Actuarial Committee

Meeting Minutes

Date	Time	Location	Staff Contact
November 8, 2016	9:30 AM	WCIRB California 1221 Broadway, Suite 900 Oakland, CA	David M. Bellusci

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Released: November 21, 2016

Members	Representing
Carolyn Bergh*	Hartford Insurance Company
Laura Carstensen	Zurich North America
James Gebhard	Farmers Insurance Group of Companies
Joanne Ottone	Berkshire Hathaway Homestate Companies
Jill Petker	Liberty Mutual Group
Mark Priven	Public Members of Governing Committee
Kate Smith	State Compensation Insurance Fund

California Department of Insurance
Ron Dahlquist
Robert Hallstrom
Giovanni Muzzarelli

WCIRB
Bill Mudge
David Bellusci
Ward Brooks
Greg Johnson
Tony Milano

* Participated via teleconference

The meeting of the Actuarial Committee was called to order at 9:30 AM, with Mr. David Bellusci, Executive Vice President and Chief Actuary, presiding.

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Approval of Minutes
The Minutes of the meetings held on September 1, 2016 and September 6, 2016, were distributed to the Committee members in advance of the meeting for review. As there were no corrections to these Minutes, a motion was made, seconded and unanimously approved to adopt the Minutes as written.

Notice

The information in these Minutes was developed by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) for the purpose of assisting the WCIRB Actuarial Committee. The WCIRB cannot make any guarantees if this information is used for any other purpose and the WCIRB shall not be liable for any damages, of any kind, whether direct, indirect, incidental, punitive or consequential, arising from the use of or reliance upon this information for any other purpose.

Item II
Medical Analytics Working Group Meeting Summary

The summary of the Medical Analytics Working Group meeting held on September 27, 2016, which was included in the Agenda materials, was accepted by the Committee.

Item AC13-10-03
SB 863 Cost Monitoring

The Committee was reminded that in March of 2013, the WCIRB submitted a comprehensive plan to monitor the emerging cost impact of Senate Bill No. 863 (SB 863). Staff presented information on emerging post-SB 863 costs based on the most current data available. Among the items discussed were the following:

1. The impact of increases to weekly permanent disability (PD) minimums and maximums for 2013 and 2014 injuries are emerging consistent with initial projections.

2. The SB 863 changes to the supplemental job displacement benefit (SJDB) were estimated to result in a small reduction in overall costs. Both the proportion of PD claims involving SJDBs and the average cost of a SJDB increased in 2013—the first year in which the SB 863 SJDB applied. It was noted that some of this increase may be attributable to the new return-to-work fund paid for by employer assessments (and outside of pure premium rates) pursuant to SB 863, in which a SJDB is required to receive payment from the fund. Staff noted that it would reflect the estimated cost impact of the recent increase in SJDB costs in the final report.

3. Data on recent PD ratings from the state Disability Evaluation Unit (DEU) showed increases to PD ratings generally comparable to prospective estimates of the SB 863 changes to PD ratings related to the elimination of the future earning capacity (FEC), the addition of a 1.4 adjustment factor to each impairment, and the elimination of PD add-ons.

4. Analysis of recent PD ratings from the DEU showed significant decreases in the prevalence of PD add-ons although the decreases were not as large as those reflected in the WCIRB's original prospective estimate. However, only a very small percentage of the DEU ratings include add-ons in post-SB 863 accident years and the prevalence of PD add-ons has also decreased significantly for older accident years which were not expected to be impacted by the SB 863 changes. Additionally, staff noted that there was no evidence of significant increase in the prevalence of PD add-ons for components not precluded by SB 863. As a result, the Committee agreed that there is no basis to change the WCIRB's original prospective estimate of the impact of the SB 863 changes related to PD add-ons.

5. After a significant decrease in lien filings in 2013 and 2014, lien filings increased sharply in 2015 and remained at the higher level until the second quarter of 2016. However, lien filings decreased significantly in the third quarter of 2016. It was noted that the third quarter decrease was not unexpected given that the 36-month statute of limitations on lien filings no longer applied beginning July 1, 2016. Information from the Division of Workers' Compensation as well as WCIRB survey data suggested that the statute of limitations was a key driver of the recent increases. However, liens filed in the third quarter of 2016 remained above the 2013 and 2014 levels. It was noted that some of the 2013 and 2014 decreases in lien filings may have been temporary and impacted by the large run-up in lien filings at the end of 2012 as well as the legal challenges to the SB 863 lien provisions occurring during that time. As a result, the consensus of the Committee was that the WCIRB's prospective estimate of a 41% reduction in lien filings resulting from SB 863 continues to be appropriate. It was noted that recent WCIRB survey data also showed the average demand and settlement costs of liens being filed continue to be generally consistent with prospective estimates.

6. SB 863's elimination of the duplicate payment for spinal surgical implants was estimated to save approximately $20,000 per procedure, while WCIRB Medical Data Call (MDC) data showed a

decrease of over $25,000, or 28%, in the average cost of these procedures since 2013. In addition, the utilization of these procedures has decreased significantly.

7. SB 863's reduction in maximum ambulatory surgical center (ASC) facility fees was estimated to reduce those costs by 25%, which was consistent with the reductions observed based on WCIRB MDC data. In addition, the proportion of post-January 1, 2013 services performed in outpatient hospitals compared to ASCs was consistent with pre-reform levels, suggesting no cost-shifting to outpatient hospitals has occurred.

8. Independent medical review (IMR) requests, after eliminating duplicate and ineligible requests, continue to occur at a rate far above the levels initially projected but have remained generally consistent since the middle of 2015. Approximately half of IMR requests are for pharmaceutical services while over 85% of IMR decisions have upheld the original utilization review (UR).

9. UR (including IMR and independent bill review) costs, medical-legal costs, and the number of expedited hearings related to medical treatment issues continue to occur at high levels and have in fact increased in the most recent year, suggesting that any reductions in frictional costs resulting from IMR and other SB 863 provisions has not materialized. It was noted that after reflecting the most current cost estimate of the impact of SB 863 and projected severity trends, average ALAE costs are emerging higher than projected. However, staff noted that a recent study of ALAE costs suggests that the recent increases in average ALAE costs is likely in part related to factors other than SB 863 (see Item AC16-11-01). It was also noted that paid ALAE development has been decreasing over the last several quarters. As a result, the consensus of the Committee was to not reflect any additional adjustment to the SB 863 cost estimates for the recent increases in average ALAE cost levels.

10. Temporary disability (TD) duration was projected to decrease by 5% as a result of SB 863 provisions related to IMR and medical provider networks (MPNs). California Workers' Compensation Institute (CWCI) information on average TD duration for accident years 2012 through 2015 show increases at approximately the pre-reform rate of growth, while WCIRB PD Claim Survey and aggregate payment data showed no evidence of a significant decrease in TD duration resulting from SB 863. As a result, the consensus of the Committee was to eliminate any estimated savings to TD duration resulting from the SB 863 IMR process.

11. WCIRB MDC data suggests that copy services paid under the first year of the new copy service fee schedule were at rates consistent with prospective estimates and overall payments for copy services remain a small proportion of total costs.

12. The changes to convert the physician fee schedule to a Resource-Based Relative Value Scale (RBRVS) basis were estimated to increase physician costs for services performed in 2014 through 2016 by a modest rate each year. WCIRB MDC data suggests continued decreases in overall physician payments per claim for service years 2014 and 2015, primarily driven by reductions in the number of transactions per fee schedule claim. Preliminary information for the first six months of the 2016 service year suggested an increase slightly lower than prospective estimates. However, staff noted that estimates for the 2014 and 2015 service years have declined significantly from the six-month cost estimates for those service years and 2016 may develop similarly. As a result, the consensus of the Committee was to update the estimates for the 2014 and 2015 service years with the most recent MDC information and eliminate the estimated increase for the 2016 service year.

13. WCIRB MDC data suggests that overall medical treatment costs continue to decrease through the first half of 2016 primarily driven by reductions in the number of transactions per claim, particularly for pharmaceutical services. It was noted that the increases in impatient service

transactions per claim was a result of fewer inpatient claims receiving more inpatient transactions. A Committee member suggested showing this information compared to total claim counts rather than only claims with an inpatient transaction.

14. It was noted that, after reflecting the most current cost estimates of SB 863 provisions that can be directly assessed (including staff's 2016 recommendations that were adopted by the Committee) and projected medical severity trends, medical severities continue to be emerging approximately 10% lower than projected for accident years 2012 through 2014. (The January 1, 2017 Pure Premium Rate Filing reflected an overall medical cost adjustment for SB 863 of -10%.) Staff noted that it plans to review the distribution of the overall SB 863 medical cost impact of -10% by accident year with the Committee early next year.

After discussion, the consensus of the Committee was that the 2016 retrospective cost evaluation of SB 863 as discussed at the meeting should be finalized and released as soon as practical. (The 2016 SB 863 Cost Monitoring Report was released on November 17, 2016.) Staff recommended that, given that SB 863 was signed over four years ago, the 2016 cost monitoring report be the final comprehensive report on the retrospective cost impact of SB 863 but that staff continue to monitor costs in any specific areas that continue to emerge (such as PD costs and the 2017 RBRVS changes) and report back to the Committee. The Committee agreed with staff's recommendation.

Item AC16-11-01
Study of ALAE

The Agenda materials included a preliminary analysis of the high levels of allocated loss adjustment expenses (ALAE) experienced in California and the drivers of recent increases in average ALAE costs. Staff presented a summary of the analysis, and the Committee noted the following:

- California has the highest ALAE costs of any state. Although California average ALAE costs are comparable to other states at 12 months, California is significantly higher than other states at later maturities in both the proportion of claims with significant defense costs as well as the average defense cost on those claims. A Claims Working Group member noted that California is the only state in which deposition costs and some other litigation fees are required to be paid for by the defense.

- Both the proportion of indemnity claims involving significant ALAE costs as well as the average ALAE cost on those claims has increased since 2012.

- Although the Los Angeles Basin area has significantly higher ALAE costs than other regions of California, average ALAE costs per claim across all regions has increased since 2012.

- Almost half of claims with significant ALAE costs at early report levels involve only temporary disability and this proportion has grown since 2012. A larger proportion of claims with significant ALAE costs involve permanent disability (PD) at later report levels. A Claims Working Group member suggested examining the distribution of ALAE costs within each injury type to determine if this phenomenon is a result of claims transitioning from temporary to PD or a result of paid ALAE development on PD claims.

- Both the proportion of indemnity claims involving cumulative injury as well as the proportion of cumulative injury claims involving significant ALAE costs have grown since 2012. However, once a claim involves significant ALAE costs, the average ALAE cost on a cumulative injury claim compared to a non-cumulative injury claim is generally consistent.

- Claim closing rates on indemnity claims involving significant ALAE costs has grown since 2012. In particular, claims closed by compromise and release and also involving significant ALAE costs has more than doubled since 2010. As a result, the Committee noted that recent increases in ALAE costs may be related to recent increases in claim settlement rates and may lead to lower ALAE development in the future. It was also noted that recent paid ALAE development has been declining.

- PD claims involving significant ALAE costs compared to other types of PD claims have a higher proportion of inpatient services and medical supplies and equipment services and a lower proportion of evaluation and management services and physical medicine services.

The Committee discussed the survey of approximately 870 PD claims issued earlier this year to better understand the drivers of ALAE costs. Among the items noted were the following:

- The majority of surveyed claims involved an applicant's attorney or a Workers' Compensation Appeals Board (WCAB) appearance, while a significant proportion involved deposition costs, liens, "pre-lien" disputes, medical cost containment program costs, surveillance or investigation costs, or subpoenaed records.

- Liens occurred on surveyed claims at a rate of over one lien per claim. The delay in the timing of the lien filing from the date of service increased significantly for services provided in 2013 and 2014, suggesting the statute of limitations on lien filings played a large role in lien filing activity since the implementation of Senate Bill No. 863 (SB 863). The average demand and settlement cost of liens were also comparable to prior WCIRB Lien Surveys in the post-SB 863 environment.

- A number of surveyed claims involved “pre-lien” disputes in which a lien had not yet been filed. A number of these “pre-lien” disputes had also been settled prior to any lien filing with settlement rates comparable to that for liens.

After discussion, the Committee accepted staff’s analysis. The Committee was advised that the final analysis of ALAE costs will be summarized in a report to be published later this year.

Item AC16-11-02
Study of Medicare Set-Asides

The Committee was advised that at the meeting of March 23, 2016, the Claims Working Group discussed a potential study on the cost of Medicare Set-Asides (MSAs). Prior to undertaking a comprehensive study, the Claims Working Group agreed that staff should compare post-settlement loss development patterns of claims that are settled through a compromise and release (C&R), which includes a settlement component for future medical losses, with those settled through a stipulated award, in which exposure to future medical losses remains open.

The Committee reviewed the comparison of loss development for claims settled through C&R to those settled through stipulated award for policy years 2003 and 2004 for cumulative trauma claims and for all permanent disability claims. The Committee was advised that the two groups of claims by settlement type had fairly similar distributions of unit statistical report “part of body” codes and pre-settlement paid medical severities. The Committee noted that, as expected, the two groups of claims have very different patterns of paid loss development. It was also noted that once development beyond tenth report level is projected based on the development for the two groups of claims through tenth report, claims closed by stipulated award had significantly higher medical loss development. A member suggested the analysis could be enhanced by comparing development on a basis discounted for the time value of money.

The Committee was advised that staff would present an outline of a potential comprehensive study on the cost impact of Medicare Set-Asides for the Claims Working Group’s consideration at their next meeting.

The meeting was adjourned at 12:35 PM.

Note to Committee Members: These Minutes, as written, have not been approved. Please refer to the meeting scheduled for December 6, 2016 for approval and/or modification.