact		(\$1.0)
ALAE and ULAE Severities	Significant Decline		---
<b>Total Medical &amp; LAE Reforms</b>	<b>(\$0.9)</b>	---	<b>(\$2.2)</b>
<b>Total Estimate – All Items</b>	<b>(\$0.2)</b>	---	<b>(\$1.4)</b>

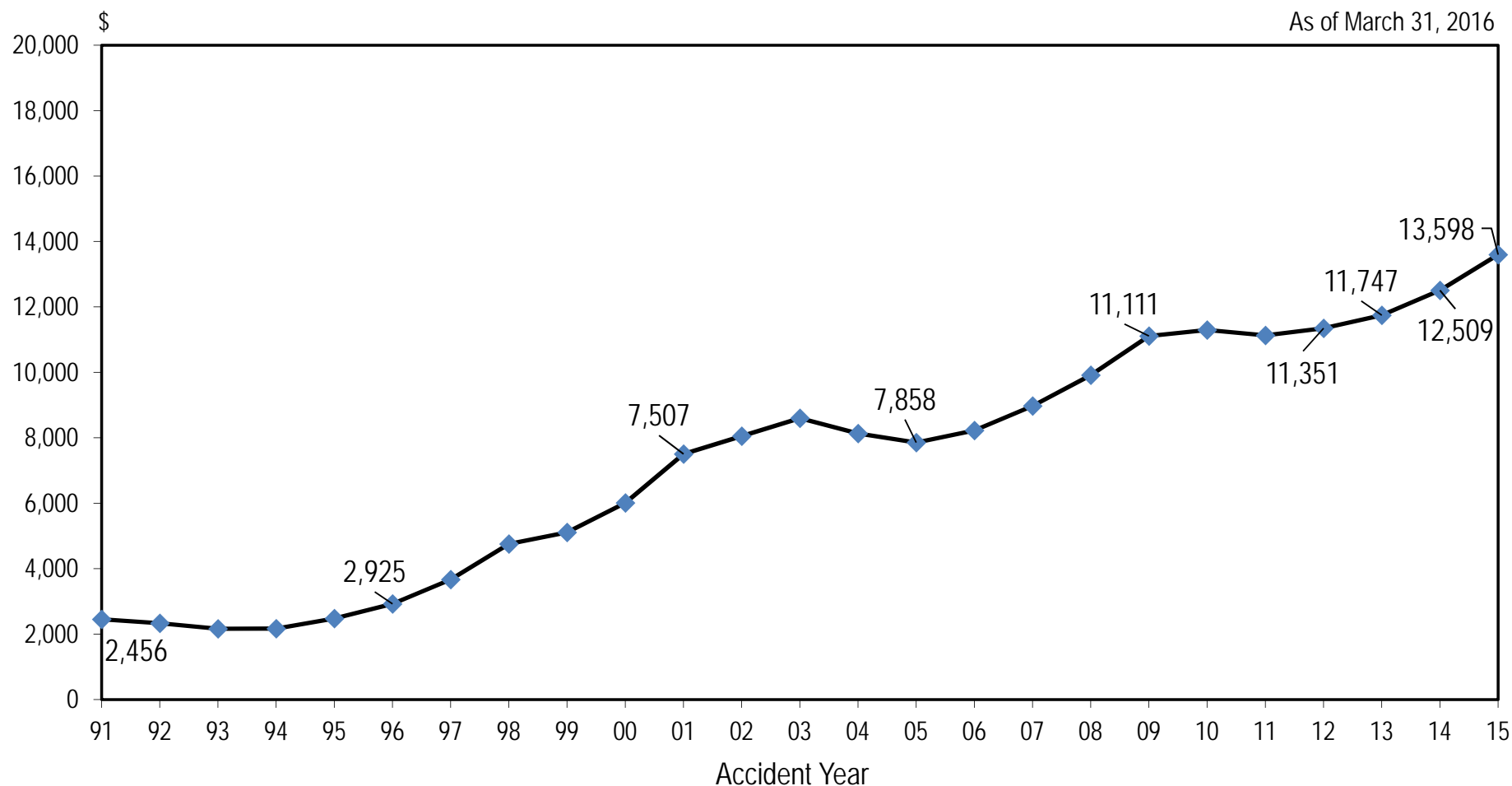
# Study of ALAE – Preliminary Results

WCIRB Actuarial Committee Meeting  
November 8, 2016

## ALAE Study – Background

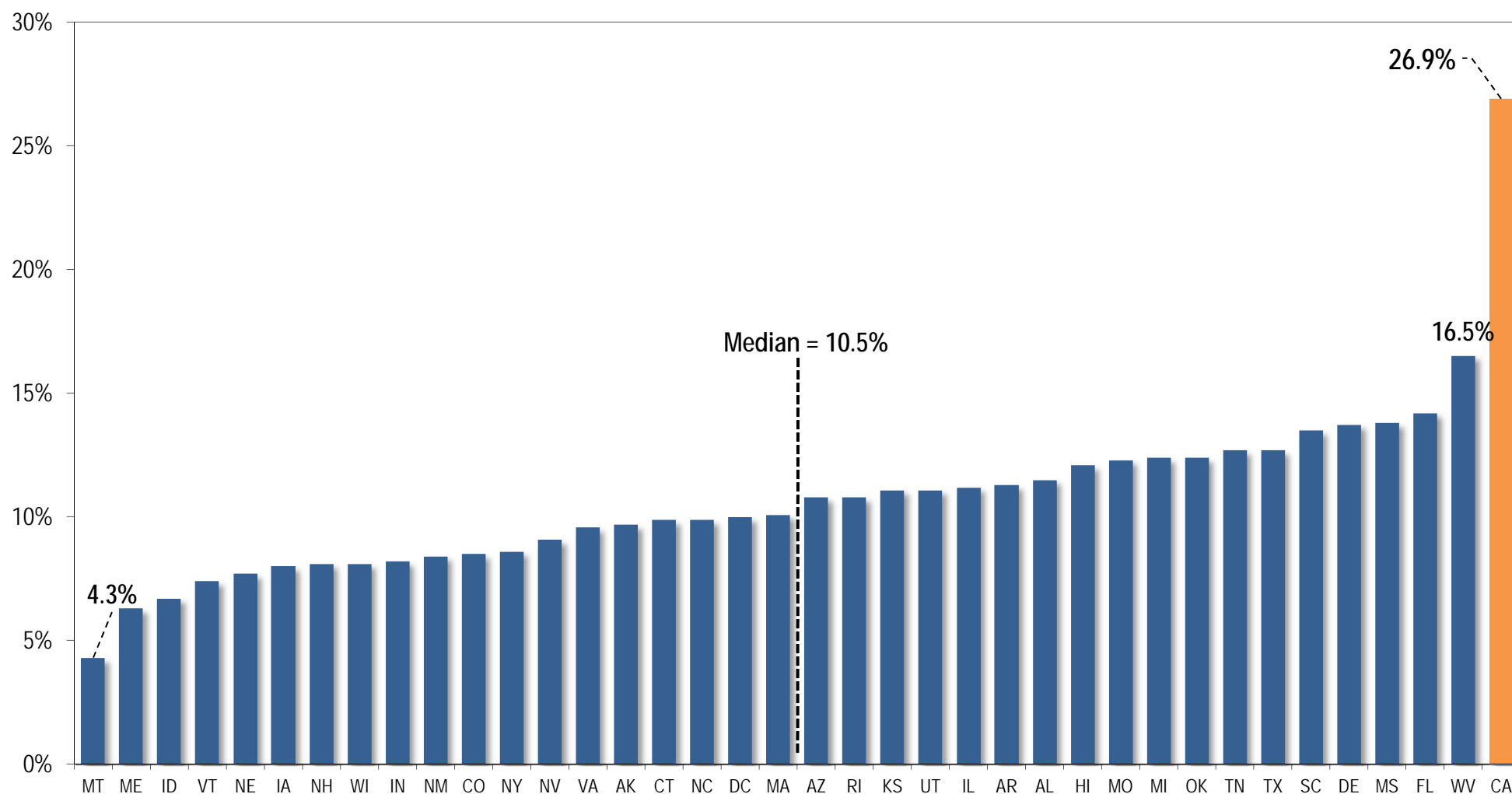
- California traditionally the highest ALAE cost state
- SB 863 provisions intended to reduce ALAE cost levels
  - Lien reforms, IMR/IBR, FEC changes (Ogilvie)
- ALAE increased 20% since 2012 and is fastest-growing cost component
- Committee and Claims Working Group recommended studying recent increases in ALAE and why ALAE costs are highest in CA

## Estimated Ultimate ALAE (Excl. MCCP) Per Indemnity Claim – Private Insurers (Exhibit 1)



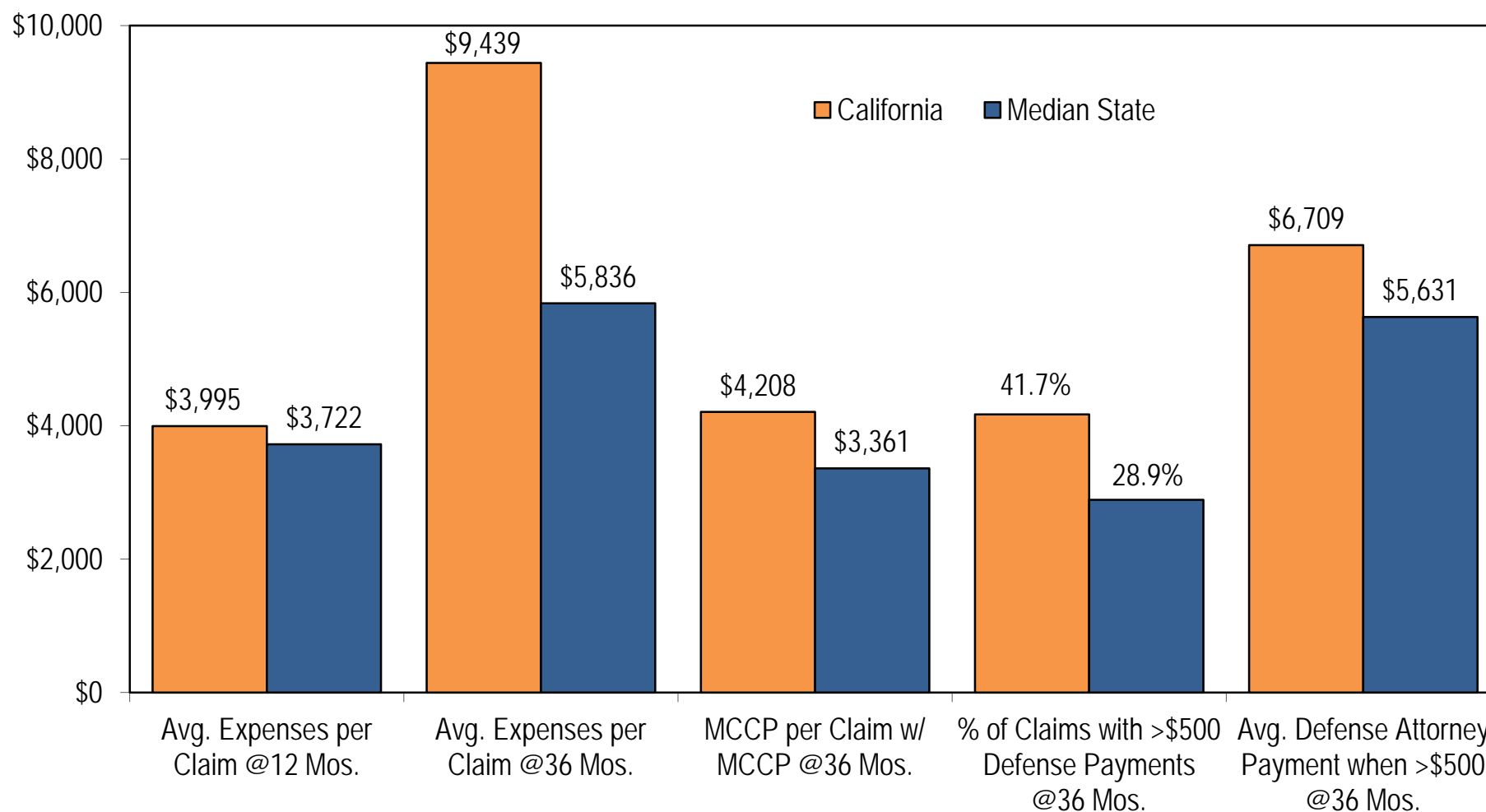


## Ratios of ALAE (DCC) to Losses by State (Exhibit 3)



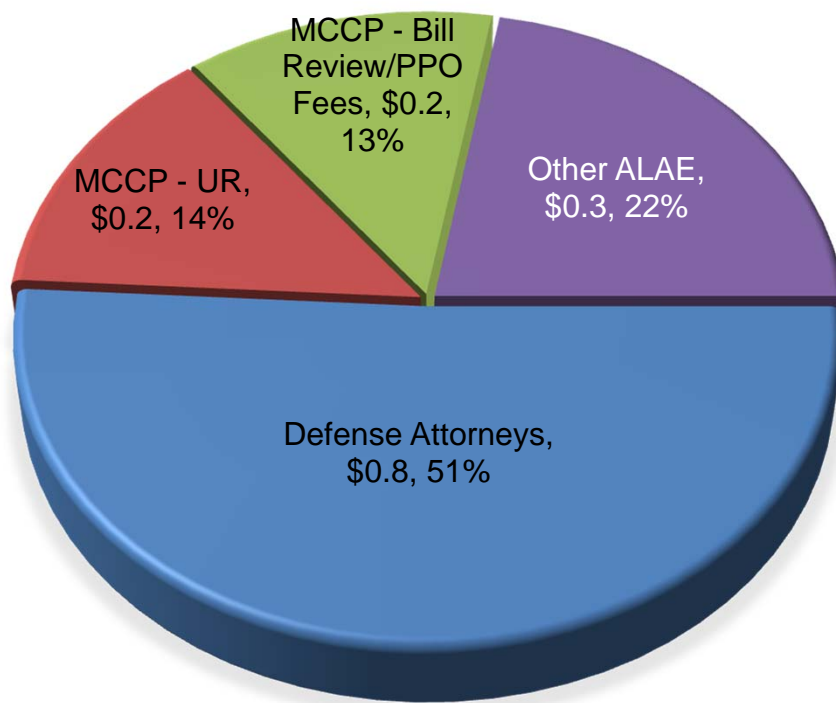
Source: NCCI Annual Statistical Bulletin – 2016 Edition

# Comparisons of California Benefit Delivery Costs

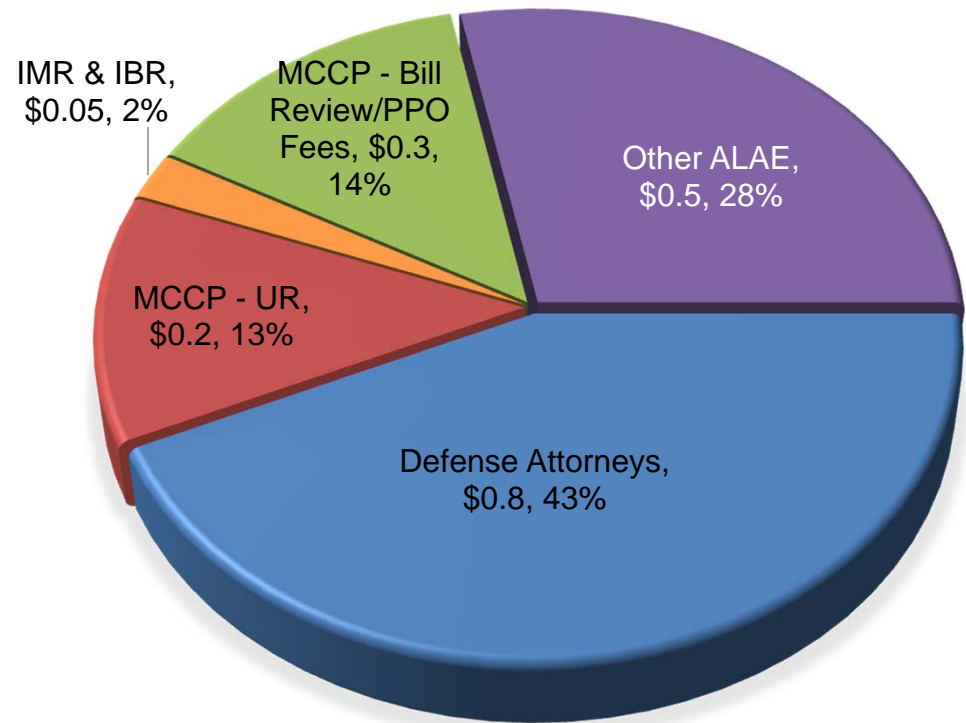


Source: WCRI *Compscope Benchmarks for California, 16<sup>th</sup> Edition*. Based on claims with 7 or more days of lost time.

## Distribution of Calendar Year Paid ALAE Costs (in Billions) (Exhibit 2)



2012 (\$1.5B)



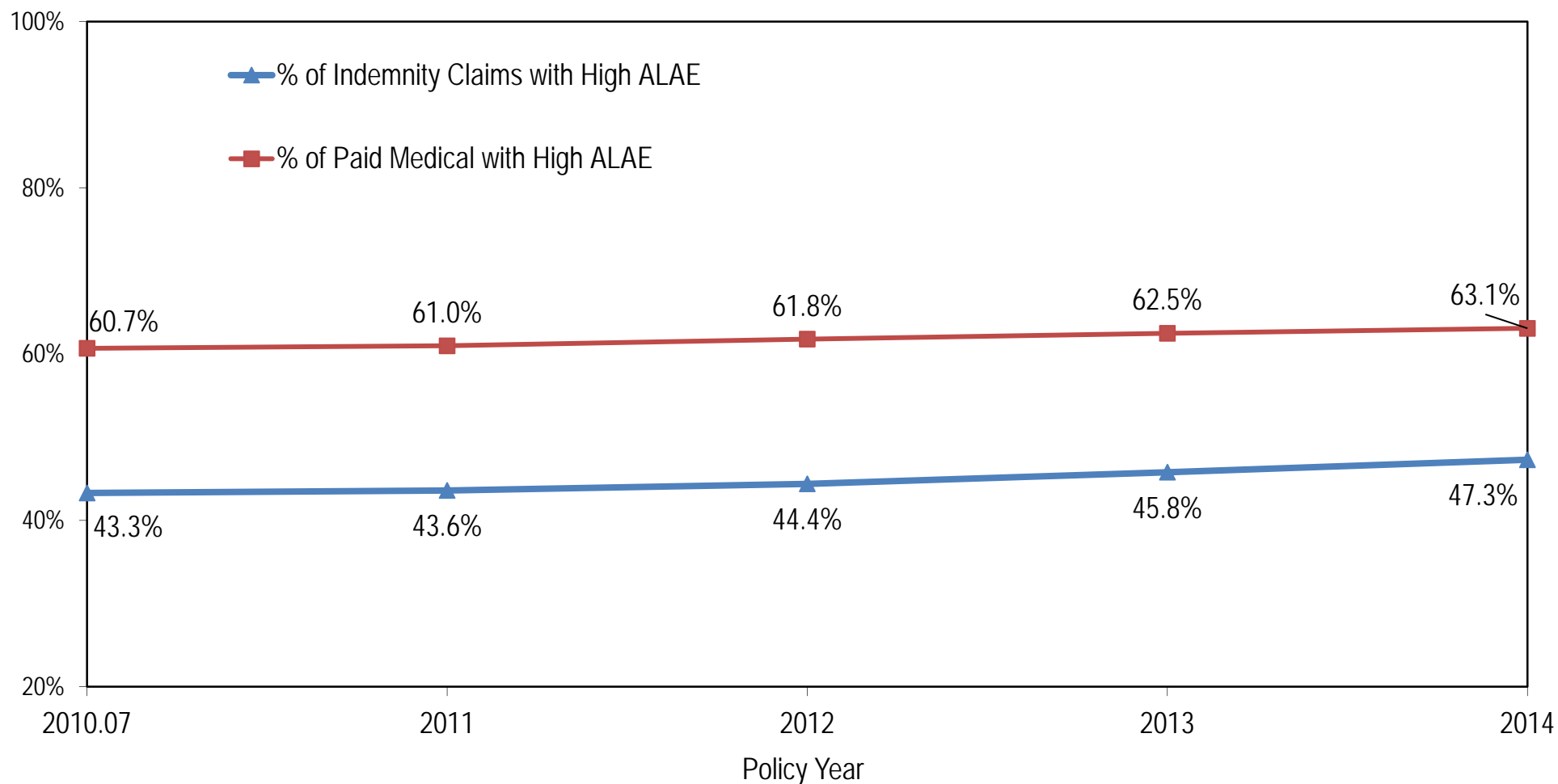
2015 (\$1.9B)

Source: WCIRB aggregate financial data calls and CWCI information on the cost of medical cost containment programs. ALAE amounts shown include all medical cost containment program costs including those reported in medical losses.

## Comparison of Claims with “Significant” ALAE Costs

- Goal: Compare characteristics of claims with significant ALAE (i.e., litigated claims) with other claims based on USR paid ALAE
  - “High ALAE” = Paid ALAE > \$1,000
  - “Low ALAE” = Paid ALAE > \$0 and up to \$1,000
  - “No ALAE” = Paid ALAE = \$0
- After change in MCCP reporting (7/1/10 policies), virtually all indemnity claims have ALAE
  - High ALAE used as proxy for litigated claim
  - Post-7/1/10 policy period focus of study
  - No indexing applied since majority of ALAE under \$1,000 is MCCP and average MCCP costs have been flat during this period

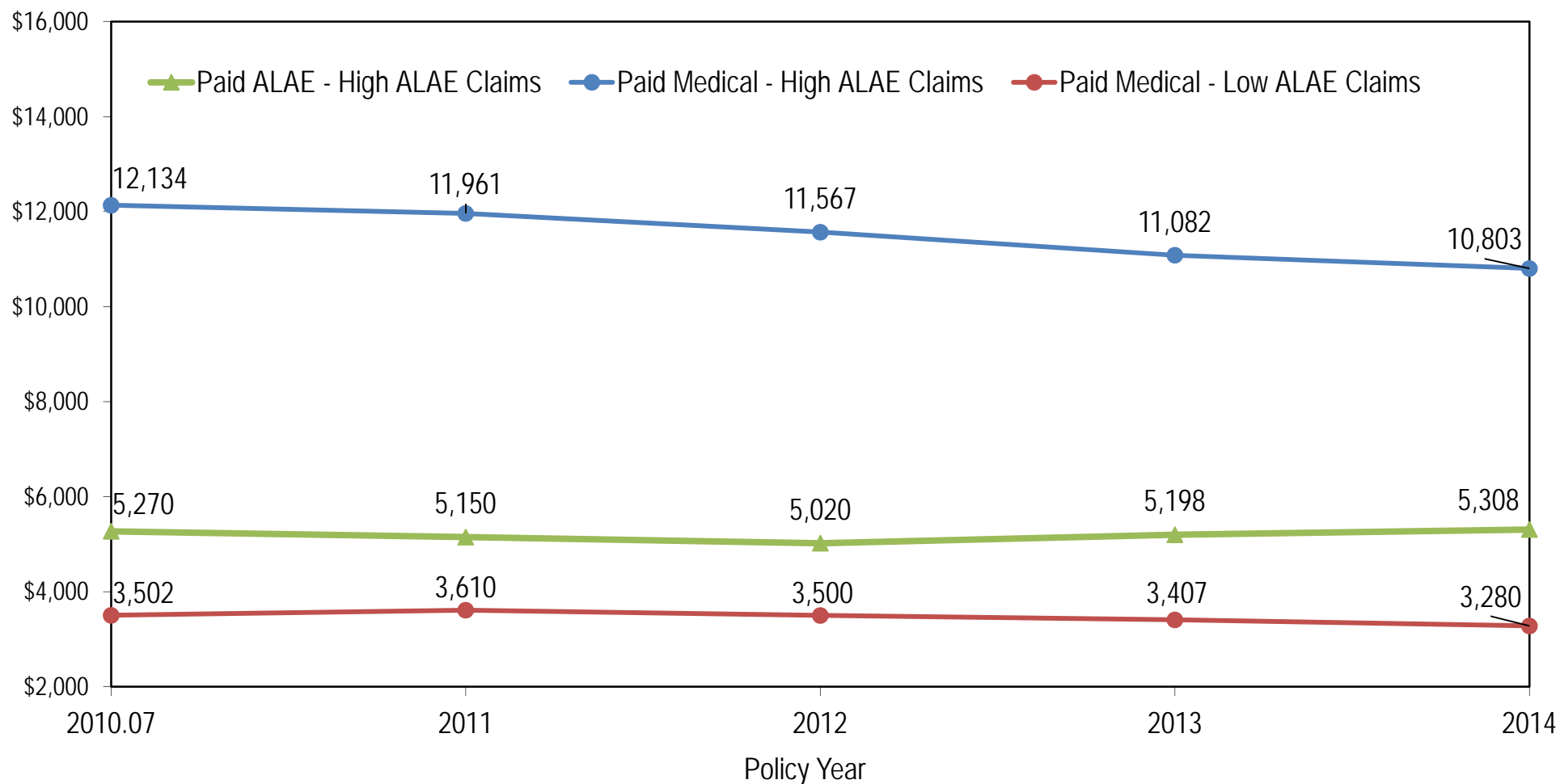
## Distribution of Indemnity Claims with High ALAE USR 1<sup>st</sup> Report Level (Exhibit 4)



Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000.

# Indemnity Claim Severity by ALAE Category

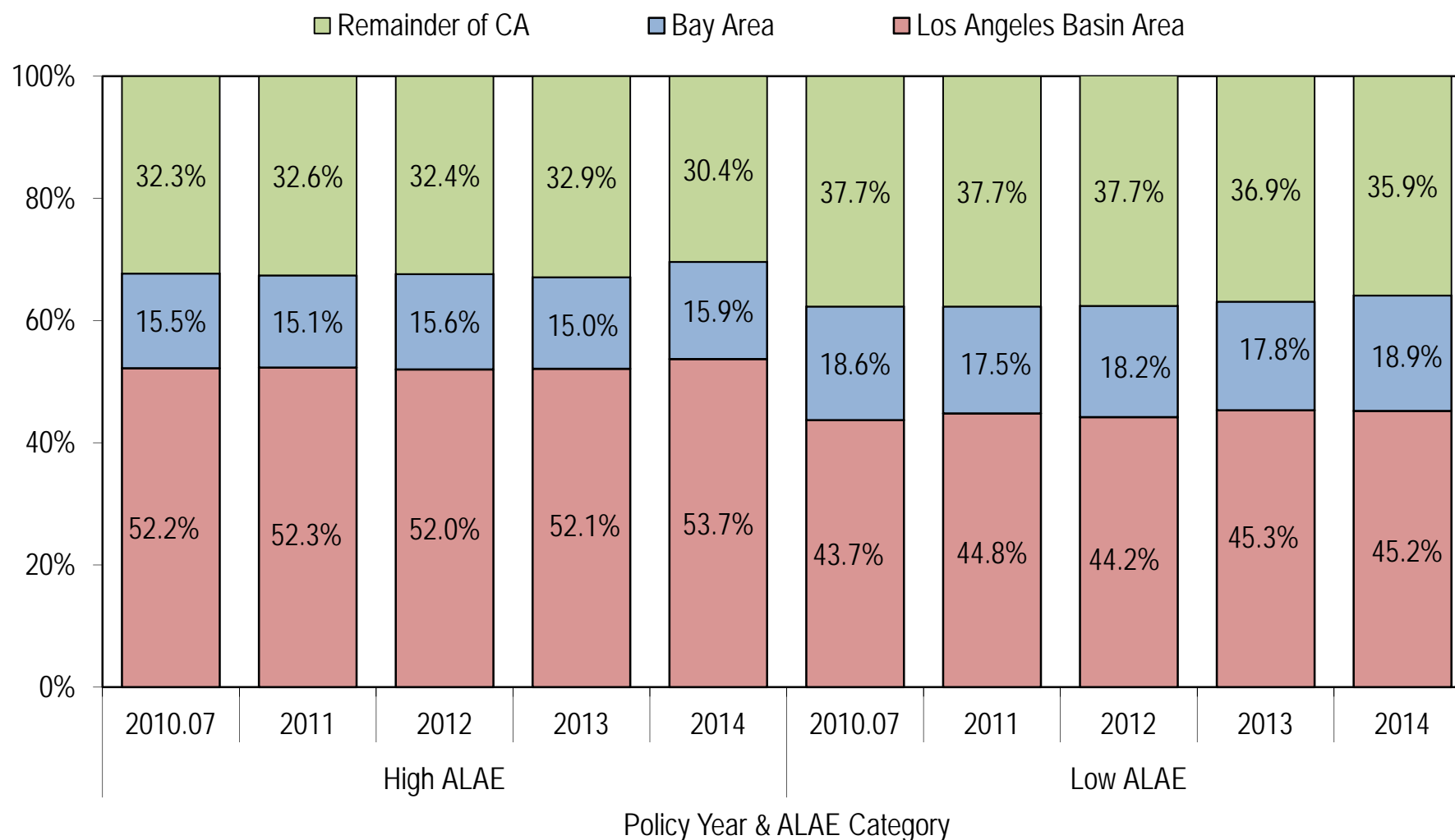
## USR 1<sup>st</sup> Report Level (Exhibit 5)



Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000. Low ALAE is ALAE >\$0 and <= \$1,000.

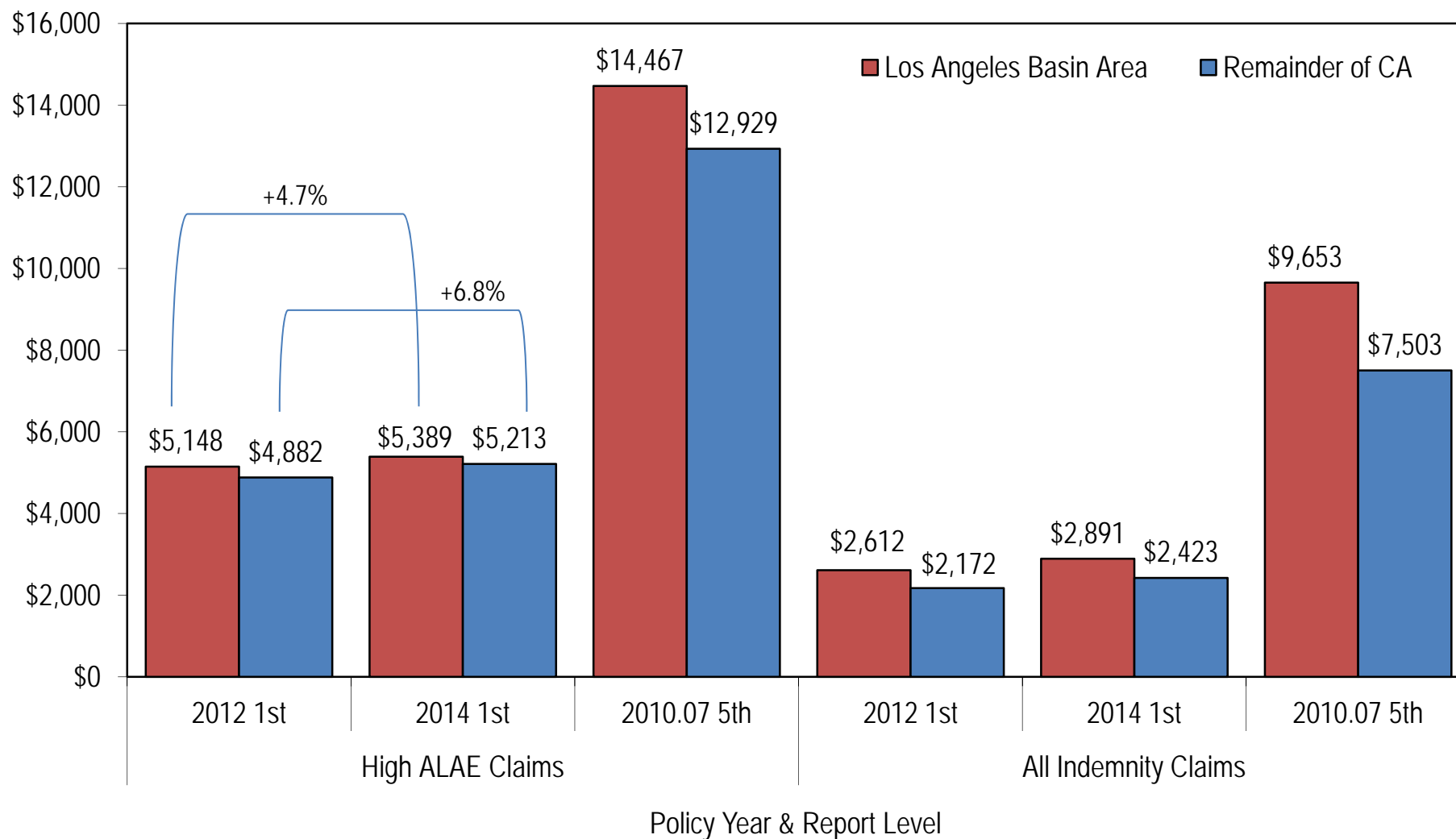
# Distribution of Indemnity Claims by Region and ALAE Category

## USR 1<sup>st</sup> Report Level (Exhibit 6.1)



Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000. Low ALAE is ALAE >\$0 and <= \$1,000.

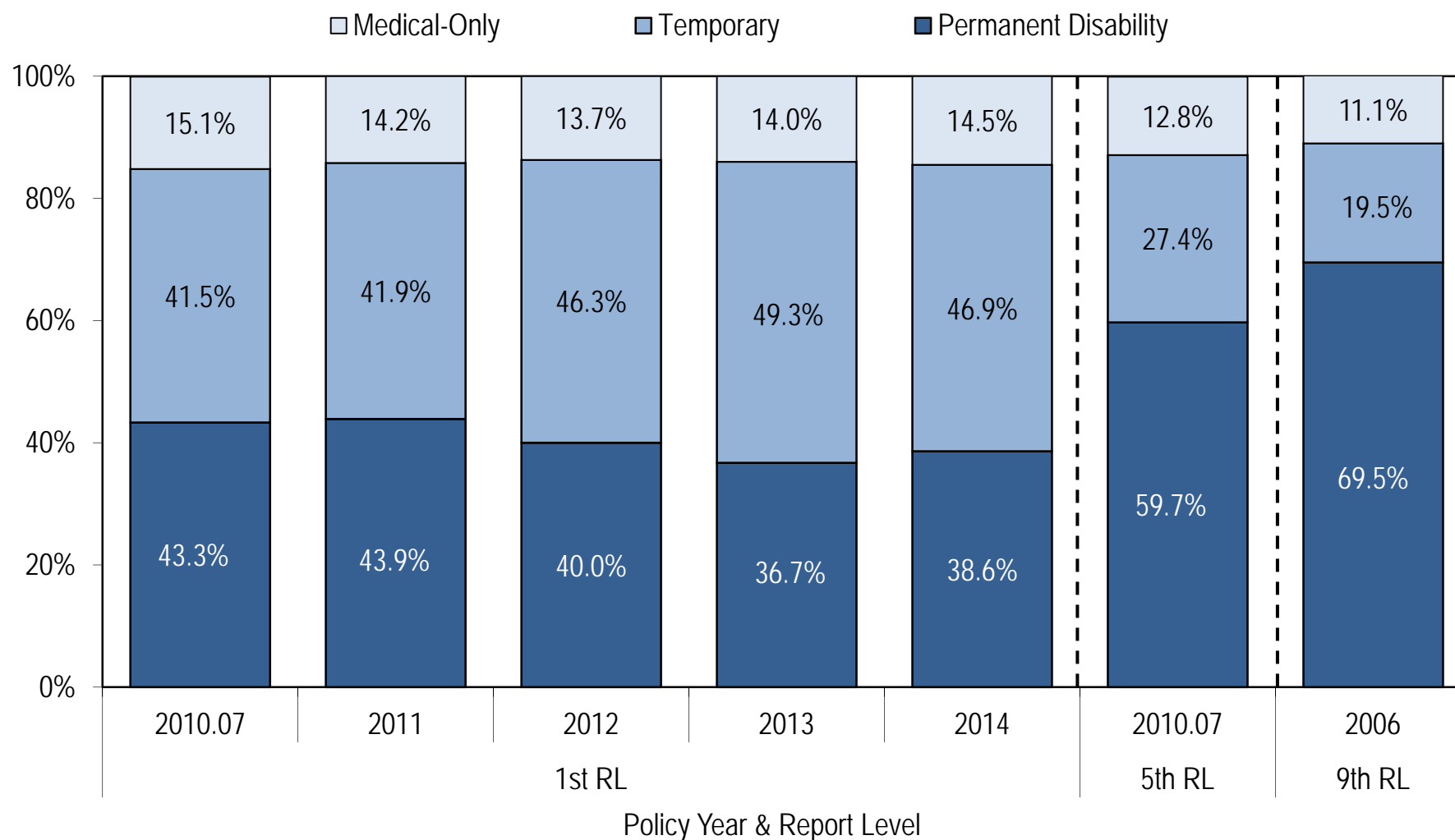
# Average ALAE Costs by Region (Exhibit 6.3)



Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000.

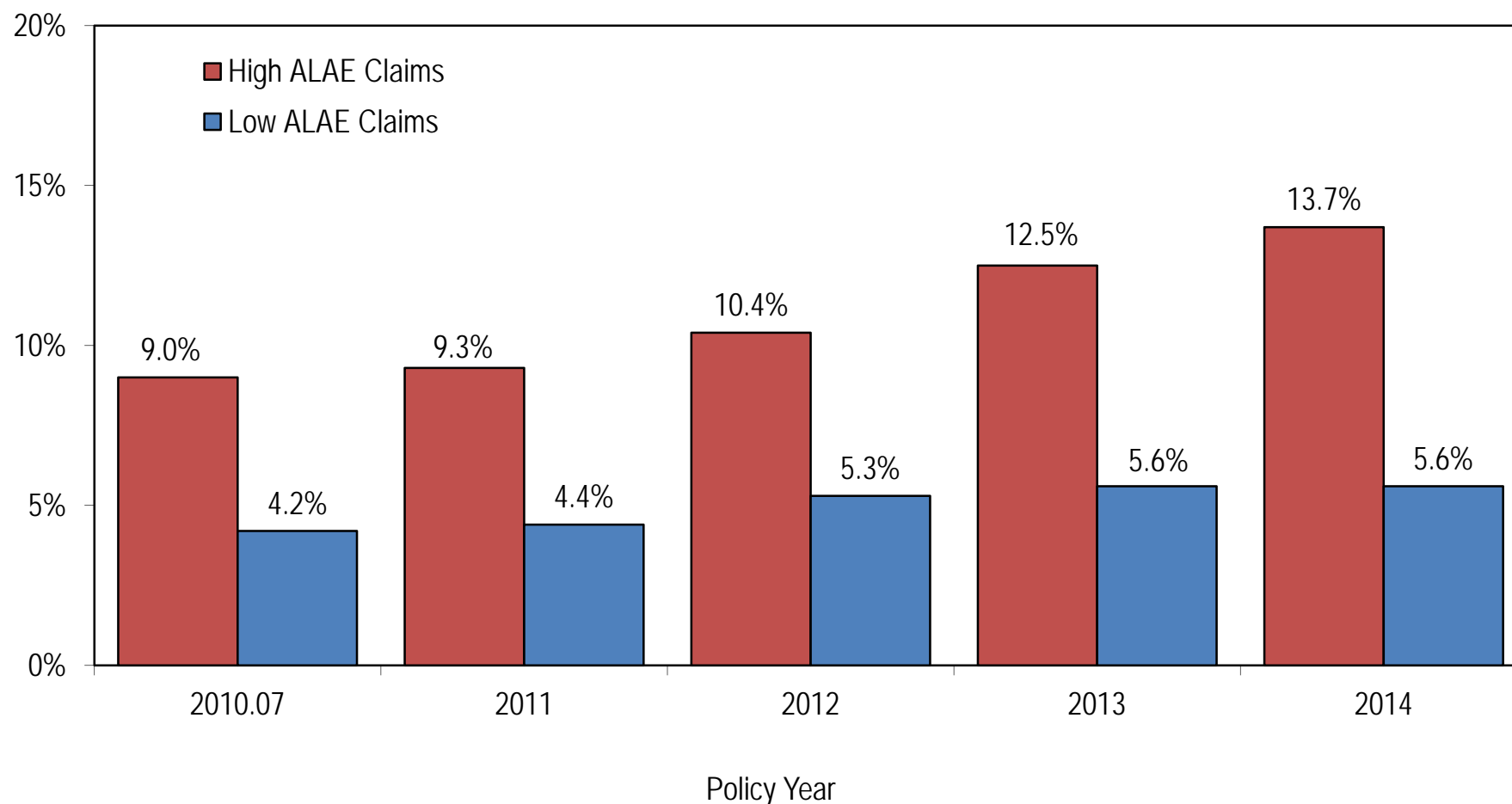


# Distribution of High ALAE Claims by Injury Type (Exhibit 7.1)



Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000.

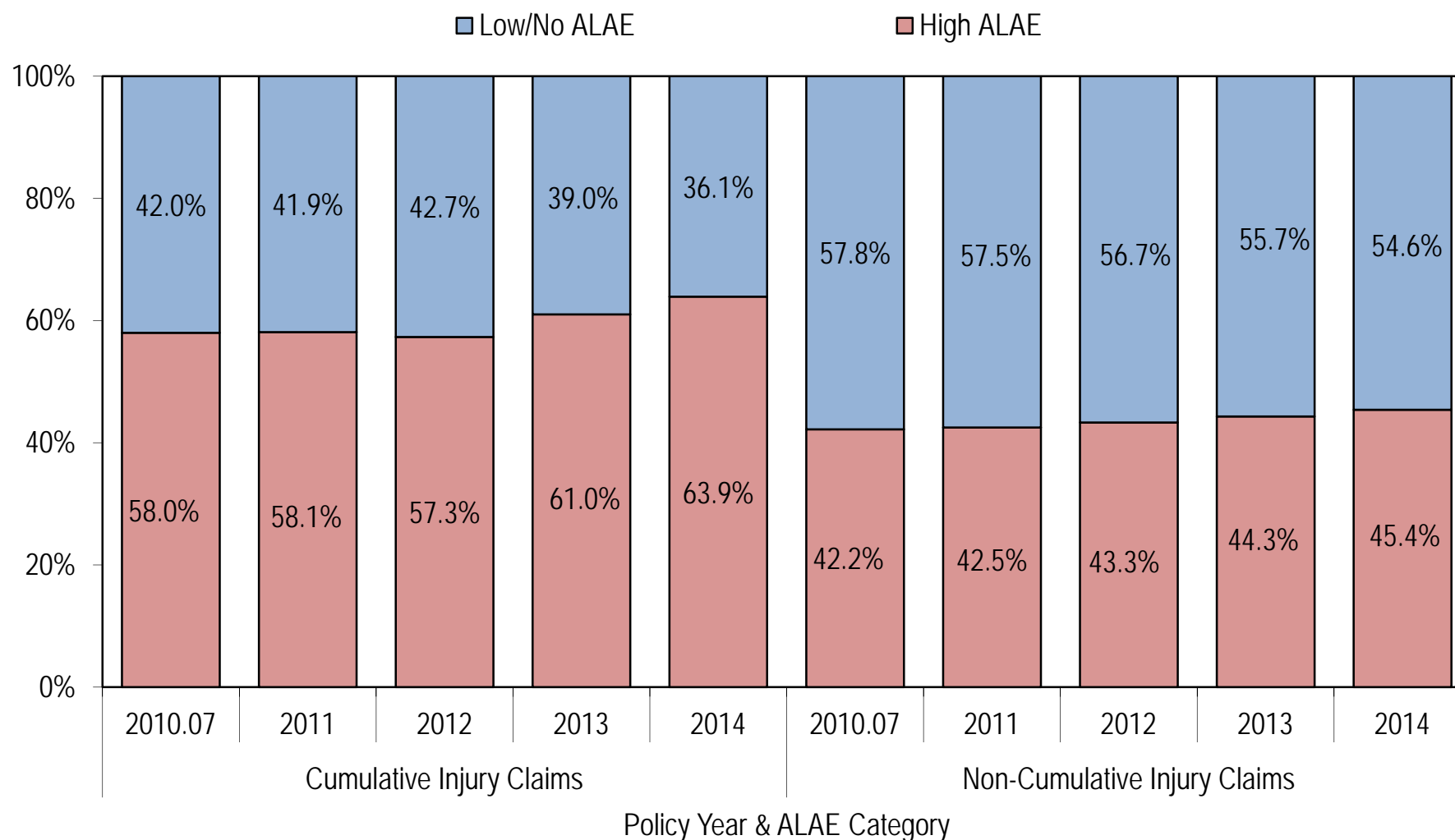
## Percentage of Claims Involving Cumulative Injury USR 1<sup>st</sup> Report Level (Exhibit 9.1)



Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000. Low ALAE is ALAE >\$0 and <= \$1,000.

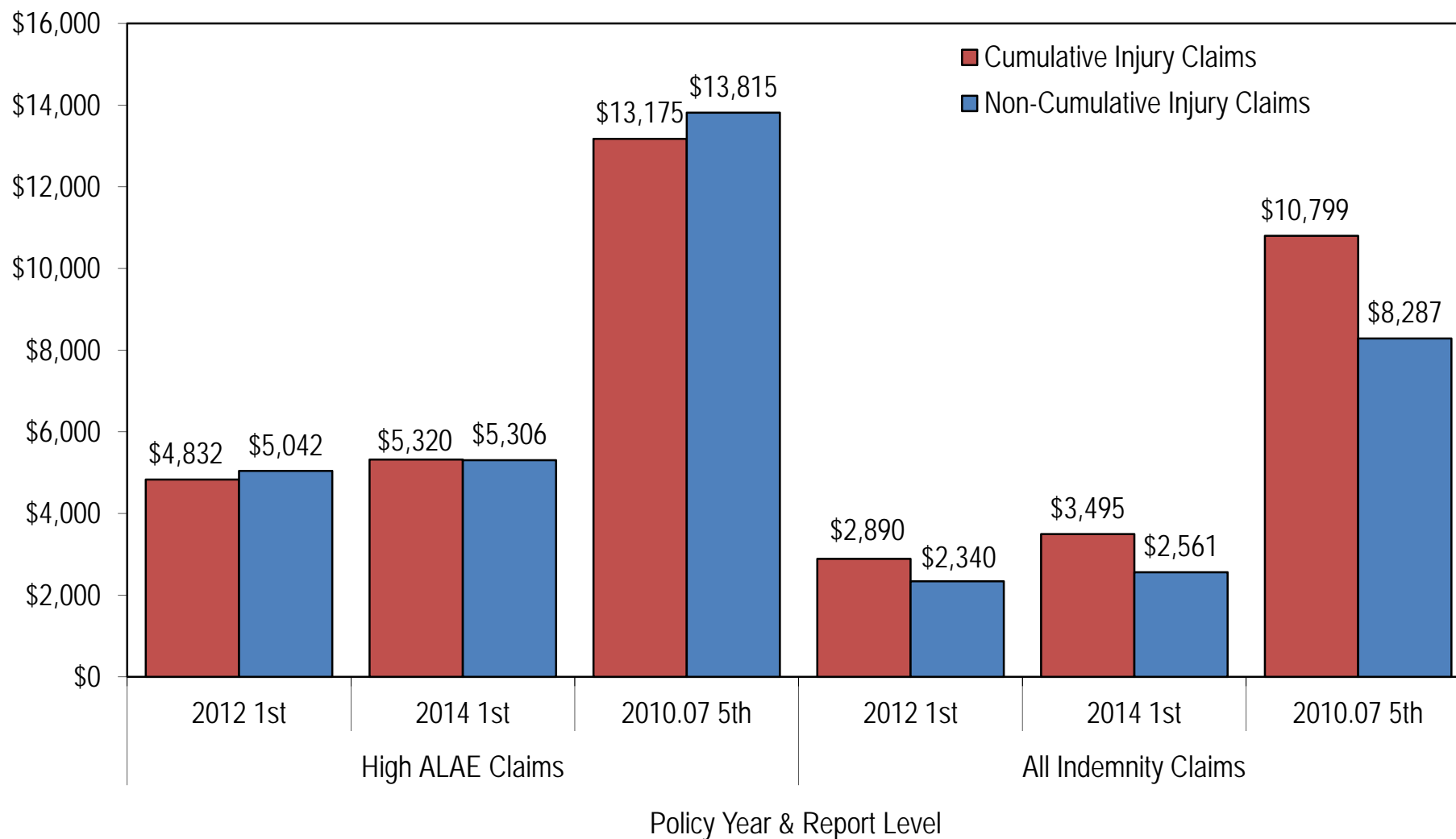
# Distribution of Indemnity Claims by Claim Type and ALAE Category

## USR 1<sup>st</sup> Report Level



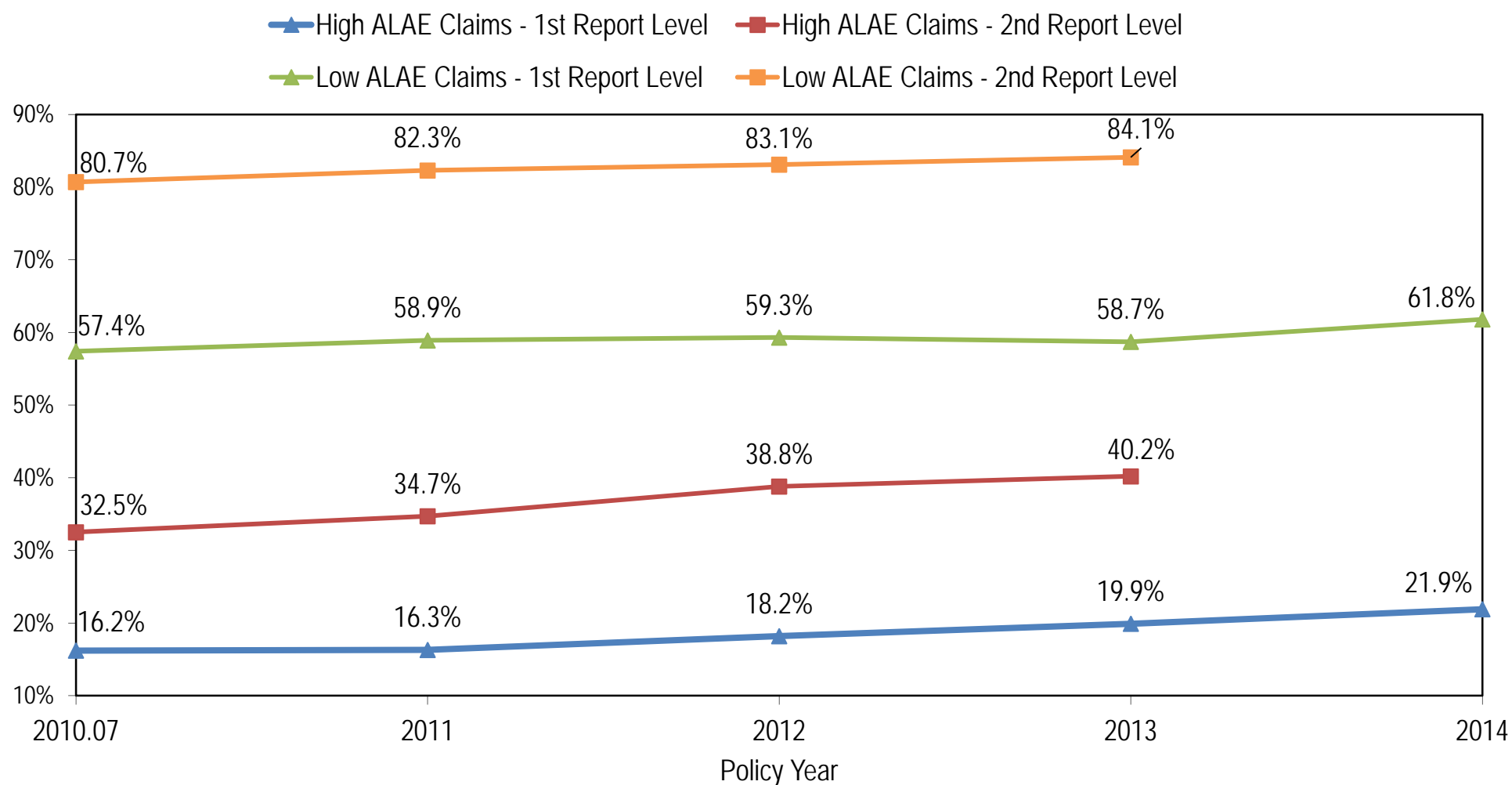
Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000. Low ALAE is ALAE >\$0 and <= \$1,000.

# Average ALAE Costs by Type of Claim (Exhibit 9.2)



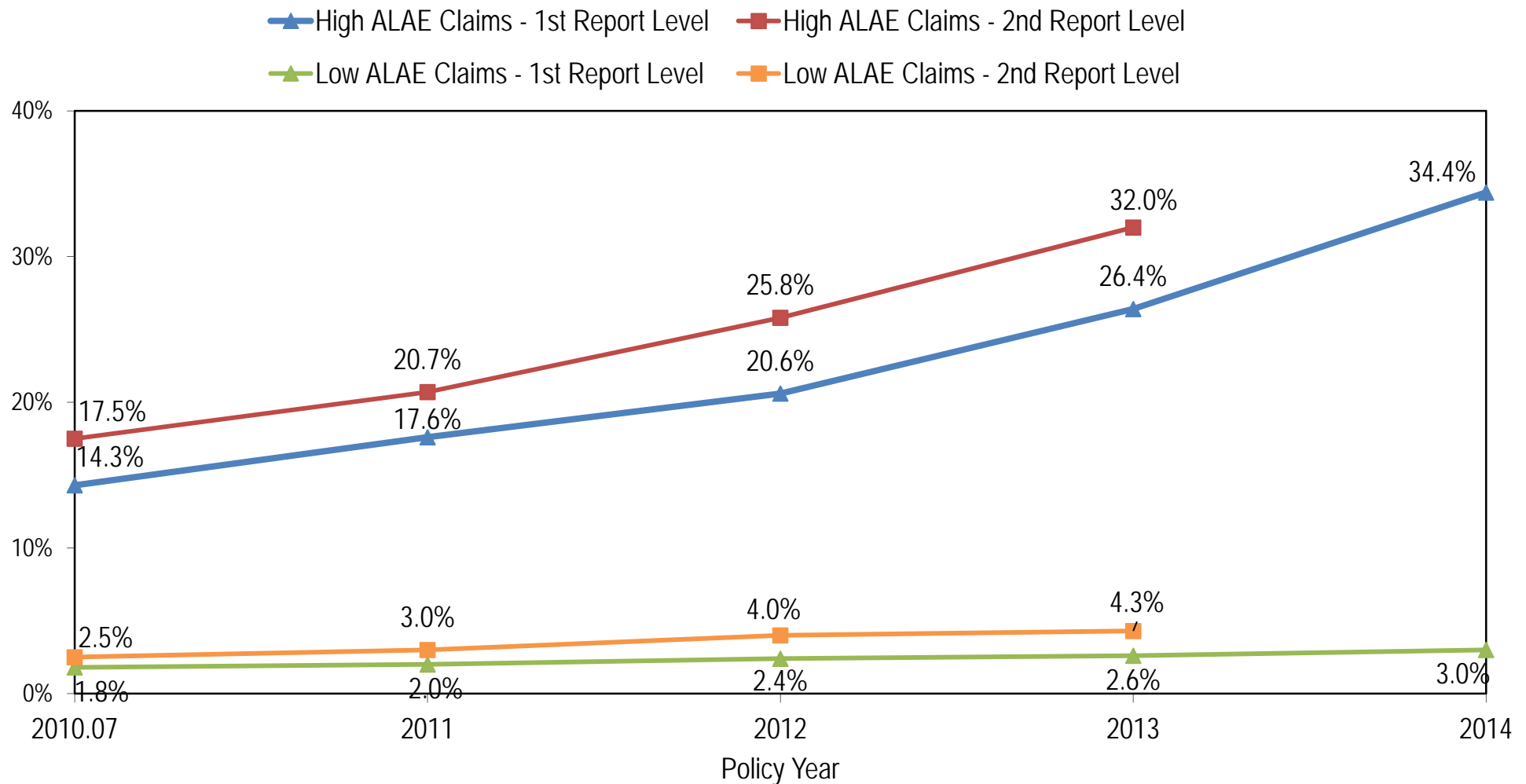
Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000.

# Indemnity Claim Closing Rates (Exhibit 10.1)



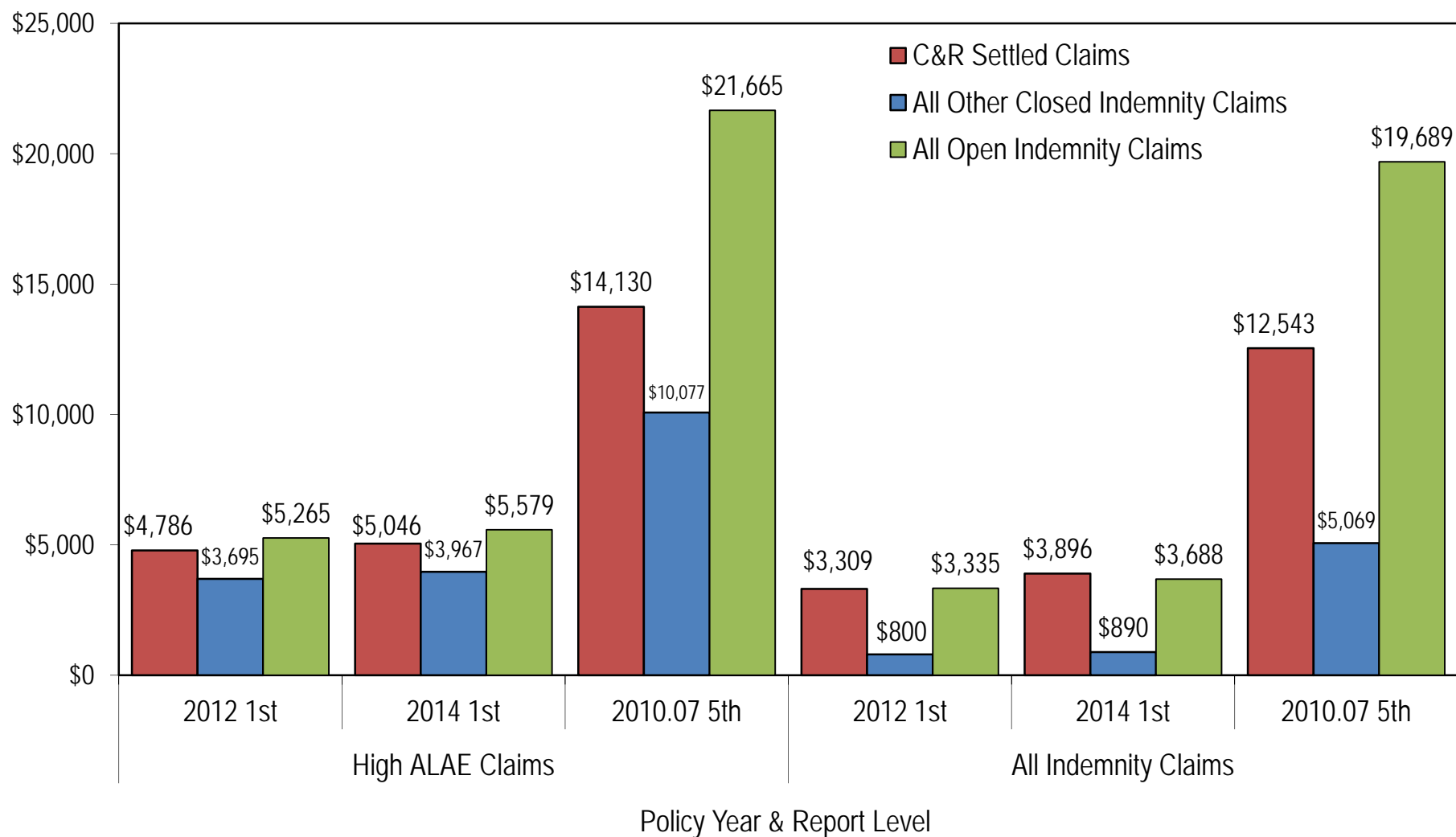
Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000. Low ALAE is ALAE >\$0 and <= \$1,000.

# Percentage of Closed Claims Settled by Compromise and Release (Exhibit 10.1)



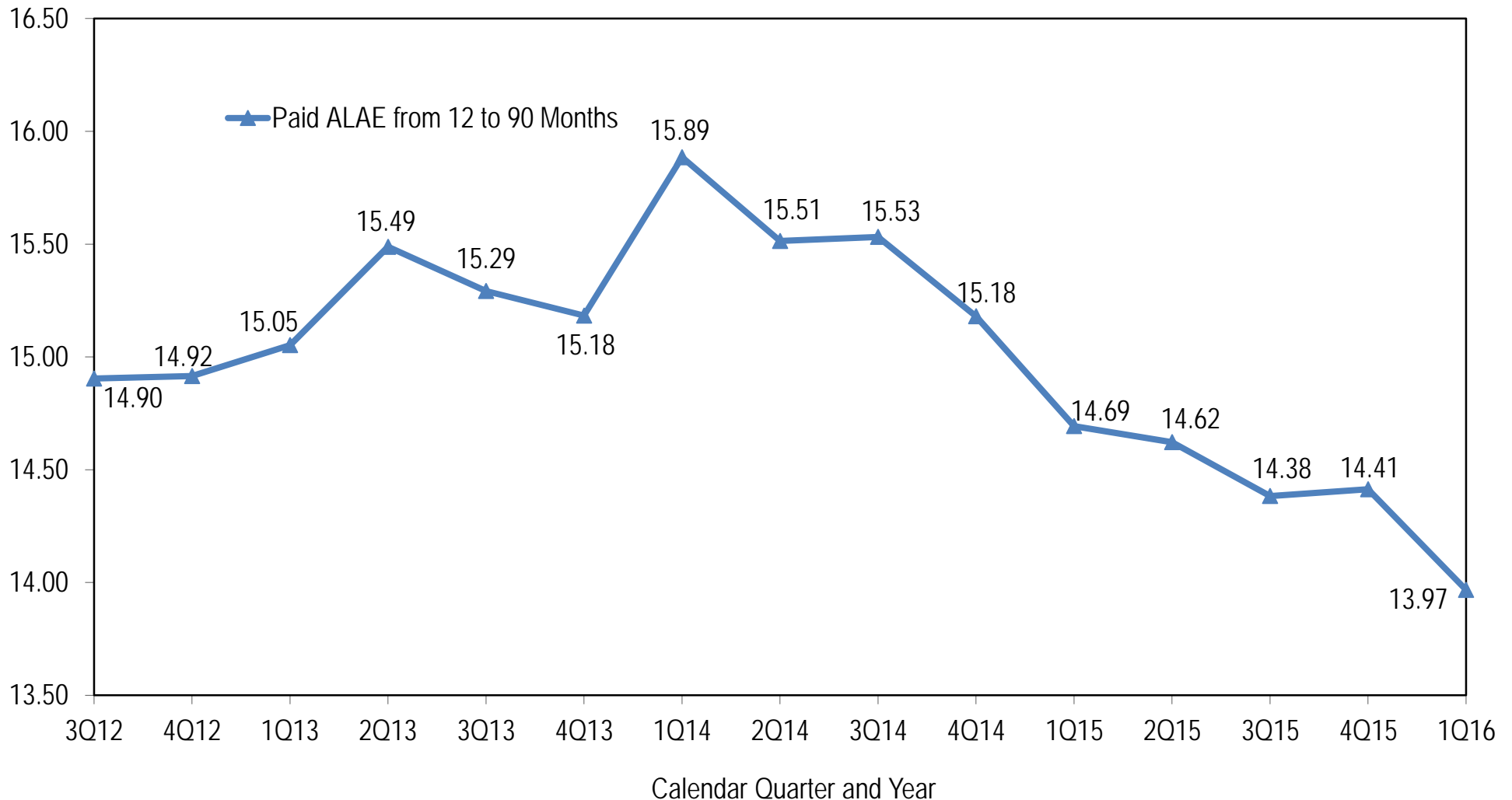
Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000. Low ALAE is ALAE >\$0 and <= \$1,000.

# Average ALAE Costs by Claim Status (Exhibit 10.2)



Source: WCIRB unit statistical data. High ALAE is paid ALAE > \$1,000.

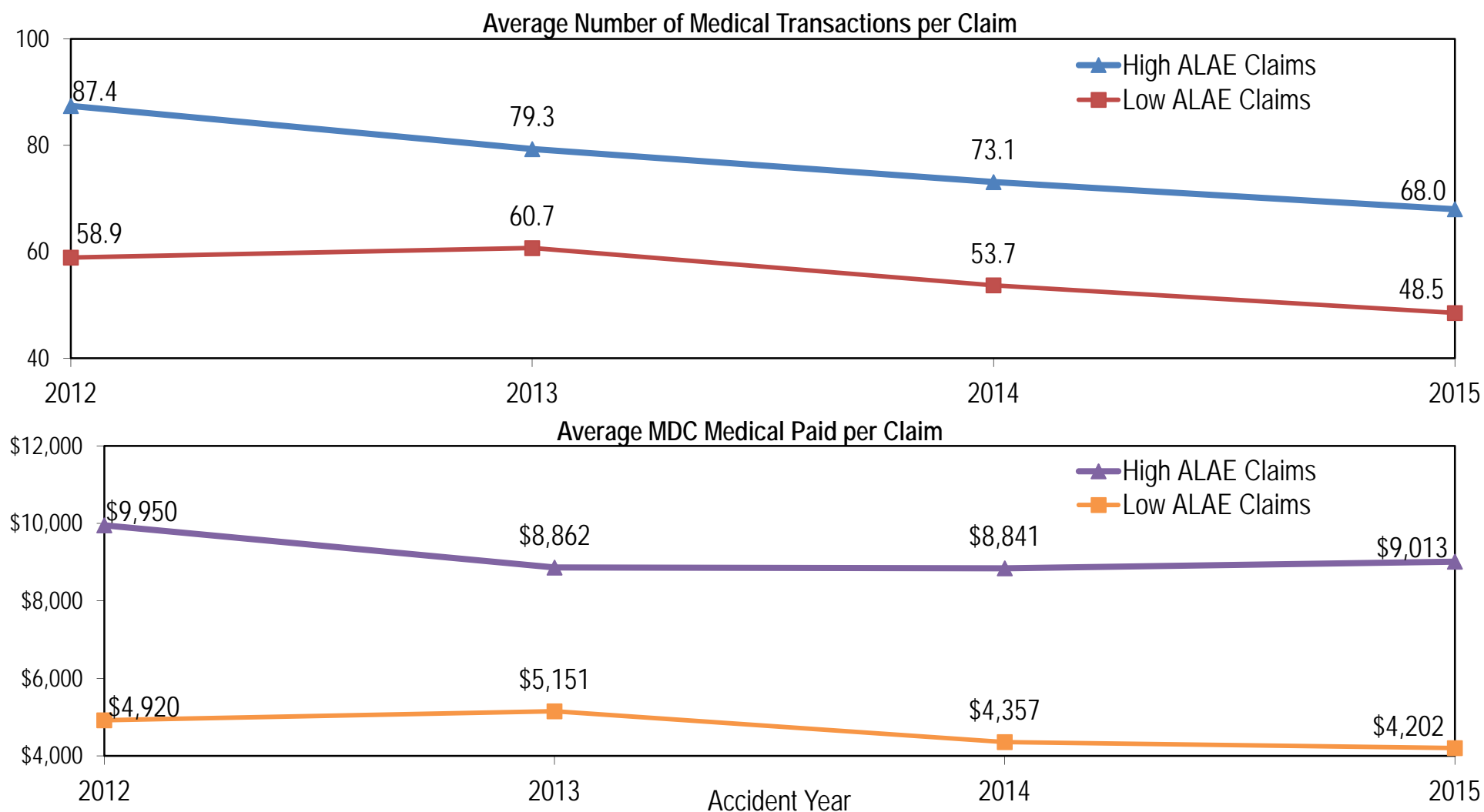
## Cumulative Quarterly Paid ALAE Development – Private Insurers



Source: WCIRB aggregate financial data calls.

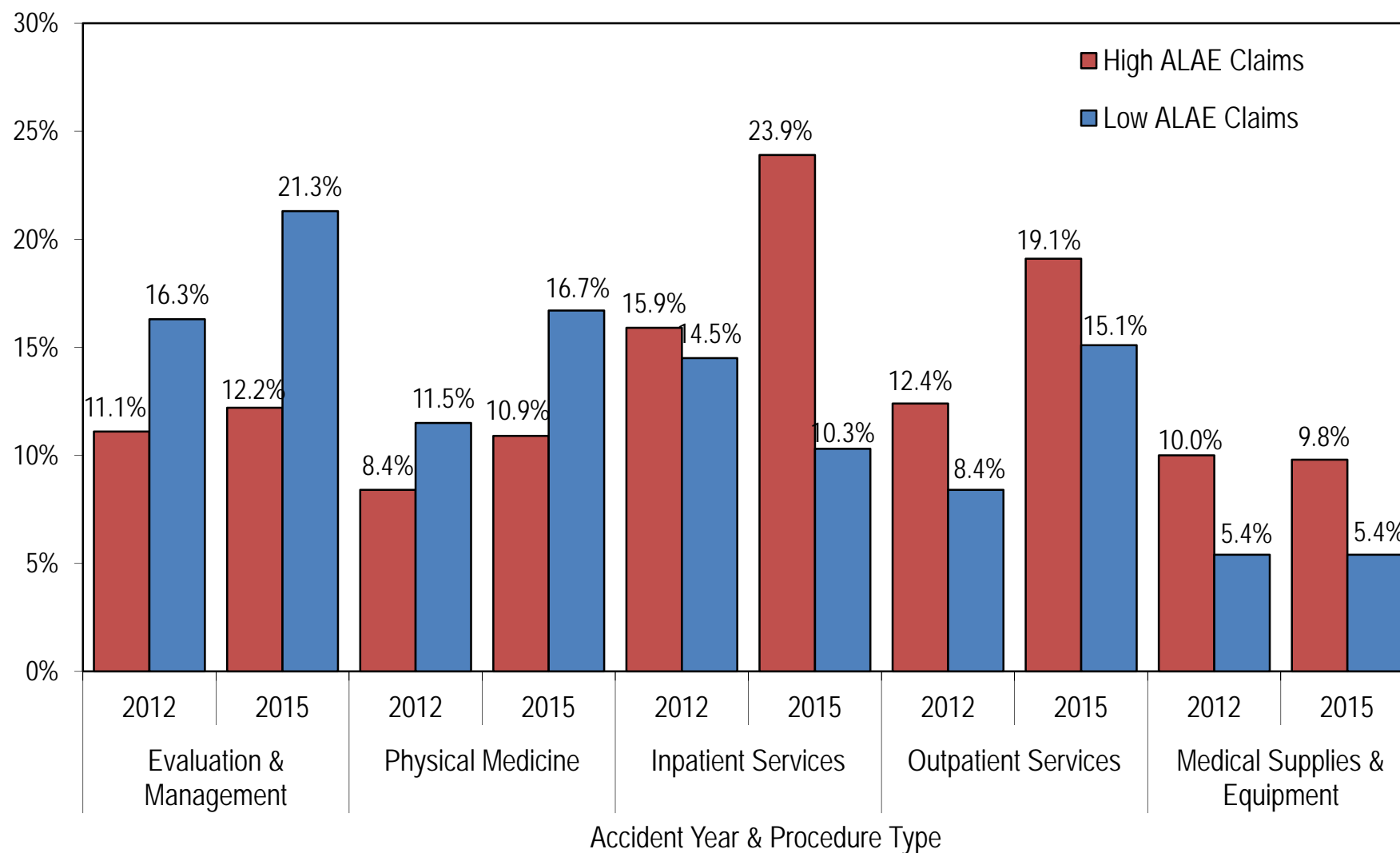


# Medical Transactions by ALAE Category for PD Claims (Exhibit 12.1)



Source: WCIRB Medical Data Call data. High ALAE is paid ALAE > \$1,000. Low ALAE is ALAE >\$0 and <= \$1,000.

# Distribution of Paid Medical by Procedure Type for PD Claims (Exhibit 12.1)



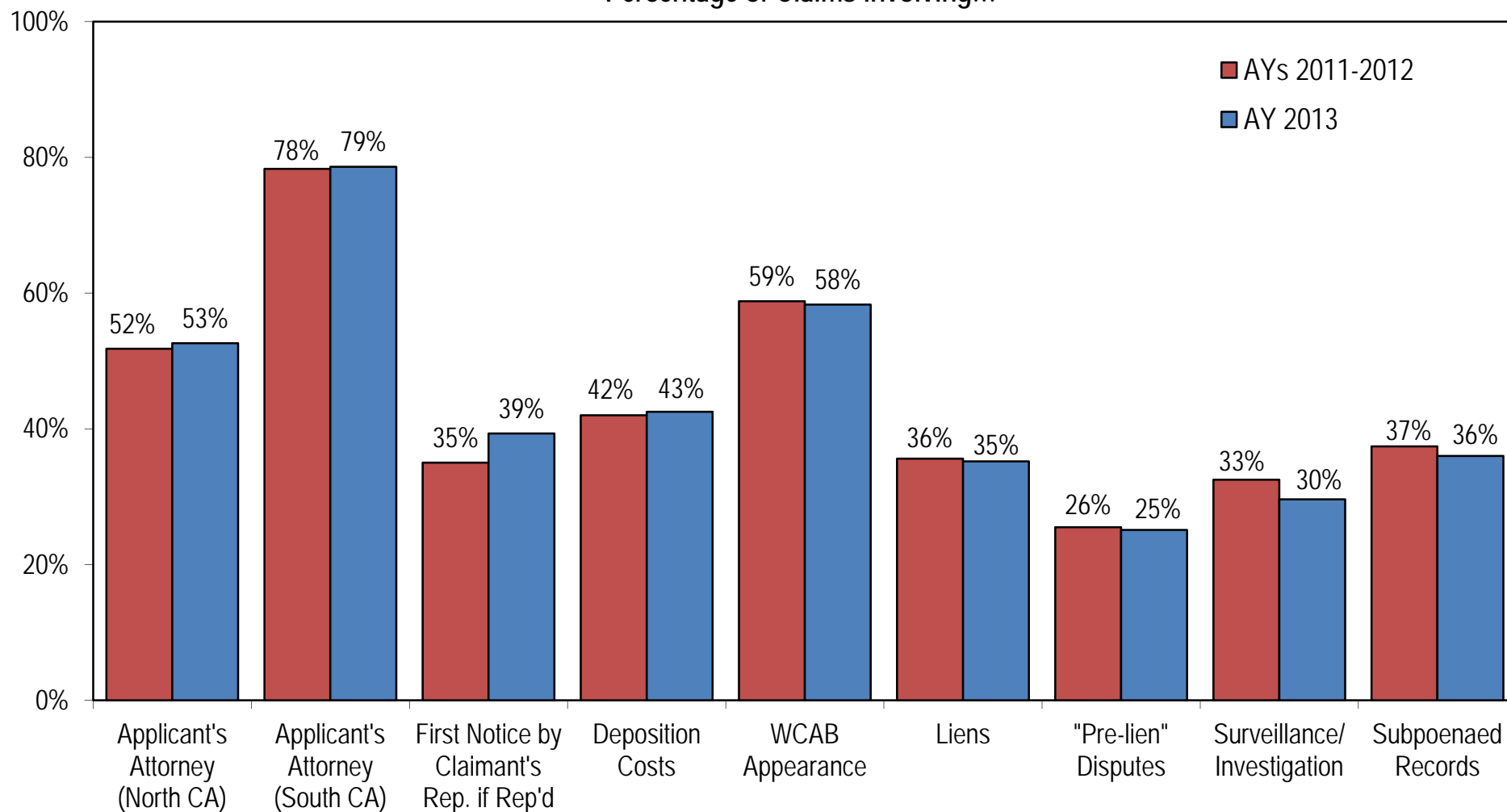
Source: WCIRB Medical Data Call data. High ALAE is paid ALAE > \$1,000. Low ALAE is ALAE >\$0 and <= \$1,000.

# ALAE Claim Survey

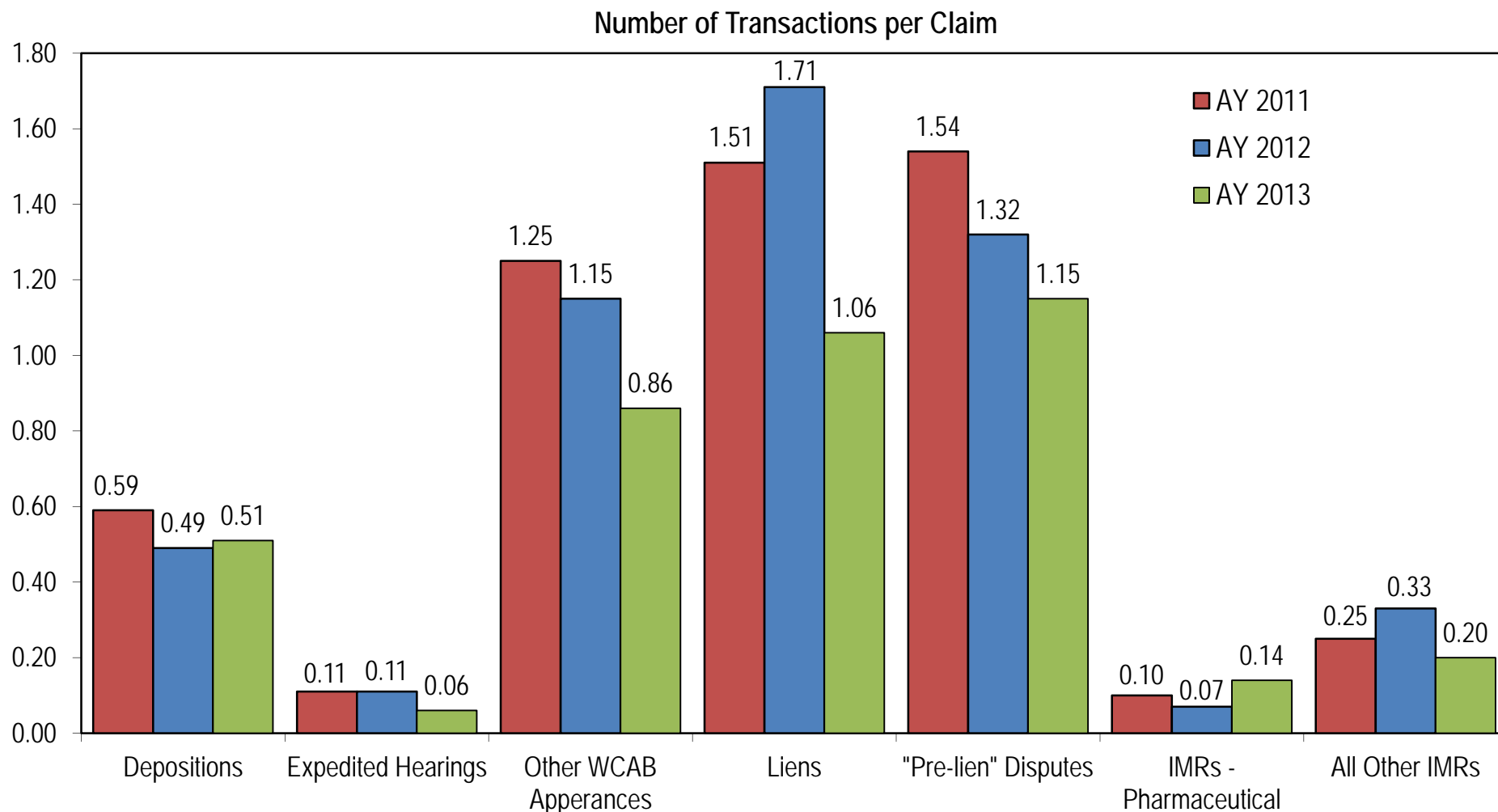
- ALAE Claim Survey issued to better understand detail underlying reported ALAE costs
  - Includes detail on any liens filed
- 870 PD claims randomly sampled from AYs 2011-2014
  - 97% of surveys returned
- Data is as of most recent maturity
  - 2013-2014 data less mature and involve fewer ALAE transactions
  - However, significant ALAE costs still occurred on these less mature claims and will likely develop higher

# ALAE Claim Survey – Claim Distributions (Exhibit 13.1 – Updated)

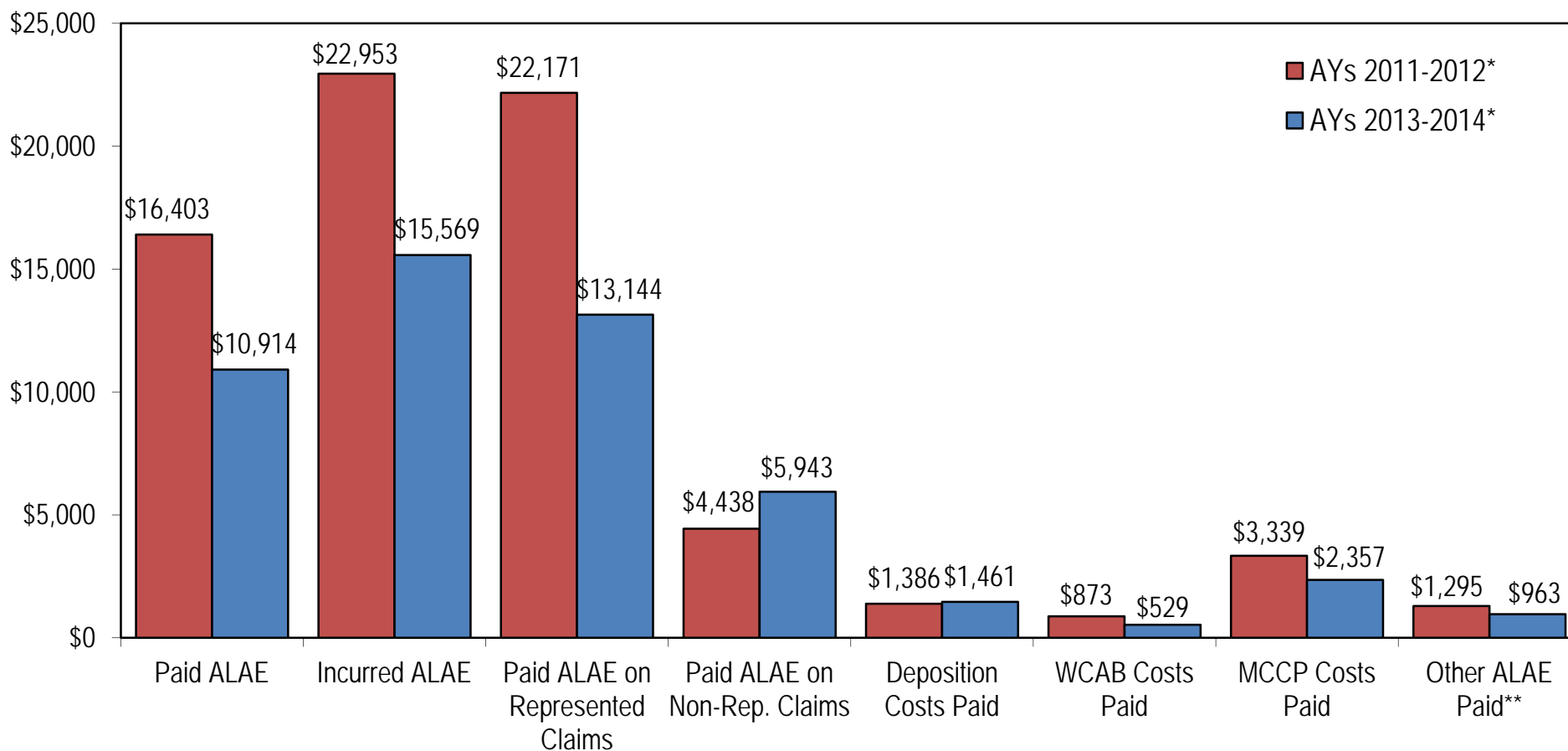
Percentage of Claims Involving...



# ALAE Claim Survey – ALAE Component Frequency (Exhibit 13.2 – Updated)



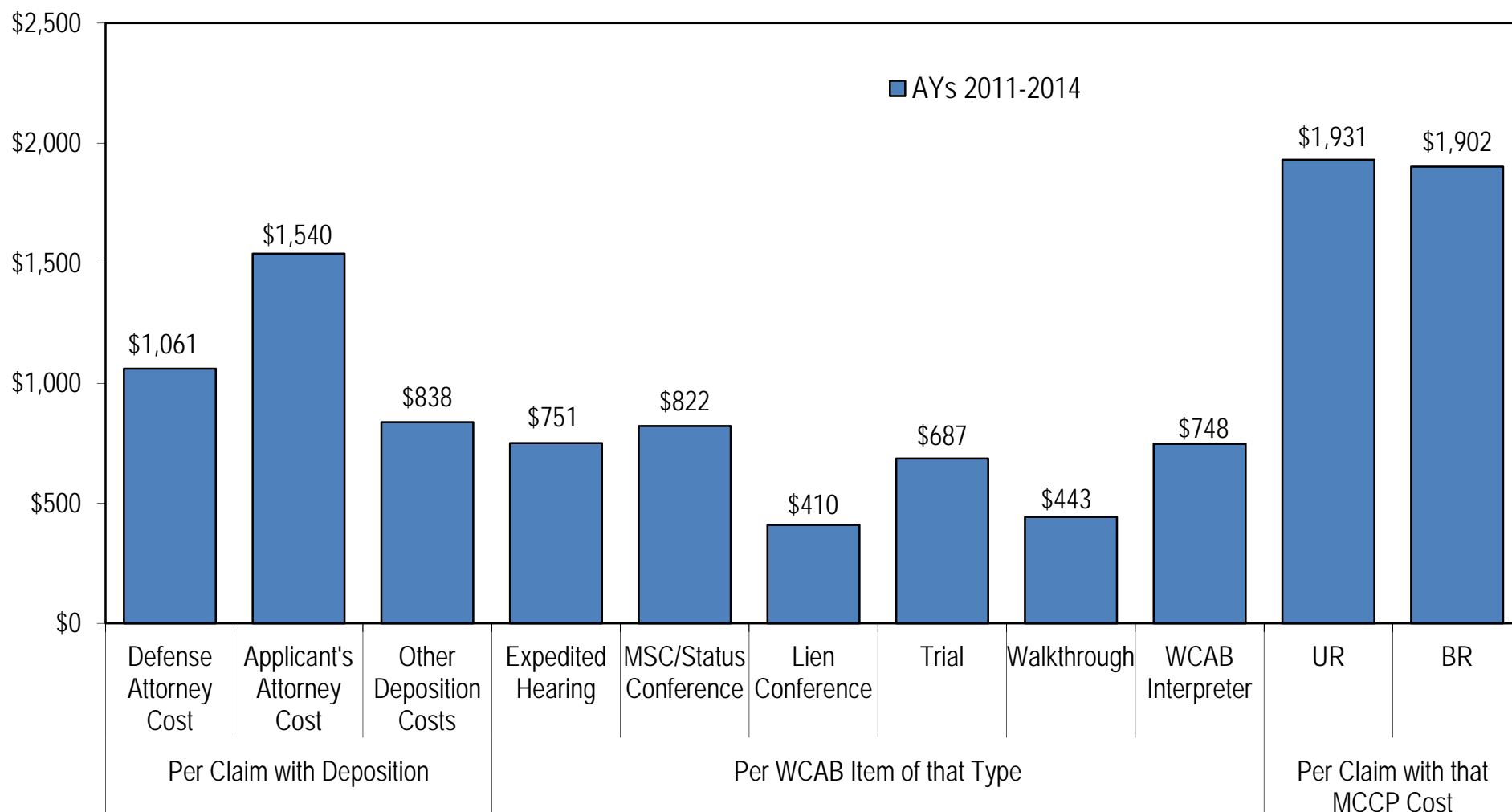
# ALAE Claim Survey – Average Costs per Claim (Exhibit 13.3)



\*Claims surveyed include data as of August 2016. AYs 2011-2012 are aged approximately 68-80 months. AYs 2013-2014 are aged approximately 44-56 months.

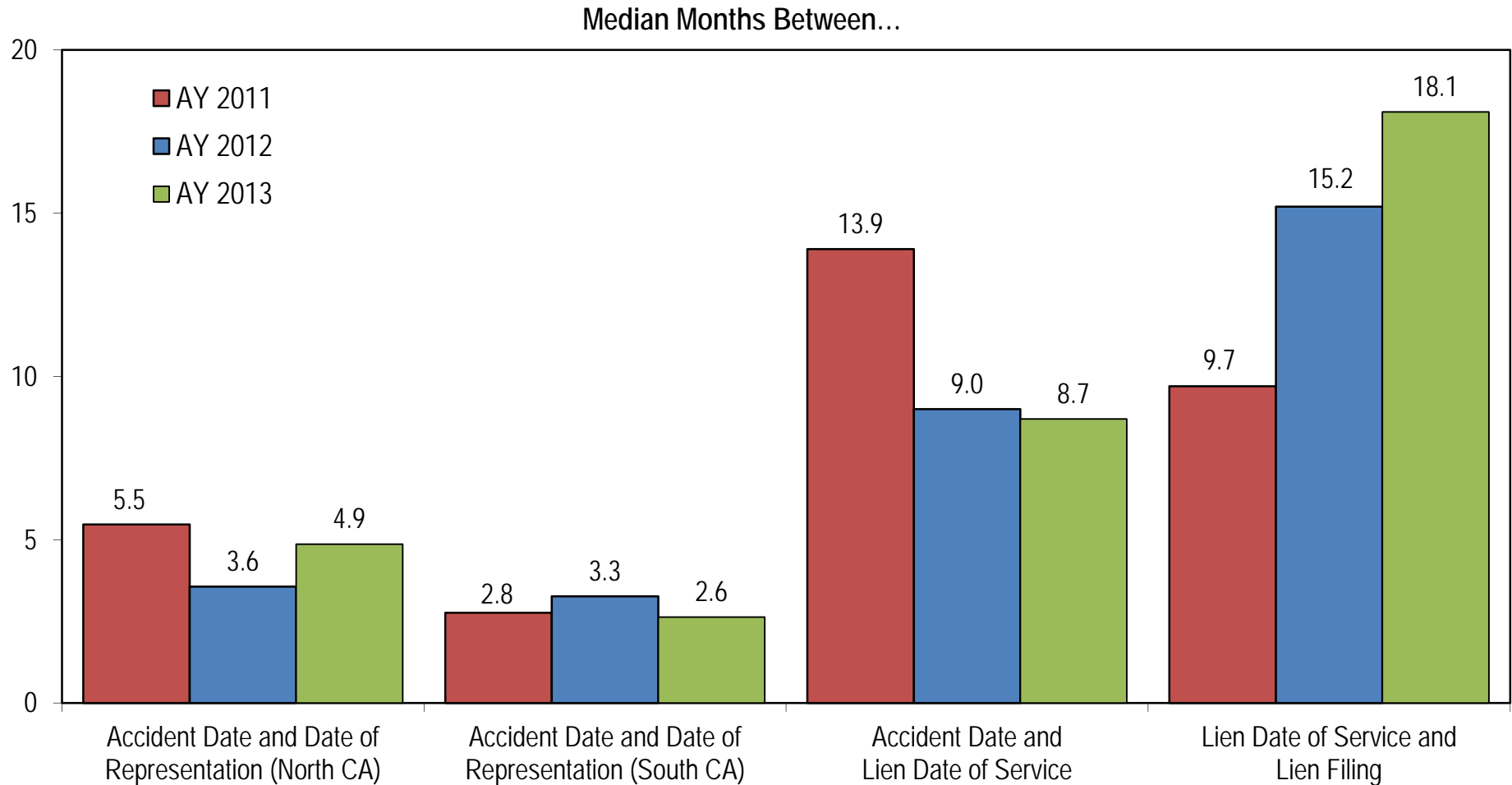
\*\*Surveillance/Investigation costs, costs of obtaining/preparing subpoenaed records, and subrogation costs.

# ALAE Claim Survey – Average Costs per ALAE Transaction (Exhibit 13.3)



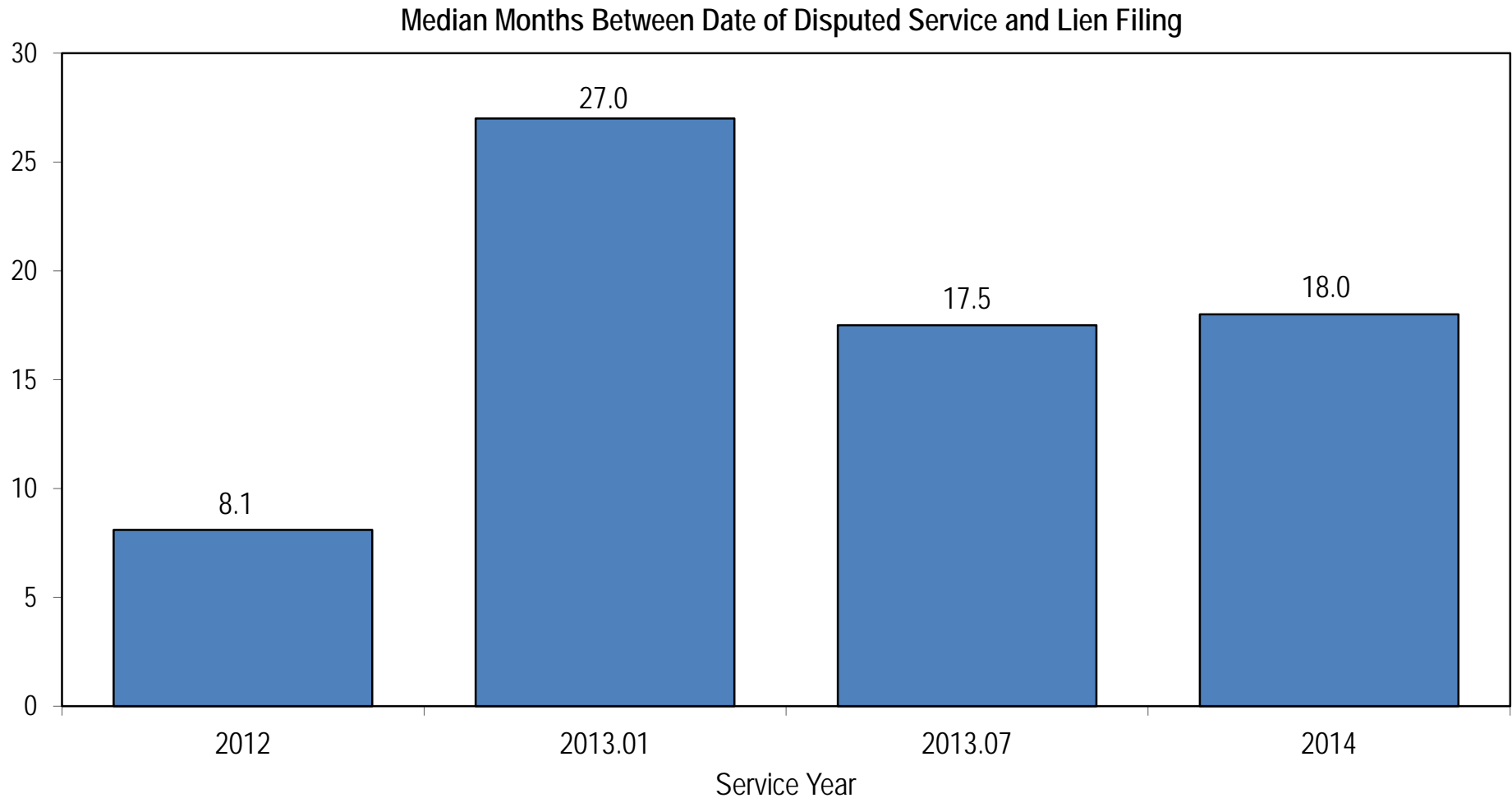
\*Surveillance/Investigation costs, costs of obtaining/preparing subpoenaed records, and subrogation costs.

## ALAE Claim Survey – Timing of ALAE Components (Exhibit 13.2 – Updated)



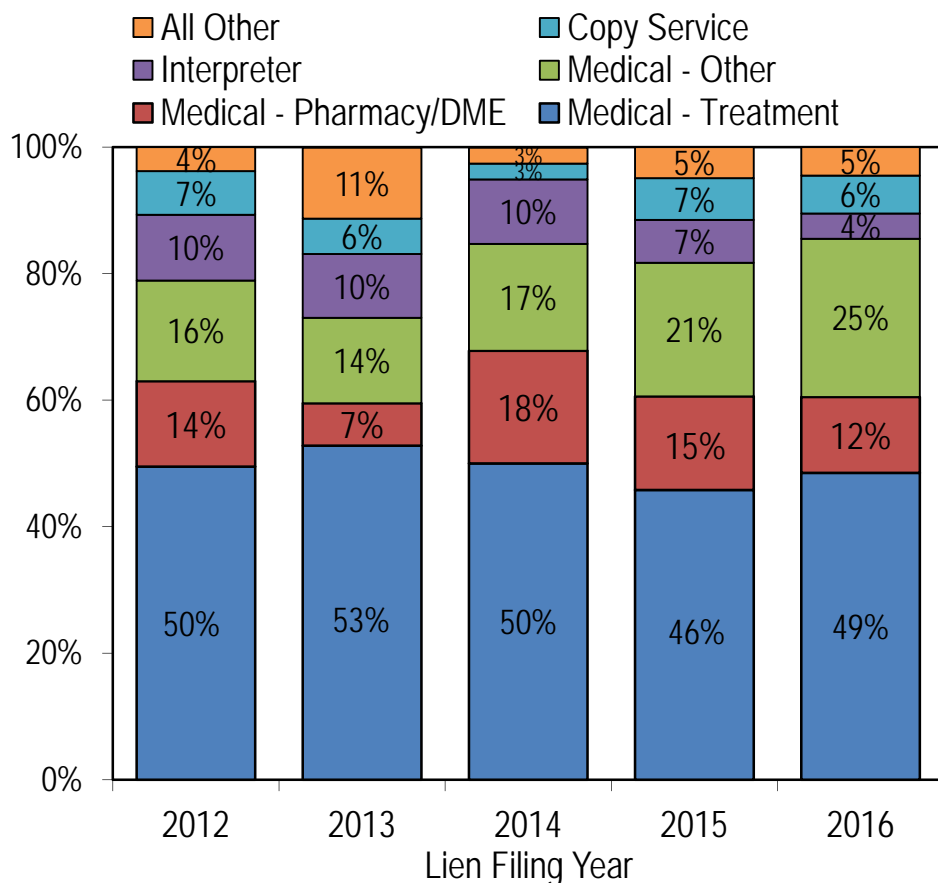


# ALAE Claim Survey – Timing of Lien Filings by Service Year

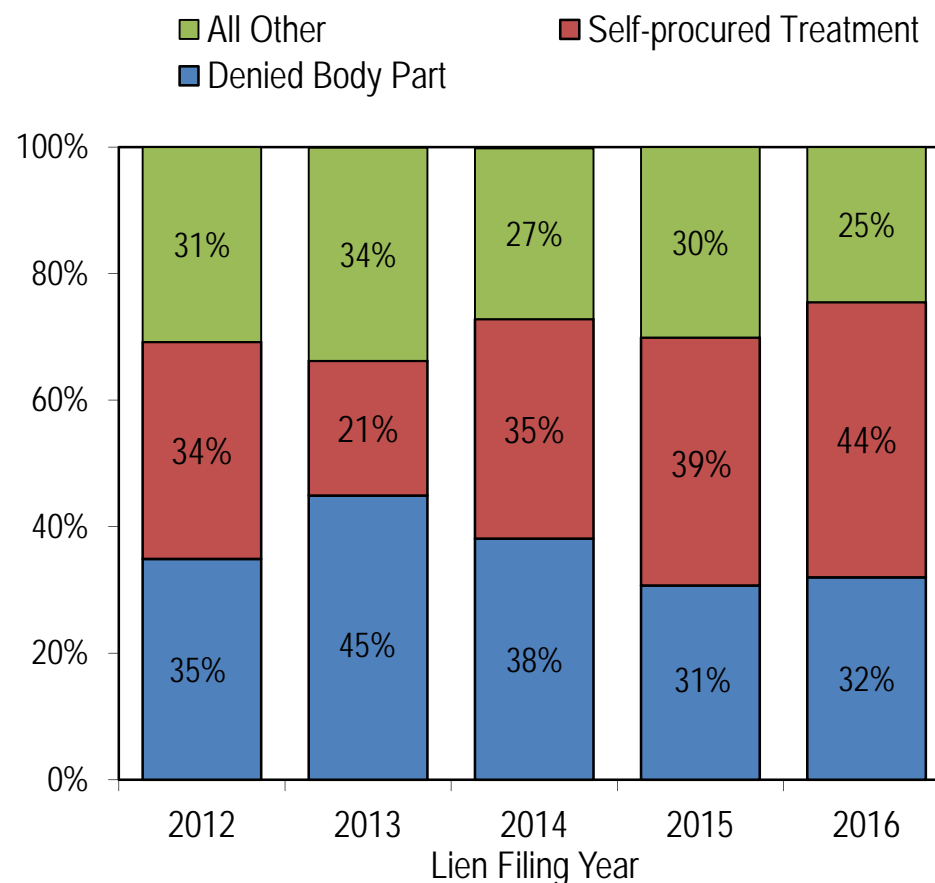


# ALAE Claim Survey – Distribution of Liens (Exhibit 13.1 – Updated)

Distribution of Liens by Type of Lien

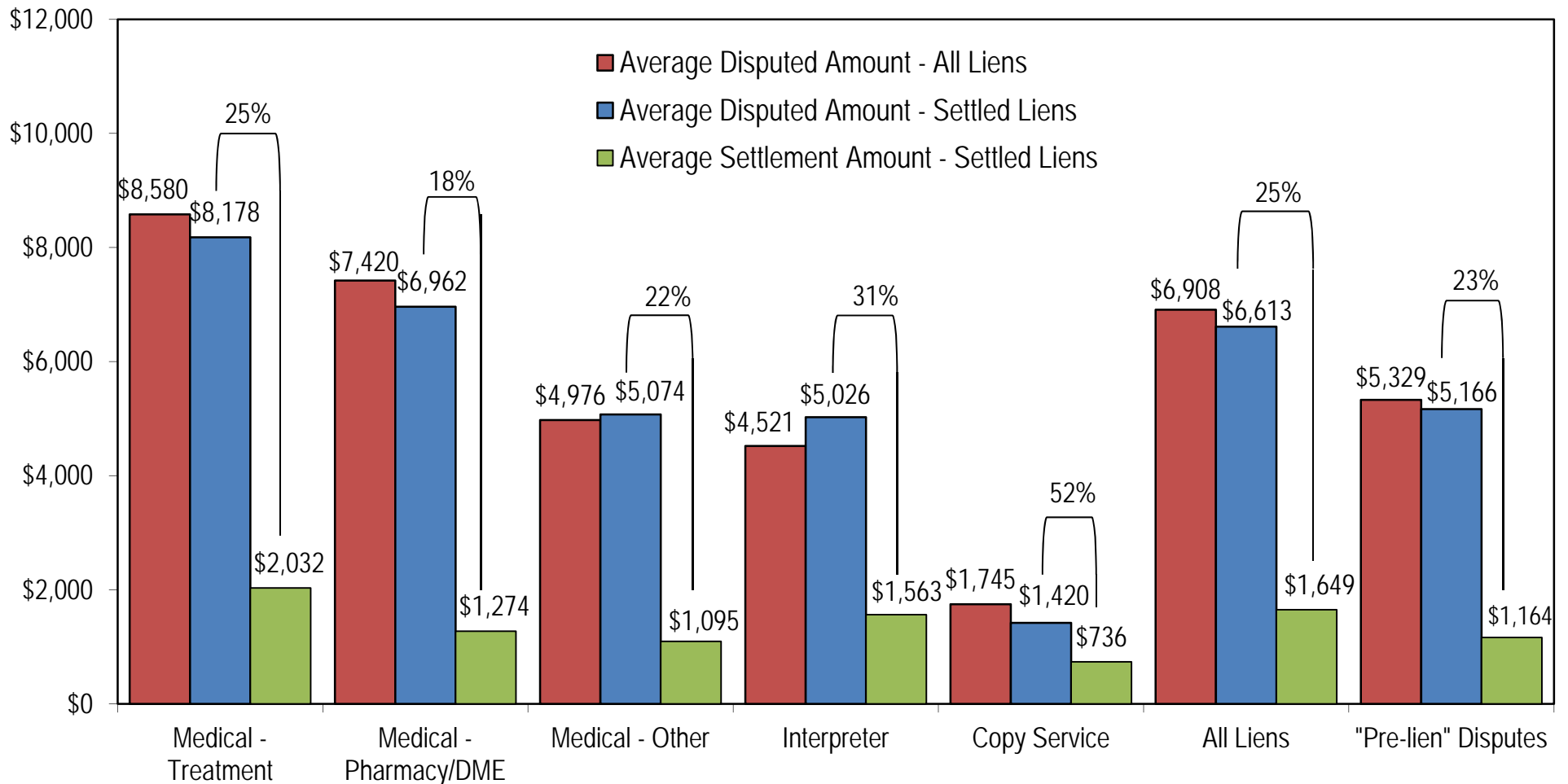


Distribution of Liens by Nature of Dispute

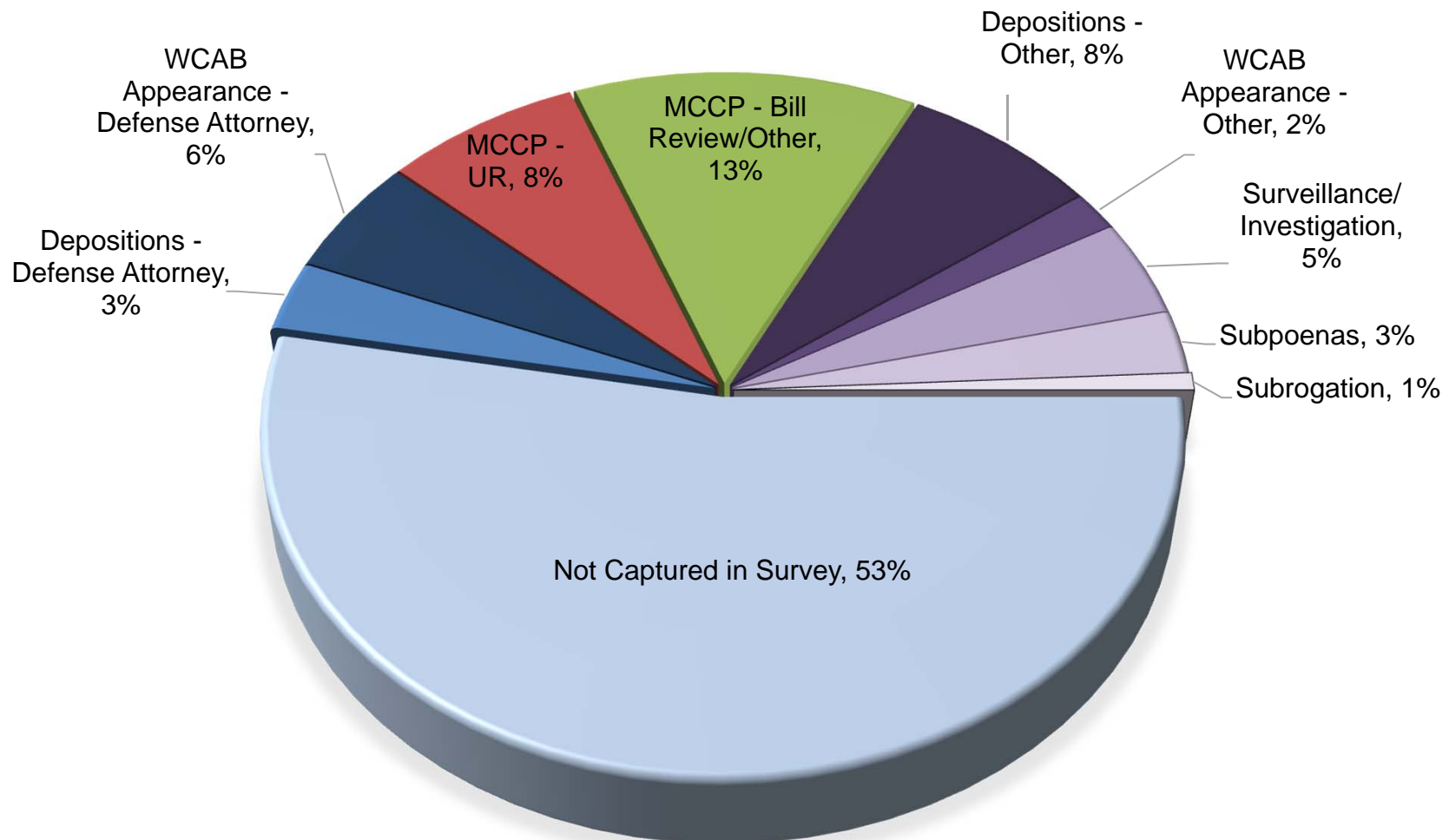


	2012	2013	2014	2015	2016 (Partial)
Total Liens Filed	289	89	118	365	200

# ALAE Claim Survey – Average Costs per Lien (Exhibit 13.4 – Updated)



# ALAE Claim Survey – Distribution of Paid ALAE Costs



## ALAE Study – Summary

- Both frequency of claims with significant ALAE costs and average ALAE on those claims has increased since 2012
- ALAE costs more focused in Los Angeles Basin area but average ALAE increasing across CA regions
- Significant ALAE occurs on Temporary claims at earlier maturities and many of these claims later transition to PD
- Recent increases in C&R settlement rates are focused in High ALAE claims and may be driving increases in ALAE
- High ALAE PD claims involve more hospital stays and medical supplies and less E&M and physical medicine
- Depositions, WCAB appearances, MCCP, liens, and “pre-lien” disputes all significant drivers of high ALAE costs in CA
- Final ALAE report to be released in December

# Study of Medicare Set-Asides

## Phase 1: Impact of Medical Cost Resolution

WCIRB Actuarial Committee Meeting  
November 8, 2016

## Impact of Medical Cost Resolution

- **How does medical development differ for similar claims with and without medical cost resolution?**
- Used WCIRB's Unit Statistical database, compare a set of PD claims with stipulated and C&R settlements at the same Report Levels.
- Analyzed Report Levels 3 and 5 from Policy Years with ten full report levels (PY 2003 and PY 2004).
- Matched these groups as closely as possible by "part of body" codes and pre-settlement severity.
- Separately analyzed Cumulative Trauma (CT) claims in both groups.
- Measured medical development by these development periods:
  - Settlement period rates (defined as the RL period plus the next RL period)
  - Post-Settlement development rates (defined as 2 RL periods post settlement through full valuation at 10 RLs)
  - Ten Report Level development rates (defined as settlement plus post-settlement rates through 10 RLs)
  - Late development rates (defined as estimated rates past 10 RLs)
  - Ultimate development to end of claim

# Table 1: Claim Development At Report Level 3

## Policy Year 2003

Paid Medical								
Settlement Type at RL 3	Number of Claims	Average Pre-Settlement	Development during Settlement Period	Development Post-Settlement to RL 10	Development, Settlement to RL 10	Estimated Development, RL 10 to Ultimate	Estimated Ultimate Development	Estimated Post-Settlement to Ultimate
Stipulations	1,677	\$15,767	1.28	1.38	1.77	1.78	3.14	2.46
C&Rs	8,436	\$15,553	1.71	1.05	1.78	1.01	1.79	1.06

## Policy Year 2004

Paid Medical								
Settlement Type at RL 3	Number of Claims	Average Pre-Settlement	Development during Settlement Period	Development Post-Settlement to RL 10	Development, Settlement to RL 10	Estimated Development, RL 10 to Ultimate	Estimated Ultimate Development	Estimated Post-Settlement to Ultimate
Stipulations	1,090	\$14,700	1.32	1.17	1.54	1.48	2.27	1.73
C&Rs	5,055	\$13,849	1.88	1.02	1.92	1.01	1.93	1.03



## Table 2: Claim Development At Report Level 3 (CT Claims Only)

### Policy Year 2003

Settlement Type at RL 3	Number of Claims	% of PD Claims	Average Pre-Settlement	Development during Settlement Period	Development Post-Settlement to RL 10	Paid Medical			
						Development, Settlement to RL 10	Estimated Development, RL 10 to Ultimate	Estimated Ultimate Development	Estimated Post-Settlement to Ultimate
Stipulations	180	11%	\$18,343	1.25	1.61	2.02	2.71	5.47	4.36
C&Rs	997	12%	\$9,223	2.01	1.06	2.14	1.01	2.15	1.07

### Policy Year 2004

Settlement Type at RL 3	Number of Claims	% of PD Claims	Average Pre-Settlement	Development during Settlement Period	Development Post-Settlement to RL 10	Paid Medical			
						Development, Settlement to RL 10	Estimated Development, RL 10 to Ultimate	Estimated Ultimate Development	Estimated Post-Settlement to Ultimate
Stipulations	81	7%	\$12,565	1.47	1.27	1.87	1.40	2.61	1.78
C&Rs	543	6%	\$9,365	2.09	1.04	2.17	1.00	2.18	1.04

## Table 3: Claim Development At Report Level 5

### Policy Year 2003

Paid Medical								
Settlement Type at RL 5	Number of Claims	Average Pre-Settlement	Development during Settlement Period	Development Post-Settlement to RL 10	Development, Settlement to RL 10	Estimated Development, RL 10 to Ultimate	<b>Estimated Ultimate Development</b>	Estimated Post-Settlement to Ultimate
Stipulations	751	\$32,373	1.28	1.21	1.55	1.64	<b>2.55</b>	1.98
C&Rs	2,542	\$29,413	1.58	1.02	1.61	1.01	<b>1.62</b>	1.03

### Policy Year 2004

Paid Medical								
Settlement Type at RL 5	Number of Claims	Average Pre-Settlement	Development during Settlement Period	Development Post-Settlement to RL 10	Development, Settlement to RL 10	Estimated Development, RL 10 to Ultimate	<b>Estimated Ultimate Development</b>	Estimated Post-Settlement to Ultimate
Stipulations	429	\$25,488	1.29	1.19	1.53	1.49	<b>2.29</b>	1.77
C&Rs	1,683	\$30,389	1.61	1.01	1.63	1.01	<b>1.64</b>	1.02

## Table 4: Claim Development At Report Level 5 (CT Claims Only)

### Policy Year 2003

Paid Medical									
Settlement Type at RL 5	Number of Claims	% of PD Claims	Average Pre-Settlement	Development during Settlement Period	Development Post-Settlement to RL 10	Development, Settlement to RL 10	Estimated Development, RL 10 to Ultimate	Estimated Ultimate Development	Estimated Post-Settlement to Ultimate
Stipulations	100	13%	\$26,233	1.29	1.20	1.55	1.81	2.80	2.17
C&Rs	329	13%	\$18,207	1.68	1.04	1.74	1.01	1.77	1.05

### Policy Year 2004

Paid Medical									
Settlement Type at RL 5	Number of Claims	% of PD Claims	Average Pre-Settlement	Development during Settlement Period	Development Post-Settlement to RL 10	Development, Settlement to RL 10	Estimated Development, RL 10 to Ultimate	Estimated Ultimate Development	Estimated Post-Settlement to Ultimate
Stipulations	48	11%	\$16,372	1.38	1.20	1.65	1.43	2.36	1.72
C&Rs	231	14%	\$19,801	1.76	1.03	1.81	1.00	1.82	1.03

## Impact of Medical Cost Resolution – Next Steps

- Analyze differences in medical payment patterns between stipulated and C&R claims using MDC data for claims with medical activity on or after July 1, 2012.
- Develop a proposal to study the characteristics of Medicare Set-Asides on their impacts on medical development.