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Governing Committee

Meeting Agenda

Date	Time	Location	Staff Contact
September 22, 2021	1:00 PM	Webinar Teleconference	Eric S. Riley

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Released: September 15, 2021

To Members of the Governing Committee, WCIRB Members and All Interested Parties:

This meeting is Open to the Public.

Please register at: https://attendee.gotowebinar.com/register/4434573804592235276

After registering, you will receive a confirmation email containing information about joining the webinar.

I. Approval of Minutes

Meeting held April 21, 2021

II. Additions to the Agenda

III. Ratification of Actions of WCIRB Committees

A. Actuarial Committee

Meetings Held March 16, 2021, April 15, 2021 and June 22, 2021

B. Classification and Rating Committee

Meeting Held May 18, 2021

IV. Unfinished Business

A. September 1, 2021 Regulatory Filing (oral report)

B. September 1, 2021 Pure Premium Rate Filing

V. New Business

A. Summary of Current and Pending Legislative, Regulatory and Judicial Actions as of September 14, 2021

VI. Next Meeting Date: December 15, 2021 (webinar teleconference)

VII. Adjournment

Antitrust Notice

As members of the Workers' Compensation Insurance Rating Bureau of California (WCIRB), you are bound, when involved in meetings, presentations or other activities of the WCIRB, to limit your actions (as well as discussions and virtual chats, other than social ones) to matters relating to the business of the WCIRB. Matters that do not relate directly to WCIRB business should be avoided. Members should particularly avoid discussions, chats or conduct that could be construed as intended to affect competition (or access to markets). Thus, as members, you should not discuss or pursue the business interests of individual insurers or others, including, in particular, the plans of individual members involving, or the possibility or desirability of (a) raising, lowering, or stabilizing prices (premiums or commissions); (b) doing business or refusing to do business with particular, or classes of, insurers, reinsurers, agents, brokers, or insureds, or in particular locales; or (c) potential actions that would affect the availability of products or service either generally or in specific markets or locales.

Notice

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Actuarial Committee

Meeting Minutes

Date	Time	Location	Staff Contact
March 16, 2021	9:00 AM	Webinar Teleconference	David M. Bellusci

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Released: May 25, 2021

Members	Representing
Mauro Garcia	Zurich North America
Ika Irsan	Republic Indemnity Company of America
Miranda Ma	American International Group
Joanne Ottone	Berkshire Hathaway Homestate Companies
Jill Petker	Liberty Mutual Group
Mark Priven	Public Members of Governing Committee
Kate Smith	State Compensation Insurance Fund
Bryan Ware	AmTrust
Chris Westermeyer	Travelers

California Department of Insurance
Mitra Sanandajifar

WCIRB
Bill Mudge
David Bellusci
Laura Carstensen
Tony Milano
Shane Steele
Julia Zhang

The webinar teleconference meeting of the Actuarial Committee was called to order at 9:00 AM following a reminder of applicable antitrust restrictions, with Mr. David Bellusci, Executive Vice President and Chief Actuary, presiding.

* * * * *

Approval of Minutes
The Minutes of the meeting held on February 16, 2021, were distributed to the Committee members in advance of the meeting for review. As there were no corrections to the Minutes, a motion was made, seconded and unanimously approved to adopt the Minutes as written.

Notice

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Item AC20-08-04
Impact of Economic Downturn on Pure Premium Rate Indications

Staff presented an updated analysis of economic changes related to the COVID-19 pandemic and their impacts on the indicated September 1, 2021 pure premium rates. This analysis included measured and forecast impacts on claim frequency, claim severity, and the statewide average wage.

Claim Frequency
The Committee was reminded that in the January 1, 2021 rate filing, forecast values of changes in the cumulative injury index were judgmentally adjusted (from zero) to reflect the average of observed changes during the prior two recessions. Staff noted that the large uptick in the index observed in prior recessions had not yet manifested itself in available accident year 2020 data. While an uptick is still possible inasmuch as cumulative trauma claims are often reported late, staff recommended not making this adjustment for the September 1, 2021 rate filing. The Committee preliminarily agreed to this recommendation.

Staff also presented findings from the August 4, 2020 meeting, showing that no censoring of the economic variables was indicated. Staff continues to recommend using uncensored values of the economic variables and the Committee agreed.

Finally, staff presented updated measurements of forecast frequency changes due to changing industrial mix. These changes were -2.67%, +0.63%, -0.46%, and -0.13% in accident years 2020 through 2023, respectively.

Claim Severity
Staff presented updated measurements of changes in claim severity due to changing industrial mix. Using updated economic forecasts, the estimated severity changes due to industrial mix were summarized as follows:

Accident Year	Severity Change Due to Industrial Mix		
	Indemnity	Medical	Total
2020	1.38%	0.95%	1.17%
2021	-0.45%	-0.31%	-0.38%
2022	-0.28%	-0.22%	-0.25%
2023	-0.01%	-0.02%	-0.01%

Statewide Average Wage
The Committee was shown the current forecasts of changes in the statewide average wage, based on the average of November 2020 Department of Finance (DoF) and March 2021 UCLA forecasts. These changes were 7.9% in 2020, 0.9% in 2021, 1.8% in 2022, and 2.8% in 2023. Staff noted that the 2020 change from the UCLA forecast was now a measured value (subject to revision), had increased substantially since the December 2020 UCLA forecast, and was significantly higher than the November DoF forecast. For these reasons, staff recommended using only the UCLA forecast value of 9.6% for the 2020 change. The Committee preliminarily agreed to this recommendation.

Staff presented an updated analysis of estimated changes in statewide average wage due to changes in industrial mix. The WCIRB has produced two methods of measuring this impact. The first, using Occupational Employment Survey data from the BLS, was available only for historic years and was used to assess the reasonableness of the second method. This method estimated a 1.8% average wage change in 2020 due to industrial mix. The second method, using employment figures from the UCLA forecast and historic wage relativities from the BLS Quarterly Census of Employment and Wages,

estimated average wage changes due to industrial mix of 1.9% in 2020, -0.4% in 2021, -0.1% in 2022, and 0.1% in 2023. Staff recommended using the estimated impacts for 2020 and 2021 average wage changes and not reflecting the industrial mix shift estimates for 2022 and 2023, given that impacts of this magnitude would not typically be included in a rate filing. The Committee preliminarily agreed to this recommendation.

Staff noted that, even including an adjustment for industrial mix, the average wage change in 2020 was much higher than a typical year, particularly since increases of this magnitude had historically only occurred during periods of high inflation or rapid economic expansion. Findings from an Economic Policy Institute (EPI) report were presented to the Committee. This report showed an extremely uneven loss of jobs by wage level in 2020, even as compared to job losses during prior recessions. Staff presented a preliminary estimate of the impact on the average wage due to differing employment gains or losses by wage level within industry. This estimate assumed that all industries employment gains or losses would differ by wage quartile in proportion to the overall national estimates from the EPI study. The consensus of the Committee was that the general approach of further adjusting the changes in average wage for employment changes by wage level was appropriate but expressed concern with some aspects of the preliminary estimate. In particular, Committee members expressed concern that the overall changes from the EPI report may not be appropriate for all industries and that national data may not be appropriate to adjust California wage estimates. Additionally, there was concern that this adjustment was not independent of the adjustment for industrial mix. Staff agreed to address these concerns at the April 15 Committee meeting, ideally using California data.

Finally, staff discussed how the estimated 2020 impact of within industry wage distribution changes might unwind over 2021-2023. Staff presented an estimate that assumed the 2020 impact would fully unwind over this time horizon. The Committee requested that estimates under various unwinding scenarios be calculated in order to understand the sensitivity of the unwinding assumption. Staff agreed to also address this at the April 15 Committee meeting.

Item AC21-02-02
Pandemic Impact on 2020 Development

The Agenda included an updated analysis of the pandemic impact on loss development emerging in 2020, which was first reviewed at the February 16, 2021 meeting. Staff summarized the analysis and noted that (a) development emerging in the fourth quarter of 2020 was similar to that in the third quarter resembling a more “typical” pattern, (b) claim settlement rates in the fourth quarter continued to decelerate, (c) the claim settlement rate adjustment to paid loss development based on December 31, 2020 experience continued to mitigate the distortions that emerged during the second quarter, and (d) a two-year average of paid loss development with claim settlement rate adjustments also mitigated some of the volatility emerging during the pandemic.

The Committee also discussed the loss development projection for accident year 2020 (excluding COVID-19 claims), which may be more significantly impacted by the pandemic than older accident years. Staff noted that an initial review of medical transaction data suggested there were not significant delays in early treatment on accident year 2020 claims. However, staff noted that there may be other issues such as shift in the mix of injuries or deferred treatment that could impact the development of accident year 2020 more severely than older accident years and there was no approach to specifically adjustment for these factors available at this time.

After discussion, the consensus of the Committee was that the two-year average claim settlement rate-adjusted paid loss development methodology should be reflected in the summary of December 31, 2020 experience to be reviewed at the April 15, 2021 meeting.

Item AC21-03-01
First Quarter 2021 Review of Diagnostics

The Agenda included the WCIRB's standard set of diagnostics that were reviewed by the Actuarial Committee and Claims Working Group on a semi-annual basis. Among the diagnostics discussed by the Committee were the following:

1. Since Senate Bill No.1160 (SB 1160) became effective January 1, 2017, the number of filed liens has continued to decrease and the decrease accelerated during the pandemic. The number of liens filed in 2020 was 18% less than 2019 and almost 80% less than 2016.
2. After declining at a moderate rate for several years, the cumulative injury share of total indemnity claims in 2019 at the preliminary first report level was higher than in 2018 in all regions. While it was noted that the information for 2019 is preliminary and early indicators for accident year 2020 suggest a decline in the proportion of cumulative injury claims, the Committee recommended that cumulative injury claims continue to be monitored.
3. After declining for several years, both the mean and median temporary disability duration have started to increase. It was noted that these increases in temporary disability duration could be a factor in recent increases in indemnity severity. A member suggested that feedback on the issue be solicited from the Claims Working Group.
4. The number of claims in excess of $1 million has continued to grow with a sharp increase in 2017, as these claims contributed significantly more to overall incurred indemnity losses and incurred medical losses. A member suggested that, in addition to other factors, some of the increase could be due to earlier recognition of these large claims due to the use of enhanced analytical models.
5. There were sharp increases in average indemnity severities continuing into 2020, while medical severities were relatively flat. It was noted that some of the increase in 2020 average indemnity severity could be due to the reduction in the number of smaller indemnity claims being filed during the pandemic. It was agreed that staff should solicit feedback from the Claims Working Group on the issue. A Committee member requested the claim severity triangle diagnostics updated with December 31, 2020 experience be provided. The updated exhibits are attached to these Minutes.
6. Retrospective evaluations of the performance of alternative loss development methodologies indicate that paid development methodologies generally continue to outperform the other methods reviewed. Staff noted that the evaluations also show that claim settlement adjustments were continuing to improve the accuracy of the paid projections. A member suggested that the latest information included in these diagnostics also suggest that the latest-year incurred projections were also performing well.

Exhibit S2.1

Average Incurred Indemnity Loss per Reported Indemnity Claim
As of December 31, 2020

Accident	Evaluated as of (in months):									
Year	12	24	36	48	60	72	84	96	108	120
1995										14,497
1996									16,773	16,810
1997								19,176	19,183	19,240
1998							21,047	21,137	21,201	21,279
1999						22,919	23,166	23,289	23,439	23,583
2000					23,115	23,478	23,639	23,902	24,087	24,203
2001				23,649	24,359	24,772	25,301	25,662	25,922	26,094
2002			20,682	22,004	22,673	23,412	23,838	24,127	24,380	24,636
2003		16,899	19,913	21,335	22,520	23,282	23,819	24,265	24,663	25,053
2004	10,717	13,799	16,014	17,311	18,017	18,789	19,293	19,842	20,205	20,515
2005	8,000	11,356	13,674	14,978	16,000	16,834	17,482	17,987	18,268	18,494
2006	8,033	12,057	14,849	16,424	17,701	18,610	19,252	19,654	19,930	20,106
2007	8,157	12,903	16,196	18,036	19,218	20,119	20,856	21,287	21,526	21,758
2008	8,573	13,914	17,738	19,935	21,321	22,208	22,807	23,215	23,467	23,682
2009	8,737	14,578	18,330	20,706	22,162	23,101	23,602	24,037	24,376	24,589
2010	8,756	14,284	18,213	20,371	21,603	22,480	23,019	23,370	23,643	23,906
2011	9,171	14,825	18,283	20,367	21,405	22,145	22,597	22,994	23,236	23,423
2012	9,181	14,686	17,984	19,696	20,849	21,646	22,127	22,460	22,758	
2013	9,386	14,528	17,690	19,446	20,412	21,023	21,423	21,676		
2014	9,279	14,665	18,266	20,157	21,264	21,836	22,172			
2015	9,633	15,347	18,830	20,617	21,534	22,057				
2016	9,816	15,310	18,539	20,158	21,032					
2017	9,971	15,619	18,941	20,469						
2018	10,564	16,378	19,652							
2019	11,013	17,122								
2020	11,835									

Accident	Annual Change									
Year	12	24	36	48	60	72	84	96	108	120
1996										16.0%
1997									14.4%	14.5%
1998								10.2%	10.5%	10.6%
1999							10.1%	10.2%	10.6%	10.8%
2000						2.4%	2.0%	2.6%	2.8%	2.6%
2001					5.4%	5.5%	7.0%	7.4%	7.6%	7.8%
2002				-7.0%	-6.9%	-5.5%	-5.8%	-6.0%	-5.9%	-5.6%
2003			-3.7%	-3.0%	-0.7%	-0.6%	-0.1%	0.6%	1.2%	1.7%
2004		-18.3%	-19.6%	-18.9%	-20.0%	-19.3%	-19.0%	-18.2%	-18.1%	-18.1%
2005	-25.3%	-17.7%	-14.6%	-13.5%	-11.2%	-10.4%	-9.4%	-9.3%	-9.6%	-9.9%
2006	0.4%	6.2%	8.6%	9.7%	10.6%	10.6%	10.1%	9.3%	9.1%	8.7%
2007	1.5%	7.0%	9.1%	9.8%	8.6%	8.1%	8.3%	8.3%	8.0%	8.2%
2008	5.1%	7.8%	9.5%	10.5%	10.9%	10.4%	9.4%	9.1%	9.0%	8.8%
2009	1.9%	4.8%	3.3%	3.9%	3.9%	4.0%	3.5%	3.5%	3.9%	3.8%
2010	0.2%	-2.0%	-0.6%	-1.6%	-2.5%	-2.7%	-2.5%	-2.8%	-3.0%	-2.8%
2011	4.7%	3.8%	0.4%	0.0%	-0.9%	-1.5%	-1.8%	-1.6%	-1.7%	-2.0%
2012	0.1%	-0.9%	-1.6%	-3.3%	-2.6%	-2.3%	-2.1%	-2.3%	-2.1%	
2013	2.2%	-1.1%	-1.6%	-1.3%	-2.1%	-2.9%	-3.2%	-3.5%		
2014	-1.1%	0.9%	3.3%	3.7%	4.2%	3.9%	3.5%			
2015	3.8%	4.7%	3.1%	2.3%	1.3%	1.0%				
2016	1.9%	-0.2%	-1.5%	-2.2%	-2.3%					
2017	1.6%	2.0%	2.2%	1.5%						
2018	5.9%	4.9%	3.8%							
2019	4.3%	4.5%								
2020	7.5%									

	Annual Trend*									
All-Year	1.6%	1.3%	0.7%	0.2%	-0.1%	-0.3%	-0.2%	0.1%	0.8%	1.6%
R^2	0.527	0.360	0.110	0.005	0.003	0.017	0.010	0.005	0.113	0.260
5-Year	4.8%	2.9%	1.5%	1.0%	0.7%	0.0%	-1.3%	-2.4%	-1.1%	1.6%
R^2	0.964	0.879	0.765	0.517	0.307	0.000	0.573	0.985	0.471	0.296

*Trend is based on an exponential distribution.

Source: WCIRB quarterly calls for experience, excluding COVID-19 claims.

Exhibit S2.2

Average Incurred Medical Loss per Reported Claim
As of December 31, 2020

Accident	Evaluated as of (in months):									
Year	12	24	36	48	60	72	84	96	108	120
1999										7,548
2000									8,099	8,231
2001								9,270	9,595	9,935
2002							9,339	9,692	9,982	10,259
2003						8,751	9,119	9,514	9,856	10,136
2004					6,870	7,280	7,727	8,054	8,310	8,525
2005				6,022	6,461	6,995	7,380	7,709	7,957	8,110
2006			6,150	6,747	7,279	7,755	8,120	8,436	8,609	8,704
2007		5,822	6,894	7,713	8,324	8,887	9,327	9,608	9,771	9,811
2008	4,801	6,513	7,800	8,780	9,565	10,126	10,508	10,770	10,873	10,918
2009	5,224	7,323	8,866	10,039	10,870	11,456	11,766	11,941	12,021	12,083
2010	5,452	7,626	9,301	10,470	11,183	11,636	11,903	12,029	12,107	12,214
2011	5,606	7,888	9,380	10,388	11,028	11,354	11,502	11,594	11,686	11,691
2012	5,736	7,820	9,072	9,801	10,300	10,597	10,745	10,893	10,953	
2013	5,868	7,793	8,771	9,443	9,777	9,966	10,093	10,146		
2014	5,699	7,361	8,397	8,993	9,276	9,508	9,604			
2015	5,802	7,446	8,408	8,903	9,137	9,285				
2016	5,910	7,498	8,304	8,628	8,871					
2017	5,890	7,306	8,066	8,436						
2018	6,111	7,655	8,419							
2019	6,140	7,721								
2020	7,053									

Accident	Annual Change									
Year	12	24	36	48	60	72	84	96	108	120
2000										9.1%
2001									18.5%	20.7%
2002								4.6%	4.0%	3.3%
2003							-2.4%	-1.8%	-1.3%	-1.2%
2004						-16.8%	-15.3%	-15.3%	-15.7%	-15.9%
2005					-6.0%	-3.9%	-4.5%	-4.3%	-4.2%	-4.9%
2006				12.0%	12.7%	10.9%	10.0%	9.4%	8.2%	7.3%
2007			12.1%	14.3%	14.4%	14.6%	14.9%	13.9%	13.5%	12.7%
2008		11.9%	13.1%	13.8%	14.9%	13.9%	12.7%	12.1%	11.3%	11.3%
2009	8.8%	12.4%	13.7%	14.3%	13.6%	13.1%	12.0%	10.9%	10.6%	10.7%
2010	4.4%	4.1%	4.9%	4.3%	2.9%	1.6%	1.2%	0.7%	0.7%	1.1%
2011	2.8%	3.4%	0.9%	-0.8%	-1.4%	-2.4%	-3.4%	-3.6%	-3.5%	-4.3%
2012	2.3%	-0.9%	-3.3%	-5.6%	-6.6%	-6.7%	-6.6%	-6.0%	-6.3%	
2013	2.3%	-0.4%	-3.3%	-3.7%	-5.1%	-6.0%	-6.1%	-6.9%		
2014	-2.9%	-5.5%	-4.3%	-4.8%	-5.1%	-4.6%	-4.8%			
2015	1.8%	1.2%	0.1%	-1.0%	-1.5%	-2.4%				
2016	1.9%	0.7%	-1.2%	-3.1%	-2.9%					
2017	-0.3%	-2.6%	-2.9%	-2.2%						
2018	3.8%	4.8%	4.4%							
2019	0.5%	0.9%								
2020	14.9%									

	Annual Trend*									
All-Year	2.1%	1.3%	1.4%	2.1%	2.7%	2.6%	2.4%	2.4%	2.7%	3.1%
R^2	0.807	0.323	0.198	0.233	0.337	0.351	0.352	0.391	0.501	0.548
5-Year	4.0%	0.9%	-0.4%	-2.6%	-3.6%	-5.0%	-5.4%	-4.2%	-0.1%	4.7%
R^2	0.715	0.446	0.102	0.963	0.956	0.970	0.991	0.879	0.002	0.652

*Trend is based on an exponential distribution.

Source: WCIRB quarterly calls for experience, excluding COVID-19 claims.

Exhibit S3.1

Average Indemnity Case Outstanding per Open Indemnity Claim
As of December 31, 2020

Accident	Evaluated as of (in months):									
Year	12	24	36	48	60	72	84	96	108	120
1995										25,767
1996									26,549	25,239
1997								28,911	27,277	29,465
1998							30,434	29,699	30,827	30,649
1999						28,465	28,610	28,974	30,092	31,882
2000					24,425	23,719	24,145	24,926	25,410	26,287
2001				20,287	19,596	19,715	21,098	22,535	24,047	25,029
2002			18,002	16,653	16,311	17,572	18,525	19,415	21,021	22,824
2003		15,894	15,237	15,154	16,691	18,589	21,005	23,704	26,698	30,003
2004	10,827	12,371	13,050	14,145	15,506	17,875	19,920	23,262	25,184	29,197
2005	7,456	9,756	11,165	12,562	14,801	17,665	20,644	23,421	25,545	27,307
2006	7,273	10,426	12,575	14,648	17,686	20,213	22,065	24,695	26,490	27,401
2007	7,309	11,116	13,804	15,990	17,881	19,708	23,634	26,259	27,908	30,962
2008	7,547	11,563	14,517	16,501	18,022	20,559	22,932	25,557	29,535	32,538
2009	7,676	12,238	14,449	16,463	18,656	20,874	22,416	25,586	28,687	31,787
2010	7,769	11,861	14,316	16,129	17,735	19,666	21,941	24,461	27,509	31,637
2011	8,334	12,622	14,659	16,944	18,476	20,359	22,454	25,113	27,845	31,130
2012	8,180	12,415	14,538	15,855	18,009	20,402	23,788	27,542	32,260	
2013	8,470	12,330	13,988	15,428	17,187	19,545	23,196	26,333		
2014	8,331	12,507	14,731	16,874	19,915	22,146	25,005			
2015	8,686	13,444	16,144	18,902	21,533	24,336				
2016	8,918	13,797	16,673	19,520	22,298					
2017	9,333	14,953	18,721	21,574						
2018	9,929	15,851	19,400							
2019	10,357	16,089								
2020	10,830									

Accident	Annual Change									
Year	12	24	36	48	60	72	84	96	108	120
1996										-2.0%
1997									2.7%	16.7%
1998								2.7%	13.0%	4.0%
1999							-6.0%	-2.4%	-2.4%	4.0%
2000						-16.7%	-15.6%	-14.0%	-15.6%	-17.6%
2001					-19.8%	-16.9%	-12.6%	-9.6%	-5.4%	-4.8%
2002				-17.9%	-16.8%	-10.9%	-12.2%	-13.8%	-12.6%	-8.8%
2003			-15.4%	-9.0%	2.3%	5.8%	13.4%	22.1%	27.0%	31.5%
2004		-22.2%	-14.4%	-6.7%	-7.1%	-3.8%	-5.2%	-1.9%	-5.7%	-2.7%
2005	-31.1%	-21.1%	-14.4%	-11.2%	-4.5%	-1.2%	3.6%	0.7%	1.4%	-6.5%
2006	-2.5%	6.9%	12.6%	16.6%	19.5%	14.4%	6.9%	5.4%	3.7%	0.3%
2007	0.5%	6.6%	9.8%	9.2%	1.1%	-2.5%	7.1%	6.3%	5.4%	13.0%
2008	3.3%	4.0%	5.2%	3.2%	0.8%	4.3%	-3.0%	-2.7%	5.8%	5.1%
2009	1.7%	5.8%	-0.5%	-0.2%	3.5%	1.5%	-2.3%	0.1%	-2.9%	-2.3%
2010	1.2%	-3.1%	-0.9%	-2.0%	-4.9%	-5.8%	-2.1%	-4.4%	-4.1%	-0.5%
2011	7.3%	6.4%	2.4%	5.1%	4.2%	3.5%	2.3%	2.7%	1.2%	-1.6%
2012	-1.8%	-1.6%	-0.8%	-6.4%	-2.5%	0.2%	5.9%	9.7%	15.9%	
2013	3.5%	-0.7%	-3.8%	-2.7%	-4.6%	-4.2%	-2.5%	-4.4%		
2014	-1.6%	1.4%	5.3%	9.4%	15.9%	13.3%	7.8%			
2015	4.3%	7.5%	9.6%	12.0%	8.1%	9.9%				
2016	2.7%	2.6%	3.3%	3.3%	3.5%					
2017	4.7%	8.4%	12.3%	10.5%						
2018	6.4%	6.0%	3.6%							
2019	4.3%	1.5%								
2020	4.6%									

	Annual Trend*									
All-Year	1.6%	1.7%	1.5%	1.2%	0.6%	0.0%	-0.4%	-0.2%	0.6%	1.1%
R^2	0.367	0.343	0.279	0.209	0.063	0.000	0.024	0.006	0.076	0.252
5-Year	5.1%	5.1%	7.2%	8.5%	6.7%	4.5%	3.0%	1.8%	1.5%	-0.2%
R^2	0.996	0.956	0.971	0.980	0.851	0.630	0.831	0.373	0.133	0.020

*Trend is based on an exponential distribution.

Source: WCIRB quarterly calls for experience, excluding COVID-19 claims.

Exhibit S3.2

Average Medical Case Outstanding per Open Indemnity Claim
As of December 31, 2020

Accident	Evaluated as of (in months):									
Year	12	24	36	48	60	72	84	96	108	120
1995										42,569
1996									37,019	39,787
1997								39,370	43,830	50,022
1998							40,864	45,891	53,152	67,069
1999						33,494	40,131	46,426	60,894	75,165
2000					26,128	30,699	36,064	46,812	55,518	63,106
2001				19,329	22,267	27,289	35,013	44,396	56,074	69,725
2002			16,078	17,743	20,420	26,774	33,759	42,824	51,807	63,089
2003		13,966	15,324	17,624	21,588	29,166	37,105	46,644	58,737	69,746
2004	12,193	12,710	14,496	18,991	25,100	31,301	40,237	49,950	58,523	72,870
2005	12,001	13,808	17,451	21,214	25,669	34,362	43,056	52,579	63,594	73,010
2006	12,121	15,586	20,279	24,656	30,730	37,902	45,281	56,182	64,995	70,820
2007	12,952	17,014	21,293	26,644	32,790	40,145	50,980	60,310	68,785	76,151
2008	13,778	17,747	22,156	27,639	33,754	42,076	50,686	60,356	70,003	76,644
2009	14,289	18,590	23,338	28,634	34,946	41,949	48,959	58,157	65,239	74,426
2010	14,632	18,857	23,482	28,827	34,291	39,998	46,538	52,569	59,232	68,269
2011	15,677	20,254	24,684	30,264	36,928	41,973	47,951	54,431	62,885	66,745
2012	15,922	20,117	23,949	27,880	32,976	39,148	45,585	55,002	62,197	
2013	15,622	19,701	22,548	26,968	31,695	37,168	44,756	51,756		
2014	14,990	18,545	21,851	26,278	31,450	37,440	43,046			
2015	15,562	19,315	23,877	29,375	35,785	40,917				
2016	15,998	20,261	24,972	29,910	35,409					
2017	16,886	21,477	26,895	32,042						
2018	17,705	22,389	26,221							
2019	17,704	22,013								
2020	17,944									

Accident	Annual Change									
Year	12	24	36	48	60	72	84	96	108	120
1996										-6.5%
1997									18.4%	25.7%
1998								16.6%	21.3%	34.1%
1999							-1.8%	1.2%	14.6%	12.1%
2000						-8.3%	-10.1%	0.8%	-8.8%	-16.0%
2001					-14.8%	-11.1%	-2.9%	-5.2%	1.0%	10.5%
2002				-8.2%	-8.3%	-1.9%	-3.6%	-3.5%	-7.6%	-9.5%
2003			-4.7%	-0.7%	5.7%	8.9%	9.9%	8.9%	13.4%	10.6%
2004		-9.0%	-5.4%	7.8%	16.3%	7.3%	8.4%	7.1%	-0.4%	4.5%
2005	-1.6%	8.6%	20.4%	11.7%	2.3%	9.8%	7.0%	5.3%	8.7%	0.2%
2006	1.0%	12.9%	16.2%	16.2%	19.7%	10.3%	5.2%	6.9%	2.2%	-3.0%
2007	6.9%	9.2%	5.0%	8.1%	6.7%	5.9%	12.6%	7.3%	5.8%	7.5%
2008	6.4%	4.3%	4.1%	3.7%	2.9%	4.8%	-0.6%	0.1%	1.8%	0.6%
2009	3.7%	4.8%	5.3%	3.6%	3.5%	-0.3%	-3.4%	-3.6%	-6.8%	-2.9%
2010	2.4%	1.4%	0.6%	0.7%	-1.9%	-4.7%	-4.9%	-9.6%	-9.2%	-8.3%
2011	7.1%	7.4%	5.1%	5.0%	7.7%	4.9%	3.0%	3.5%	6.2%	-2.2%
2012	1.6%	-0.7%	-3.0%	-7.9%	-10.7%	-6.7%	-4.9%	1.1%	-1.1%	
2013	-1.9%	-2.1%	-5.8%	-3.3%	-3.9%	-5.1%	-1.8%	-5.9%		
2014	-4.0%	-5.9%	-3.1%	-2.6%	-0.8%	0.7%	-3.8%			
2015	3.8%	4.1%	9.3%	11.8%	13.8%	9.3%				
2016	2.8%	4.9%	4.6%	1.8%	-1.0%					
2017	5.5%	6.0%	7.7%	7.1%						
2018	4.9%	4.2%	-2.5%							
2019	0.0%	-1.7%								
2020	1.4%									

	Annual Trend*									
All-Year	2.6%	3.1%	3.3%	3.5%	3.2%	2.3%	1.7%	1.9%	2.4%	2.7%
R^2	0.920	0.825	0.765	0.755	0.665	0.572	0.445	0.597	0.558	0.476
5-Year	2.8%	3.7%	5.0%	4.9%	2.7%	-1.0%	-2.2%	-1.9%	-2.7%	-3.7%
R^2	0.848	0.867	0.863	0.868	0.473	0.080	0.766	0.429	0.482	0.866

*Trend is based on an exponential distribution.

Source: WCIRB quarterly calls for experience, excluding COVID-19 claims.

Exhibit S4.1

Average Paid Indemnity Loss per Reported Indemnity Claim
As of December 31, 2020

Accident Year	Evaluated as of (in months): 12	24	36	48	60	72	84	96	108	120
1995										13,429
1996									15,265	15,527
1997								17,205	17,595	17,790
1998							18,321	18,956	19,342	19,719
1999						19,472	20,494	21,123	21,631	22,017
2000					18,701	20,244	21,122	21,840	22,400	22,770
2001				17,685	20,096	21,638	22,728	23,504	24,069	24,482
2002			13,264	16,990	19,241	20,687	21,653	22,339	22,786	23,203
2003		7,958	13,335	16,894	19,052	20,447	21,367	22,032	22,631	23,162
2004	2,723	6,996	10,909	13,466	15,026	16,154	16,949	17,651	18,287	18,842
2005	2,501	6,398	9,584	11,799	13,227	14,260	15,098	15,816	16,484	16,966
2006	2,672	6,815	10,353	12,658	14,334	15,609	16,657	17,468	18,073	18,544
2007	2,836	7,324	11,163	13,804	15,680	17,083	18,203	19,013	19,626	20,153
2008	3,104	7,911	12,187	15,318	17,548	19,113	20,227	21,040	21,592	22,083
2009	3,109	7,997	12,541	15,869	18,242	19,861	21,032	21,926	22,595	23,100
2010	3,071	7,966	12,567	15,916	18,135	19,701	20,842	21,615	22,192	22,658
2011	3,129	8,143	12,713	15,880	17,989	19,496	20,558	21,390	21,934	22,291
2012	3,246	8,212	12,629	15,715	17,771	19,274	20,234	20,924	21,398	
2013	3,189	8,134	12,704	15,837	17,794	19,041	19,846	20,392		
2014	3,152	8,314	13,247	16,475	18,519	19,794	20,554			
2015	3,279	8,701	13,708	16,949	18,910	19,958				
2016	3,417	8,884	13,702	16,742	18,406					
2017	3,474	9,071	13,913	16,707						
2018	3,729	9,459	14,104							
2019	3,885	9,737								
2020	4,252									

Accident Year	Annual Change 12	24	36	48	60	72	84	96	108	120
1996										15.6%
1997									15.3%	14.6%
1998								10.2%	9.9%	10.8%
1999							11.9%	11.4%	11.8%	11.7%
2000						4.0%	3.1%	3.4%	3.6%	3.4%
2001					7.5%	6.9%	7.6%	7.6%	7.5%	7.5%
2002				-3.9%	-4.3%	-4.4%	-4.7%	-5.0%	-5.3%	-5.2%
2003			0.5%	-0.6%	-1.0%	-1.2%	-1.3%	-1.4%	-0.7%	-0.2%
2004		-12.1%	-18.2%	-20.3%	-21.1%	-21.0%	-20.7%	-19.9%	-19.2%	-18.7%
2005	-8.2%	-8.6%	-12.1%	-12.4%	-12.0%	-11.7%	-10.9%	-10.4%	-9.9%	-10.0%
2006	6.9%	6.5%	8.0%	7.3%	8.4%	9.5%	10.3%	10.4%	9.6%	9.3%
2007	6.1%	7.5%	7.8%	9.1%	9.4%	9.4%	9.3%	8.8%	8.6%	8.7%
2008	9.4%	8.0%	9.2%	11.0%	11.9%	11.9%	11.1%	10.7%	10.0%	9.6%
2009	0.1%	1.1%	2.9%	3.6%	4.0%	3.9%	4.0%	4.2%	4.6%	4.6%
2010	-1.2%	-0.4%	0.2%	0.3%	-0.6%	-0.8%	-0.9%	-1.4%	-1.8%	-1.9%
2011	1.9%	2.2%	1.2%	-0.2%	-0.8%	-1.0%	-1.4%	-1.0%	-1.2%	-1.6%
2012	3.7%	0.8%	-0.7%	-1.0%	-1.2%	-1.1%	-1.6%	-2.2%	-2.4%	
2013	-1.8%	-0.9%	0.6%	0.8%	0.1%	-1.2%	-1.9%	-2.5%		
2014	-1.2%	2.2%	4.3%	4.0%	4.1%	4.0%	3.6%			
2015	4.0%	4.7%	3.5%	2.9%	2.1%	0.8%				
2016	4.2%	2.1%	0.0%	-1.2%	-2.7%					
2017	1.7%	2.1%	1.5%	-0.2%						
2018	7.3%	4.3%	1.4%							
2019	4.2%	2.9%								
2020	9.5%									

	Annual Trend* 12	24	36	48	60	72	84	96	108	120
All-Year	2.6%	2.0%	1.3%	0.6%	0.3%	0.0%	0.1%	0.3%	0.9%	1.7%
R^2	0.887	0.780	0.372	0.081	0.014	0.000	0.001	0.021	0.126	0.267
5-Year	5.6%	2.9%	1.4%	1.2%	1.3%	0.7%	-0.6%	-1.8%	-0.5%	2.3%
R^2	0.956	0.981	0.899	0.551	0.595	0.369	0.284	0.970	0.121	0.465

*Trend is based on an exponential distribution.

Source: WCIRB quarterly calls for experience, excluding COVID-19 claims.

Exhibit S4.2

Average Paid Medical Loss per Indemnity Claim
As of December 31, 2020

Accident	Evaluated as of (in months):									
Year	12	24	36	48	60	72	84	96	108	120
2002										23,713
2003									22,146	23,034
2004								19,253	20,330	21,310
2005							18,577	19,816	21,100	21,983
2006						19,385	20,953	22,403	23,412	24,259
2007					19,635	21,816	23,766	25,209	26,298	27,157
2008				18,763	21,908	24,417	26,274	27,676	28,676	29,493
2009			15,656	19,995	23,501	26,036	27,851	29,176	30,158	30,908
2010		10,505	15,810	20,334	23,552	25,895	27,668	28,857	29,726	30,456
2011	4,095	9,981	15,148	19,153	22,057	24,293	25,782	26,907	27,694	28,212
2012	4,102	9,681	14,411	18,097	20,747	22,597	23,911	24,864	25,471	
2013	4,091	9,238	13,809	17,199	19,492	21,036	22,078	22,724		
2014	3,822	9,015	13,501	16,700	18,812	20,305	21,230			
2015	3,886	9,115	13,428	16,589	18,536	19,736				
2016	4,072	9,270	13,341	16,155	17,848					
2017	4,261	9,467	13,523	16,102						
2018	4,437	9,882	13,939							
2019	4,355	9,512								
2020	4,313									

Accident	Annual Change									
Year	12	24	36	48	60	72	84	96	108	120
2003										-2.9%
2004									-8.2%	-7.5%
2005								2.9%	3.8%	3.2%
2006							12.8%	13.1%	11.0%	10.4%
2007						12.5%	13.4%	12.5%	12.3%	11.9%
2008					11.6%	11.9%	10.6%	9.8%	9.0%	8.6%
2009				6.6%	7.3%	6.6%	6.0%	5.4%	5.2%	4.8%
2010**			1.0%	1.7%	0.2%	-0.5%	-0.7%	-1.1%	-1.4%	-1.5%
2011**		-5.0%	-4.2%	-5.8%	-6.3%	-6.2%	-6.8%	-6.8%	-6.8%	-7.4%
2012	0.2%	-3.0%	-4.9%	-5.5%	-5.9%	-7.0%	-7.3%	-7.6%	-8.0%	
2013	-0.3%	-4.6%	-4.2%	-5.0%	-6.1%	-6.9%	-7.7%	-8.6%		
2014	-6.6%	-2.4%	-2.2%	-2.9%	-3.5%	-3.5%	-3.8%			
2015	1.7%	1.1%	-0.5%	-0.7%	-1.5%	-2.8%				
2016	4.8%	1.7%	-0.6%	-2.6%	-3.7%					
2017	4.6%	2.1%	1.4%	-0.3%						
2018	4.1%	4.4%	3.1%							
2019	-1.9%	-3.7%								
2020	-1.0%									

	Annual Trend*									
All-Year	1.0%	-0.6%	-1.8%	-2.6%	-2.3%	-1.0%	0.9%	2.7%	3.7%	3.9%
R^2	0.402	0.169	0.713	0.828	0.484	0.069	0.045	0.303	0.581	0.705
5-Year	1.4%	1.5%	0.7%	-1.6%	-3.5%	-5.1%	-6.6%	-6.3%	-3.2%	1.1%
R^2	0.451	0.599	0.441	0.938	0.952	0.959	0.990	0.949	0.571	0.102

*Trend is based on an exponential distribution.

**Entries for accident years 2010 and 2011 only reflect the paid cost of medical cost containment programs attributable to policies with effective dates prior to July 1, 2010. Entries for accident years 2012 and subsequent exclude the paid cost of medical cost containment programs.

Source: WCIRB quarterly calls for experience, excluding COVID-19 claims.

Exhibit S4.3

Average Paid Medical Loss per Claim**
As of December 31, 2020

Accident Year	Evaluated as of (in months): 12	24	36	48	60	72	84	96	108	120
1999										6,335
2000									6,878	7,093
2001								7,822	8,126	8,409
2002							7,921	8,289	8,586	8,853
2003						7,175	7,587	7,962	8,280	8,588
2004					5,329	5,814	6,226	6,565	6,900	7,206
2005				4,450	5,055	5,532	5,928	6,287	6,662	6,919
2006			4,054	4,916	5,590	6,131	6,584	7,002	7,296	7,541
2007		3,299	4,597	5,624	6,402	7,054	7,632	8,061	8,384	8,641
2008	1,808	3,710	5,198	6,398	7,385	8,170	8,748	9,184	9,501	9,755
2009	1,944	4,072	5,788	7,258	8,439	9,297	9,905	10,351	10,679	10,927
2010	1,987	4,204	6,102	7,708	8,853	9,672	10,297	10,718	11,021	11,278
2011	1,837	4,115	6,032	7,511	8,574	9,390	9,936	10,344	10,630	10,819
2012	1,855	4,066	5,862	7,244	8,238	8,931	9,417	9,770	9,993	
2013	1,884	4,006	5,767	7,076	7,963	8,550	8,950	9,198		
2014	1,827	3,916	5,640	6,862	7,663	8,224	8,568			
2015	1,839	3,957	5,608	6,794	7,524	7,979				
2016	1,926	4,046	5,618	6,685	7,323					
2017	1,957	3,999	5,498	6,444						
2018	2,041	4,196	5,729							
2019	2,020	4,105								
2020	2,224									

Accident Year	Annual Change 12	24	36	48	60	72	84	96	108	120
2000										12.0%
2001									18.1%	18.6%
2002								6.0%	5.7%	5.3%
2003							-4.2%	-3.9%	-3.6%	-3.0%
2004						-19.0%	-17.9%	-17.5%	-16.7%	-16.1%
2005					-5.1%	-4.9%	-4.8%	-4.2%	-3.5%	-4.0%
2006				10.5%	10.6%	10.8%	11.1%	11.4%	9.5%	9.0%
2007			13.4%	14.4%	14.5%	15.0%	15.9%	15.1%	14.9%	14.6%
2008		12.4%	13.1%	13.8%	15.4%	15.8%	14.6%	13.9%	13.3%	12.9%
2009	7.5%	9.8%	11.4%	13.4%	14.3%	13.8%	13.2%	12.7%	12.4%	12.0%
2010	2.2%	3.2%	5.4%	6.2%	4.9%	4.0%	4.0%	3.5%	3.2%	3.2%
2011	-7.6%	-2.1%	-1.2%	-2.6%	-3.1%	-2.9%	-3.5%	-3.5%	-3.6%	-4.1%
2012	1.0%	-1.2%	-2.8%	-3.6%	-3.9%	-4.9%	-5.2%	-5.5%	-6.0%	
2013	1.6%	-1.5%	-1.6%	-2.3%	-3.3%	-4.3%	-5.0%	-5.9%		
2014	-3.0%	-2.3%	-2.2%	-3.0%	-3.8%	-3.8%	-4.3%			
2015	0.7%	1.0%	-0.6%	-1.0%	-1.8%	-3.0%				
2016	4.7%	2.3%	0.2%	-1.6%	-2.7%					
2017	1.6%	-1.2%	-2.1%	-3.6%						
2018	4.3%	4.9%	4.2%							
2019	-1.0%	-2.2%								
2020	10.1%									

	Annual Trend* 1.0%	0.9%	1.7%	2.6%	3.4%	3.3%	3.2%	3.1%	3.5%	3.9%
All-Year										
R^2	0.430	0.293	0.307	0.355	0.471	0.466	0.441	0.460	0.557	0.619
5-Year	3.2%	1.1%	0.1%	-2.1%	-2.9%	-4.0%	-4.6%	-3.2%	1.0%	6.1%
R^2	0.817	0.573	0.014	0.959	0.986	0.992	0.996	0.746	0.065	0.741

*Trend is based on an exponential distribution.

**All entries reflect the paid cost of medical cost containment programs.

Source: WCIRB quarterly calls for experience, excluding COVID-19 claims.

Exhibit S5.1

Average Paid Indemnity Loss per Closed Indemnity Claim**
As of December 31, 2020

Accident Year	Evaluated as of (in months): 12	24	36	48	60	72	84	96	108	120
1995										11,569
1996									12,828	13,211
1997								14,434	14,939	15,230
1998							15,361	16,220	16,759	17,263
1999						15,612	16,869	17,746	18,427	18,957
2000					14,364	16,311	17,637	18,368	19,183	19,794
2001				12,517	15,782	17,549	18,855	19,905	20,696	21,282
2002			7,675	12,539	15,199	16,897	18,250	19,206	19,840	20,329
2003		3,400	9,088	12,801	15,102	16,881	17,998	18,772	19,417	20,037
2004	1,320	3,604	7,073	9,918	11,932	13,223	14,109	14,814	15,617	16,489
2005	1,371	2,980	5,712	8,396	10,276	11,432	12,323	13,182	14,226	14,917
2006	1,425	3,290	6,287	9,085	11,007	12,429	13,649	14,896	15,779	16,537
2007	1,393	3,509	6,780	9,652	11,762	13,486	15,072	16,255	17,198	18,066
2008	1,511	3,833	7,482	10,675	13,230	15,526	17,002	18,257	19,239	19,975
2009	1,592	4,087	7,858	11,268	14,286	16,398	18,105	19,452	20,410	21,220
2010	1,537	4,150	8,065	11,823	14,662	16,697	18,401	19,620	20,465	21,159
2011	1,660	4,491	8,635	12,264	14,964	16,935	18,460	19,605	20,450	21,008
2012	1,834	5,041	9,156	12,602	15,159	17,066	18,362	19,397	20,079	
2013	2,115	5,362	9,552	12,990	15,455	17,122	18,253	19,076		
2014	2,131	5,628	10,176	13,777	16,334	17,929	19,000			
2015	2,340	6,177	10,888	14,485	16,882	18,269				
2016	2,493	6,545	11,027	14,466	16,445					
2017	2,591	6,644	11,134	14,346						
2018	2,872	7,022	11,390							
2019	3,152	7,052								
2020	3,289									

Accident Year	Annual Change 12	24	36	48	60	72	84	96	108	120
1996										14.2%
1997									16.5%	15.3%
1998								12.4%	12.2%	13.3%
1999							9.8%	9.4%	10.0%	9.8%
2000						4.5%	4.6%	3.5%	4.1%	4.4%
2001					9.9%	7.6%	6.9%	8.4%	7.9%	7.5%
2002				0.2%	-3.7%	-3.7%	-3.2%	-3.5%	-4.1%	-4.5%
2003			18.4%	2.1%	-0.6%	-0.1%	-1.4%	-2.3%	-2.1%	-1.4%
2004		6.0%	-22.2%	-22.5%	-21.0%	-21.7%	-21.6%	-21.1%	-19.6%	-17.7%
2005	3.9%	-17.3%	-19.2%	-15.3%	-13.9%	-13.5%	-12.7%	-11.0%	-8.9%	-9.5%
2006	3.9%	10.4%	10.1%	8.2%	7.1%	8.7%	10.8%	13.0%	10.9%	10.9%
2007	-2.3%	6.7%	7.9%	6.2%	6.9%	8.5%	10.4%	9.1%	9.0%	9.2%
2008	8.5%	9.2%	10.4%	10.6%	12.5%	15.1%	12.8%	12.3%	11.9%	10.6%
2009	5.3%	6.6%	5.0%	5.6%	8.0%	5.6%	6.5%	6.5%	6.1%	6.2%
2010	-3.5%	1.5%	2.6%	4.9%	2.6%	1.8%	1.6%	0.9%	0.3%	-0.3%
2011	8.0%	8.2%	7.1%	3.7%	2.1%	1.4%	0.3%	-0.1%	-0.1%	-0.7%
2012	10.5%	12.2%	6.0%	2.8%	1.3%	0.8%	-0.5%	-1.1%	-1.8%	
2013	15.3%	6.4%	4.3%	3.1%	2.0%	0.3%	-0.6%	-1.7%		
2014	0.8%	5.0%	6.5%	6.1%	5.7%	4.7%	4.1%			
2015	9.8%	9.7%	7.0%	5.1%	3.4%	1.9%				
2016	6.5%	6.0%	1.3%	-0.1%	-2.6%					
2017	3.9%	1.5%	1.0%	-0.8%						
2018	10.9%	5.7%	2.3%							
2019	9.8%	0.4%								
2020	4.3%									

	Annual Trend*									
All-Year	6.2%	5.8%	3.5%	1.9%	1.2%	0.9%	0.7%	1.0%	1.5%	2.3%
R^2	0.965	0.947	0.666	0.337	0.174	0.099	0.083	0.136	0.266	0.391
5-Year	7.8%	3.4%	2.5%	2.5%	2.5%	2.0%	0.5%	-0.5%	0.9%	3.7%
R^2	0.977	0.936	0.849	0.704	0.775	0.880	0.284	0.492	0.276	0.691

*Trend is based on an exponential distribution.

**Paid indemnity losses used in the severity calculations above represent paid indemnity losses on closed claims only.

Source: WCIRB quarterly calls for experience, excluding COVID-19 claims.

Exhibit S5.2

Average Paid Medical Loss per Closed Indemnity Claim***
As of December 31, 2020

Accident	Evaluated as of (in months):									
Year	12	24	36	48	60	72	84	96	108	120
2002										19,712
2003									17,946	18,776
2004								14,783	15,911	17,215
2005							13,721	14,989	16,653	17,964
2006						13,974	15,703	17,480	18,871	20,192
2007					13,537	15,692	18,081	19,993	21,645	23,145
2008				12,320	15,329	18,568	20,748	22,683	24,305	25,491
2009			9,367	13,297	17,213	20,201	22,694	24,759	26,147	27,614
2010		5,623	9,765	14,252	17,913	20,768	23,407	25,262	26,608	27,694
2011	2,105	5,233	9,687	13,891	17,258	20,228	22,424	24,081	25,253	26,008
2012	2,341	5,631	9,999	13,802	17,059	19,413	21,119	22,429	23,412	
2013	2,414	5,751	10,021	13,652	16,556	18,595	19,989	20,929		
2014	2,387	5,805	10,060	13,669	16,372	18,160	19,309			
2015	2,503	6,243	10,431	13,849	16,220	17,717				
2016	2,709	6,471	10,486	13,496	15,509					
2017	2,835	6,648	10,635	13,467						
2018	2,972	6,954	11,098							
2019	3,405	6,685								
2020	2,861									

Accident	Annual Change									
Year	12	24	36	48	60	72	84	96	108	120
2003										-4.7%
2004									-11.3%	-8.3%
2005								1.4%	4.7%	4.3%
2006							14.4%	16.6%	13.3%	12.4%
2007						12.3%	15.1%	14.4%	14.7%	14.6%
2008					13.2%	18.3%	14.8%	13.5%	12.3%	10.1%
2009				7.9%	12.3%	8.8%	9.4%	9.2%	7.6%	8.3%
2010**			4.2%	7.2%	4.1%	2.8%	3.1%	2.0%	1.8%	0.3%
2011**		-6.9%	-0.8%	-2.5%	-3.7%	-2.6%	-4.2%	-4.7%	-5.1%	-6.1%
2012	11.2%	7.6%	3.2%	-0.6%	-1.2%	-4.0%	-5.8%	-6.9%	-7.3%	
2013	3.1%	2.1%	0.2%	-1.1%	-2.9%	-4.2%	-5.4%	-6.7%		
2014	-1.1%	0.9%	0.4%	0.1%	-1.1%	-2.3%	-3.4%			
2015	4.9%	7.5%	3.7%	1.3%	-0.9%	-2.4%				
2016	8.2%	3.7%	0.5%	-2.6%	-4.4%					
2017	4.6%	2.7%	1.4%	-0.2%						
2018	4.8%	4.6%	4.3%							
2019	14.6%	-3.9%								
2020	-16.0%									

	Annual Trend*									
All-Year	4.3%	3.0%	1.6%	0.4%	0.7%	1.8%	3.6%	5.2%	5.6%	5.5%
R^2	0.841	0.882	0.944	0.110	0.065	0.202	0.388	0.595	0.739	0.769
5-Year	3.0%	2.1%	2.2%	-0.4%	-2.1%	-3.3%	-4.9%	-4.4%	-1.1%	3.2%
R^2	0.280	0.678	0.922	0.316	0.926	0.980	0.993	0.859	0.109	0.465

*Trend is based on an exponential distribution.

**Entries for accident years 2010 and 2011 only reflect the paid cost of medical cost containment programs attributable to policies with effective dates prior to July 1, 2010. Entries for accident years 2012 and subsequent exclude the paid cost of medical cost containment programs.

***Paid medical losses used in the severity calculations above represent paid medical losses on closed indemnity claims only.

Source: WCIRB quarterly calls for experience, excluding COVID-19 claims.

Item AC21-03-02
12/31/2020 Experience Review

Staff presented a summary of the preliminary analysis of statewide accident year experience evaluated as of December 31, 2020 (excluding COVID-19 claims), which was included in the Agenda. It was noted that the analysis included in the Agenda was preliminary in that it did not fully address several open issues for the September 1, 2021 Pure Premium Rate Filing that were discussed in other Agenda items. During the discussion, the Committee noted the following:

- Paid and incurred indemnity and medical loss development for the fourth quarter of 2020 was emerging generally consistent with the third quarter and the pre-pandemic pattern.

- Indemnity claim settlement rates continued to decelerate. Claim settlement rates for accident year 2018 at 24 months and accident year 2019 at 12 months are significantly below the comparable settlement rate for the prior year.

- The number of liens filed in the immediate pre-pandemic period was approximately 70% below the level filed shortly prior to the implementation of Senate Bill No. 1160 (SB 1160) and Assembly Bill No. 1244 (AB 1244). The Committee was reminded that the medical loss development projection included an adjustment for the impact of SB 1160 and AB 1244 on future lien filings based on an estimated 60% reduction in lien filings resulting from the reforms. Staff recommended updating this factor with the estimated pre-pandemic lien reduction of 70%. The consensus of the Committee was that this was appropriate. A Committee member recommended reviewing the continued appropriateness of the adjustment in the future given that the reforms were implemented several years ago and may now be substantially reflected in the emerging experience.

- Staff's review of medical fee schedule updates adopted by the Division of Workers' Compensation (DWC) since the January 1, 2021 Pure Premium Rate Filing in general revealed no significant changes that required special adjustments to the on-leveling of medical losses. Staff advised the Committee that the impact of the March 1, 2021 changes to the Official Medical Fee Schedule and the April 1, 2021 changes to the Medical-Legal Fee Schedule adopted by the DWC would be discussed with the Committee at the next meeting after obtaining feedback from the Claims Working Group and Medical Analytics Working Group.

- The indemnity claim frequency change for accident year 2020 based on the preliminary measure of changes in indemnity claim counts compared to changes in statewide employment levels showed a decrease generally consistent with that projected in the January 1, 2021 Pure Premium Rate filing. Given the significant changes in the industrial mix in 2020, staff recommended adjusting the preliminary 2020 frequency measure for the estimated impact of these shifts on the reported claim counts and exposure as measured by employment levels. The net impact of these adjustments was a modest increase to the preliminary 2020 frequency measure. The consensus of the Committee was that staff's recommended adjustments were appropriate.

- Average on-level indemnity severities show modest increases for accident years 2018 and 2019, and a more significant increase for 2020. The increase for 2020 is likely impacted by shifts in the wage distribution of injured workers and increases in temporary disability (TD) duration during the pandemic period. The Committee recommended that staff review the distribution of wages of injured workers in 2020 and changes in TD duration for discussion at the next meeting. Staff noted that the projected average annual indemnity severity trend of 1.0% reflected in the Agenda

and in the January 1, 2021 Pure Premium Rate Filing continued to be a reasonable basis for the updated summary of December 31, 2020 experience to be reviewed at the next meeting.

- Average on-level medical severities show a modest increase for accident year 2018, and moderate decreases for 2019 and 2020. The decrease for 2020 may impacted by shifts in the distribution of injuries and delays or deferrals of medical treatment during the pandemic. Staff noted that the average annual medical severity trend of 2.5% reflected in the Agenda based on the January 1, 2021 Pure Premium Rate Filing projection was likely high given the generally flat to declining medical severities over the last several years. Staff recommended a preliminary medical severity trend of 1.0% as a reasonable basis for the updated summary of December 31, 2020 experience to be reviewed at the next meeting.

- Given the significant and likely temporary shifts in exposure, industrial mix, claim frequency, and indemnity and medical severities for accident year 2020 and the challenges in projecting indemnity and medical loss development for accident year 2020, staff recommended basing the projected September 1 ,2021 loss ratio on accident year 2019 only rather than the average of accident years 2019 and 2020. The consensus of the Committee was that this approach should be reflected in the updated summary of December 31, 2020 experience to be reviewed at the next meeting. Committee members also suggested reviewing alternative trending projections based on the average of the latest two accident years as well as a projection based on the average of 2018 and 2019.

The Committee was reminded that a full range of alternative loss development and trending projections will be reviewed at the next meeting where the recommended methodologies for the September 1, 2021 Pure Premium Rate Filing will be determined.

Item AC21-03-04
9/1/2021 Filing – COVID-19 Claim Cost Projection

The Committee discussed the COVID-19 claim cost projection reflected in the January 1, 2021 Pure Premium Rate Filing. The Committee was advised that based on COVID-19 claim experinece emerging thus far, staff was estimating that the actual COVID-19 claim volume for accident year 2020 will be significantly higher than projected in the January 1, 2021 Pure Premium Rate Filing, while the average COVID-19 severity will be somewhat lower than projected. Also, the COVID-19 claim volume emerging for accident year 2021 will likely be somehat higher than expected, while the accident year 2022 COVID-19 claim volume should be much less if the vaccines continue to work as expected.

The Committee also discussed the information currently available on projections of future levels of COVID-19. Given that the available models reviewed suggested that COVID-19 rates were plateauing at relatively low levels before significant levels of exposure on post-September 1, 2021 policies will arise, the consensus of the Committee was that a COVID-19 claim cost projection for the September 1, 2021 to August 30, 2022 policy period may not be appropriate. However, before finalizing any recommendations, the Committee agreed to review updated COVID-19-related information at the April 15, 2021 meeting.

Item AC21-03-05
Pandemic Impact on Premium Measures

The Committee was reminded that exposure levels dropped significantly during the sharp economic downturn in the second quarter of 2020. The Committee was also reminded that, during the Great Recession, there were significant and atypical amounts of return premiums that were distorting measures of calendar year earned premium. The Agenda included an analysis of premiums earned in calendar year 2020 for potential distortions in premium measures caused by the pandemic. Staff presented a summary of the analysis and noted that (a) premiums declined significantly in calendar year 2020, driven by continued insurer rate decreases and stagnant economic growth, (b) development of insurer premium in 2020 was generally consistent with the Great Recession period and (c) premiums from older policies as well as from new and renewal policies earned in 2020 were emerging lower than the comparable pre-pandemic period. Staff also noted that, the alternative approaches reviewed to develop policy year 2019 and 2020 premium amounts using Great Recession era premium development factors resulted in modest differences from the reported earned premium amounts.

After discussion, given that (a) the recent slowdown was sudden and sharp coming in early 2020 compared to the gradual changes experienced during the Great Recession that impacted several years, (b) many insurers reflected the impact of the slowdown in their in-force policies or policy renewals in part as a result of directives from the Insurance Commissioner, and (c) there was no indication of reduced calendar year 2020 premiums arising from audit adjustments on 2019 policies due to reduced 2019 exposure, the consensus of the Committee was that an adjustment to earned premium for 2020 for the impact of the pandemic was not appropriate at this time. The Committee recommended that premium development in subsequent quarters continue to be monitored closely. A Committee member also suggested staff solicit feedback from the Underwriting Working Group as to the drivers of premium changes in 2020 and anticipated changes in the near future.

The meeting was adjourned at 1:15 PM.

Note to Committee Members: These Minutes, as written, have not been approved. Please refer to the meeting scheduled for June 22, 2021 for approval and/or modification.

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Actuarial Committee

Meeting Minutes

Date	Time	Location	Staff Contact
April 15, 2021	9:00 AM	Webinar Teleconference	David M. Bellusci

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Released: May 25, 2021

Members	Representing
Mauro Garcia	Zurich North America
Ika Irsan	Republic Indemnity Company of America
Miranda Ma	American International Group
Joanne Ottone	Berkshire Hathaway Homestate Companies
Jill Petker	Liberty Mutual Group
Mark Priven	Public Members of Governing Committee
Kate Smith	State Compensation Insurance Fund
Bryan Ware	AmTrust
Chris Westermeyer	Travelers

California Department of Insurance
Mitra Sanandajifar

WCIRB
Bill Mudge
David Bellusci
Laura Carstensen
Tony Milano
Shane Steele
Julia Zhang

The webinar teleconference meeting of the Actuarial Committee was called to order at 9:00 AM following a reminder of applicable antitrust restrictions, with Mr. David Bellusci, Executive Vice President and Chief Actuary, presiding.

* * * * *

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
Working Group Meeting Summaries

The summaries of the Claims Working Group meeting held on March 22, 2021 and the Medical Analytics Working Group meeting held on April 1, 2021 were included in the Agenda for the Committee's review and were accepted by the Committee.

Item AC20-08-04
Impact of Economic Downturn on Pure Premium Rate Indications

The Committee was reminded that at the March 16, 2021 meeting, the following staff recommendations were preliminarily agreed to:

- WCIRB frequency model projections for 2020 to 2023 should not assume a recession-related increase in the cumulative injury index, as this phenomenon is not yet observed in available accident year 2020 data.
- Absent an update to the California Department of Finance forecast, the 2020 projected change in the statewide average wage should be based on the March 2021 UCLA forecast data, which was primarily based on actual economic information for 2020. Projected changes for 2021, 2022, and 2023 should be based on the average of the March 2021 UCLA and November 2020 California Department of Finance forecasts.
- Projected changes in the statewide average wage based on UCLA and California Department of Finance forecasts should be adjusted to remove impacts of changing industry mix on the average wage. This adjustment removes 1.9% in 2020 and adds 0.4% in 2021. (Changes due to industrial mix in 2022 and 2023 are negligible.)

Staff presented an updated version of a potential additional adjustment to the projected growth in statewide average wages to reflect that the change in average wage, even within industry, was distorted from a pure premium ratemaking perspective by greater than average employment loss within industry sector at lower wage levels. Staff noted that a preliminary adjustment presented at the March 16, 2021 meeting had used nationwide data that was not differentiated by industry. The updated estimate relied on two data sets of California information. The March 2021 UCLA forecast was used to determine industry-level changes in employment and employment distributions. Distributions of employment by wage level and industry were derived from Current Population Survey (CPS) data from the Census Bureau, as compiled by the Economic Policy Institute. Staff noted that the annual values shown in the exhibits were averages of 12 monthly values and that certain industrial sectors with sparse California data had been combined.

Impact of Wage Distribution in 2020
Staff detailed the derivation of the statewide average wage using observed 2019 levels of industry mix, wage distribution within industry, and average wage by industry and wage quartile. This calculation served as the baseline overall wage level in the estimate.

Staff noted that due to differences in the underlying data sets, the overall industry-level employment changes in the CPS data will not equal the changes from the UCLA forecast. The derivation of an off-balance factor by industry was shown so that the employment changes from the two data sets coincide at the industry level. Staff noted that since this off-balance factor was applied uniformly to all wage quartiles for a particular industry, its application does not impact the within-industry 2020 wage distribution.

Staff detailed the derivation of the average wage using 2020 wage levels by industry. This average wage was calculated using the observed 2019 industry mix and average wages by industry and quartile. These values were combined with the 2020 wage distribution by industry. Staff noted that the resulting average wage reflected only changes in the wage distribution within industries, as the only difference between this value and the observed 2019 value was the distribution of employees by wage level within industries. Staff recommended using the overall estimate of the impact of the changing wage distributions within industries of 4.3% to adjust the 2020 average wage growth estimate for pure premium ratemaking purposes.

Impact of Wage Distribution in Future Years
Staff noted that while the 2020 change in the statewide average wage was artificially inflated by the loss of lower wage employees within industries from the workforce, changes in future years would be artificially deflated by the return of at least some of these employees to the workforce.

Staff presented the impact under various assumptions as to the return of the workforce to the pre-2020 wage distribution within industries. The scenarios ranged from the complete return to the previous wage distribution to no future changes. The scenarios were defined as follows:

- Full Unwinding: Assumed that the measured 4.3% 2020 impact on the statewide average wage would fully reverse over the 2021-2023 forecast horizon.
- No Unwinding: Assumed that changes to the wage distribution within industries were permanent.
- Proportional to Industry Mix: Assumed that impacts on the statewide average wage from the change in the wage distribution within industry will reverse in proportion to the reversal due solely to industrial mix.
- Midpoint: Assumed a reversal halfway between the Full Unwinding and Proportional to Industry Mix scenarios.

Staff noted that a prevailing thought among economists is that much of the low wage employment will return, but due to acceleration in automation trends and other factors, some of the change in the wage distribution is permanent. Given the magnitude of the impact of the wage distribution relative to impact of industrial mix, staff believed an unwinding greater than proportional to industry mix is reasonable. Combined with the sparsity of forecasts on the subject, staff recommended the midpoint scenario.

After discussion, the consensus of the Committee was that the recommended adjustments to the wage level and frequency model projections for 2020 to 2023, as presented by staff, should be included in the projections for the September 1, 2021 Pure Premium Rate Filing.

Item AC21-03-01
First Quarter 2021 Review of Diagnostics

At the March 16, 2021 meeting, the Committee discussed a number of system diagnostics and provided feedback to be discussed with the Claims Working Group (CWG) or requested additional information. Staff summarized the feedback provided by the CWG at the meeting of March 22, 2021 as well as the additional information that has been compiled. Among the items discussed by the Committee were the following:

1. At the March 16, 2021 meeting, the Committee requested CWG feedback on the continued post-pandemic slowdown in claims settlement. The Committee was advised that CWG members noted that there continues to be pandemic-related challenges in getting claims settled including obtaining approvals of settlements at WCAB offices.
2. At the March 16, 2021 meeting, the Committee requested CWG feedback on the sharp increase in claims in excess of $1 million. The Committee was advised that the CWG discussed a number of factors that could be increasing the proportion of very large claims. These include earlier recognition of these large claims due to use of enhanced analytical models, improved medical treatment of very serious injuries, improving mortality, increased home health and related costs and that the impacts of medical reforms may not be having as great an impact on serious traumatic claims as on less severe claims.
3. At the March 16, 2021 meeting, the Committee requested CWG feedback on the recent increase in temporary disability duration. The Committee was advised that CWG members suggested that with recent challenges in assessing when a workers' injury is permanent and stationary and in returning injured workers to work during the pandemic, temporary disability duration is likely to continue to increase.
4. At the March 16, 2021 meeting, the Committee discussed the relative frequency of cumulative trauma (CT) claims, particularly those filed following the employee's termination and requested that updated information on 2020 CT claims be provided. Staff presented a summary of the share of indemnity claims that were reported as CT claims by accident quarter based on transactional indemnity data. While there was no indication of increasing CT claims in 2020 despite the significant level of job loss, the Committee agreed that information should continue to be monitored as the year further develops.
5. At the March 16, 2021 meeting, the Committee requested staff to review information on injured worker weekly wages in 2020 to assess whether, with the sharp reduction in low wage employment, the average wage of injured workers grew similarly to that of all employees. Staff presented a summary of the change in injured worker average wages in 2020 based on a sample of transactional indemnity data. The Committee was advised that there was sharp growth in injured worker average weekly wages for most industries, although the typical average growth was somewhat below the average growth over all employees.
6. At the March 16, 2021 meeting, the Committee reviewed the preliminary information on 2020 medical severity growth and requested that additional explanatory information be provided. Staff presented several summary exhibits related to medical severities. The Committee was advised that while the average paid medical severity on all claims had increased by about 10% in 2020, the average paid on indemnity claims was essentially flat. Staff presented a summary of non-COVID-19 claims filed in 2020 that showed the decline in medical-only claims filed was more than twice that on indemnity claims, which largely explained the differences in 2020 medical severity growth between all claims and indemnity claims.

The Committee also reviewed a summary of 2019 and 2020 claims by diagnostic grouping based on the WCIRB's algorithm for assigning claims to diagnostic groups based on the medical transactions on the claim. The information showed that there were significant declines in the frequency of most non-COVID-19 diagnosis claim groupings. As a result, there was no indication of shifting diagnoses driving changes in average severities.

Item AC21-03-02
12/31/2020 Experience Review

The Agenda included an updated analysis of December 31, 2020 experience, which was first reviewed at the March 16, 2021 meeting. The Committee was advised that the updated analysis reflected several refinements from the analysis reviewed at the March 16, 2021 meeting based in part on the discussions from that meeting.

The Committee reviewed loss development and the alternative loss development projections included in the Agenda (Item AC21-04-02). Staff noted that the loss development methodology included in the Agenda and recommended by staff is generally consistent with that reflected in the January 1, 2021 Pure Premium Rate Filing and was primarily based on two-year average paid loss development adjusted for reforms and changes in claim settlement rates. Staff noted that, as discussed at prior meetings, the two-year average was recommended to reduce volatility in loss development emerging during the pandemic period. A motion was made, seconded, and unanimously passed to base the indemnity loss development projection on the method as presented in the Agenda to compute the indicated September 1, 2021 average advisory pure premium rate.

With respect to medical loss development, a motion was made and seconded to base the medical loss development projection on the method as presented in the Agenda to compute the indicated September 1, 2021 average advisory pure premium rate. The motion passed with eight in favor and one opposed. (The Actuary representing the Public Members of the Governing Committee who opposed the motion recommended a medical loss development methodology that assigned some weight to a projection based on incurred loss development.)

Staff noted that each year, the Division of Workers' Compensation (DWC) adjusts weekly minimum and maximum temporary disability and permanent total disability benefits by statute. In accordance with statute, increases in these benefits were based on the change in the state average weekly wage (SAWW) for employees covered by unemployment insurance for the 12 months ending March 31 of the prior year. Based on a review of the SAWW for the period ending September 30, 2020, the anticipated increase to January 1, 2022 benefits will likely be significantly higher than typical (7.9% based on September 30, 2020 data)as the change in SAWW will be impacted by distributional shifts in wage levels as discussed at prior meetings. As a result, staff reflected the anticipated increase in the on-level adjustments for indemnity benefits in the analysis included in the Agenda. Conversely, staff also reflected an anticipated flat statutory benefit level effective January 1, 2023 given that growth in the SAWW for 2021 and 2022 is anticipated to be modest as some of the impact of the shift in wage distribution begins to reverse. The consensus of the Committee was that these adjustments were appropriate.

Staff noted that the preliminary accident year 2020 (ex-COVID) frequency change after staff's recommended adjustments for shifts in industrial mix is a moderate decrease generally consistent with the decrease projected in the January 1, 2021 Pure Premium Rate Filing. The frequency changes projected by the WCIRB's frequency model were modest increases for 2021 through 2023 primarily driven by the forecast economic recovery. A Committee member questioned the appropriateness of using the actual 2020 frequency change given the pandemic-related volatility. Staff replied that indemnity claim counts at 12 months were less subject to shifting development patterns compared to paid losses and prior studies have shown that the preliminary measure of the frequency change at 12 months was more predictive of the actual change compared to the WCIRB's frequency model. Another Committee member noted that the projected average change from 2019 to the September 1, 2021 to August 31, 2022 policy period was a modest annual decrease which appeared reasonable. After discussion, the majority of Committee members agreed that the claim frequency projections as presented in the Agenda were appropriate.

The Committee noted that the projected annual on-level indemnity severity trend of 1.0% reflected in the Agenda gave some weight to the increases in projected on-level indemnity severities for 2018 and 2019 and some weight to the decreases experienced over the last several prior years and was consistent with the indemnity severity trend reflected in the January 1, 2021 Pure Premium Rate Filing. Given the volatility arising during the pandemic, staff recommended not giving significant weight to the sharp increase in the accident year 2020 on-level indemnity severity when selecting the on-level indemnity severity trend. Similarly, staff recommended basing the projected loss ratio for September 1, 2021 to August 31, 2022 policies on applying the projected frequency and average on-level indemnity severity trend to accident year 2019 only. The Committee discussed the alternative indemnity trending projections included in the Agenda (AC21-04-02). After discussion, a motion was made and seconded to use the indemnity trending projection methodology as presented in the Agenda, with the refinements to the wage level projection as discussed in Item AC20-08-04. The motion passed with eight in favor and one opposed. (The Actuary representing the Public Members of the Governing Committee who opposed the motion supported an indemnity severity trending methodology which varied the trend rate by year.)

The Committee noted that the average annual medical severity trend of 1.0% reflected in the Agenda gave consideration to the recent period of generally flat-to-declining on-level medical severities while also considering longer-term trends given that a significant portion of medical costs were paid many years after the claim occurs. It was also noted that the 1.0% average annual on-level medical severity trend was generally consistent with the approximate average rate of growth over the most recent two pre-pandemic years (2018 and 2019). As with indemnity, staff recommended not giving significant weight to the moderate decrease in the accident year 2020 on-level medical severity when selecting the on-level medical severity trend and as this decrease was likely related to shifts in medical services and injury types during the pandemic period and applying the selected trends to accident year 2019 only. The Committee discussed the alternative medical trending projections included in the Agenda (AC21-04-02). After discussion, a motion was made and seconded to use the medical trending projection methodology as presented in the Agenda, with the refinements to the wage level projection as discussed in Item AC20-08-04. The motion passed with eight in favor and one opposed. (The Actuary representing the Public Members of the Governing Committee who opposed the motion supported a somewhat lower medical severity trend.)

Item AC21-03-04
9/1/2021 Filing – COVID-19 Claim Cost Projection

At the March 16, 2021 meeting, the Committee discussed the COVID-19 claim cost projection reflected in the January 1, 2021 Pure Premium Rate Filing and the potential cost of COVID-19 claims incurred on policies incepting between September 1, 2021 and August 31, 2022. Given that the available models used by the WCIRB in the January 1, 2021 Pure Premium Rate Filing were currently forecasting that COVID-19 rates were plateauing at relatively low levels before significant levels of exposure on post-September 1, 2021 policies will arise, the consensus of the Committee was that a COVID-19 claim cost provision for the September 1, 2021 to August 31, 2022 policy period may not be appropriate. However, before finalizing any recommendations, the Committee agreed to review updated COVID-19-related information at the April 15, 2021 meeting.

Staff summarized the updated information on COVID-19 claims being filed and the available model forecasts of future COVID-19 infections and deaths. As was discussed at the March 16, 2021 meeting, with the winter surge of COVID-19 infections, the volume of claims to be reported for accident year 2020 were two to three times higher than projected in the WCIRB's January 1, 2021 Pure Premium Rate Filing and 2021 is appearing to emerge at level relatively consistent with WCIRB projections. Conversely, it was noted that early preliminary estimates of the average severity of COVID-19 claims were below the filing projections. In addition, the Committee was advised that three of the latest published pandemic forecasts projected a very significant drop in COVID-19 hospitalizations and deaths by late summer 2021. While the Committee generally agreed with staff's suggestion that there will continue to be some COVID-19 claims continuing into 2022, given the information from the available forecasts, the consensus of the Committee was that projected September 1, 2021 advisory pure premium rates should not reflect a provision for COVID-19 claims on policies incepting between September 1, 2021 and August 31, 2022.

Item AC21-04-01
9/1/2021 Filing – Loss Adjustment Expense Experience Review

The Committee was advised that although unallocated loss adjustment expense (ULAE) experience for calendar year 2020 is not yet available, the Agenda included an updated ULAE projection that reflected ULAE experience through calendar year 2019, the ULAE projection methodology refinements adopted by the Committee at the December 11, 2020 meeting, and updated frequency, wage level, and loss projections based on December 31, 2020 experience. The Committee noted that the ULAE projection in the Agenda was based on the average of the open claim count-based methodology and recent calendar year paid ULAE to paid loss ratios for private insurers based on the latest two calendar years (2018 and 2019). Staff noted that the wage level trends included in the Agenda did not yet reflect the refinements to the wage level projection for shifting wage levels within industries as discussed in Item AC20-08-04 and adopted by the Committee. After discussion, a motion was made, seconded, and unanimously passed to use the ULAE projection methodologies as presented in the Agenda and recommended by staff, with the refinements to the wage level projections as discussed in Item A20-08-04, for purposes of computing the indicated September 1, 2021 average advisory pure premium rate.

The Committee reviewed the analysis of allocated loss adjustment expense (ALAE) experience through December 31, 2020 that was included in the Agenda as well as alternative ALAE projection methodologies. The Committee noted that paid ALAE development continues to decrease moderately. The Committee also noted that the adjustments to paid ALAE development for changes in claim settlement rates based on the methodology reflected in the January 1, 2021 Pure Premium Rate Filing appear to be working well as they more accurately projected the next period's paid ALAE age-to-age factor compared to using the latest year's unadjusted factor. The Committee was reminded that the claim settlement rate adjustments were only applied when the annual change in claim settlement rate is more than 1.5% in absolute value. Similar to the loss development projection, staff recommended using a two-year average of paid ALAE development with adjustments for changes in claim settlement rates rather than the latest year's factor in order to mitigate volatility emerging during the pandemic period.

The Committee noted that changes in ALAE severities have been modest over the last several years. As discussed earlier for the loss components of the projection, given the volatility emerging during the pandemic, staff recommended not giving significant weight to the accident year 2020 ALAE severities when selecting the ALAE severity trend. The Committee was advised that the approximate average ALAE severity trend based on the short-term and longer-term average rates of growth through 2019 of 1.0% is somewhat lower than the projected ALAE severity trend reflected in the January 1, 2021 Pure Premium Rate Filing. Staff also noted that, consistent with the loss projections given the volatility in the accident year 2020 data, the ALAE projection included in the Agenda and recommended by staff was based on trending from accident year 2019 ALAE experience only.

The Committee was reminded of the methodology to adjust the ALAE to loss ratio for the impact of the Senate Bill No. 1160 reforms related to lien filings, which was consistent with the methodology used in the January 1, 2021 Pure Premium Rate Filing and updated based on a 70% total reduction in lien filings based on a review of the latest lien filing information from the Division of Workers' Compensation. After discussion, a motion was made and seconded to use the ALAE projection methodologies as presented in the Agenda and recommended by staff for purposes of computing the indicated September 1, 2021 average advisory pure premium rate. The motion passed with eight in favor and one opposed. (The Actuary representing the Public Members of the Governing Committee who opposed the motion supported a somewhat lower ALAE severity trend projection.)

The Committee next reviewed the analysis of medical cost containment program (MCCP) cost experience through December 31, 2020 as well as alternative MCCP cost projection methodologies. Staff noted that, similar to ALAE excluding MCCP costs, a two-year average of paid MCCP cost development was recommended to mitigate volatility emerging during the pandemic period. It was noted that average MCCP per indemnity claim decreased in 2019 and 2020 following an increase in 2018. The Committee was advised that the MCCP severity trend of -1.0% reflected in the Agenda was based on the approximate average of the calendar year and accident year average MCCP severity trends through 2019. Staff also noted that, consistent with ALAE excluding MCCP costs, the MCCP cost projection included in the Agenda and recommended by staff was based on trending from accident year 2019 only. After discussion, a motion was made and seconded to use the MCCP cost projection methodologies as presented in the Agenda and recommended by staff for purposes of computing the indicated September 1, 2021 average advisory pure premium rate. The motion passed with eight in favor and one opposed. (The Actuary representing the Public Members of the Governing Committee who opposed the motion supported a somewhat lower MCCP cost severity trend projection.)

Item AC21-04-02
9/1/2021 Filing – Review of Alternative Loss Projection Methodologies

The Agenda materials included a number of alternative loss development and trending methodologies that had been reflected in prior WCIRB pure premium rate filings or discussed at prior Actuarial Committee meetings.

The Committee reviewed summaries of the alternative loss projection methodologies during the discussion of loss development and trending methodologies in the context of its review of December 31, 2020 experience. (Please refer to the Minutes for Item AC21-03-02.)

Item AC21-04-03
Evaluation of New Medical-Legal Fee Schedule

The Committee was advised that effective April 1, 2021, the Division of Workers' Compensation (DWC) adopted significant changes to California's Medical-Legal Fee Schedule (Schedule).[1] Staff presented the WCIRB's prospective cost evaluation of the April 1, 2021 Schedule based on medical-legal services provided in 2018 and 2019. The Committee was advised that the key assumptions underlying the cost evaluation were reviewed by the Claims Working Group and Medical Analytics Working Group. Feedback from both working groups was incorporated in the evaluation.

Staff summarized the key changes in the April 1, 2021 Schedule, which include changes to procedure codes, relative values and modifiers, the elimination of the time component in billing medical-legal evaluations and new codes for record review and sub rosa recording review. The Committee was advised that, consistent with the WCIRB's standard process in evaluating fee schedule changes, this prospective evaluation assumed the mix of medical-legal services overall under the new schedule is generally consistent with that in 2018 and 2019, except for a lower use (-15%) of the supplemental medical-legal evaluations based on published research and feedback from claims and medical experts.[2] The Committee was advised that, based on the underlying assumptions reviewed, the April 1, 2021 Schedule is estimated to increase the overall cost of medical-legal services by 22%.

The Committee was also advised that the highest level of uncertainty in the evaluation was around the cost of record review under the April 1, 2021 Schedule. Staff's approach in evaluating this change was to compare the cost of each medical-legal evaluation in 2018 and 2019 paid in accordance with the pre-April 1, 2021 Schedule including the amounts paid for additional time provisions to an estimated cost under the April 1, 2021 Schedule. In restating paid amounts that reflected billing for additional time provisions, the WCIRB assumed that one-third of the median time of the current evaluations involve record review and that physicians are reviewing on average 100 pages per hour. Staff shared with the Committee that several members from the Claims Working Group and the Medical Analytics Working Group expressed concern that the per page record review bill component could potentially produce significantly higher costs than what was estimated based on the 100 pages reviewed per hour assumption underlying the cost evaluation. As a result, staff tested the sensitivity of the key assumptions by computing alternative cost estimates for record review assuming 50 page and 150 pages on average are reviewed per hour. The overall cost impact of the April 1, 2021 Schedule was estimated to be 11 percentage points lower based on the 50 page per hour assumption, while assuming a review rate of 150 pages per hour would increase the overall cost estimate by 13 percentage points.

A Committee member asked about the estimated average cost including the record review component for ML104 as ML104 under the pre-April schedule had the highest paid per transaction among all medical-legal evaluations. Staff reviewed the available data following the meeting and estimates that assuming physicians review on average 100 pages per hour, the average payment for ML104 would be about $3,200 inclusive of the record review cost, which is about 16% lower than the average paid per ML104 transaction in 2018 and 2019. However, the estimated average payments including record review costs for ML102 and ML103 are much higher than their historical average payments, mostly due to a much higher flat fee for both procedures under the April 1, 2021 Schedule. Also, under the April 1, 2021 Schedule, ML102 through ML104 are combined into one ML evaluation code (ML201). Given the significant structural changes to the payment system under the April 1, 2021 Schedule and that the changes were apparently intending to help reduce incidences of possible misuse of hourly billing provisions more likely seen in ML104, it is challenging to draw concrete conclusions from the comparison

[1] Title 8, **California Code of Regulations, Sections 9793, 9794 & 9795.** https://www.dir.ca.gov/dwc/DWCPropRegs/2020/Medical-Legal-Fee-Schedule/Med-Legal-Fee-Schedule.htm
[2] DWC Initial Statement of Reasons. Medical Legal Fee Schedule, October 2020.

between the estimated average payments including record review costs for ML104 and the corresponding historical average payments.

Staff noted that the 22% indicated increase in medical-legal costs due to the implementation of the April 1, 2021 Schedule translates to an approximate 1.4% increase in overall medical costs since medical-legal costs comprise approximately 6.5% of overall medical costs.[3] The Committee was advised that the April 1, 2021 Schedule applies to all medical-legal services provided on or after that date including those on claims incurred against in-force or expired policies. Nevertheless, staff noted it was not recommending any adjustments to the advisory pure premium rates applicable to the unexpired terms of in-force policies.

After discussion, a motion was made, seconded and unanimously passed to reflect the cost impact of the April 1, 2021 Schedule based on the methodology and assumptions presented by staff in the September 1, 2021 Pure Premium Rate Filing.

[3] *2019 California Workers' Compensation Losses and Expenses,* WCIRB, June 2020. MCCP costs paid as medical costs in 2019 were excluded.

Item AC21-04-04
Evaluation of Updates to Official Medical Fee Schedule

The Committee was advised that effective March 1, 2021, the Division of Workers' Compensation (DWC) adopted significant changes to the Evaluation and Management (E&M) Section of the Official Medical Fee Schedule (Schedule). The March 1, 2021 Schedule changes include updated relative value units and conversion factors and significant changes to how providers bill for E&M services. Staff presented the WCIRB's prospective cost impact evaluation of the March 1, 2021 Schedule changes at the meeting. The Committee was advised that the cost evaluation reflected the potential impact of the changes to reimbursement rates for E&M services and the impact of the changes to the billing processes would be evaluated later in 2021 and 2022 based on actual billing patterns and payments under the revised schedule. The Committee was also advised that that the key assumptions underlying the cost evaluation were reviewed by the Claims Working Group and Medical Analytics Working Group. Feedback from both working groups was incorporated in the evaluation.

The Committee was advised that, consistent with the WCIRB's standard process in evaluating fee schedule changes, this prospective evaluation assumed the mix of E&M office/outpatient visits under the March 1, 2021 Schedule changes was generally consistent with that in 2019. Staff noted that the average network discount for these E&M office/outpatient visit procedures as reflected in the WCIRB's medical transaction data was approximately 12% and the evaluation assumed the average fee schedule discount would be maintained under the revised Fee Schedule. Staff also noted that the typical annual inflationary adjustment contemplated in the regular Schedule update based on Medicare is 2-3%, which was assumed to be maintained under the March 1, 2021 Schedule changes and the cost impact estimate was net of the standard inflationary impact. The Committee was advised that, based on the underlying assumptions reviewed, the cost impact of the March 1, 2021 Schedule changes to the reimbursement rates for the E&M office/outpatient visits was estimated to be 15%.[1]

The Committee was advised that the 15% indicated increase in E&M office/outpatient visits costs due to the implementation of the March 1, 2021 Schedule changes translates to an approximate 2.4% increase in overall medical costs since costs of E&M office/outpatient visits comprise approximately 15.9% of overall medical costs.[2] The Committee was further advised that the March 1, 2021 Schedule changes apply to all medical services provided on or after that date including those on claims incurred against in-force or expired policies. Nevertheless, staff noted it was not recommending any adjustments to the advisory pure premium rates applicable to the unexpired terms of in-force policies.

After discussion, a motion was made, seconded and unanimously passed to reflect the cost impact of the March 1, 2021 Schedule changes based on the methodology and assumptions presented by staff in the September 1, 2021 Pure Premium Rate Filing.

[1] The WCIRB also compared the cost impact estimate of the March 1, 2021 Schedule changes using E&M services provided in 2020 as the basis for the computation. The estimate cost impact using the 2020 E&M service mix as the computation base was similar with that using 2019 (15.5% compared to 15%).

[2] *2019 California Workers' Compensation Losses and Expenses,* WCIRB, June 2020. The 15.9% represents payments for E&M office/outpatient visits relative to all payments for medical services including copy services and interpreter services. The component of claim settlement payments for future medical services, Medicare set-aside related costs and medical lien payments were assumed to reflect E&M office/outpatient visits services proportionate to total medical services.

The meeting was adjourned at 1:25 PM.

Note to Committee Members: These Minutes, as written, have not been approved. Please refer to the meeting scheduled for June 22, 2021 for approval and/or modification.

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Actuarial Committee

Meeting Minutes

Date	Time	Location	Staff Contact
June 22, 2021	9:00 AM	Webinar Teleconference	David M. Bellusci

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Released: August 3, 2021

Members	Representing
Mauro Garcia	Zurich North America
Ika Irsan	Republic Indemnity Company of America
Miranda Ma	American International Group
Joanne Ottone	Berkshire Hathaway Homestate Companies
Jill Petker	Liberty Mutual Group
Mark Priven	Public Members of Governing Committee
Kate Smith	State Compensation Insurance Fund
Bryan Ware	AmTrust
Chris Westermeyer	Travelers

California Department of Insurance
Mitra Sanandajifar

WCIRB
Bill Mudge
David Bellusci
Laura Carstensen
Tony Milano
Dilan Sahin
Katrina Sonka
Serina Wu
Julia Zhang

The meeting of the Actuarial Committee was called to order at 9:00 AM following a reminder of applicable antitrust restrictions, 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 March 15, 2021 and April 16, 2021, 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 these 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 AC16-06-05
Update on Medical Severity Trends by Component

Staff presented an update to the WCIRB's medical severity trend analysis using medical transaction data through December 31, 2020. The update included a comparison of the severity trends before and after the COVID-19 pandemic started and excluded COVID-19 claims.

The Committee was advised that the total medical paid per claim increased by 4% in the pre-COVID-19 period (before March 15, 2020) and 10% in the pandemic period (March 15, 2020 to December 31, 2020). The increase in medical severity during the pandemic period was driven by increases in both paid per transaction and medical service utilization. Staff suggested that these results were at least in part due to shifts in claim mix in which indemnity claims that tend to be more severe and utilize more medical services declined at a significantly lower rate than did medical-only claims.

The Committee was advised of the following specific severity trends:

- *Physical Therapy*: Increases in the number of physical therapy visits per claim during the pandemic is similar to the increase during the pre-pandemic period in 2020. Together with the continued steady increase in the paid per transaction, physical therapy paid per claim increased by 10% in the pandemic period.

- *Telemedicine*: Use of telemedicine services per claim increased by more than 50-fold during the pandemic period.

- *Pharmaceuticals*: Pharmaceutical costs per claim continued to drop (-14%) in the pre-COVID-19 period, mostly driven by continuously steep declines in opioid costs (-42%). During the pandemic period, however, pharmaceutical costs per claim increased by 14%, mostly due to increased use of non-opioids.

- *Inpatient and Outpatient*: Utilization of inpatient services decreased during the pandemic period partly due to the shelter-in-place orders, while the paid per episode increased at a higher rate than during the pre-pandemic level, suggesting more intensive care needed during hospitalization. Higher paid per episode contributed to an increase in the paid per claim. Increased paid per claim for outpatient care after the pandemic started was mostly driven by higher levels of service utilization per claim.

Item AC17-12-02
Legislative Cost Monitoring Update – SB 1160 UR Provisions

Staff shared the updated cost impact analysis of the provisions of Senate Bill No. 1160 (SB 1160) related to utilization review (UR) that were effective January 1, 2018. The analysis was based on medical transaction information three years post reform through December 31, 2020. The Committee was reminded that the SB 1160 UR provisions exempt certain medical services provided in the first 30 days following the date of injury from prospective UR. Staff noted that accident year 2020 data was shown for informational purposes only as it was heavily affected by the COVID-19 pandemic and the patterns were mostly due to factors not related to the SB 1160 UR provisions.

Staff noted the following based on the two years after the SB 1160 UR provisions became effective:

- The number of physical therapy visits per claim increased in the first 30 days from the date of injury, while utilization of other types of medical services decreased during the same period.

- Physical therapy services were provided earlier. The median time from injury to first physical therapy in the first 30 days decreased by 17%, from 12 days for accident year 2017 claims to 10 days for accident year 2019 claims.

- There was less utilization of physical therapy services in the 5 months following the first 30 days.

Given this information, the Committee was advised that the updated evaluation showed no indication of the SB 1160 UR provisions significantly impacting the cost of medical services through 6 months from the date of injury, and the increased medical severity is driven mostly by regular fee schedule updates. Staff also noted that there is no indication of the UR provisions significantly impacting UR costs within two years of the reform implementation.

Item AC21-06-01
3/31/2021 Experience Review

Staff presented a summary of the analysis of statewide accident year experience evaluated as of March 31, 2021, which was included in the Agenda. It was noted that the projected loss ratio for policies incepting between September 1, 2021 and August 31, 2022 based on March 31, 2021 experience was consistent with the projection included in the September 1, 2021 Pure Premium Rate Filing which reflected December 31, 2020 experience. During the discussion, the Committee noted the following:

- Loss development projections based on March 31, 2021 experience were generally consistent with those based on December 31, 2020 experience, with paid development generally modestly increasing for earlier periods and modestly decreasing for more mature periods.

- Indemnity claim settlement rates continued to decelerate. Claim settlement rates for accident year 2018 at 39 months and accident year 2019 at 27 months are significantly below the comparable settlement rate for the prior year. The claim settlement rate for accident year 2020 (excluding COVID-19 claims) at 15 months is relatively similar to that for accident year 2019.

- The most recent projections of wage level changes based on the UCLA Anderson and California Department of Finance forecasts show a modestly higher average wage change projected for 2021 and a modestly lower change projected for 2022 compared to those based on earlier forecasts reflected in the September 1, 2021 Pure Premium Rate Filing. The Committee was reminded of the adjustments to the average wage change forecasts discussed at prior meetings and reflected in the September 1, 2021 Pure Premium Rate Filing. After reflecting the adjustments in the same manner as in the filing, the updated wage forecasts had an overall modest impact on the loss ratio projection.

- The indemnity claim frequency change for accident year 2020 (excluding COVID-19 claims) based on the preliminary measure of changes in indemnity claim counts at 15 months compared to changes in statewide employment levels showed a decrease generally consistent with that reflected in the September 1, 2021 Pure Premium Rate Filing. The indemnity claim frequency change for the first quarter of accident year 2021 (excluding COVID-19 claims) compared to the first quarter of 2020 shows a significant increase. Staff noted that when including COVID-19 claims, the indemnity claim frequency changes for 2020 and the first quarter of 2021 are significantly above the pre-pandemic level.

- Average on-level indemnity severities continue to show modest increases for accident years 2018 and 2019 and a more significant increase for 2020. The indicated increase for 2020 projected based on 15 months was somewhat lower than the increase projected based on 12 months experience. As discussed at prior meetings, the 2020 average indemnity claim severity is likely impacted by shifts in the wage distribution of injured workers and increases in temporary disability duration during the pandemic period.

- Average on-level medical severities show a moderate increase for accident year 2018 and modest decreases for 2019 and 2020. As discussed at prior meetings, the decrease for 2020 may be impacted by shifts in the distribution of injuries and delays or deferrals of medical treatment during the pandemic. Projected changes in accident year 2018 through 2020 average medical severities based on March 31, 2021 experience increased from those projected based on December 31, 2020 experience.

- After declining consistently for the last several years, paid ALAE development in the first quarter of 2021 increased. This is likely related to the recent decreases in claim settlement rates and claims activity beginning to increase after declining during the pandemic period.

- Paid and incurred development on COVID-19 claims from 12 to 15 months was higher compared to development on non-COVID-19 claims. Some of this difference is likely due to the winter surge in infections resulting in a significant number of accident year 2020 COVID-19 claims being filed in the first quarter of 2021.

Item AC21-06-02
Impact of High Deductible Health Plans

Staff shared the preliminary research findings on the potential impact of high deductible health plans in group health on claim frequency and utilization of medical services in the workers' compensation system. The research study was suggested by the Medical Analytics Working Group and is intended to examine if certain injuries on which there is often a question as to whether the injury was work-related may be treated in the workers' compensation system more often in the earlier part of the year than in the later part as workers with high deductible health plans often have not met their annual deductibles early in the year.

The Committee was advised that there were higher levels of utilization of major surgery and pharmaceuticals, especially brand name drugs, in the workers' compensation system in the first quarter compared to the fourth quarter, when workers have often met their deductibles. Staff found less evidence of this pattern among physical therapy utilization and frequency of soft tissue claims. In addition, the study included two control groups, fracture claims and emergency room visits, that would not typically be affected by the cost-sharing element of group health insurance. The Committee was advised that there was no evidence for any potential increased filing of claims in the workers' compensation system during periods in which group health deductibles are typically not exhausted among claims and services in the control groups.

Several Committee members suggested reviewing classification mix impacts and economic factors that may interact with the impact of high deductible health plans and assess if, in addition to frequency, there is any evidence of similar patterns on claim severity. A Committee member also suggested examining the types of services provided on soft tissue claims. Staff agreed to further explore these areas in future analyses. Lastly, the Committee was advised that the WCIRB has acquired a new group health dataset and plans to conduct more analyses on the impact of changes in group health on workers' compensation claim costs.

Item AC21-06-03
WCIRB Member Analytical Tools

Staff provided demonstrations of several new benchmarking analytical tools that have or will shortly become available to WCIRB Members. These analytical tools shown included several significant enhancements to WCIRB Inquiry, the WCIRB's new indemnity benchmarking reports based on indemnity transaction data and WCIRB ClassIntel[sm].

The meeting was adjourned at 11:30 AM.

Note to Committee Members: These Minutes, as written, have not been approved. Please refer to the meeting scheduled for September 14, 2021 for approval and/or modification.

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Classification and Rating Committee

Meeting Minutes

Date	Time	Location	Staff Contact
May 18, 2021	9:30 AM	Webinar Teleconference	Brenda Keys

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Released: June 2, 2021

Members:	Represented By:
Insurance Company of the West	Stacey McAdam
National Union Fire Insurance Company of Pittsburgh PA	Ellen Sonkin
Preferred Employers Insurance Company	John Bennett
Security National Insurance Company	Matt Zender
State Compensation Insurance Fund	Gregory Hanel
WCF National Insurance	Christine Closser
Zenith Insurance Company	Sarah Elston

California Department of Insurance
Yvonne Hauscarriague
Brentley Yim

WCIRB
Brenda Keys, Chair
Bill Mudge
David Bellusci
Laura Carstensen
Carrie Kosnik
Allison Lightfoot
Eric Riley
Chris M. Wong
Julia Zhang
Anna Zieba

The meeting of the Classification and Rating Committee was called to order at 9:30 AM followed by a reminder of applicable antitrust restrictions, with Ms. Brenda Keys, Senior Vice President and Chief Legal Officer, presiding.

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Approval of Minutes
The Minutes of the meeting held on February 2, 2021 were distributed to the Committee members in advance of the meeting for review. As there were no corrections to the Minutes, a motion was made, seconded and unanimously approved to adopt the Minutes as written.

Notice

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Item III-A
Experience Rating Eligibility Threshold

Staff presented a summary of its analysis of the experience rating eligibility threshold that was previously accepted by the Actuarial Committee at its meeting of December 11, 2020. The Committee was advised that the analysis indicated that past exposure and claim experience is predictive of future claim costs for employers well below the current eligibility threshold. The Committee was further advised that these results suggest that lowering the experience rating eligibility threshold could help both to incentivize safety for smaller employers and to distribute the costs of the workers' compensation system in a fair manner. Staff suggested beginning outreach to develop a proposal to initially lower the eligibility threshold modestly so that approximately 10,000 additional employers would be eligible for experience rating. In addition, staff suggested modifying the Experience Rating Plan to apply limits to modifications for the newly experience rated employers, as well as the smallest currently rated employers, to mitigate potential volatility for these small employers.

Staff responded to questions as to how the outreach would be structured by explaining that it would be targeted broadly to a variety of stakeholders and include group meetings, webinars and updates to the WCIRB website and to the WCIRB x-mod calculator. Staff indicated that the earliest this change to lower the eligibility threshold would potentially be filed would be in early 2022 as part of the September 1, 2022 filing, but with any change proposed to be effective September 1, 2023 to allow time for outreach and education.

A Member asked how the current eligibility in California compares to other states. Staff explained that eligibility thresholds in other states are often set at a level that includes a larger share of employers than in California. Additionally it was noted that while some other states have merit rating plans for even smaller employers, staff recommended expanding the current plan in California rather than adding a merit rating plan because administering a second plan would be more burdensome and result in swings in experience modifications due to employers changing plans rather than based on their claim experience.

A Member raised a question as to the potential administrative burden to the WCIRB, insurers and producers of expanding the pool of experience rated employers. Staff indicated that limiting the initial change in eligibility to only affect an additional 10,000 employers, the vast majority of which would likely be claim-free, should mitigate the administrative burden. Any other potential related rule changes, such as potentially lowering the threshold for physical audits, will be discussed with the Committee at a later time.

Following the discussion, the consensus of the Committee was that staff should begin implementing the comprehensive outreach to obtain stakeholder feedback on the proposal.

Item III-B
WCIRB Policy Data Quality Program and WCIRB Unit Statistical Data Quality Program Revisions

The Committee was advised that staff was proposing revisions to the *WCIRB Policy Data Quality Program* (PDQP) and *WCIRB Unit Statistical Data Quality Program* (USDQP) as part of the WCIRB's ongoing efforts to improve the effectiveness of its data quality programs. A detailed explanation of the proposed changes was included in the Agenda.

In summary, staff recommended the following changes to be effective October 1, 2021.

1. Refine two existing PDQP metrics to align with recent updates to the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* for policy, cancellation and reinstatement transactions[1]:

   - *Submission Timeliness – Policies* (5% tolerance for submissions >30 days)

     Amend the policy reporting timeliness standard from 60 days from policy inception to 30 days from policy inception.

   - *Submission Timeliness – Cancellations/Reinstatement* (5% tolerance for submissions >30 days)

     Amend the cancellation/reinstatement reporting timeliness standard from 60 days from issuance to 30 days from issuance.

2. Refine other existing PDQP and USDQP metrics to improve their effectiveness in detecting potential data quality issues:

   - *Responsiveness to Policy Work Items* (20% tolerance for work items unresolved > 60 days)

     Amend the work item responsiveness metric to incorporate all unresolved policy work items that have passed the 60-day threshold.

   - *Responsiveness to USR Work Items* (20% tolerance for work items unresolved > 60 days)

     Amend the work item responsiveness metric to incorporate all unresolved USR work items that have passed the 60-day threshold.

3. Incorporate editorial changes for clarity and consistency with other WCIRB data quality programs.

Following staff's presentation and a brief discussion, there was a consensus among the Committee members that the proposed changes to the *WCIRB Policy Data Quality Program* and the *WCIRB Unit Statistical Data Quality Program* should be referred to the Governing Committee for approval.

[1] WCIRB staff noted an error in the Agenda materials and clarified that 96% of all current policies, cancellations and reinstatements are submitted within the updated USRP standards.

WCIRB Policy Data Quality Program

Effective ~~January 2020~~October 2021

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I. Background and Purpose

Timely, complete and accurate policy data is critical to the development of correct experience modifications and the provision of accurate policyholder coverage information, as well as to ensure the proper and complete use of approved policy forms. The *WCIRB Policy Data Quality Program* (Program) is intended to assist and encourage insurers in identifying and, as appropriate, modifying their data reporting procedures, thereby enhancing the timeliness, completeness and accuracy of their policy submissions to the WCIRB and minimizing any adverse impact from the inaccurate or untimely submission of data on the overall quality of WCIRB data.

II. General Administration of the Program

A. Eligibility and Participation Requirements

1. This Program is administered on an insurer group basis. For purposes of the Program, an insurer group (hereinafter collectively referred to as "insurer") is based on the ownership groups designated by the National Association of Insurance Commissioners (NAIC).[1]
2. Insurers that wrote at least 100 policies and $35 million[2] in total California workers' compensation written pure premium in the latest available calendar year[3] will be subject to the Program.
3. An insurer that is subject to the Remedial Procedures detailed in Part V, Section B, shall remain subject to the Program even if the insurer's premium volume or policy count falls below the eligibility standards noted above.
4. Notwithstanding the above, the WCIRB reserves the right to include any insurer in the Program.

Insurers must designate a primary authorized individual to act as the Program Coordinator to receive all correspondence related to the Program. An insurer shall immediately notify the WCIRB of any change in the designated Program Coordinator or his/her contact information by emailing pdqp@wcirb.com. Failure to do so prevents an insurer from asserting that it did not receive written notifications related to the Program, including for purposes of waiving fines.

III. Accuracy of Electronic Reporting

A. Selection of Policy Transactions Subject to Part III of the Program

1. Scheduling Insurer Review: The WCIRB will establish a schedule to ensure that each insurer subject to the Program will be issued a Selection List of policy documents to be submitted to the WCIRB for purposes of verifying the accuracy of electronically reported policy data at least once every ~~four~~three years. The WCIRB will notify each insurer of its schedule at least three months in advance of publishing the Selection List. The WCIRB reserves the right to initiate more frequent reviews based on the findings for an individual insurer.
2. Quota: The minimum selection quota for each insurer is twenty policies, twenty endorsements and ten cancellation/reinstatement transactions. Based upon its initial review of the documents, and as necessary to conduct a complete and thorough analysis, the WCIRB may issue the insurer a supplemental Selection List of additional policy documents to be submitted to the WCIRB.

[1] In some instances, to reflect insurers' business operations, insurers within a particular NAIC group may be grouped into separate subgroups for purposes of the Program.

[2] This amount is subject to change by the WCIRB president based on significant changes in the average statewide rate level.

[3] This standard is based on direct written premium at the advisory pure premium rate level as reported on the WCIRB call for quarterly experience. This pure premium is after the application of experience modifications but prior to the application of deductible credits.

3. Selection List(s): The WCIRB will issue each insurer scheduled for review a Selection List comprising a sample of the insurer's recently submitted policy transactions. The Selection List will indicate the ~~WCIRB file number,~~ insurer's ~~name, policyholder name~~California insurer code, policy number, and policy effective date.
4. Providing Requested Materials: Within thirty days following publication of the Selection List, the insurer shall submit electronic copies (print images or PDFs) of the hard copy documents provided to policyholders, representing each of the requested policy transactions ("hard copy" or "hard copies"). Hard copy documents must be submitted electronically and in the manner prescribed by the WCIRB.
5. Fines for Delinquent Material: Submissions will not be considered received until all requested materials are provided to the WCIRB.
    a. If all of the requested materials are not received by the WCIRB within thirty days following publication of the Selection List, the insurer will be charged a $500 fine.
    b. If all of the requested materials are still not received by the WCIRB within sixty days following publication of the Selection List, the insurer will be charged another $500 fine, and the WCIRB will provide the insurer with an updated Selection List that identifies a new sample of policy transactions.
        i. If all of the requested materials from the updated Selection List are not received by the WCIRB within thirty days following publication of the updated Selection List, the insurer will be charged a $1,000 fine.
        ii. If all of the requested materials from the updated Selection List are still not received by the WCIRB within sixty days following publication of the updated Selection List, the insurer will be charged another $1,000 fine, and the insurer's results will be subject to remedial action as described in Part V, Section B.
    c. Waivers of fines for delinquent materials may be granted at the WCIRB's sole discretion upon a demonstration of good cause, provided an application for waiver is received within thirty days following publication of the Selection List or updated Selection List.

B. Comparison of Hard Copy to Electronic Transactions

The WCIRB will compare the following data elements submitted electronically with the corresponding information on the hard copy policy documents:

1. Policyholder Name(s)
2. Address – Mailing
3. Address – Location(s)
4. Classification(s)
5. Coverage Dates
6. Experience Modification(s)
7. Form Number(s)
8. Forms – Variable Text on Limiting and Restricting Endorsements

Based on its initial review, the WCIRB may determine that a complete and thorough analysis requires examination of additional information. If so, the WCIRB will send the insurer a request for additional documents and/or policy transactions. Submission of the requested hard copy documents to the WCIRB is subject to the same timeline(s) and fines as set forth in Part III, Section A, Rules 4 and 5, except that the time period will begin on the date the WCIRB issued its request or updated request for the additional information.

At the close of its review of all submitted documents, the WCIRB will advise the insurer of its findings:

1. Subject to Part III, Section A, Rule 1, if there were no differences between the hard copy and electronic transactions, then no further action is needed until the next scheduled selection.
2. If there were differences between the hard copy and electronic transactions, then the WCIRB will require the insurer to identify the root cause of each difference and submit a proposed time frame for remedying the identified cause(s), which will be subject to WCIRB approval. At the end of the agreed-upon time frame, the WCIRB will provide the insurer with a new Selection List of policy transactions, and submission of the requested hard copy documents to the WCIRB will be subject to the same timeline(s) and fines as set forth in Part III, Section A, Rules 4 and 5.
    a. Subject to Part III, Section A, Rule 1, if the WCIRB's review of these documents shows that the identified issues have been resolved, then no further action is needed until the next scheduled selection.
    b. If the WCIRB determines that the identified issues have not been resolved by the agreed-upon time frame, the insurer's results will be subject to remedial action as described in Part V, Section B.

IV. Data Quality Metrics

All policy transactions will be reviewed using the data quality measurements outlined in this Part. Within thirty days from the end of each quarter, the WCIRB will publish for each participating insurer a report detailing the insurer's results with respect to policy transactions submitted to the WCIRB during the quarter as well as during the latest four-quarter period. Unless otherwise specified, if an insurer's results over a four-quarter period exceed the designated tolerance in the Appendix for one or more of the data quality measurements outlined in this Part, the insurer's results will be subject to remedial action pursuant to the Administrative Procedures described in Part V, provided the established minimum volume during the four-quarter period is met.

Refer to the Appendix for the designated tolerance and minimum volume for each metric.

A. Timeliness

1. *Submission Timeliness – Policies*

The "Submission Timeliness – Policies" data quality metric measures an insurer's success in submitting all policies on a timely basis as specified in the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP).[4] Specifically, for each insurer, the percentage of policies[5] received more than ~~sixty~~thirty days after the policy inception date is determined as follows for the time period under review:

$$\frac{\text{Number of policies received more than ~~sixty~~thirty days after the policy inception date}}{\text{Total number of policies received}}$$

2. *Submission Timeliness – Cancellations/Reinstatements*

The "Submission Timeliness – Cancellations/Reinstatements" data quality metric measures an insurer's success in submitting all cancellations and reinstatements ~~on a timely basis as specified in the USRP~~within thirty days after the issuance date.[6] Specifically, for each insurer, the

[4] Pursuant to Part 2, Section 1, Rule 1a(1), of the USRP, policies are due to the WCIRB no later than ~~sixty~~thirty days after policy inception.

[5] "Policies" includes the following WCPOLS transactions: New Policy, Renewal Policy, Annual Rating Endorsement, and Renewal Certificate/Renewal Agreement.

[6] ~~Pursuant to Part 2, Section 1, Rule 3, of the USRP,~~This requirement will ensure that cancellations~~/~~ and reinstatements are ~~due~~ reported to the WCIRB ~~no later than sixty days~~in a timely manner after issuance ~~date~~of such transactions.

percentage of cancellations and reinstatements received more than ~~sixty~~thirty days after the issuance date is determined as follows for the time period under review:

Number of cancellations and reinstatements received more than ~~sixty~~thirty days after the issuance date
Total number of cancellations and reinstatements received

3. *Responsiveness to Policy Work Items*

The "Responsiveness to Policy Work Items" data quality metric measures an insurer's success in responding on a timely and accurate basis to WCIRB policy work item inquiries related to verifying the accuracy of data reported on policies. This metric looks at the volume of work items that remain unresolved for more than sixty days from issuance of the inquiry.[7] Specifically, for each insurer, the responsiveness to policy work items percentage is determined as follows for the time period under review:

Number of ~~policy~~unresolved work items[8] ~~more than~~that have passed the sixty--day~~s from issuance of the inquiry~~threshold[9]
Total of the number of ~~policy~~resolved work items ~~closed~~within the sixty-day threshold plus the number of unresolved work items that have passed the sixty-day threshold

4. *Unmatched Policy Transactions – Cancellations/Reinstatements*

The "Unmatched Policy Transactions – Cancellations/Reinstatements" data quality metric measures an insurer's success in reporting required policy transactions to the WCIRB. ~~As a measure of this, t~~This metric looks at the volume of cancellations and reinstatements reported to the WCIRB that are not matched within sixty days to its corresponding policy~~ies previously submitted to the WCIRB~~. Specifically, for each insurer, the percentage of unmatched cancellations and reinstatements is determined as follows for the time period under review:

Number of cancellations and reinstatements not matched within sixty days
Total number of cancellations and reinstatements received

5. *Unmatched USRs*

The "Unmatched USRs" data quality metric measures an insurer's success in reporting required policy transactions to the WCIRB. ~~As a measure of this, t~~This metric looks at the volume of original[10] first report level unit statistical reports (USRs) reported to the WCIRB that are not matched within sixty days to its corresponding policy ~~information previously submitted to the WCIRB~~. Specifically, for each insurer, the percentage of unmatched USRs is determined as follows for the time period under review:

Number of original first report level USRs not matched within sixty days
Total number of original first report level USRs received

[7] The date of issuance of the inquiry is the date the work item is generated by the WCIRB and the insurer is notified. This metric only considers the days a work item is assigned to the insurer and does not include the days a work item is pending with the WCIRB.

[8] ~~An inquiry is considered "closed" when WCIRB records reflect the WCIRB Connect work item as "closed" or "approved".~~

[9] ~~The date of issuance of the inquiry is the date the work item is generated by the WCIRB and the insurer is notified. This metric only considers the days a work item is assigned to the insurer and does not include the days a work item is pending with the WCIRB.~~Work items unresolved within the sixty-day period are not counted in the metric because their responsiveness under the metric has not yet been determined. Any work items resolved after the sixty-day threshold would have already been counted in the rolling four-quarter metric results used to evaluate insurers.

[10] An "original" USR refers to the first submission of the USR at a specific report level.

B. Completeness and Accuracy

~~1. *Unmatched Policy Transactions – Cancellations/Reinstatements*~~

~~The "Unmatched Policy Transactions – Cancellations/Reinstatements" data quality metric measures an insurer's success in reporting required policy transactions to the WCIRB. As a measure of this, this metric looks at the volume of cancellations and reinstatements reported to the WCIRB that are not matched within sixty days to policies previously submitted to the WCIRB. Specifically, for each insurer, the percentage of unmatched cancellations and reinstatements is determined as follows for the time period under review:~~

~~Number of cancellations and reinstatements not matched within sixty days~~
~~Total number of cancellations and reinstatements received~~

~~2. Unmatched USRs~~

~~The "Unmatched USRs" data quality metric measures an insurer's success in reporting required policy transactions to the WCIRB. As a measure of this, this metric looks at the volume of original[11] first report level unit statistical reports (USRs) reported to the WCIRB that are not matched within sixty days to corresponding policy information previously submitted to the WCIRB. Specifically, for each insurer, the percentage of unmatched USRs is determined as follows for the time period under review:~~

~~Number of original first report level USRs not matched within sixty days~~
~~Total number of original first report level USRs received~~

~~2.~~1. *Experience Modification Reporting Success – Policy Transactions*

The "Experience Modification Reporting Success – Policy Transactions" data quality metric measures an insurer's success in reporting its initial policies[12] to the WCIRB with WCIRB published experience modification data within sixty days of receipt of the initial policy. Specifically, for each insurer, the percentage of initial policies reported with experience modification audit errors is determined as follows for the time period under review:

$$\frac{\text{Number of initial policies with unresolved experience modification audit errors sixty days after receipt of the initial policy}}{\text{Total number of initial policies with published experience modifications}}$$

~~3.~~2. *Forms Compliance*

The "Forms Compliance" data quality metric measures an insurer's success related to the use of approved policy forms and the endorsement of provisions required by California law using approved forms. Specifically, for each insurer, all instances are identified where an unapproved form is used, along with a count of the number of policies impacted. In addition, all instances are identified where a policy is not endorsed with provisions required by California law using approved forms.

Insurer results for this metric are advisory only. However, an insurer may be subject to remedial action as described in Part V if deficiencies are identified.

~~[11] An "original" USR refers to the first submission of the USR at a specific report level.~~

[12] An "initial policy" is the first of any of the following WCPOLS transactions received by the WCIRB: New Policy, Renewal Policy, Annual Rerate Endorsement and Renewal Certificate/Renewal Agreement.

V. Administrative Procedures

A. Review of Results from Part IV, *Data Quality Metrics*

Unless otherwise specified, if an insurer's results over a four-quarter period exceed the designated tolerance for one or more of the data quality measurements specified in Part IV, the insurer will be notified in writing by WCIRB staff within thirty days following the end of the four-quarter period.

Within thirty days of this notice, the insurer must submit either:

1. A detailed written explanation that includes sufficient documentation confirming that the data exceeding the designated tolerance is correct as reported and does not indicate a data and/or reporting deficiency, or
2. A remediation plan that describes the data and/or reporting deficiencies that caused the designated tolerance(s) to be exceeded, the actions the insurer has taken or will take to remedy the deficiencies, and the time frame by which the insurer expects all the deficiencies will be resolved and its performance will meet Program tolerances.

Insurers shall provide, at the request of the WCIRB, all relevant documents required to validate the accuracy and completeness of reported data.

The WCIRB president or his/her designated representative (hereafter collectively referred to as "the WCIRB") will respond to the insurer within thirty days of receipt of the insurer's written explanation or remediation plan.

The insurer will be subject to the Remedial Procedures described in Section B if any of the following occurs:

1. No detailed written explanation or remediation plan is submitted by the insurer within thirty days of the WCIRB's initial notice;[13]
2. ~~t~~The WCIRB determines the insurer's detailed written explanation does not provide sufficient documentation confirming that the data exceeding the designated tolerance is correct as reported;
3. The WCIRB determines that the insurer's data and/or reporting deficiencies have not been resolved and its results continue to exceed the Program tolerances; or
4. Notwithstanding an insurer's results under Parts III and IV of the Program, the WCIRB determines that an insurer has (1) systemic data and/or reporting deficiencies or (2) egregiously or persistently failed to timely, completely and satisfactorily respond to WCIRB requests for written explanation or documentation to validate the quality of reported data.

B. Remedial Procedures

1. Stage 1: WCIRB Staff. The following actions shall be taken when the WCIRB determines that an insurer must undergo Stage 1 remediation.
    a. The WCIRB will notify the insurer that it is subject to Stage 1 remediation and determine the time frame by which all the deficiencies must be resolved and the Program tolerances must be met (Remediation Evaluation Period) to avoid being cited to the Classification and Rating Committee for further administrative action as described in Stage 2. The Remediation Evaluation Period shall encompass a minimum of two quarters and may be subsequently extended until enough data has been attained to produce a credible determination of whether all the deficiencies have been remediated.

[13] An extension of the deadline may be granted, provided the insurer requests an extension on or before the original deadline. All extensions are subject to written pre-approval by WCIRB staff on a case-by-case basis.

i. If the insurer does not make significant progress in resolving all the deficiencies and meeting the Program tolerances during the Remediation Evaluation Period, the insurer will be cited to the Classification and Rating Committee for further administrative action as described in Stage 2.

ii. If significant progress is made in resolving all the deficiencies and results meet the Program tolerances during the Remediation Evaluation Period, such performance must be sustained over the subsequent four consecutive quarters (Remediation Monitoring Period); otherwise, the insurer will be cited to the Classification and Rating Committee for further administrative action as described in Stage 2.

iii. If significant progress is made in resolving all the deficiencies and results meet the Program tolerances during the Remediation Evaluation Period, and such performance is sustained through the Remediation Monitoring Period, the insurer will not be cited to the Classification and Rating Committee as described in Stage 2. If, following the Remediation Monitoring Period, (a) the insurer's results for one or more of the data quality metrics specified in Part IV exceed one or more of the Program tolerances, (b) data and/or reporting deficiencies are identified, or (c) both types of issues are identified, the insurer's performance will again be subject to remedial action pursuant to Part V.

2. Stage 2: Classification and Rating Committee. If an insurer's results do not meet the Program's tolerances and all deficiencies are not resolved after completion of Stage 1 as described above, the insurer will be subject to the following:

   a. The WCIRB will cite the insurer to the Classification and Rating Committee.

   b. Within thirty days of notification of citation to the Classification and Rating Committee, the insurer shall provide a new remediation plan that describes:

      i. The specific remedial measures to be undertaken by the insurer,

      ii. The time frames during which the remedial measures will be implemented, and

      iii. The date by which the insurer expects all of its data and/or reporting deficiencies will be resolved and its performance will meet Program tolerances.

   c. An officer of the insurer will be required to meet with the Classification and Rating Committee to explain why the insurer's remediation plan submitted in Stage 1 failed to achieve the desired results and to present the new remediation plan.

   d. At the meeting of the Classification and Rating Committee, the following actions shall be taken:

      i. The insurer's performance with respect to Part III, the data quality metrics listed in Part IV, and any other data quality concerns in other WCIRB data quality programs will be reported to the Classification and Rating Committee;

      ii. A fine equal to 1/100 of 1% of the most recent certified calendar year written pure premium[14] at the time the insurer was notified that it had been cited to the Classification and Rating Committee pursuant to subparagraph a. above, subject to a minimum of $5,000 and a maximum of $50,000, will be imposed; and

      iii. A Remediation Evaluation Period will be established.

   e. The Classification and Rating Committee may recommend any additional lawful administrative actions it deems necessary, reasonable or appropriate to facilitate or

[14] Complete calendar year (January 1 to December 31) direct written premium at the pure premium rate level (prior to application of deductible credits), as reported on the WCIRB *Data Call for Direct California Workers' Compensation Experience* (due by February of the following year), that has been certified as to its accuracy on the *WCIRB Financial Call Data Certification* (due by June of the following year) submitted by that insurer.

encourage the insurer's implementation of adequate remedial measures, including citation to the Governing Committee.

f. The WCIRB will report the Classification and Rating Committee's findings and actions to the appropriate insurance company officer and advise of the following:

i. If the insurer does not make significant progress in resolving all the deficiencies and meeting the Program tolerances during the Remediation Evaluation Period, the insurer will be cited to the Governing Committee for further administration action as described in Stage 3.

ii. If significant progress is made in resolving all the deficiencies and results meet the Program tolerances during the Remediation Evaluation Period, such performance must be sustained through the Remediation Monitoring Period; otherwise, the insurer will be cited to the Governing Committee for further administrative action as described in Stage 3.

iii. If significant progress is made in resolving all the deficiencies and results meet the Program tolerances during the Remediation Evaluation Period, and such performance is sustained through the Remediation Monitoring Period, the insurer will not be cited to the Governing Committee. If, following the Remediation Monitoring Period, (a) results for one or more of the data quality metrics specified in Part IV exceed the Program's designated tolerances, (b) data and/or reporting deficiencies are identified, or (c) both types of issues are identified, the insurer's performance will again be subject to remedial action pursuant to Part V.

3. Stage 3: Governing Committee. If an insurer's results do not meet the Program's tolerances and all deficiencies are not resolved after completion of Stage 2 as described above, the insurer will be subject to the following:

a. The WCIRB will cite the insurer to the Governing Committee.

b. Within thirty days of notification of citation to the Governing Committee, the insurer shall provide a new remediation plan that describes:

i. The specific remedial measures to be undertaken by the insurer,

ii. The time frames during which the remedial measures will be implemented, and

iii. The date by which the insurer expects all of its deficiencies will be resolved and its performance will meet Program tolerances.

c. A senior officer of the insurer will be required to meet with the Governing Committee to explain why the insurer's remediation plan submitted in Stage 2 failed to achieve the desired results and to present the new remediation plan.

d. The insurer's performance with respect to Part III, the data quality metrics listed in Part IV, and any other data quality concerns in other WCIRB data quality programs will be reported to the Governing Committee.

e. Within sixty days of notification to the insurer that it has been cited to the Governing Committee:

i. A Remediation Evaluation Period will be established; and

ii. A monthly fine equal to 1/100 of 1% of the most recent certified calendar year written pure premium[15] at the time the insurer was notified that it had been cited to the

[15] Complete calendar year (January 1 to December 31) direct written premium at pure premium rate level (prior to application of deductible credits), as reported on the WCIRB *Data Call for Direct California Workers' Compensation Experience* (due by February of the following year), that has been certified as to its accuracy on the *WCIRB Financial Call Data Certification* (due by June of the following year) submitted by that insurer.

Classification and Rating Committee pursuant to Paragraph 2, Stage 2: Classification and Rating Committee, subparagraph a, subject to a minimum of $5,000 and a maximum of $50,000, will be imposed. The monthly fine will continue until such time as:

- Enough data has been reported and evaluated subsequent to the meeting with the Governing Committee to produce a credible evaluation of the insurer's performance, and
- The insurer's performance meets Program tolerances and resolves all of the deficiencies.

f. The Governing Committee may recommend any additional lawful administrative actions it deems necessary, reasonable or appropriate to facilitate or encourage the insurer's implementation of adequate remedial measures, including citation to the California Insurance Commissioner.

g. The WCIRB will report the Governing Committee's findings and actions to the appropriate insurance company senior officer and advise of the following:

i. If the insurer does not make significant progress in resolving all the deficiencies and meeting Program tolerances during Remediation Evaluation Period, the WCIRB president will, unless instructed otherwise by the Governing Committee, cite the insurer to the California Insurance Commissioner for consideration of further remedial action, including but not limited to additional fines, penalties, and/or suspension of authority to transact workers' compensation insurance. The citation to the California Insurance Commissioner will include a report on the insurer's performance with respect to this Program and any other data quality concerns in other WCIRB data quality programs.

ii. If significant progress is made in resolving all the deficiencies, and results meet the Program tolerances during the Remediation Evaluation Period, such performance must be sustained through the Remediation Monitoring Period; otherwise, the insurer will be cited to the California Insurance Commissioner unless the Governing Committee instructs the WCIRB president otherwise.

iii. If significant progress is made in resolving all the deficiencies, results meet the Program tolerances during the Remediation Evaluation Period, and such performance is sustained through the Remediation Monitoring Period, the insurer will not be cited to the California Insurance Commissioner. If, following the Remediation Monitoring Period, (a) the insurer's results exceed the Program's designated tolerances for one or more of the data quality metrics specified in Part IV, (b) data and/or reporting deficiencies are identified, or (c) both types of issues are identified, the insurer's performance will again be subject to remedial action pursuant to Part V.

4. An insurer whose results are approaching Program tolerances or that has data and/or reporting deficiencies may be requested to meet periodically or correspond with the WCIRB for the purpose of outlining the remedial measures the insurer proposes to implement to improve performance.

Appendix

Metric Tolerances

Unless otherwise specified:

- The data quality metrics in this Program are measured against specified tolerances defined below. The WCIRB evaluates each metric's tolerance from time to time, taking into consideration the distribution of statewide data.
- If an insurer exceeds a designated metric tolerance over a four-quarter period, the insurer's results will be subject to remedial action as described in Part V, provided the minimum volume for the metric is met during the four-quarter period.

	Metric	Tolerance	Minimum Volume for Remediation	Other Criteria
Timeliness				
1	Submission Timeliness – Policies	5%	25 policies received more than ~~sixty~~thirty days after the policy inception date	
2	Submission Timeliness – Cancellations/Reinstatements	5%	25 cancellations and/or reinstatements received more than ~~sixty~~thirty days after the issuance date	
3	Responsiveness to Policy Work Items	20%	25 unresolved policy work items ~~closed more than~~that passed the sixty ~~-~~days ~~from issuance of the inquiry~~threshold	
4	Unmatched Policy Transactions – Cancellations/Reinstatements	2%	25 cancellations and/or reinstatements not matched within sixty days	
5	Unmatched USRs	2%	25 original first report level USRs not matched within sixty days	
Completeness and Accuracy				
~~1~~	~~Unmatched Policy Transactions – Cancellations/Reinstatements~~	~~2%~~	~~25 cancellations and/or reinstatements not matched within sixty days~~	
~~2~~	~~Unmatched USRs~~	~~2%~~	~~25 original first report level USRs not matched within sixty days~~	

Appendix

	Metric	Tolerance	Minimum Volume for Remediation	Other Criteria
3	Experience Modification Reporting Success – Policy Transactions	10%	25 initial policies reported with experience modification audit errors within sixty days of receipt of the initial policy	
4	Forms Compliance	N/A	N/A	Insurer results for this metric are advisory only. However, an insurer may be subject to remedial action as described in Part V if deficiencies are identified

WCIRB Unit Statistical Data Quality Program

Effective ~~January 2020~~October 2021

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I. Background and Purpose

Reliable statistical data is critical to the development of accurate classification pure premium rates and experience modifications. The *WCIRB Unit Statistical Data Quality Program* (Program) is intended to assist and encourage insurers in identifying and, as appropriate, modifying their data reporting procedures, thereby enhancing the timeliness, completeness and accuracy of their unit statistical report (USR) submissions to the WCIRB and minimizing any adverse impact from the inaccurate or untimely submission of data on the overall quality of WCIRB data used for experience rating and ratemaking.

II. General Administration of the Program

A. Eligibility and Participation Requirements

1. This Program is administered on an insurer group basis. For purposes of the Program, an insurer group (hereinafter collectively referred to as "insurer") is based on the ownership groups designated by the National Association of Insurance Commissioners (NAIC).[1]
2. Insurers that wrote at least 100 policies and $35 million[2] in total California workers' compensation written pure premium in the latest available calendar year[3] will be subject to the Program.
3. An insurer that is subject to the Remedial Procedures detailed in Part IV, Section B, shall remain subject to the Program even if the insurer's premium volume or policy count falls below the eligibility standards noted above.
4. Notwithstanding the above, the WCIRB reserves the right to include any insurer in the Program.

Insurers must designate a primary authorized individual to act as the Program Coordinator to receive all correspondence related to the Program. An insurer shall immediately notify the WCIRB of any change in the designated Program Coordinator or his/her contact information by emailing dataqualityprogram@wcirb.com. Failure to do so prevents an insurer from asserting that it did not receive written notifications related to the Program, including for purposes of waiving fines.

B. Insurer Results

Within thirty days from the end of each quarter, the WCIRB will publish for each participating insurer a report detailing the insurer's results with respect to USRs submitted to the WCIRB during the quarter as well as during the latest four-quarter period. Unless otherwise specified, if an insurer's results over a four-quarter period exceed the designated tolerance in the Appendix for one or more of the data quality measurements specified in Part III, the insurer's results will be subject to remedial action pursuant to the Administrative Procedures described in Part IV, provided the established minimum volume during the four-quarter period is met.

III. Data Quality Metrics

Refer to the Appendix for the designated tolerance(s) and minimum volume(s) for each metric.

A. Timeliness

1. *Submission Timeliness – USRs*

The "Submission Timeliness – USRs" data quality metric measures an insurer's success in submitting all original[4] USRs on a timely basis as specified in the *California Workers'*

[1] In some instances, to reflect insurers' business operations, insurers within a particular NAIC group may be grouped into separate subgroups for purposes of the Program.

[2] This amount is subject to change by the WCIRB president based on significant changes in the average statewide rate level.

[3] This standard is based on direct written premium at the advisory pure premium rate level as reported on the WCIRB call for quarterly experience. This pure premium is after the application of experience modifications but prior to the application of deductible credits.

[4] An "original" USR refers to the first submission of the USR at a specific report level.

Compensation Uniform Statistical Reporting Plan—1995 (USRP).[5] Specifically, for each insurer, the percentage of original USRs received after the month of the USR's due date is determined as follows for the time period under review:

$$\frac{\text{Number of original USRs received after the month of the USR's due date as specified by the USRP}}{\text{Total number of original USRs received}}$$

2. *Responsiveness to USR Work Items*

The "Responsiveness to USR Work Items" data quality metric measures an insurer's success in responding on a timely and accurate basis to WCIRB USR work item~~s~~ inquiries related to verifying the accuracy of data reported on USRs. This metric looks at the volume of work items that remain unresolved for more than sixty days from issuance of the inquiry.[6] Specifically, for each insurer, the responsiveness to USR work items percentage is determined as follows for the time period under review:

$$\frac{\text{Number of ~~USR~~unresolved work items ~~closed~~[7] ~~more than~~that have passed the sixty-~~days from issuance of the inquiry~~threshold[8]}}{\text{Total of the number of ~~USR~~resolved work items ~~closed~~within the sixty-day threshold plus the number of unresolved work items that have passed the sixty-day threshold}}$$

B. Completeness and Accuracy

1. *Large Policies with No Claims*

The "Large Policies with No Claims" data quality metric measures an insurer's success in reporting claims by identifying "large policies"[9] for which one or more claims are expected, but no claims are reported. This metric includes two parts:

a. *Policies with at least $250,000 in modified pure premium and no reported claims on the original first report level USR:*

For each insurer, the percentage of large policies with no claims reported is determined as follows for the time period under review:

$$\frac{\text{Number of original first report level USRs for large policies that are reported with no claims}}{\text{Total number of original first report level USRs for large policies}}$$

b. *Policies with at least $1,000,000 in modified pure premium and no reported claims on the original first report level USR:*

[5] Pursuant to Part 4, Section I, Rule 3, of the USRP, first report level USRs are due to the WCIRB no later than 20 months after the inception date of the policy. Subsequent report level USRs are due every 12 months thereafter.

[6] The date of issuance of the inquiry is the date the work item is generated by the WCIRB and the insurer is notified. This metric only considers the days a work item is assigned to the insurer and does not include the days a work item is pending with the WCIRB.

[7] ~~An inquiry is considered "closed" when WCIRB records reflect the WCIRB Connect work item as "closed" or "approved".~~

[8] ~~The date of issuance of the inquiry is the date the work item is generated by the WCIRB and the insurer is notified. This metric only considers the days a work item is assigned to the insurer and does not include the days a work item is pending with the WCIRB.~~Work items unresolved within the sixty day period are not counted in the metric because their responsiveness under the metric has not yet been determined. Any work items resolved after the sixty-day threshold would have already been counted in the rolling four-quarter metric results used to evaluate insurers.

[9] "Large Policies" are defined using modified pure premium (gross of deductible credits). Modified pure premium for a policy is determined based on applying the policy's experience modification(s) to the sum generated by applying the California advisory pure premium rates for each classification to the payroll reported in that classification.

For each large policy with at least $1,000,000 in modified pure premium reported with no claims on the original first report level USR, acceptable documentation[10] is required[11] to verify that no claims exist for the policy term at the original first report level USR. An insurer will be subject to further evaluation as described in Part IV if either of the following occur:

i. Acceptable documentation is not provided within thirty days from issuance of the work item;[12] or

ii. The documentation indicates that claims occurred within the term of the policy, denoting a claim reporting deficiency.

2. *~~Late Reported~~ Specific Injury Claims Initially Reported After First Report Level*

The "~~Late Reported~~ Specific Injury Claims Initially Reported After First Report Level" data quality metric measures an insurer's success in reporting claims on a timely basis. This metric evaluates the volume of specific injury[13] claims that are first reported to the WCIRB after the first report level USR.[14] Specifically, for each insurer, the percentage of late reported specific injury claims is determined based on two components, with separate tolerances, as defined below for the time period under review:

$$\frac{\text{Number of specific injury claims reported for the first time on second level USRs}}{\text{Total number of specific injury claims reported on first level USRs}}$$

$$\frac{\text{Number of specific injury claims reported for the first time on third or subsequent level USRs}}{\text{Total number of specific injury claims reported on first level USRs}}$$

3. *USRs with Edit Failures That Impact Experience Rating*

The "USRs with Edit Failures That Impact Experience Rating" data quality metric measures an insurer's success in submitting USR data that is ready to be used in the promulgation of experience modifications. The metric measures the volume of USRs that contain one or more edit failures that must be resolved before the experience modifications using the data in those USRs can be published. Specifically, for each insurer, the percentage of USRs that contain one or more edit failures that impact experience rating is determined as follows for the time period under review:

$$\frac{\text{Number of USRs processed with one or more edit failures that impact experience rating}}{\text{Total number of USRs processed}}$$

This metric has two possible tolerances—depending on whether the insurer's average policyholder payroll size is "large" or "small". Refer to the Appendix for the designated tolerances.

[10] Documentation acceptable to the WCIRB may include:
(a) Loss runs, corresponding with the policy term, from the system(s) of the source(s) administering the claims, indicating that no claims exist within the term of the policy; if claims were administered by one or more third party administrators (TPAs), the loss runs must originate from the system(s) of the TPA(s); or
(b) Written confirmation from a certified actuary or company officer from the source(s) administering the claims, certifying that no claims exist at first unit statistical report level for the policy; if claims were administered by one or more TPAs, the written confirmation must be from a certified actuary or company officer of the TPA. The written confirmation(s) must be provided on the company letterhead of the source(s) administering the claims.

[11] A WCIRB Connect USR work item will be created to request the documentation.

[12] An extension of the deadline may be granted, provided the insurer requests an extension via the USR work item on or before the original deadline. All extensions are subject to written pre-approval by WCIRB staff on a case-by-case basis. If an approved extended deadline is not adhered to, the insurer will be subject to further evaluation as described in Part IV.

[13] "Specific injury" claims are claims reported on USRs as trauma claims (not cumulative injury or occupational disease claims).

[14] The USRP provides that the first USR is due 20 months from policy inception; each of the second through tenth level reports is due at subsequent 12-month intervals on claims reported as open at the immediately prior report level. (See footnote 5.)

4. *USRs with Inaccurate Experience Modifications or Experience Modification Effective Dates Reported*

   The "USRs with Inaccurate Experience Modifications or Experience Modification Effective Dates Reported" data quality metric measures an insurer's success in ensuring that USR data reflects the correct experience modification information. The metric measures the volume of USRs that contain reported experience modification information that differs from the WCIRB published experience modification information. Specifically, for each insurer, the percentage of USRs containing reported experience modification information that differs from the WCIRB published experience modification information is determined as follows for the time period under review:

$$\frac{\text{Number of USRs}[15] \text{ processed with reported experience modifications or experience modification effective dates differing from the published experience modification information}}{\text{Total number of USRs}[16] \text{ processed for policies with published experience modifications}}$$

5. *USRs with Critical Preprocessing Edit Failures*

   The "USRs with Critical Preprocessing Edit Failures" data quality metric measures an insurer's success in submitting USR data that passes initial validations and is available for further processing and use by the WCIRB. Specifically, for each insurer, the percentage of USRs that are rejected as a result of one or more critical preprocessing edit failures[17] is determined as follows for the time period under review:

$$\frac{\text{Number of USRs received with critical preprocessing edit failures}}{\text{Number of USRs received with critical, non-critical or no preprocessing edit failures}}$$

6. *USRs with Data Quality Edit Failures*

   The "USRs with Data Quality Edit Failures" data quality metric measures an insurer's success in submitting USR data without inaccuracies that may impact ratemaking. The metric measures the volume of USRs that contain one or more data quality edit failures. Specifically, for each insurer, the percentage of USRs that contain one of more data quality edit failures is determined as follows for the time period under review:

$$\frac{\text{Number of USRs processed with one or more data quality edit failures}}{\text{Total number of USRs processed}}$$

   This metric has two categories—depending on whether the insurer's average policyholder payroll size is "large" or "small". (See Appendix.) Insurer results for both categories within this metric are advisory only. However, an insurer may be subject to remedial action as described in Part IV if deficiencies are identified.

IV. Administrative Procedures

A. Review of Results

Unless otherwise specified, if an insurer's results over a four-quarter period exceed the designated tolerance for one or more of the data quality measurements specified in Part III, the insurer will be notified in writing by WCIRB staff within thirty days following the end of the four-quarter period.

Within thirty days of this notice, the insurer must submit either:

[15] For policies with published experience modifications.

[16] Original first report level USRs for policies with published experience modifications, and any corrections to first report level USRs (for policies with published experience modifications) where exposure is being updated.

[17] https://www.wcirb.com/data-reporting/unit-statistical-data/preprocessing-and-audit-validations

1. A detailed written explanation that includes sufficient documentation confirming that the data exceeding the designated tolerance is correct as reported and does not indicate a data and/or reporting deficiency, or
2. A remediation plan that describes the data and/or reporting deficiencies that caused the designated tolerance(s) to be exceeded, the actions the insurer has taken or will take to remedy the deficiencies, and the time frame by which the insurer expects all the deficiencies will be resolved and its performance will meet Program tolerances.

Insurers shall provide, at the request of the WCIRB, all relevant documents required to validate the accuracy and completeness of reported data. This includes, but is not limited to, loss runs, premium audit documentation and certifications attesting that no claims exist on a policy or policies.

The WCIRB president or his/her designated representative (hereafter collectively referred to as "the WCIRB") will respond to the insurer within thirty days of receipt of the insurer's written explanation or remediation plan.

The insurer will be subject to the Remedial Procedures described in Section B if any of the following occurs:

1. No detailed written explanation or remediation plan is submitted by the insurer within thirty days of the WCIRB's initial notice.[18]
2. The WCIRB determines the insurer's detailed written explanation does not provide sufficient documentation confirming that the data exceeding the designated tolerance is correct as reported.
3. The WCIRB determines that the insurer's data and/or reporting deficiencies have not been resolved and its results continue to exceed the Program tolerances; or
4. Notwithstanding an insurer's results under Part III of the Program, the WCIRB determines that an insurer has (1) systemic data and/or reporting deficiencies or (2) egregiously or persistently failed to timely, completely and satisfactorily respond to WCIRB requests for written explanation or documentation to validate the quality of reported data.

B. Remedial Procedures

1. Stage 1: WCIRB Staff. The following actions shall be taken when the WCIRB determines that the insurer must undergo Stage 1 remediation.
    a. The WCIRB will notify the insurer that it is subject to Stage 1 remediation and determine the time frame by which all the deficiencies must be resolved and the Program tolerances must be met (Remediation Evaluation Period) to avoid being cited to the Classification and Rating Committee for further administrative action as described in Stage 2. The Remediation Evaluation Period shall encompass a minimum of two quarters and may be subsequently extended until enough data has been attained to produce a credible determination of whether all the deficiencies have been remediated.
        i. If the insurer does not make significant progress in resolving all the deficiencies and meeting the Program tolerances during the Remediation Evaluation Period, the insurer will be cited to the Classification and Rating Committee for further administrative action as described in Stage 2.
        ii. If significant progress is made in resolving all the deficiencies and results meet the Program tolerances during the Remediation Evaluation Period, such performance must be sustained over the subsequent four consecutive quarters (Remediation Monitoring Period); otherwise, the insurer will be cited to the Classification and Rating Committee for further administrative action as described in Stage 2.

[18] An extension of the deadline may be granted, provided the insurer requests an extension on or before the original deadline. All extensions are subject to written pre-approval by WCIRB staff on a case-by-case basis.

iii. If significant progress is made in resolving all the deficiencies, results meet the Program tolerances during the Remediation Evaluation Period, and such performance is sustained through the Remediation Monitoring Period, the insurer will not be cited to the Classification and Rating Committee as described in Stage 2. If, following the Remediation Monitoring Period, (a) the insurer's results for one or more of the data quality metrics specified in Part III exceed one or more of the Program tolerances, data and/or reporting deficiencies are identified, or (c) both types of issues are identified, the insurer's performance will again be subject to remedial action pursuant to Part IV.

2. Stage 2: Classification and Rating Committee. If an insurer's results do not meet the Program's tolerances and all deficiencies are not resolved after completion of Stage 1 as described above, the insurer will be subject to the following:

   a. The WCIRB will cite the insurer to the Classification and Rating Committee.

   b. Within thirty days of notification of citation to the Classification and Rating Committee, the insurer shall provide a new remediation plan that describes:

      i. The specific remedial measures to be undertaken by the insurer,

      ii. The time frames in which the remedial measures will be implemented, and

      iii. The date by which the insurer expects all of its data and/or reporting deficiencies will be resolved and its performance will meet Program tolerances.

   c. An officer of the insurer will be required to meet with the Classification and Rating Committee to explain why the insurer's remediation plan submitted in Stage 1 failed to achieve the desired results and to present the new remediation plan.

   d. At the meeting of Classification and Rating Committee, the following actions shall be taken:

      i. The insurer's performance with respect to the data quality metrics listed in Part III and any other data quality concerns in other WCIRB data quality programs will be reported to the Classification and Rating Committee;

      ii. A fine equal to 1/100 of 1% of the most recent certified calendar year written pure premium[19] at the time the insurer was notified that it had been cited to the Classification and Rating Committee pursuant to subparagraph a. above, subject to a minimum of $5,000 and a maximum of $50,000, will be imposed; and

      iii. A Remediation Evaluation Period will be established.

   e. The Classification and Rating Committee may recommend any additional lawful administrative actions it deems necessary, reasonable or appropriate to facilitate or encourage the insurer's implementation of adequate remedial measures, including citation to the Governing Committee.

   f. The WCIRB will report the Classification and Rating Committee's findings and actions to the appropriate insurance company officer and advise of the following:

      i. If the insurer does not make significant progress in resolving all the deficiencies and meeting the Program tolerances during the Remediation Evaluation Period, the insurer will be cited to the Governing Committee for further administration action as described in Stage 3.

[19] Complete calendar year (January 1 to December 31) direct written premium at the pure premium rate level (prior to application of deductible credits), as reported on the WCIRB *Data Call for Direct California Workers' Compensation Experience* (due by February of the following year), that has been certified as to its accuracy on the *WCIRB Financial Call Data Certification* (due by June of the following year) submitted by that insurer.

ii. If significant progress is made in resolving all the deficiencies and results meet the Program tolerances during the Remediation Evaluation Period, such performance must be sustained through the Remediation Monitoring Period; otherwise, the insurer will be cited to the Governing Committee for further administrative action as described in Stage 3.

iii. If significant progress is made in resolving all the deficiencies, results meet the Program tolerances during the Remediation Evaluation Period, and such performance is sustained through the Remediation Monitoring Period, the insurer will not be cited to the Governing Committee. If, following the Remediation Monitoring Period, (a) results for one or more of the data quality metrics specified in Part III exceed the Program's designated tolerances, (b) data and/or reporting deficiencies are identified, or (c) both types of issues are identified, the insurer's performance will again be subject to remedial action pursuant to Part IV.

3. Stage 3: Governing Committee. If an insurer's results do not meet the Program's tolerances and all deficiencies are not resolved after completion of Stage 2 as described above, the insurer will be subject to the following:

   a. The WCIRB will cite the insurer to the Governing Committee.

   b. Within thirty days of notification of citation to the Governing Committee, the insurer shall provide a new remediation plan that describes:

      i. The specific remedial measures to be undertaken by the insurer,

      ii. The time frames in which the remedial measures will be implemented, and

      iii. The date by which the insurer expects all of its deficiencies will be resolved and its performance will meet Program tolerances.

   c. A senior officer of the insurer will be required to meet with the Governing Committee to explain why the insurer's remediation plan submitted in Stage 2 failed to achieve the desired results and to present the new remediation plan.

   d. The insurer's performance with respect to the data quality measurements listed in Part III and any other data quality concerns in other WCIRB data quality programs will be reported to the Governing Committee.

   e. Within sixty days of notification to the insurer that it has been cited to the Governing Committee:

      i. A Remediation Evaluation Period will be established; and

      ~~i.~~ii. A monthly fine equal to 1/100 of 1% of the most recent certified calendar year written pure premium[20] at the time the insurer was notified that it had been cited to the Classification and Rating Committee pursuant to paragraph 2, Stage 2: Classification and Rating Committee, subparagraph a., subject to a minimum of $5,000 and a maximum of $50,000, will be imposed. The monthly fine will continue until such time as:

         - Enough data has been reported and evaluated subsequent to the meeting with the Governing Committee to produce a credible evaluation of the insurer's performance, and

         - The insurer's performance meets Program tolerances and resolves all the deficiencies.

[20] Complete calendar year (January 1 to December 31) direct written premium at pure premium rate level (prior to application of deductible credits), as reported on the WCIRB *Data Call for Direct California Workers' Compensation Experience* (due by February of the following year), that has been certified as to its accuracy on the *WCIRB Financial Call Data Certification* (due by June of the following year) submitted by that insurer.

f. The Governing Committee may recommend any additional lawful administrative action it deems necessary, reasonable or appropriate to facilitate or encourage the insurer's implementation of adequate remedial measures, including citation to the California Insurance Commissioner.

g. The WCIRB will report the Governing Committee's findings and actions to the appropriate insurance company senior officer and advise of the following:

i. If the insurer does not make significant progress in resolving all the deficiencies and meeting Program tolerances during the Remediation Evaluation Period, the WCIRB president will, unless instructed otherwise by the Governing Committee, cite the insurer to the California Insurance Commissioner for consideration of further remedial action, including but not limited to additional fines, penalties, and/or suspension of authority to transact workers' compensation insurance. The citation to the California Insurance Commissioner will include a report on the insurer's performance with respect to this Program and any other data quality concerns in other WCIRB data quality programs.

ii. If significant progress is made in resolving all the deficiencies, and results meet the Program tolerances during the Remediation Evaluation Period, such performance must be sustained through the Remediation Monitoring Period; otherwise, the insurer will be cited to the California Insurance Commissioner unless the Governing Committee instructs the WCIRB president otherwise.

iii. If significant progress is made in resolving all the deficiencies, results meet the Program tolerances during the Remediation Evaluation Period, and such performance is sustained through the Remediation Monitoring Period, the insurer will not be cited to the California Insurance Commissioner. If, following the Remediation Monitoring Period, (a) the insurer's results exceed the Program's designated tolerances for one or more of the data quality metrics specified in Part III, (b) data and/or reporting deficiencies are identified, or (c) both types of issues are identified, the insurer's performance will again be subject to review and evaluation pursuant to Part IV.

4. An insurer whose results are approaching Program tolerances or that has data and/or reporting deficiencies may be requested to meet periodically or correspond with the WCIRB for the purpose of outlining the remedial measures the insurer proposes to implement to improve performance.

Appendix

Metric Tolerances

Unless otherwise specified:

- The data quality metrics in this Program are measured against specified tolerances defined below. The WCIRB evaluates each metric's tolerance(s) from time to time, taking into consideration the distribution of statewide data.
- If an insurer exceeds a designated metric tolerance over a four-quarter period, the insurer's results will be subject to further evaluation as described in Part IV, provided the minimum volume for the metric is met during the four-quarter period.

	Metric	Tolerance	Minimum Volume for Remediation
Timeliness			
1	Submission Timeliness – USRs	7%	20 delinquent original USRs
2	Responsiveness to USR Work Items	20%	25 unresolved USR work items ~~closed more than~~that passed the sixty-day~~s from issuance of the inquiry~~threshold
Completeness and Accuracy			
1	Large Policies with No Claims: Policies with at least $250,000 in modified pure premium and no reported claims on original first report level USR *Note: All policies with at least $1,000,000 in modified pure premium and no reported claims on original first report level USRs are subject to review as described in Part III.*	6%	5 original first report level USRs for large policies that are reported with no claims
2	~~Late Reported~~ Specific Injury Claims: Initially Reported on Report Level 2	4%	15 specific injury claims reported for the first time on Report Level 2
	~~Late Reported~~ Specific Injury Claims: Initially Reported on Report Levels 3-10	1%	5 specific injury claims reported for the first time on Report Levels 3-10
3	USRs with Edit Failures That Impact Experience Rating	5% for insurers with large average policyholder payroll size of at least $1,250,000	20 USRs processed with one or more edit failures that impact experience rating

Appendix

	Metric	Tolerance	Minimum Volume for Remediation
		2% for insurers with small average policyholder payroll size of less than $1,250,000	10 USRs processed with one or more edit failures that impact experience rating
4	USRs with Inaccurate Experience Modifications or Experience Modification Effective Dates Reported	5%	10 USRs processed with reported experience modifications or experience modification effective dates differing from the published experience modification information
5	USRs with Critical Preprocessing Edit Failures	1%	5 USRs received with critical preprocessing edit failures
6	USRs with Data Quality Edit Failures	N/A (advisory) For insurers with large average policyholder payroll size of at least $1,250,000	N/A Insurer results for this metric are advisory only. However, an insurer may be subject to remedial action as described in Part IV if deficiencies are identified
		N/A (advisory) For insurers with small average policyholder payroll size of less than $1,250,000	N/A Insurer results for this metric are advisory only. However, an insurer may be subject to remedial action as described in Part IV if deficiencies are identified

Item III-C
Carnivals and Circuses Study

9185, *Carnivals or Circuses – all employees – including Clerical Office Employees, Clerical Telecommuter Employees and Outside Salespersons*

The Committee was advised that WCIRB staff conducted a study of Classification 9185, *Carnivals or Circuses – all employees – including Clerical Office Employees, Clerical Telecommuter Employees and Outside Salespersons* to determine if it should continue to be a stand-alone classification or if some or all of its operations should be combined with other classifications. A copy of the draft report was provided to the Committee in the Agenda.

During the presentation, WCIRB staff noted that employers assigned to Classification 9185 do not develop sufficient data to produce a statistically credible advisory pure premium rate. Staff also advised the Committee that employers operating circuses and traveling carnivals have significantly different business operations, underlying hazards and claim experience. Therefore, the WCIRB evaluated the scope of several classifications with relatively similar operations to circuses and carnivals, respectively. Based on this review, WCIRB staff determined that:

1. Within Classification 9185, there is a clear line of demarcation between the operations of traveling carnivals and those of circuses. In addition, traveling carnival operations appear significantly more hazardous than those of circuses and have significantly higher loss to payroll ratios.

2. Circus employers have similar operations, loss to payroll ratios, and typical causes of injury as employers assigned to Classifications 9154, *Theaters – not motion picture – all employees other than performers and directors of performers – including managers, stage hands, box office employees or ushers*, and 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C.*.

3. Employers operating traveling carnivals share some operational similarities with employers assigned to Classifications 9016(1), *Amusement or Recreational Facilities – N.O.C. – all employees other than those engaged in the operation or maintenance of amusement devices, restaurants or retail stores,* and 9180(1), *Amusement or Recreational Facilities – N.O.C. – operation or maintenance of amusement devices – including ticket collectors connected therewith*; however, the loss to payroll ratios for the traveling carnival subgroup have been significantly higher for more than a decade, and this subgroup has dissimilar typical causes of injury.

4. Removing the circus employer subgroup from Classification 9185 and amending theater Classifications 9154 and 9156 to include circus operations would have minimal impact (less than 1%) on the employers currently assigned to Classifications 9154 and 9156. Similarly, no longer including circus employers within the scope of Classification 9185 would have only a modest impact on the carnival subgroup and all other employers that remain in Classification 9185. Classification 9185 currently includes standard exception employees, while Classifications 9154 and 9156 do not. However, based on feedback from industry representatives and a review of WCIRB inspection reports, it is the WCIRB's understanding that a significant proportion of circus employees would not meet the strict guidelines needed to be classified as standard exception employees. Similarly, while the payroll of performers in Classification 9156 is subject to limitation, that of employees in Classifications 9185 and 9154 is not. Based on feedback from industry representatives and a review of payroll information on WCIRB inspection reports, it is the WCIRB's understanding that very little circus reported payroll would have been limited if a limitation had applied to circuses, and no adjustment to the historical experience or classification relativity for circuses is needed.

5. Circus employers currently assigned to Classification 9185 that would be reassigned to Classifications 9154 and 9156 would see a significant reduction in the selected loss to payroll ratio. This reduction is consistent with the subgroup's historical loss experience.

Based on the study findings detailed in the report, the WCIRB recommended the following amendments to Part 3, *Standard Classification System,* of the *California Workers' Compensation Uniform Statistical Reporting Plan—1995:*

1. Amend Classification 9154, *Theaters – not motion picture – all employees other than performers and directors of performers – including managers, stage hands, box office employees or ushers*, to include circus employees who are not performers and to clarify its intended application.

2. Amend Classification 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C.*, to include all circus employees who are performers, including musicians, and directors of performers and to clarify its intended application.

3. Amend Classification 9185, *Carnivals or Circuses*, to remove circus operations.

Following staff's presentation, a motion was made, seconded and unanimously passed to recommend that the proposed changes be included in the September 1, 2022 Regulatory Filing.

Carnivals and Circuses Study

9185, *Carnivals or Circuses – all employees – including Clerical Office Employees, Clerical Telecommuter Employees and Outside Salespersons*

Executive Summary

Objectives
Employers assigned to Classification 9185, *Carnivals or Circuses – all employees – including Clerical Office Employees, Clerical Telecommuter Employees and Outside Salespersons*, do not develop sufficient data to produce a statistically credible advisory pure premium rate. Consistent with the WCIRB's practice of reviewing classifications with relatively low statistical credibility, the WCIRB studied business operations and the payroll and claim experience of employers currently assigned to Classification 9185 to determine if it should continue to be a stand-alone classification or if some or all of the operations in Classification 9185 should be combined with the operations in other classifications. This study addresses the following questions:

1. Are there distinct and easily identifiable subgroups of employers that are currently assigned to Classification 9185?

2. If there are distinct and easily identifiable subgroups, should they be included in other existing classifications or continue to be assigned to Classification 9185?

Findings
The key findings of this study are:

1. Within Classification 9185, there is a clear line of demarcation between the operations of traveling carnivals and those of circuses. In addition, traveling carnival operations appear significantly more hazardous than those of circuses and have significantly higher loss to payroll ratios.

2. Circus employers have similar operations, loss to payroll ratios, and typical causes of injury as employers assigned to Classifications 9154, *Theaters – not motion picture – all employees other than performers and directors of performers – including managers, stage hands, box office employees or ushers*, and 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C*.

3. Employers operating traveling carnivals share some operational similarities with employers assigned to Classifications 9016(1), *Amusement or Recreational Facilities – N.O.C. – all employees other than those engaged in the operation or maintenance of amusement devices, restaurants or retail stores,* and 9180(1), *Amusement or Recreational Facilities – N.O.C. – operation or maintenance of amusement devices – including ticket collectors connected therewith*; however, the loss to payroll ratios for the traveling carnival subgroup have been significantly higher for more than a decade, and this subgroup has dissimilar typical causes of injury.

4. Removing the circus employer subgroup from Classification 9185 and amending theater Classifications 9154 and 9156 to include circus operations would have minimal impact (less than 1%) on the employers currently assigned to Classifications 9154 and 9156. Similarly, no longer including circus employers within the scope of Classification 9185 would have only a modest impact on the carnival subgroup and all other employers that remain in Classification 9185. Classification 9185 currently includes standard exception employees, while Classifications 9154 and 9156 do not. However, based on feedback from industry representatives and a review of WCIRB inspection reports, it is the WCIRB's understanding that a significant proportion of circus

employees would not meet the strict guidelines needed to be classified as standard exception employees. Similarly, while the payroll of performers in Classification 9156 is subject to limitation, that of employees in Classifications 9185 and 9154 is not. However, based on feedback from industry representatives and a review of payroll information on WCIRB inspection reports, it is the WCIRB's understanding that very little circus reported payroll would have been limited if a limitation had applied to circuses, and no adjustment to the historical experience or classification relativity for circuses is needed.

5. Circus employers currently assigned to Classification 9185 that would be reassigned to Classifications 9154 and 9156 would see a significant reduction in the selected loss to payroll ratio. This reduction is consistent with the subgroup's historical loss experience.

Recommendations
Based on the findings, the WCIRB recommends the following:

1. Amend Classification 9154, *Theaters – not motion picture – all employees other than performers and directors of performers – including managers, stage hands, box office employees or ushers*, to include circus employees who are not performers and to clarify its intended application.

2. Amend Classification 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C.*, to include all circus employees who are performers, including musicians, and directors of performers and to clarify its intended application.

3. Amend Classification 9185, *Carnivals or Circuses*, to remove circus operations.

I. Introduction

Employers assigned to Classification 9185, *Carnivals or Circuses,* do not develop sufficient data to produce a statistically credible advisory pure premium rate, which can result in undue volatility in the pure premium rate from year-to-year. Specifically, the credibility for both medical and indemnity is around 0.4.[1] The low credibility is a result of a decreasing number of employers engaged in Carnival or Circus operations. In policy years 2006 through 2018, only 50 employers reported data in Classification 9185, and at the time of this study, only 9 employers are reporting payroll in this classification. In addition, over time, the operations of circuses and carnivals have diverged as circuses have shifted toward more theatrical and artistic performances, while carnival operations have remained largely unchanged. As an apparent result, circuses have developed different hazard experience than carnival operations.

The WCIRB studied the business operations and the payroll and claim experience of employers currently assigned to Classification 9185 to determine if Classification 9185 should continue to be a stand-alone classification or if some or all of the operations contemplated in that Classification should be combined with the operations in other classifications. In this regard, the WCIRB also evaluated the scope of several classifications that have relatively similar operations to Classification 9185. This study addresses the following questions:

1. Are there distinct and easily identifiable subgroups of employers that are currently assigned to Classification 9185?

2. If there are distinct and easily identifiable subgroups, should they be included in other existing classifications or continue to be assigned to Classification 9185?

[1] WCIRB January 1, 2021 Regulatory Filing

II. Analysis Approach

The WCIRB analyzed business operations and payroll and claim experience of employers operating circuses and carnivals using both qualitative and quantitative data from a variety of sources.

Classification Inspection Reports: The WCIRB has Classification Inspection Reports pertaining to about one-half of the employers reporting payroll in Classification 9185. The WCIRB reviewed these inspection reports to better understand the business operations of employers assigned to Classification 9185 and employee responsibilities.

Industry Outreach: The WCIRB contacted members of the industry, including employers and industry associations, to gain insight into the operational characteristics of circuses and carnivals.

Unit Statistical Reports: The WCIRB analyzed the historical Unit Statistical Report (USR) data reported for Classification 9185, including employers' payroll and loss experience and injury characteristics of claims, between policy years 1993 and 2018. Losses were limited to $500,000 per claim to minimize large swings in the loss to payroll ratios over time often seen in small classifications.

Other Jurisdictions: The WCIRB reviewed the classification of circuses and carnivals in several other jurisdictions.[2]

Similar Classifications: Using the same data sources and methodology used in the review of Classification 9185, the WCIRB reviewed several classifications, including two classifications pertaining to theaters and two involving amusement parks[3] that have relatively similar operations to Classification 9185.

Classification Relativity Data: Classification relativities submitted as part of the WCIRB's January 1, 2021 Regulatory Filing were used to analyze the impact of the potential reclassification of Classification 9185 operations on both the employers that are recommended to be included in other existing classifications and the employers currently assigned to the destination classifications.

III. Analysis Results

1. Two Distinct Subgroups in Classification 9185

Classification 9185, *Carnivals or Circuses*, applies to all operations of circuses as well as all operations of traveling carnivals that provide entertainment and amusement rides. Between policy years 2006 and 2018, there were 30 carnival employers accounting for 60% of the total payroll of Classification 9185 and 4 circus employers accounting for only 8% of the classification's payroll.[4] The remainder of the payroll assigned to Classification 9185 was developed by either staffing companies or by employers for which the WCIRB has no record of their operations. The number of staffing companies dropped sharply over time, with only 1 reporting payroll in this classification during the past six years.

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[2] Jurisdictions reviewed were: National Council on Compensation Insurance, Inc., Workers' Compensation Insurance Rating Bureau of Massachusetts, the Delaware and Pennsylvania Compensation Rating Bureaus and the Compensation Advisory Organization of Michigan. See Appendix II for a summary of how these jurisdictions classify carnivals and circuses.

[3] Classifications 9154, *Theaters – not motion picture – all employees other than performers and directors of performers – including managers, stage hands, box office employees or ushers*, 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C.*, 9016(1), *Amusement or Recreational Facilities – N.O.C. – all employees other than those engaged in the operation or maintenance of amusement devices, restaurants or retail stores* and 9180(1), *Amusement or Recreational Facilities – N.O.C. – operation or maintenance of amusement devices – including ticket collectors connected therewith*. See Section III, *Analysis Results,* Part 2 and 3 for the analysis of the potential reclassifications.

[4] Policy year 2006 is the earliest year the WCIRB has sufficient data and information to determine if an employer had circus, carnival or other types of operations. Therefore, the data analysis on the circus and carnival employers focused on policy years 2006 through 2018.

- **Traveling Carnival and Circus Operations**
  Based on a review of WCIRB inspection reports for employers assigned to Classification 9185, as well as interviews with employers operating carnivals and circuses, the WCIRB found that traveling carnivals and circuses operate quite differently.

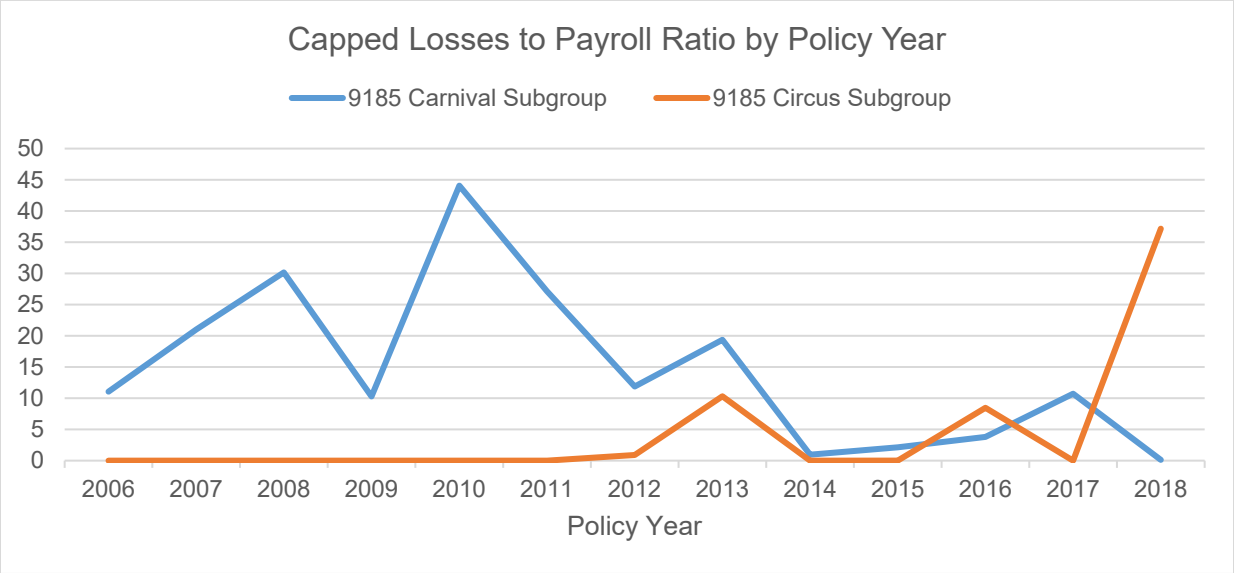
  Specifically, traveling carnival operations typically involve the set-up, operation and tear-down of large equipment for rides and amusement devices. Because transporting larger heavy-duty mechanical rides requires tractor trailer trucks, it is common for employers that operate traveling carnivals to contract the transport of large equipment to separate trucking firms. In addition to equipment set-up, operation and tear-down, a crew of employees also engages in event operations, including providing security and selling tickets, food and souvenirs.

  Employers that operate circuses, on the other hand, rarely are involved in setting up and operating large mechanical equipment. These employers primarily produce theatrical and artistic performances that involve acrobatic and athletic elements. Circus performers typically include acrobats, trapeze acts, musicians, dancers and other entertainers. Based on an interview with a circus employer that has been in the industry for over 20 years, like with many theater companies, it is not uncommon for circuses to classify their performers as independent contractors. While, like carnivals, circuses may retain event staff, the event staff do not share in the same exposure to heavy equipment set-up, operation and tear-down.

  Classification 9185 includes clerical office, clerical telecommuter and outside sales employees. Given the way circuses and traveling carnivals operate and staff's review of the inspection reports for circus and carnival operations, both typically have few, if any, employees whose duties would fall within the strict definition of the standard exception classifications.

- **Payroll and Claim Experience of Traveling Carnivals and Circuses**
  Based on the USR data between 2006 and 2018, the loss to payroll ratio for the Classification 9185 carnival employers was consistently and significantly higher than that for the Classification 9185 circus employers except for a few years (Figure 1). In fact, circus employers had zero losses for most of the policy years and had only seven claims during this entire period. Conversely, carnival employers had more than 260 claims reported during the same period. The 13-year weighted average loss to payroll ratio for carnival employers ($11.9 per $100 of payroll) is more than four times higher than that for circus employers ($2.7 per $100 of payroll). The only policy years for which circus employers had a higher loss to payroll ratio than carnival employers were 2016, when three claims occurred, including a large claim that involved a fall injury with $134,000 of incurred losses, and 2018, when one claim involving a broken ankle occurred and a relatively small amount of payroll was reported.

Figure 1. Historical Loss to Payroll Ratios[5] Comparing Classification 9185 Circus Employers with Classification 9185 Carnival Employers



	Loss to Payroll Ratio (00s) (13-Year Weighted Average)[6]
Classification 9185 Circus Subgroup	2.7
Classification 9185 Carnival Subgroup	11.9

In summary, employers operating circuses and traveling carnivals have significantly different business operations, underlying hazards and claim experience. In that the objective of the Standard Classification System is *to group employers into classifications so that each classification reflects the risk of loss common to those employers*, circuses and traveling carnivals should no longer be assigned to the same classification based on the data detailed above. However, since the credibility of Classification 9185 is already low (approximately 40%), the WCIRB explored the potential of combining each of the circus and carnival employer subgroups in Classification 9185 with existing classifications that have relatively similar operations.

2. Potential Reclassification of the Classification 9185 Circus Subgroup

The WCIRB identified two theater companion classifications to potentially reassign the Classification 9185 circus operations:

- 9154, *Theaters – not motion picture – all employees other than performers and directors of performers – including managers, stage hands, box office employees or ushers*
- 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C.*[7]

[5] Loss to payroll ratios before policy year 2018 were calculated using the losses and payroll reported at the second Report Level (RL). For policy year 2018, losses and payroll reported at the first RL, the latest data that we have on 2018 policies, were used to calculate the loss to payroll ratio. The same methodology was used for Figures 2 and 3.

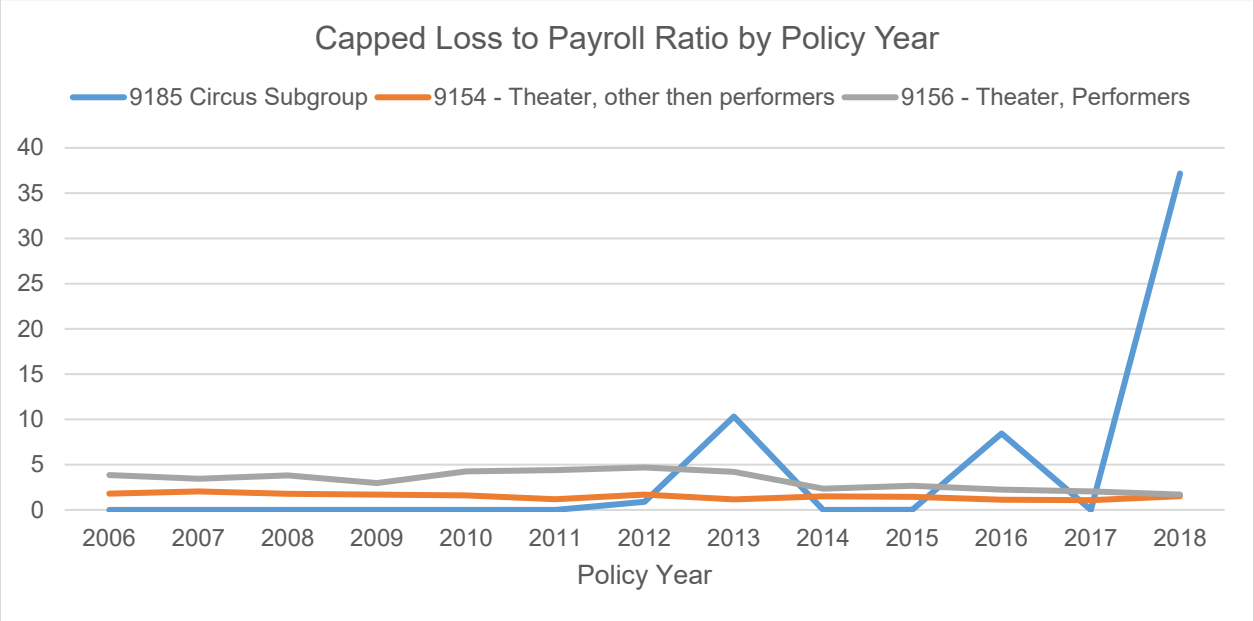
[6] The 13-year weighted average loss to payroll ratio was calculated as the aggregate losses over the 13-year period divided by the aggregate payroll during the same period.

[7] Classifications 9154 and 9156 are "Companion Classifications". The USRP at Part 3, Section II, Rule 4, defines Companion Classifications as: "[t]wo classifications that together describe the operations that normally prevail in a business. Businesses that are classified using related companion classifications, as identified by the classification footnote, shall constitute a single enterprise."

The operations contemplated under these two classifications are similar to circus operations. Classification 9156 in particular includes performers of live onstage dance, music and other theatrical performances, all of which are also part of the modern circus performance. In fact, in reviewing the operations of some large traveling theater and dance companies, there is no clear line of demarcation between their operations and the operations of "circuses" currently assigned to Classification 9185. In addition, like theater companies, circuses assigned to Classification 9185 also retain non-performers, such as ticket sellers, stage hands and lighting technicians.

In addition to similar operational characteristics, employers assigned to Classifications 9154 and 9156 have loss to payroll experience relatively similar to that of circus employers. As shown in Figure 2, between policy years 2006 and 2018, the loss to payroll ratio for circus employers was consistently lower than that for employers assigned to either Classification 9154 or Classification 9156, except for three policy years when five claims were reported, and only one claim involved a heavy loss of $134,000 from a fall injury. The 13-year average loss to payroll ratio for circus employers ($2.7 per $100 of payroll) is relatively similar to the average for the theater non-performers assigned to Classification 9154 ($1.5 per $100 of payroll) and the theater performers assigned to Classification 9156 ($3.3 per $100 of payroll).

Figure 2. Historical Loss to Payroll Ratios Comparing Classification 9185 Circus Employers with Employers in Classifications 9154 and 9156



	Loss to Payroll Ratio (00s) (13-Year Weighted Average)[8]
Classification 9185 Circus Subgroup	2.7
Classification 9154 Non-Performers	1.5
Classification 9156 Performers	3.3

[8] The 13-year weighted average loss to payroll ratio was calculated as the aggregate losses over the 13-year period divided by the aggregate payroll during the same period.

Despite limited loss information for circus employers, as only seven claims were reported for circus employers between policy years 2006 and 2018, the causes of injury of these seven claims are comparable to those of claims reported in both Classifications 9154 and 9156.[9]

The payroll of performers in Classification 9156 is subject to limitation, while that of employees in Classifications 9185 and 9154 is not. However, based on feedback from industry representatives and a review of WCIRB Inspection Report payroll information for Classification 9185 circus employers, the wage of circus performers often falls below the payroll cap. Therefore, it is the WCIRB's understanding that very little circus reported payroll would have been limited if a limitation had applied to circuses.

The WCIRB's analysis indicates that circus employers have business operations and loss to payroll experience similar to those of employers assigned to Classifications 9154 and 9156. The WCIRB, therefore, recommends amending Classifications 9154 and 9156 to include circus operations. The impact of this recommendation on employers currently assigned to Classifications 9154 and 9156 and on employers in the Classification 9185 circus subgroup is shown in the Impact Analysis section of this report.

3. Potential Reclassification of the Classification 9185 Carnival Subgroup

The WCIRB identified two companion amusement facilities classifications to potentially reassign the Classification 9185 carnival operations:

- 9016(1), *Amusement or Recreational Facilities – N.O.C. – all employees other than those engaged in the operation or maintenance of amusement devices, restaurants or retail stores*[10]
- 9180(1), *Amusement or Recreational Facilities – N.O.C. – operation or maintenance of amusement devices – including ticket collectors connected therewith*

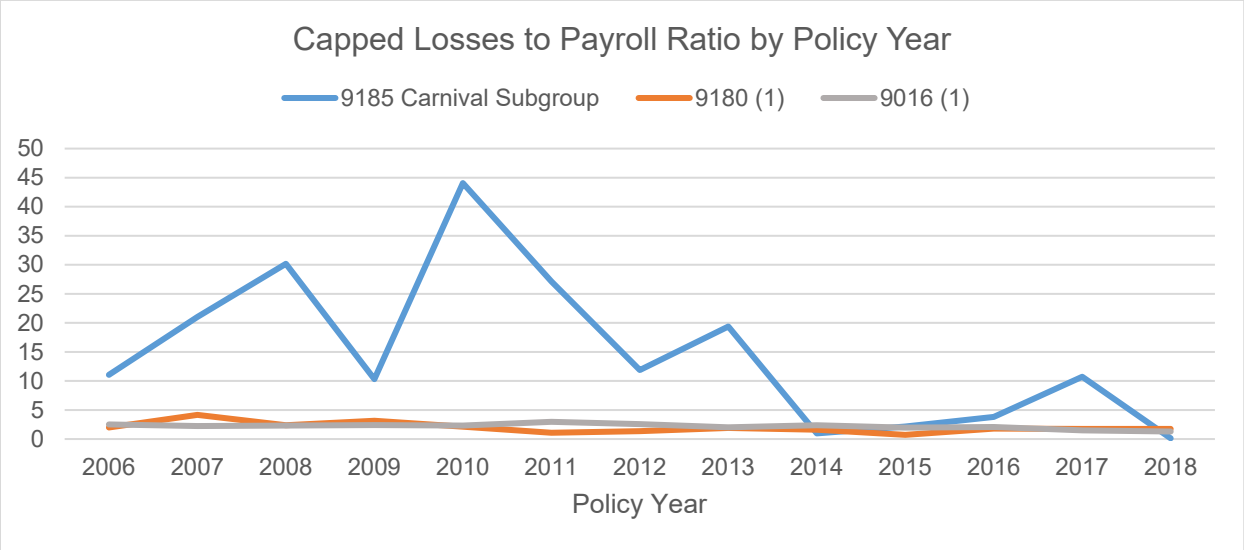
The operations contemplated under Classifications 9016(1) and 9180(1) are somewhat similar to traveling carnival operations. Most notably, both traveling carnivals and amusement facilities engage in the operation and maintenance of amusement rides and entertainment devices, as well as event operations, including providing security and selling tickets, food and souvenirs.

As shown in Figure 3, the loss to payroll ratio for Classification 9185 carnival employers is significantly higher than that for employers in both Classifications 9016(1) and 9180(1), except for policy years 2014 and 2018. The 13-year weighted average loss to payroll ratio for carnival employers is five times higher than that of both Classification 9016(1) and Classification 9180(1).

[9] The causes of injury for the circus employee claims include strain injuries and falls, which are among the top five causes of injuries for both classifications 9154 and 9156.

[10] Classifications 9180(1) and 9016(1) are Companion Classifications.

Figure 3. Historical Loss to Payroll Ratios Comparing Classification 9185 Carnival Employers with Employers in Classifications 9016(1) and 9180(1)

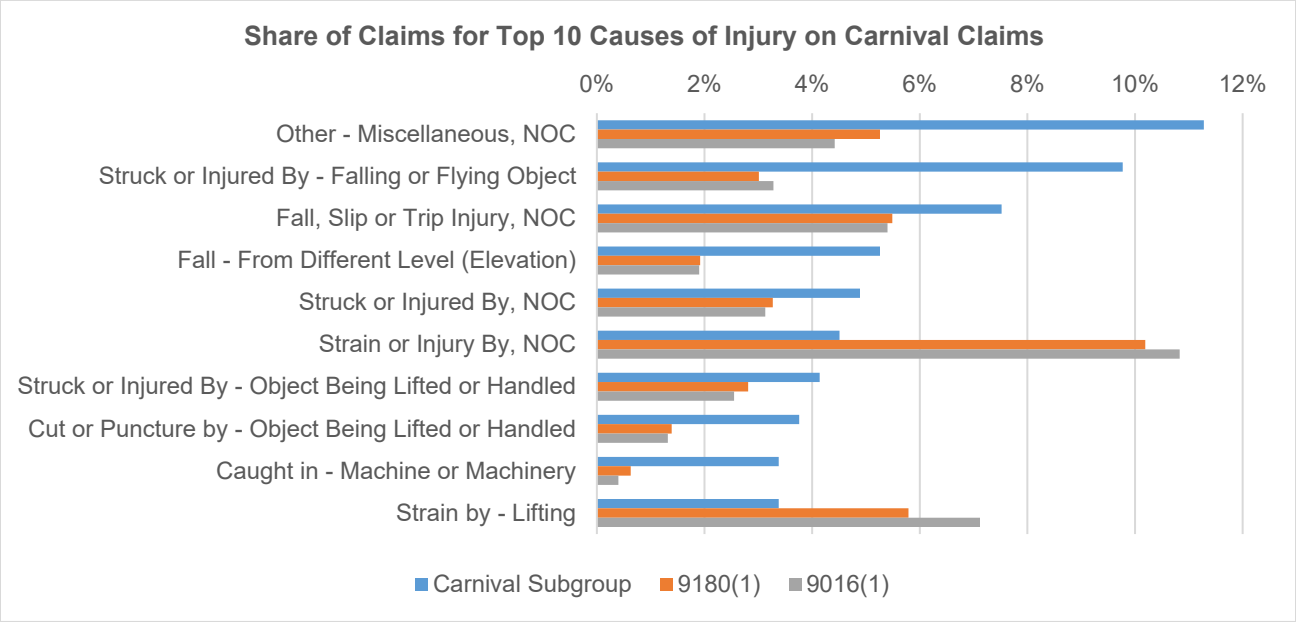


	Loss to Payroll Ratio (00s) (13-Year Weighted Average)[11]
Classification 9185 Carnival Subgroup	11.9
Classification 9016(1)	2.1
Classification 9180(1)	1.9

The WCIRB also compared the leading causes of injury reported for Classification 9185 carnival employee claims to those of claims reported for employees in Classifications 9016(1) and 9180(1). As shown in Figure 4, Classification 9185 carnival employee claims are more likely to involve injuries from falls or being struck by falling or flying objects, likely resulting from setting up rides and amusement devices, while claims from Classification 9016(1) and 9180(1) employees tend to involve strain injuries that are consistent with operating and maintaining amusement devices.

[11] The 13-year weighted average loss to payroll ratio was calculated as the aggregate losses over the 13-year period divided by the aggregate payroll during the same period.

Figure 4. Top 10 Causes of Injury on Claims in the Classification 9185 Carnival Subgroup and Corresponding Claim Shares in Classifications 9016(1) and 9180(1)



While the business operations of traveling carnivals bear some similarity to the operations of amusement or recreational facilities assigned to Classifications 9016(1) and 9180(1), the loss to payroll experience and cause of injury distribution suggest that operating traveling carnivals is significantly more hazardous than operating and maintaining amusement facilities. Therefore, the WCIRB does not recommend combining carnivals with either of these two classifications and recommends that traveling carnival operations continue to be assigned to Classification 9185, despite its relatively low credibility.

Although the WCIRB does not recommend changes to the classification for traveling carnivals at this time, in view of the documented similarities between traveling carnivals and some aspects of the amusement industry, the WCIRB plans to conduct further study of Classifications 9016(1) and 9180(1) in the future to assess similarities in business operations and loss experience between traveling carnivals and aspects of the amusement industry.

IV. Impact Analysis

The WCIRB evaluated the impact of reclassifying circus operations to the theater companion classifications on employers currently assigned to these classifications, as well as on circus employers.[12] Classification relativities for Classifications 9185, 9154 and 9156, as well as the Classification 9185 circus and carnival subgroups, are included in Appendix III.

1. Impact on Employers in Classifications 9154 and 9156

Table 1 shows that the selected loss to payroll ratio for Classification 9154 would increase by 0.03% after the inclusion of circus operations, while Classification 9156 would see a 0.11% increase. Therefore, the overall impact of reclassifying the Classification 9185 circus operations to Classifications 9154 and 9156 would be minimal.

[12] Based on the loss and payroll experience of the employers currently assigned to Classifications 9154 and 9156 and data for the small number of circus employers, the WCIRB thinks it is reasonable to assume that 20% of circus payroll and 15% of circus losses are from non-performers and therefore would be reported in Classification 9154, and 80% of circus payroll and 85% of circus losses are from performers and would be reported in Classification 9156.

Table 1. Changes in the Selected (Unlimited) Loss to Payroll Ratio for Classifications 9154 and 9156 Under Proposed Recommendations

Classification 9154 (A)	Classifications 9154 and 9185 Circus Subgroup Combined (weighted[13]) (B)	% Difference (B/A-1)
1.677	1.678	+0.03%
Classification 9156	**Classifications 9156 and 9185 Circus Subgroup Combined (weighted[14])**	**% Difference**
2.990	2.993	+0.11%

2. Impact on Employers Currently Assigned to Classification 9185

The WCIRB also analyzed the impact to: (a) circus employers if circus operations are assigned to Classifications 9154 and 9156, and (b) carnival employers and all other employers that would continue to be assigned to Classification 9185.

As shown in Table 2, after combining circus employers with both Classifications 9154 and 9156, circus employers would have a significant drop in their selected loss to payroll ratio (-74%), while carnival employers and all other employers that would continue to be assigned to Classification 9185 would experience a modest increase in their selected loss to payroll ratio (13.8%). Since the circus employers would be included in an existing classification, the WCIRB is recommending that the normal 25% limitation on year-to-year classification relativity changes not apply to the circus employer subgroup.

Table 2. Changes in the Selected (Unlimited) Loss to Payroll Ratio for Classifications 9154 and 9156 Under Proposed Recommendations

Classification 9185 (A)	9185 Circus Subgroup (weighted[15]) (B)	% Difference (B/A-1)
10.681	2.730	-74.4%
Classification 9185	**9185 Carnival Subgroup and All Others**	**% Difference**
10.681	12.155	+13.8%

[13] Because Classifications 9154 and 9156 are Companion Classifications, the Classification 9185 circus employers would be reporting only a fraction of the payroll and losses, specifically the payroll and losses of non-performers, to Classification 9154. Therefore, the combined employer experience in Classification 9154 and the Classification 9185 circus subgroup was weighted to reflect the apportionment of payroll and losses to Classification 9154.

[14] Similar to the apportionment of payroll and losses to Classification 9154, the remaining payroll and losses of performers were portioned to Classification 9156 in the combined set.

[15] The Classification 9185 circus employers would be reporting payroll and losses to both Classifications 9154 and 9156; therefore, the loss to payroll ratio for the reclassified circus operations was a weighted average of (1) the combined Classification 9154 and the circus operations and (2) the combined Classification 9156 and the circus operations.

V. Findings

Based on this review, the WCIRB has determined:

1. Within Classification 9185, there is a clear line of demarcation between the operations of traveling carnivals and those of circuses. In addition, traveling carnival operations appear significantly more hazardous than those of circuses and have significantly higher loss to payroll ratios.

2. Circus employers have similar operations, loss to payroll ratios, and typical causes of injury as employers assigned to Classifications 9154, *Theaters – not motion picture – all employees other than performers and directors of performers – including managers, stage hands, box office employees or ushers*, and 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C*.

3. Employers operating traveling carnivals share some operational similarities with employers assigned to Classifications 9016(1), *Amusement or Recreational Facilities – N.O.C. – all employees other than those engaged in the operation or maintenance of amusement devices, restaurants or retail stores,* and 9180(1), *Amusement or Recreational Facilities – N.O.C. – operation or maintenance of amusement devices – including ticket collectors connected therewith*; however, the loss to payroll ratios for the traveling carnival subgroup have been significantly higher for more than a decade, and this subgroup has dissimilar typical causes of injury. The WCIRB intends to conduct a comprehensive review of Classifications 9016(1) and 9180(1) in the future to further assess similarities in business operations and loss experience between traveling carnivals and aspects of the amusement industry.

4. Removing the circus employer subgroup from Classification 9185 and amending theater Classifications 9154 and 9156 to include circus operations would have minimal impact (less than 1%) on the employers currently assigned to Classifications 9154 and 9156. Similarly, no longer including circus employers within the scope of Classification 9185 would have only a modest impact on the carnival subgroup and all other employers that remain in Classification 9185. Classification 9185 currently includes standard exception employees, while Classifications 9154 and 9156 do not. However, based on feedback from industry representatives and a review of WCIRB inspection reports, it is the WCIRB's understanding that a significant proportion of circus employees would not meet the strict guidelines needed to be classified as standard exception employees. Similarly, while the payroll of performers in Classification 9156 is subject to limitation, that of employees in Classifications 9185 and 9154 is not. However, based on feedback from industry representatives and a review of payroll information on WCIRB inspection reports, it is the WCIRB's understanding that very little circus reported payroll would have been limited if a limitation had applied to circuses, and no adjustment to the historical experience or classification relativity for circuses is needed.

5. Circus employers currently assigned to Classification 9185 that would be reassigned to Classifications 9154 and 9156 would see a significant reduction in the selected loss to payroll ratio. This reduction is consistent with the subgroup's historical loss experience.

VI. Recommendations

Based on the findings, the WCIRB recommends the following:

1. Amend Classification 9154, *Theaters – not motion picture – all employees other than performers and directors of performers – including managers, stage hands, box office employees or ushers*, to include circus employees who are not performers and to clarify its intended application.

2. Amend Classification 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C.*, to include all circus employees who are performers, including musicians, and directors of performers and to clarify its intended application.

3. Amend Classification 9185, *Carnivals or Circuses – all employees – including Clerical Office Employees, Clerical Telecommuter Employees and Outside Salespersons*, to remove circus operations.

Appendix I – History

The following is a timeline of the significant changes to the scope and application relevant to Classification 9185, *Carnivals or Circuses*:

- **1944:** The Classification and Rating Committee at its meeting on September 12, 1944 requested that a new classification for carnivals or circuses be established using the rate for Classification 9180, *Amusement Parks or Exhibitions.*

- **1945:** Classification 9185, *Carnivals or Circuses – all employees including Clerical, Salesman, Drivers, Chauffeurs and their Helpers*, was established with the same rate as Classification 9180, *Amusement Parks or Exhibitions – Operation and maintenance of merry-go-rounds, swings, roller coasters or other amusement devices not specifically classified in this Manual – including ticket sellers or collectors connected therewith; Drivers, Chauffeurs and their Helpers*.

- **1970:** The WCIRB conducted a study to review the classifications that included salesmen and clerical office employees to deteremine the feasibility of amending these classifications to permit salesmen and clerical office employees to be separately classified. Based on this review, it was determined that Classification 9185 should continue to include salesmen and clerical office employees.

- **2021:** Based on the establishment of Classification 8871, *Clerical Telecommuter Employees – N.O.C.*, as a Standard Exception, Classificaiton 9185 was among 41 classificaitons amended to include *Clerical Telecommuter Employees.*

Appendix II – Other Jurisdictions

The WCIRB reviewed how other jurisdictions classify the operations reviewed in this study, including surveying members of the Policy Research Advisory Committee (PRAC) on whether they have encountered any issues administering the classifications applicable to traveling carnival or circus operations, and whether they have studied this classification/industry or have plans to study it in the future. Almost all other jurisdictions retain Classification 9186 for traveling carnivals or circuses, and it is administered similarly to how the WCIRB administers Classification 9185. Classification 9186 in other jurisdictions also applies to traveling rodeos, traveling animals shows, traveling automobile stunt shows and traveling device operators. This classification applies to ticket sellers in connection with these operations but does not include Clerical Office Employees or Outside Salespersons. Some jurisdictions retain a weekly payroll limitation for Classification 9186, while California does not have a weekly payroll limitation for Classification 9185. However, Classification 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C.,* in California is subject to a maximum remuneration per year per person.

The National Council on Compensation Insurance, Inc. (NCCI) advised that the credibility and rate fluctuation for Classification 9186 varies greatly from state to state. NCCI is currently planning to propose some changes to Classification 9186 and other amusement classifications for the consistent inclusion of ticket sellers and gate attendants, and to clarify that 9186 applies to all traveling amusement operations. It was noted that in NCCI jurisdications Classification 9016 applies to amusement parks or exhibitions at fixed locations, and there is a large rate differential between these two classifications.

The Wisconsin Rating Bureau advised that Classification 9186 generates a fair amount of payroll in their state and there is not currently any plan to study 9186 due to credibility concerns.

The Workers' Compensation Insurance Rating Bureau of Massachusetts (WCIRBMA) advised that due to its low credibility, in 1999, Classification 9186 was combined for ratemaking with Classification 9180, *Amusement Device Operation NOC*. At the time, Classification 9186 contained a weekly payroll limitation; however, Classification 9180 did not. Therefore, when they were combined the rate decreased drastically.

The Delaware and Pennsylvania Compensation Rating Bureaus (DCRB/PCRB) use Classification 939, *Carnival, Circus or Amusement Device Operator – Travelling,* which is applied in a manner similar to Classification 9186 in other jurisdictions. Interestingly, Classification 939 was initially established in 1984 and was later merged with Classification 969, *Amusements Outdoor.* Later, in 1999, Classification 939 was reestablished. Both PCRB and DCRB have observed declines in the loss costs for Classification 939. However, because the scope of this classification is narrow and well defined, they do not experience misapplication or confusion with other classifications.

In contrast to other jurisdictions, the Compensation Advisory Organization of Michigan uses Classification 9015, *Buildings – NOC – Operation by Owner of Lessee,* to classify carnivals and circuses and does not use Classification 9186. This classification is fully credible, there are not apparent issues with misapplication, and they do not have plans to study this classification/industry in the future.

Appendix III – Classification Relativities[16]

Table 1: All of Classification 9185 – Classification Relativity at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Indemnity Losses	Adjusted Medical Losses	Adjusted Total Losses	Adjusted Loss to Payroll Ratio (00s)
2013	4,211,294	42,198	493,825	536,023	12.728
2014	3,931,739	142,508	225,754	368262	9.366
2015	7,139,712	80,549	170,094	250,643	3.511
2016	6,751,793	202,040	183,077	385117	5.704
2017	7,148,579	189,183	547,143	736326	10.300
Total	29,183,118	656,478	1,619,893	2,276,371	

Adjusted Loss to Payroll Ratio	7.800
Selected Loss to Payroll Ratio	10.681

Credibility	
Indemnity	Medical
0.38	0.45

Table 2: Classification 9185 Circus Subgroup – Classification Relativity at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Indemnity Losses	Adjusted Medical Losses	Adjusted Total Losses	Adjusted Loss to Payroll Ratio (00s)
2013	537,854	2959	35439	38,398	7.139
2014	219,796	0	0	0	0.000
2015	2,743,614	0	421	421	0.015
2016	1,626,363	88417	74860	163277	10.039
2017	1,576,906	0	0	0	0.000
Total	6,704,534	91376	110,720	202,095	

Adjusted Loss to Payroll Ratio	3.014
Selected Loss to Payroll Ratio	9.262

Credibility	
Indemnity	Medical
0.21	0.25

[16] WCIRB January 1, 2021 Regulatory Filing.

Table 3: Classification 9185 Carnival Subgroup – Classification Relativity at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Indemnity Losses	Adjusted Medical Losses	Adjusted Total Losses	Adjusted Loss to Payroll Ratio (00s)
2013	3,644,186	39,387	460,113	499,500	13.707
2014	3,685,567	142,397	225,579	367976	9.984
2015	4,152,912	34,927	62,666	97,593	2.350
2016	4,896,185	113657	107,769	221426	4.522
2017	5,474,189	55903	513,552	569455	10.403
Total	21,853,038	386,271	1,369,679	1,755,950	

Adjusted Loss to Payroll Ratio	8.035
Selected Loss to Payroll Ratio	10.859

Credibility	
Indemnity	Medical
0.34	0.40

Table 4: All of Classification 9154 – Classification Relativity at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Indemnity Losses	Adjusted Medical Losses	Adjusted Total Losses	Adjusted Loss to Payroll Ratio (00s)
2015	514,992,164	3,999,534	4,615,742	8,615,276	1.673
2016	631,936,097	3,970,312	5,358,739	9,329,051	1.476
2017	761,325,549	5,418,158	4,546,037	9,964,195	1.309
Total	1,908,253,811	13,388,004	14,520,518	27,908,522	

Adjusted Loss to Payroll Ratio	1.463
Selected Loss to Payroll Ratio	1.677

Credibility	
Indemnity	Medical
1.00	1.00

Table 5: All of Classification 9156 – Classification Relativity at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Indemnity Losses	Adjusted Medical Losses	Adjusted Total Losses	Adjusted Loss to Payroll Ratio (00s)
2013	90,529,962	1,322,321	1,794,592	3,116,913	3.443
2014	94,542,356	902,284	1,086,281	1988565	2.103
2015	87,562,064	1,184,947	1,252,359	2,437,306	2.784
2016	100,882,858	1,375,384	1,328,199	2703583	2.680
2017	107,961,023	1,252,246	1,152,223	2404469	2.227
Total	481,478,262	6,037,182	6,613,654	12,650,836	

Adjusted Loss to Payroll Ratio	2.627
Selected Loss to Payroll Ratio	2.990

Credibility	
Indemnity	Medical
0.94	0.83

Recommendation
Amend Classification 9185, *Carnivals or Circuses,* to reassign circus operations to Classifications 9154, *Theaters – not motion picture*, and 9156, *Theaters – dance, opera or theater companies.*

PROPOSED

CARNIVALS ~~OR CIRCUSES~~ – all employees – including Clerical Office Employees, Clerical Telecommuter Employees and Outside Salespersons **9185**

This classification applies to all operations of traveling carnivals that provide entertainment and amusement rides, including but not limited to transporting, setting up and taking down amusement sites and equipment, assisting patrons on and off rides, operating game booths and arcades, providing entertainment, selling and taking tickets, providing security, selling food and souvenirs, cleaning and maintaining equipment and premises, and operating and controlling amusement rides. ~~This classification also applies to all operations of circuses, including performers, entertainers and the care, feeding and training of circus animals.~~

Rental and operation of game booths at locations where no mechanical amusement rides are operated shall be classified as 8017(1), *Stores – retail.*

Amusement parks at fixed locations shall be classified as 9016(1)/9180(1), *Amusement or Recreational Facilities – N.O.C.*

The production of live dance, opera, dramatic, comedic, circus or other theatrical presentations before a live audience shall be assigned to companion Classifications 9156, *Theaters – dance, opera and theater companies*, or 9154, *Theaters – not motion picture – all employees other than performers and directors of performers.*

The operation of events, including but not limited to farmers' markets, flea markets, street fairs, swap meets, art or antique festivals, trade shows (public or private), fun runs, foot races, cycling events, marathons, triathlons and athletic charity events, shall be classified as 9095, *Event Market, Festival or Trade Show Operation*.

* * * * * * *

Recommendation
Amend Classification 9154, *Theaters – not motion picture,* to include circus employees who are not performers, such as managers, stage technicians, box office employees or ushers, as these operations are more properly assignable to 9154, and to clarify the intended application.

PROPOSED

THEATERS – not motion picture – all employees other than performers and directors of performers – including managers, stage ~~hands~~technicians, box office employees or ushers **9154**

This classification applies to the production of live musical, dance, opera, dramatic, comedic, circus or other theatrical presentations before a live audience or the operation of venues used for such live entertainment. This classification includes all theater employees other than performers

and directors of performers, including managers, stage technicians, box office employees or ushers.

Also refer to companion Classification 9156, *Theaters – dance, opera or theater companies – all performers and directors of performers – N.O.C.,* and to companion Classification 9151, *Theaters – musical entertainment – live performances.*

If an employee who performs duties described by Classification 9154 also performs duties described by Classifications 9151 or 9156, the payroll of that employee may be divided between Classifications 9154 and 9156, or between Classifications 9151 and 9154 provided the employer maintains accurate records supported by time cards or time book entries that show such division. Refer to Section V, Rule 3.

* * * * * * *

Recommendation
Amend Classification 9156, *Theaters – dance, opera or theater companies,* to include circus employees who are performers or directors of performers, as these operations are more properly assignable to 9156, and to clarify the intended application.

PROPOSED

THEATERS – dance, opera or theater companies – all performers and directors of performers – N.O.C. **9156**

The entire remuneration of performers and directors of performers shall be included, subject to a maximum of $139,100 per year per person. When such employees do not work the entire year, the payroll limitation shall be prorated based upon the number of weeks in which such employees worked during the policy period.

This classification applies to the production of live musical, dance, opera, dramatic, comedic, circus or other theatrical presentations before a live audience. This classification includes all ~~stage~~ performers, directors and musicians in connection ~~therewith~~with the theater operations.

Musical entertainers who are not employees of dance, opera or theater companies, but who provide entertainment for a live audience, including but not limited to orchestras, touring bands, casual or steady engagement music groups and event disc jockeys, shall be classified as 9151, *Theaters – musical entertainment*.

The operation of motion picture theaters shall be classified as 9155, *Theaters – motion picture.*

Also refer to companion Classification 9154, *Theaters – not motion picture – all employees other than performers and directors of performers.*

If an employee who performs duties described by Classification 9156 also performs duties described by Classification 9154, the payroll of that employee may be divided between Classifications 9154 and 9156, provided the employer maintains accurate records supported by time cards or time book entries that show such division. See Section V, Rule 3, *Division of Single Employee's Payroll*.

* * * * * * *

Recommendation
Amend Classification 9016(1), *Amusement or Recreational Facilities – N.O.C. – all employees other than those engaged in the operation or maintenance of amusement devices, restaurants or retail stores,* for consistency with other proposed changes.

PROPOSED

AMUSEMENT OR RECREATIONAL FACILITIES – N.O.C. – all employees other than those engaged in the operation or maintenance of amusement devices, restaurants or retail stores **9016(1)**

This classification applies to the operation of amusement or recreational facilities, including but not limited to amusement parks, water parks, miniature golf courses, batting cages, bumper car facilities, archery ranges, water excursions/tours, laser tag, airsoft or paintball facilities, Nordic (cross-country) ski facilities and zoos, including veterinarians employed by zoos.

This classification also applies to the operation of golf driving ranges that are not operated by golf courses or country clubs.

This classification also applies to automobile or horse race-track operations by employers that are not public agencies.

This classification also applies to the operation of athletic or sports venues, including ballparks and stadiums, during non-sporting activities, including but not limited to concerts and exhibitions.

Boat marinas or boat rental facilities shall be classified as 9016(4), *Boat Marina and Boat Rental Operation*.

Golf courses or country clubs shall be classified as 9060, *Clubs – country or golf*.

Traveling carnivals ~~or circuses~~ shall be classified as 9185, *Carnivals ~~or Circuses~~*.

The operation of events, including but not limited to farmers' markets, flea markets, street fairs, swap meets, art or antique festivals, trade shows (public or private), fun runs, foot races, cycling events, marathons, triathlons and athletic charity events shall be classified as 9095, *Event Market, Festival or Trade Show Operation*.

The operation of race-tracks by public agencies shall be classified as 9410/9420, *Municipal, State or Other Public Agency Employees*.

Bowling centers shall be classified as 9092(1), *Bowling Centers*.

Billiard halls shall be classified as 9092(2), *Billiard Halls.*

Skating rinks or skate parks shall be classified as 9092(3), *Skating Centers.*

Also refer to companion Classification 9180(1), *Amusement or Recreational Facilities – N.O.C. – operation or maintenance of amusement devices*.

If an employee who performs duties described by Classification 9016(1) also performs duties described by Classification 9180(1), the payroll of that employee may be divided between Classifications 9016(1) and 9180(1), provided the employer maintains accurate records supported by time cards or time book entries that show such division. See Section V, Rule 3, *Division of Single Employee's Payroll*.

Restaurants or retail stores shall be separately classified.

* * * * * * *

Recommendation
Amend Classification 9180(1), *Amusement or Recreational Facilities – N.O.C. – operation or maintenance of amusement devices – including ticket collectors connected therewith,* for clarity and consistency with other proposed changes.

PROPOSED

AMUSEMENT OR RECREATIONAL FACILITIES – N.O.C. – operation or maintenance of amusement devices – including ticket collectors ~~connected therewith~~ **9180(1)**

This classification applies to the operation or maintenance of amusement devices at recreational facilities, including but not limited to amusement parks, zoos, water parks, miniature golf courses, batting cages, bumper car facilities, archery ranges, water excursions/tours and laser tag, airsoft or paintball facilities.

This classification also applies to guided tours for water-based activities or water-based athletic or fitness instructional programs at locations other than swimming pools, including but not limited to surfing, scuba, kayaking, paddle boarding or kite surfing on lakes, bays, rivers or oceans.

This classification also applies to guided wilderness expeditions; motorsports operations; or ski instructors, ski patrol personnel or employees engaged in ski trail grooming at ski resort locations that exclusively provide Nordic (cross-country) skiing activities. This classification also applies to the detonation of fireworks for pyrotechnic displays.

Traveling carnivals ~~or circuses~~ shall be classified as 9185, *Carnivals ~~or Circuses~~.*

Employers that operate boat marinas and boat rental facilities shall be classified as 9016(4), *Boat Marina and Boat Rental Operation*.

Bowling centers shall be classified as 9092(1), *Bowling Centers*.

Billiard halls shall be classified as 9092(2), *Billiard Halls.*

Skating rinks or skate parks shall be classified as 9092(3), *Skating Centers.*

The operation of Alpine (downhill) ski resorts, including the operation of Nordic (cross-country) ski trails at Alpine ski resort locations, shall be classified as 9184, *Ski Resorts – Alpine.*

Also refer to companion Classification 9016(1), *Amusement or Recreational Facilities – N.O.C. – all employees other than those engaged in the operation or maintenance of amusement devices, restaurants or retail stores*.

If an employee who performs duties described by Classification 9180(1) also performs duties described by Classification 9016(1), the payroll of that employee may be divided between Classifications 9016(1) and 9180(1), provided the employer maintains accurate records supported by time cards or time book entries that show such division. See Section V, Rule 3, *Division of Single Employee's Payroll*.

Restaurants or retail stores shall be separately classified.

* * * * * * *

Recommendation
Amend Classification 9095, *Event Market, Festival or Trade Show Operation,* for clarity and consistency with other proposed changes.

PROPOSED

EVENT MARKET, FESTIVAL OR TRADE SHOW OPERATION – all employees – N.O.C. **9095**

This classification applies to employers that organize and operate events or rent spaces to vendors that sell products or provide information to customers. Such events include but are not limited to farmers' markets, flea markets, street fairs, swap meets, art or antique festivals and trade shows (public or private). This classification also applies to the operation of events, including but not limited to fun runs, foot races, cycling events, marathons, triathlons and athletic charity events.

Employers that promote or market events but do not operate events shall be separately classified.

Traveling carnivals ~~or circuses~~ shall be classified as 9185, *Carnivals ~~or Circuses~~.*

The rental, delivery ~~and~~or set up of temporary chain link fences or road traffic safety barricades when performed by separate concerns shall be classified as 8028, *Equipment or Machinery Rental Yards.*

The rental, service or repair of portable toilets when performed by separate concerns shall be classified as 9426, *Septic or Portable Toilet Services.*

Vendors, performers, entertainers, retail stores ~~and~~or the preparation and sale of food shall be separately classified.

* * * * * * *

Recommendation
Amend Classification 9155, *Theaters – motion picture,* for clarity and consistency with other proposed changes.

PROPOSED

THEATERS – motion picture – all employees other than employees exclusively engaged in restaurant or tavern operations **9155**

This classification applies to all employees engaged in the operation of "walk-in" or "drive-in" motion picture theaters, including but not limited to ushers, motion picture projection and sound equipment operators, box office and snack bar cashiers, security staff and parking lot attendants.

The operation of a concession stand or snack bar by separate concerns shall be classified as 9079(2), *Concessionaires.*

~~Theater stage~~Theatrical performers, directors ~~and~~or musicians engaged in dance, opera, dramatic, comedic, circus or other theatrical presentations before a live audience shall be classified as 9156, *Theaters – dance, opera and theater companies.*

Orchestras, touring bands, casual or steady engagement music groups ~~and~~or event disc jockeys engaged in the provision of musical entertainment before a live audience shall be classified as 9151, *Theaters – musical entertainment.*

Employees other than ~~stage~~ performers, directors ~~and~~or musicians engaged in the operation of live performance theaters shall be classified as 9154, *Theaters – not motion picture.*

The payroll of employees engaged exclusively in restaurant or tavern operations shall be separately classified as 9079(1), *Restaurants or Taverns*.

* * * * * * *

Recommendation
Amend Classification 9151, *Theaters – musical entertainment,* for clarity and consistency with other proposed changes.

PROPOSED

THEATERS – musical entertainment – live performances – all performers and directors of performers **9151**

The entire remuneration of performers and directors of performers shall be included subject to a maximum of $139,100 per year per person. When such employees do not work the entire year, the payroll limitation shall be prorated based upon the number of weeks in which such employees worked during the policy period.

This classification applies to employers that provide musical entertainment for a live audience. This classification includes but is not limited to orchestras, touring bands, casual or steady engagement music groups and event disc jockeys. This classification also applies to stage performers ~~and~~or dancers incidental to the musical performance.

Theatrical performers, directors or musicians engaged in d~~D~~ance, opera, ~~ballet~~dramatic, comedic, circus or other live theater performers ~~including musicians~~ shall be classified as 9156, *Theaters – dance, opera or theater companies*.

Also refer to companion Classification 9154, *Theaters – not motion picture – all employees other than performers and directors of performers.*

If an employee who performs duties described by Classification 9151 also performs duties described by Classification 9154, the payroll of that employee may be divided between Classifications 9151 and 9154 provided the employer maintains accurate records supported by time cards or time book entries that show such division. See Section V, Rule 3, *Division of Single Employee's Payroll*.

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Recommendation
Amend Section VIII, *Abbreviated Classifications – Numeric Listing*, for consistency with other proposed changes.

PROPOSED

Section VIII – Abbreviated Classifications – Numeric Listing

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-
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9185 Carnivals~~/Circuses~~

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Recommendation
Amend Appendix IV, *Classifications Including Clerical Office Employees, Clerical Telecommuter Employees or Outside Salespersons*, for consistency with other proposed changes.

PROPOSED

Appendix IV

Classifications Including Clerical Office Employees, Clerical Telecommuter Employees or Outside Salespersons

See Section III, *General Classification Procedures*, Rule 4, *Standard Exceptions*, Subrule c, *Standard Exception Classification Procedures*.

Code	Name	Including Clerical Office Employees / Clerical Telecom-muter Employees	Including Outside Salespersons
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•			
•			
9185	Carnivals~~/Circuses~~	X	X
•			
•			
•			

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Item III-D
Tile and Cabinet Stores and Stone Material Dealers Study

8010, *Stores – hardware, electrical or plumbing supplies – wholesale or retail*
8017(1), *Stores – retail – N.O.C.*
8059, *Stores – tile – wholesale or retail*
8232(2), *Building Material Dealers – commercial – including counterpersons*

The Committee was advised that WCIRB staff conducted a study of employers engaged in the sale of products used in the construction or remodeling of kitchens or bathrooms including: cabinet retailers assigned to Classification 8017(1), *Stores – retail*; tile stores assigned to Classification 8059, *Stores – tile;* and stone material, slab or countertop dealers assigned to Classification 8232(2), *Building Material Dealers.* A copy of the draft report detailing the WCIRB's findings and recommendations was provided to the Committee in the Agenda.

During the presentation, WCIRB staff informed the Committee that there is significant overlap and similarity of operations between stores specializing in the sale of tile and those specializing in the sale of cabinets. These employers constitute a distinct and identifiable group engaged in a relatively homogenous set of operations and combining them into a single store classification (Classification 8059) would have little impact on the pure premium rates for either the reassigned employers or Classification 8059 as a whole. Staff noted that some employers that sell tile or cabinets also sell stone slabs, stone countertops or other stone materials. These stone slab and countertop sales operations, currently separately assigned to Classification 8232(2), *Building Material Dealers,* developed a distinctly higher loss to payroll ratio than that developed by Classification 8059, *Stores – tile*. Further, the loss to payroll ratio for the stone material sales operations is more consistent with Classification 8232(2) as a whole than that of Classification 8059 and should continue to be assigned to 8232(2).

Staff also discussed simplification of the classification procedures for the combined store classification so that, to avoid the complexities of the Multiple Enterprises Rule, the higher-rated operations consisting of stocking, handling or delivering building materials, would be separately classified as 8232(2), *Building Material Dealers*, if building material sales exceed 10% of sales. Finally, staff discussed the application of the *Stores* Special Industry Classification Procedures to building material dealers and amending Classifications 8010, *Stores – hardware, electrical or plumbing supplies*, 8232(1), *Lumberyards*, and 8232(2) for consistency with the changes recommended to administer Classification 8059, *Stores – tile*, and 8232(2).

Based on the study findings detailed in the report, the WCIRB recommended the following amendments to Part 3, *Standard Classification System*, of the *California Workers' Compensation Uniform Statistical Reporting Plan—1995:*

1. Amending Classification 8059, *Stores – tile,* to

    a. Direct that the classification includes the sale of cabinets, including but not limited to kitchen or bathroom cabinets and, as appropriate, reassign operations currently assigned to Classification 8017(1), *Stores – retail*, to Classification 8059.

    b. Direct that when building material sales exceed 10% of gross receipts, employees, other than store salespersons or cashiers, who are engaged in stocking, handling or delivering building materials are separately classified as 8232(2), *Building Material Dealers*; and when building material sales do not exceed 10% of gross receipts, these employees are included in Classification 8059.

2. Amending Classification 8232(2), *Building Material Dealers,* to:

    a. Direct that the classification includes the sale of stone material, stone slabs or fabricated stone products; and that the classification also includes the sale of countertops, including but not limited to granite, marble, limestone or other natural stone, quartz, engineered stone, laminate or solid surface countertops.

    b. Direct that when, at a single location, the sale of store merchandise, including but not limited to tile, cabinets or hardware, electrical or plumbing supplies exceeds 25% of gross receipts, employees who sell, stock, handle or deliver store merchandise shall be separately classified to the applicable *Stores* Industry Group classification; cashiers who process sales of store merchandise in addition to building materials shall also be assigned to the applicable *Stores* Industry Group classification.

3. Amending Classifications 8010, *Stores – hardware, electrical or plumbing supplies,* 8232(1), *Lumberyards,* and 8232(2), *Building Material Dealers*, for consistency with the changes recommended to administer Classifications 8059, *Stores – tile,* and 8232(2).

Staff advised the Committee that within the next several years, the WCIRB intends to conduct a comprehensive review of Classification 8232 to determine whether its constituents continue to represent employers engaged in a relatively homogenous set of operations that have relatively similar loss experience.

During the discussion, a Committee member suggested that the proposed reference to countertops assignable to Classification 8232(2) be expanded to specifically list the various types of stone countertops including marble, quartz and limestone materials. WCIRB staff and the Committee agreed with the suggested revision.

Following the Committee's discussion, a motion was made, seconded and unanimously passed to recommend that the proposed changes, as amended, be included in the September 1, 2022 Regulatory Filing.

Tile and Cabinet Stores and Stone Material Dealers Study

8010, *Stores – hardware, electrical or plumbing supplies – wholesale or retail*
8017(1), *Stores – retail – N.O.C.*
8059, *Stores – tile – wholesale or retail*
8232(2), *Building Material Dealers – commercial – including counterpersons*

Executive Summary

Objective

Employers specializing in the sale of products used in the construction or remodeling of kitchens and bathrooms frequently sell a variety of products, including cabinets and tile. Some of these employers also sell stone slabs, stone countertops or other stone materials. There is, however, no single classification that specifically contemplates the sale of this combination of merchandise. Instead, distinct classifications exist for each product: cabinet retailers are assigned to Classification 8017(1), *Stores – retail*; tile stores are assigned to Classification 8059, *Stores – tile;* and stone material, slab or countertop dealers are assigned to Classification 8232(2), *Building Material Dealers.* Although employers that sell a variety of these products are engaged in relatively homogenous operations, they are classified in accordance with the *Stores Special Industry Classification Procedures* and the *Multiple Enterprises* rule – a process that can lead to disparate results for otherwise similar operations.

To address this issue, the WCIRB conducted a comprehensive review of employers engaged in the sale of tile, cabinets and stone material, slabs or countertops to determine:

1. If employers that sell tile and cabinets are a distinct and easily identifiable group engaged in a relatively homogenous set of operations.

2. If so, whether all employers specializing in the sale of tile and cabinets should be combined into a single classification.

3. If employers that sell tile and cabinets are combined into a single classification and some of these employers also sell stone material, stone slabs or fabricated stone products, including but not limited to stone countertops (stone material):

   a. Should all such operations be assigned to a single store classification; or

   b. Should Classification 8232(2) continue to be assigned to the stone material portion of such operations.

Findings

The WCIRB's review of employers engaged in the sale of tile, cabinets and stone material found:

1. There is significant overlap and similarity of operations between stores specializing in the sale of tile and those specializing in the sale of cabinets. Taken together, this group constitutes a distinct and identifiable group of employers engaged in a relatively homogenous set of operations. Further, reassigning cabinet retailers currently assigned to 8017(1), *Stores – retail,* to Classification 8059, *Stores – tile*, would have little impact on the pure premium rates for either the reassigned employers or Classification 8059 as a whole.

2. Some employers that sell tile or cabinets also sell stone material. These stone material sales operations, currently separately assigned to Classification 8232(2), *Building Material Dealers,* develop a distinctly higher loss to payroll ratio than that developed by Classification 8059, *Stores – tile*. While not fully credible, the loss to payroll ratio for the stone material sales operations is more consistent with that of Classification 8232(2) than that of Classification 8059. Accordingly,

stone material sales should continue to be separately assigned to Classification 8232(2), provided the sale of stone materials represents greater than 10% of total sales.

3. When the sale of stone materials in a tile or cabinet store represents greater than 10% of total sales, employees engaged in stocking, handling or delivering stone products should be assigned to Classification 8232(2) and common sales or cashiering operations should be assigned to Classification 8059. This approach will avoid the complexities of the *Multiple Enterprises* rule and ensure that Classification 8232(2) applies to employees engaged in stocking, handling or delivering the stone products.

4. When a building material dealer also sells tile or cabinets (or other store merchandise), employees engaged in the store operations should be separately assigned to the appropriate store classification, provided the store merchandise sales represent greater than 25% of total sales.

5. Stores specializing in the sale of tile or cabinets that also sell building materials or lumber should be administered similarly to hardware stores assigned to Classification 8010, *Stores – hardware, electrical or plumbing supplies,* which also sell building materials or lumber. Accordingly, Classifications 8010, 8232(1), *Lumberyards*, and 8232(2) should be amended for consistency based on the proposed changes to Classification 8059.

Recommendations
Based on these findings, the WCIRB recommends:

1. Amending Classification 8059, *Stores – tile,* to

   a. Direct that the classification includes the sale of cabinets, including but not limited to kitchen or bathroom cabinets and, as appropriate, reassign operations currently assigned to Classification 8017(1), *Stores – retail*, to Classification 8059.

   b. Direct that when building material sales exceed 10% of gross receipts, employees, other than store salespersons or cashiers, who are engaged in stocking, handling or delivering building materials are separately classified as 8232(2), *Building Material Dealers*; and when building material sales do not exceed 10% of gross receipts, these employees are included in Classification 8059.

2. Amending Classification 8232(2), *Building Material Dealers,* to

   a. Direct that the classification includes the sale of stone material, stone slabs or fabricated stone products; and that the classification also includes the sale of countertops, including but not limited to granite, marble, limestone or other natural stone, quartz, engineered stone, laminate or solid surface countertops.

   b. Direct that when, at a single location, the sale of store merchandise, including but not limited to tile, cabinets or hardware, electrical or plumbing supplies exceeds 25% of gross receipts, employees who sell, stock, handle or deliver store merchandise shall be separately classified to the applicable *Stores* Industry Group classification; cashiers who process sales of store merchandise in addition to building material shall also be assigned to the applicable *Stores* Industry Group classification.

3. Amending Classifications 8010, *Stores – hardware, electrical or plumbing supplies,* 8232(1), *Lumberyards,* and 8232(2), *Building Material Dealers*, for consistency with the changes recommended to administer Classifications 8059, *Stores – tile,* and 8232(2).

In addition to the above, within the next several years, the WCIRB intends to conduct a comprehensive review of Classification 8232 to determine whether its constituents continue to represent employers engaged in a relatively homogenous set of operations that have relatively similar loss experience.

Introduction and Background
The WCIRB reviewed the classifications applicable to the sale of products used in the construction or remodeling of kitchens and bathrooms to address specific classification concerns and determine if these classifications constitute a distinct and identifiable group of employers engaged in relatively similar operations. This review was driven by the considerable overlap in both the nature of the business operations and the type of products sold by employers in the tile, cabinet and stone material sales industry.[1] Additionally, the WCIRB regularly receives questions regarding the points of demarcation between the classifications in question.

The objective of this study is to determine:

1. If employers that sell tile and cabinets are a distinct and easily identifiable group engaged in a relatively homogenous set of operations.

2. If so, whether all employers specializing in the sale of tile and cabinets should be combined into a single classification.

3. If employers that sell tile and cabinets are combined into a single classification and some of these employers also sell stone material, stone slabs or fabricated stone products, including but not limited to stone countertops (stone material):

    a. Should all operations assigned to a single *Stores* classification; or

    b. Should Classification 8232(2) continue to be assigned to the stone material portion of their operations.

Scope of Classification Assignments Under Review
The operations of employers engaged in the sale of kitchen or bathroom construction or remodeling products are typically assigned to one or more of the following classifications:

Classification 8017(1), *Stores – retail – N.O.C.*
Classification 8017(1) applies to retail stores engaged in the sale of items not more specifically described by another *Stores* classification. As there is no *Stores* classification that specifically describes cabinet sales, retail stores that sell cabinets have been assigned to Classification 8017(1). However, many stores that sell cabinets also sell tile, stone slabs or countertops, or other merchandise that may fall outside the scope of Classification 8017(1). While most cabinets are intended for use in kitchen or bathroom environments, there is no material difference between cabinets that may be installed in other settings, including but not limited to laundry rooms, garages or storage rooms. Stores that sell cabinets that are installed in settings other than kitchens or bathrooms have also been assigned to Classification 8017(1).

Classification 8059, *Stores – tile – wholesale or retail*
Classification 8059[2] applies to stores engaged in the sale of tile, including but not limited to ceramic, stone, porcelain and glass tile. This classification directs that dealers in stone slabs or countertops, including but not limited to those comprised of marble, granite, quartz and limestone, are assigned to Classification 8232(2)*, Building Material Dealers.* It is not uncommon for employers that sell tile to also

[1] During its review, the WCIRB also analyzed how other jurisdictions classify employers that sell kitchen and bathroom construction or remodeling products, specifically tile, cabinets and stone materials. A summary of the classifications maintained by the National Council on Compensation Insurance (NCCI) for the operations subject to this study can be found in Appendix I.

[2] Classification 8059 was established in 1989 for wholesale or retail store locations that specialize in the sale of ceramic tile and amended in 2016 to direct that the sale of stone and slab countertops is classified as 8232(2).

sell stone material, slabs or fabricated stone products, including but not limited to stone countertops, as well as cabinets and related kitchen and bathroom remodeling products.

Classification 8232(2), *Building Material Dealers – commercial – including counterpersons*
Classification 8232(2)[3] applies to the sale of building materials, including but not limited to sand, gravel, cement, drilling mud, brick, fencing wire, wallboard, doors, roofing paper, paneling, decorative stone and foundation piers. This classification also includes the delivery of building materials. While not specifically referenced, this classification is also assigned to dealers of stone slabs or stone countertops. Employers engaged in the sale of stone materials, slabs or countertops generally sell marble, granite, limestone or other natural stone, quartz, engineered stone, laminate or other solid surface countertops or slabs. Classification 8232(2) also directs that the operation of a store for the sale of hardware, electrical or plumbing supplies is separately classified as 8010, *Stores – hardware, electrical or plumbing supplies*.

Description of Operations
Employers that sell kitchen or bathroom construction or remodeling products frequently sell a variety of items used in building or remodeling kitchens or baths.[4] Products include tile and cabinets, and in some cases, stone material. While these employers are generally engaged in similar operations and are in competition with each other, they may be classified differently based on minor operational differences. There are three slightly different business models that are prevalent in stores that sell kitchen or bathroom construction or remodeling products.

Description of Operations	Model 1	Model 2	Model 3
Type of Products for Sale	Tile and cabinets; a minor amount of incidental supplies – tubes of caulk, caulk guns, blades and similar items	Same as those in Model 1 **AND** stone material.	Same as Model 2
Product Display	In a showroom	In a showroom that is physically separated from the stone material and store inventory storage area	Same as Model 2
Customers	General contractors and general public	Same as Model 1	Same as Model 1
Employees' Activities	**All employees** assist customers with their design concepts, write sales orders and process payments	1. **Salespersons** show customers product samples exclusively from within the showroom. 2. Separate **employees that work in the inventory storage area** stock, ship and receive stone material and other showroom items. 3. If customers are permitted to view product within the inventory storage area, they are assisted by **inventory storage area employees** not the showroom salespersons.	1. **Salespersons** show customers stone products by walking them through the inventory storage area. 2. Same as Model 2. 3. Customers are permitted to view stone material within the inventory storage area **assisted by showroom salespersons**.

[3] Classification 8232 is an original Manual classification. This classification was amended in 1965 to allow store operations in connection with 8232 operations, and in 2016 to direct that the sale of decorative stone is classified as 8232(2).
[4] Employers that sell a combination of cabinets, tile and stone slabs or countertops often also sell a minor amount of ancillary items used in the construction or remodeling of kitchens and bathrooms including handles, faucets, fixtures, sinks, ventilation hoods and other related kitchen and bathroom remodeling materials that account for a nominal amount of their overall sales.

Description of Operations	Model 1	Model 2	Model 3
Potential Classification Assignment	8059 or 8017(1) depending on the type of customer and percentage of tile sold	A store classification and 8232(2) based on the *Multiple Enterprises* rule	Often the higher-rated 8232(2) based on the *Multiple Enterprises* rule

Classification Analysis

Employers Selling Tile and Cabinets
With regard to classifying stores, the *Stores Special Industry Classification Procedures*[5] direct that the applicable *Stores* classification is determined based upon the type of merchandise sold and whether the operations are wholesale or retail.

Like tile stores, cabinet stores typically sell to both retail customers as well as contractors and other professional users. Classification 8017(1) is designated as a *retail* classification; however, it is often difficult to discern whether the majority of gross receipts are from sales to retail customers as defined in the *Stores Special Industry Classification Procedures*.[6]

As indicated in Model 1 above, a store that sells both tile and cabinets would be classified based on the percentage of tile sold. If tile sales exceed 25% of gross receipts, the store is assigned to Classification 8059*, Stores – tile*, as 8059 is currently higher rated than Classification 8017(1). Accordingly, many stores that sell cabinets are assigned to Classification 8059 because the sale of tile exceeds 25% of gross receipts.

As stores selling both tile and cabinets constitute a distinct and identifiable group of employers engaged in a relatively homogenous set of operations, in the current study, the WCIRB analyzed the feasibility of assigning stores that sell cabinets to Classification 8059. Additionally, as Classification 8059 applies to both wholesale and retail operations, combining stores that sell cabinets with Classification 8059 addresses the challenge of discerning whether the majority of gross receipts are from sales to retail customers. This approach would provide consistent classification treatment for similar operations.

Employers Selling Tile, Cabinets and Stone Materials
Models 2 and 3 describe many employers that sell stone materials in addition to tile and cabinets.

In Model 2, the store showroom is physically separated from the stone material and store inventory storage area. Under a *Multiple Enterprises* rule analysis, since employees' activities in the inventory storage area are integral to both the store and building material dealer operations,[7] the showroom can only be assigned to a lower-rated store classification if it develops the governing payroll.[8] If it does not develop the governing payroll, the store showroom employees must be assigned to the higher-rated Classification 8232(2).[9] Additionally, the classification of store employees in Model 2 is complicated by

[5] The *Stores Special Industry Classification Procedures* are found in the USRP at Part 3, *Standard Classification System*, Section IV, *Special Industry Classification Procedures*, Rule 6, *Stores*.

[6] Pursuant to the *Stores* rule, "the term retail is defined as the selling of merchandise to the general public for personal or household consumption or use.…A store that sells merchandise on both a wholesale and a retail basis shall be assigned to the appropriate store classification, depending upon whether the gross receipts are primarily (more than 50%) from wholesale or retail sales." (Part 3, *Standard Classification System*, Section IV, *Special Industry Classification Procedures*, Rule 6, *Stores*.)

[7] When employees, other than Miscellaneous Employees or employees engaged in operations described by a General Inclusion, either: (a) alternate between two or more separately classifiable operations, or (b) engage in a single activity or work in a single department that is integral to two or more separately classifiable activities, Interchange of Labor exists. (USRP at Part 3, Section II, Rule 11, *Interchange of Labor*.)

[8] Under a *Multiple Enterprises* rule analysis, where there is physical separation and Interchange of Labor, if the operation that develops the most payroll is described by the classification with the lower pure premium rate, the payroll of employees engaged in activities described by the lower-rated classification who do not interchange can be assigned to that classification.

[9] Under *Multiple Enterprises* rule analysis, where there is physical separation and Interchange of Labor, if the operation that develops the most payroll is described by the classification with the higher pure premium rate, all employees are assigned to the higher-rated classification.

the fact that salespersons who write orders for stone material likely meet the definition of *counterpersons* who must be specifically included in Classification 8232(2).

Model 3 differs only slightly from Model 2 in that sales employees take customers into the inventory storage area to view stone material, resulting in no physical separation and an interchange of labor as the salespersons walk through the inventory storage area showing stone material to customers. In this model, because the showroom employees are showing the 8232(2) products to customers, these employees are most often assigned to the higher-rated Classification 8232(2).[10]

Although the employers described in Models 2 and 3 sell identical merchandise and have only slight operational differences, the *Multiple Enterprises* rule can result in inconsistent classification assignments for employers engaged in relatively similar operations. To address this inconsistency, the WCIRB explored whether the sale of stone material should be included in Classification 8059 (see discussion in the Statistical Analysis section).[11]

Additional Classification Considerations
The WCIRB also found that similar issues exist for many hardware stores that sell both building materials and store merchandise. For example, Classification 8010, *Stores – hardware, electrical or plumbing supplies,*[12] directs that when lumber or building material sales exceed 10% of gross receipts,[13] employees, other than store cashiers, engaged in handling or delivering lumber or building materials are separately classified as 8232(1), *Lumberyards*, or 8232(2), *Building Material Dealers*. As a result, only the employees directly involved in handling, stocking or delivering lumber or building materials are separately classified. As none of these classifications contain a restriction on dividing a single employee's payroll, employees engaged in operations that are described by Classification 8232 in addition to Classification 8010 are subject to Section V, Rule 3, *Division of Single Employee's Payroll*.

Similar to hardware stores that also sell lumber or other building materials, many tile or cabinet stores sell stone material and may sell other building materials.[14] If Classification 8059 is modeled in a manner similar to Classification 8010, when building material sales exceed 10% of gross receipts, employees engaged in handling, stocking or delivering building materials can be separately classified as 8232(2),[15] while cashiers and store salespersons who sell both building materials and other store merchandise can be assigned to Classification 8059. When building material sales do not exceed 10% of gross receipts, the employees who handle, stock or deliver building materials are included in Classification 8059. Amending Classification 8059 to include such direction would lead to more consistent classification assignments and data reporting.

In conjunction with the footnote in Classification 8010 referenced above, Classifications 8232(1), *Lumberyards*, and 8232(2), *Building Material Dealers*, contain footnotes directing that the operation of a

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[10] Under *Multiple Enterprises* rule analysis, where there is no physical separation and Interchange of Labor exists, (1) if the operation that develops the most payroll is described by the classification with the higher pure premium rate, all employees are assigned to the higher-rated classification; and (2) if the operation that develops the most payroll is described by the classification with the lower pure premium rate, the payroll of employees whose activities interchange with those described by the higher-rated classification are assigned to the higher-rated classification, unless complete and accurate payroll records are maintained per Section V, Rule *3, Division of Single Employee's Payroll.*

[11] Changes to the *Multiple Enterprises* rule were approved at the October 13, 2020 Classification and Rating Committee meeting to be included in the September 1, 2021 Regulatory Filing. The proposed rule change requires that distinct operations be *Physically Separated* in order to be separately classified and removes *Interchange of Labor* and the *Governing* classification from the *Multiple Enterprises* rule analysis. The proposed changes included in this study address the issue of physical separation for these employers as these operations will be separately classified and not subject to the *Multiple Enterprises* rule.

[12] Classification 8010 was established January 1, 2020.

[13] When a store engages in the sale of building materials, a higher-rated category of non-store merchandise, such sales become determinative for classification assignment purposes when they exceed 10% of gross receipts.

[14] While less common, it is possible for lumberyard products assignable to Classification 8232(1), *Lumberyards,* to be sold by the same employer that sells tile or cabinets.

[15] As neither of these classifications contain a restriction on dividing a single employee's payroll, employees engaged in operations that are described by Classification 8232(2) in addition to Classification 8059 are subject to Section V, Rule 3, *Division of Single Employee's Payroll*.

store for the sale of hardware, electrical or plumbing supplies is separately classified as 8010 and that cashiers who work in support of hardware, electrical or plumbing supplies sales in addition to lumber and building material sales are classified as 8010. The WCIRB reviewed the administration of Classification 8010 in connection with lumberyards and building material dealers and noted that some employers sell only minimal amounts of store merchandise. However, in order to establish a store operation where store cashiers or store salespersons are retained and separately classified (provided they do not handle, stock or deliver building materials), the amount of store merchandise sold needs to exceed 25%[16] of gross receipts. Amending Classification 8232(2) to provide similar specific direction regarding 8059 store operations would promote consistent classification assignments and data reporting. Conforming amendments to Classifications 8010, *Stores – hardware, electrical or plumbing supplies*, 8232(1), *Lumberyards*, and 8232(2), *Building Material Dealers*, should also be made for consistency.

Based upon the above classification analysis, the WCIRB conducted the following statistical analysis to determine the propriety of: (1) combining all employers specializing in the sale of tile and cabinets into Classification 8059 and (2) including within Classification 8059 the sale of stone material.

Statistical Analysis
As discussed above, employers that sell tile and cabinets constitute a distinct and identifiable industry, and some of these employers also sell stone material. Therefore, the WCIRB compared the average loss to payroll ratios for Classifications 8017, 8059 and 8232(2) based on the 2021 Classification Relativity data.

Table 1 shows the Classification Relativity[17] data for all of Classification 8017[18] at the policy year 2021 level. The experience of these employers is fully credible with two years of experience.

Table 1: All of Classification 8017
Classification Relativity Data at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Losses	Adjusted Loss to Payroll Ratio (00s)
2016	11,976,626,051	222,377,099	1.857
2017	12,554,372,783	219,979,014	1.752
	24,530,998,834	442,356,112	

Adjusted Loss to Payroll Ratio: 1.803
Selected (Unlimited) Loss to Payroll Ratio[19]: 2.026

Credibility	
Indemnity	**Medical**
1.00	1.00

[16] Pursuant to the *Stores Special Industry Classification Procedures*, 25% of gross receipts is commonly used to establish the significance of store sales and determine the applicable store classification when an employer sells more than one type of merchandise. Although 8232 is not a store classification, the same rationale would apply. This solution was modeled after the classification procedures for the operation of combination gasoline stations and stores as directed in Section IV, *Special Industry Classification Procedures*, Rule 6h, *Stores.*

[17] The Classification Relativities used in this study are from statewide ratemaking data from the WCIRB's January 1, 2021 Regulatory Filing.

[18] Based on the most recent Classification Relativity data, Classification 8017 includes approximately 20,700 employers.

[19] The Selected (Unlimited) Loss to Payroll Ratio is the basis of the pure premium rate and the expected loss rate for the classification(s). It is derived from the loss to payroll experience from the latest two-, three-, four- or five-year periods by taking into account the following: previous year's pure premium rate, credibility and the impact of atypically large claims, etc.

Table 2 shows the Classification Relativity data for employers assigned to Classification 8017 that sell cabinets.[20] These employers generated lower levels of payroll and had very few claims, contributing to significantly lower loss to payroll ratios than those of all employers assigned to Classification 8017; however, the subset represents a small number of employers and has very low statistical credibility and, as a result, their loss experience does not warrant meaningful inferences.

Table 2: Classification 8017 Cabinet Subset
Classification Relativity Data at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Losses	Adjusted Loss to Payroll Ratio (00s)
2013	3,836,266	0	0.000
2014	4,790,934	3467	0.072
2015	5,618,462	295	0.005
2016	6,777,014	0	0.000
2017	7,548,477	0	0.000
	28,571,153	3,762	

Adjusted Loss to Payroll Ratio: 0.013
Selected (Unlimited) Loss to Payroll Ratio: 1.738

Credibility	
Indemnity	**Medical**
0.24	0.23

Table 3 shows the Classification Relativity data for all of Classification 8059.[21] These loss to payroll ratios are higher than those for the cabinet subset of 8017; however, the data for the cabinet subset has very limited statistical credibility.

Table 3: All of Classification 8059
Classification Relativity Data at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Losses	Adjusted Loss to Payroll Ratio (00s)
2013	66,593,895	2,038,106	3.06
2014	76,494,219	1,789,734	2.34
2015	122,742,378	2,003,494	1.632
2016	121,415,480	1,880,885	1.549
2017	113,218,136	1,733,867	1.531
	500,464,107	9,446,085	

Five-Year Adjusted Loss to Payroll Ratio: 1.887
Selected (Unlimited) Loss to Payroll Ratio: 2.18

[20] This subset is comprised of only 22 employers as most employers that sell cabinets have been assigned to other classifications, including 8059 and 8232, based on the sale of additional merchandise.
[21] Based on the most recent Classification Relativity data, Classification 8059 includes approximately 320 employers.

Credibility	
Indemnity	**Medical**
0.75	0.76

As many tile stores also sell cabinets, and in light of the very limited experience in the cabinet subset and similarity of operations with stores in Classification 8059, the WCIRB computed the payroll and loss experience for the combined Classification 8059 and the cabinet subset of 8017[22] (Table 4). Due to the limited experience in the 8017 cabinet subset, the loss to payroll ratios and statistical credibility of the combination of Classification 8059 and the cabinet subset of 8017 are very similar to those for Classification 8059. This indicates that combining Classification 8059 and the cabinet subset of 8017 would have minimal impact on the loss to payroll ratio and statistical credibility for Classification 8059.

Table 4: All of Classification 8059 and 8017 Cabinet Subset
Classification Relativity Data at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Losses	Adjusted Loss to Payroll Ratio (00s)
2013	70,887,276	2,064,960	2.930
2014	81,171,870	1,818,629	2.240
2015	120,422,279	2,008,674	1.668
2016	128,333,142	1,863,022	1.452
2017	120,673,541	1,748,191	1.449
	521,488,109	9,503,475	

Five-Year Adjusted Loss to Payroll Ratio: 1.822
Selected (Unlimited) Loss to Payroll Ratio: 2.109

Credibility	
Indemnity	**Medical**
0.76	0.77

Because some tile or cabinet stores that also sell stone material are assigned to Classification 8232, the WCIRB reviewed the Classification Relativity data for all of Classification 8232[23] to determine if the sale of stone material should be included in Classification 8059 (Table 5). The experience of employers assigned to 8232 is fully credible with two years of experience and the loss to payroll ratio is at a significantly higher level than that of Classification 8017.

[22] Based on the most recent Classification Relativity data, the combination of Classification 8059 and the cabinet subset of 8017 includes approximately 340 employers.
[23] Based on the most recent Classification Relativity data, Classification 8232 includes approximately 1,700 employers.

Table 5: All of Classification 8232
Classification Relativity Data at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Losses	Adjusted Loss to Payroll Ratio (00s)
2016	1,045,188,769	39,677,704	3.796
2017	1,206,965,908	38,762,622	3.212
	2,252,154,676	78,440,326	

Five-Year Adjusted Loss to Payroll Ratio: 3.483
Selected (Unlimited) Loss to Payroll Ratio: 4.317

Credibility	
Indemnity	**Medical**
1.0	1.0

Table 6 shows the Classification Relativity data for the stone countertop subset of Classification 8232,[24] comprised of employers that specialize in the sale of stone materials. The experience of the stone countertop subset of 8232 is only moderately credible, and the loss to payroll ratios for this group of employers are higher than those of all employers assigned to 8232.

Table 6: Classification 8232 Stone Countertop Subset
Classification Relativity Data at Policy Year 2021 Level

Policy Year	Adjusted Payroll	Adjusted Losses	Adjusted Loss to Payroll Ratio (00s)
2013	31,622,733	2,244,259	7.097
2014	40,361,466	2,408,962	5.968
2015	47,851,576	1,847,304	3.860
2016	50,315,350	2,089,526	4.153
2017	56,414,736	2,480,207	4.396
	226,565,860	11,070,258	

Five-Year Adjusted Loss to Payroll Ratio: 4.886
Selected (Unlimited) Loss to Payroll Ratio: 5.300

Credibility	
Indemnity	**Medical**
0.72	0.64

[24] This subset is comprised of approximately 120 employers that specialize in the sale of stone slabs, stone countertops or stone material that have been assigned to Classification 8232 based on the percentage of products sold. These employers may also sell additional items used in the construction or remodeling of kitchens and bathrooms.

Table 7 compares the indicated selected (unlimited) loss to payroll ratio of the 8232 countertop subset to that of both Classification 8232 as a whole and Classification 8059. The loss to payroll ratio for the 8232 stone countertop subset, though not fully credible, is significantly higher (by 143%) than that for tile stores. In view of this difference, the WCIRB does not recommend including the sale of stone material in Classification 8059.

In view of the difference in the loss to payroll ratio between the 8232 stone countertop subset and the full 8232 group, further research is warranted and the WCIRB recommends performing a comprehensive review of Classification 8232 in the next several years to further assess if the stone countertop subset as well as other potentially distinct subsets currently included in Classification 8232 need to be separately classified. Prior to the comprehensive review, the WCIRB recommends that employers specializing in the sale of stone materials continue to be assigned to Classification 8232.

Table 7: Classification 8059 and 8232 Countertop Subset
Comparison of Selected (Unlimited) Loss to Payroll Ratio at Policy Year 2021 Level

8232 Countertop Subset	Classification 8232	Difference
5.300	4.317	0.983 (22.77%)
8232 Countertop Subset	Classification 8059	Difference
5.300	2.180	3.12 (143.12%)

Table 8 compares the indicated selected (unlimited) loss to payroll ratio of the 8017 cabinet subset to that of both Classification 8017 as a whole and Classification 8059. The loss to payroll ratio of the cabinet subset in 8017 is somewhat comparable to both 8017 as a whole and Classification 8059. Therefore, combining the 8017 cabinet subset and Classification 8059 will not negatively impact the experience of employers in the 8017 cabinet subset.

Table 8: Classification 8059 and 8017 Cabinet Subset
Comparison of Selected (Unlimited) Loss to Payroll Ratio at Policy Year 2021 Level

8017 Cabinet Subset	Classification 8017	Difference
1.738	2.026	-0.288 (-14.22%)
8017 Cabinet Subset	Classification 8059	Difference
1.738	2.18	-0.442 (-20.28%)

Impact Analysis
The WCIRB recommends combining employers that sell cabinets (currently assigned to Classification 8017) with tile stores (assigned to Classification 8059). Table 9 shows that the recommended change would result in a modest increase (+4.1%) in the selected loss to payroll ratio for cabinet stores and a modest decrease (-3.3%) for employers currently assigned to Classification 8059.

Table 9: Classification 8059 and 8017 Cabinet Subset
Comparison of Selected (Unlimited) Loss to Payroll Ratio at Policy Year 2021 Level

Classification 8059	Classifications 8059 and 8017 Cabinet Subset Combined	Difference
2.180	2.109	-0.071 (-3.3%)
Classification 8017	Classifications 8059 and 8017 Cabinet Subset Combined	Difference
2.026	2.109	0.083 (+4.1%)

Findings
The WCIRB's review of employers engaged in the sale of tile, cabinets and stone material found:

1. There is significant overlap and similarity of operations between stores specializing in the sale of tile and those specializing in the sale of cabinets. Taken together, this group constitutes a distinct and identifiable group of employers engaged in a relatively homogenous set of operations. Further, reassigning cabinet retailers currently assigned to 8017(1), *Stores – retail,* to Classification 8059, *Stores – tile*, would have little impact on the pure premium rates for either the reassigned employers or Classification 8059 as a whole.

2. Some employers that sell tile or cabinets also sell stone material. These stone material sales operations, currently separately assigned to Classification 8232(2), *Building Material Dealers*, develop a distinctly higher loss to payroll ratio than that developed by Classification 8059, *Stores – tile*. While not fully credible, the loss to payroll ratio for the stone material sales operations is more consistent with that of Classification 8232(2) than that of Classification 8059. Accordingly, stone material sales should continue to be separately assigned to Classification 8232(2), provided the sale of stone materials represents greater than 10% of total sales.

3. When the sale of stone material in a tile or cabinet store represents greater than 10% of total sales, employees engaged in stocking, handling or delivering stone products should be assigned to Classification 8232(2) and common sales or cashiering operations should be assigned to Classification 8059. This approach will avoid the complexities of the *Multiple Enterprises* rule and ensure that Classification 8232(2) applies to employees engaged in stocking, handling or delivering the stone products.

4. When a building material dealer also sells tile or cabinets (or other store merchandise), employees engaged in the store operations should be separately assigned the appropriate store classification, provided the store merchandise sales represent greater than 25% of total sales.

5. Stores specializing in the sale of tile or cabinets that also sell building materials or lumber should be administered similarly to hardware stores assigned to Classification 8010, *Stores – hardware, electrical or plumbing supplies,* which also sell building materials or lumber. Accordingly, Classification 8010, 8232(1), *Lumberyards*, and 8232(2) should be amended for consistency based on the proposed changes to Classification 8059.

Recommendations
Based on these findings, the WCIRB recommends:

1. Amending Classification 8059, *Stores – tile,* to

    a. Direct that the classification includes the sale of cabinets, including but not limited to kitchen or bathroom cabinets and, as appropriate, reassign operations currently assigned to Classification 8017(1), *Stores – retail*, to Classification 8059.

b. Direct that when building material sales exceed 10% of gross receipts, employees, other than store salespersons or cashiers, who are engaged in stocking, handling or delivering building materials are separately classified as 8232(2), *Building Material Dealers*; and when building material sales do not exceed 10% of gross receipts, these employees are included in Classification 8059.

2. Amending Classification 8232(2), *Building Material Dealers,* to

   a. Direct that the classification includes the sale of stone material, stone slabs or fabricated stone products; and that the classification also includes the sale of countertops, including but not limited to granite, marble, limestone or other natural stone, quartz, engineered stone, laminate or solid surface countertops.

   b. Direct that when, at a single location, the sale of store merchandise, including but not limited to tile, cabinets or hardware, electrical or plumbing supplies exceeds 25% of gross receipts, employees who sell, stock, handle or deliver store merchandise shall be separately classified to the applicable *Stores* Industry Group classification; cashiers who process sales of store merchandise in addition to building materials shall also be assigned to the applicable *Stores* Industry Group classification.

3. Amending Classifications 8010*, Stores – hardware, electrical or plumbing supplies,* 8232(1), *Lumberyards*, and 8232(2), *Building Material Dealers*, for consistency with the changes recommended to administer Classifications 8059 and 8232(2).

In addition to the above, within the next several years, the WCIRB intends to conduct a comprehensive review of Classification 8232 to determine whether its constituents continue to represent employers engaged in a relatively homogenous set of operations that have relatively similar loss experience.

Appendix I

Classification Procedures in Other Jurisdictions
The WCIRB reviewed how other jurisdictions classify the operations reviewed in this study, focusing on how the National Council on Compensation Insurance, Inc. (NCCI) classifies these operations.

NCCI retains the following classifications for operations covered in this study:

- Classification 8058, *Building Material Dealer – New Materials Only – Store Employees,* with cross reference to *Home Improvement Center – New Materials Only – Store Employees,* is assignable to employees of building material dealers, home improvement centers and lumberyards who are engaged in store operations. Home improvement centers are defined as building material dealers characterized by an extensive store operation handling a wide variety of products in addition to normal building materials and related hardware items. A home improvement center contemplates both inside sales and outside yard operations.

- Classification 8232, *Building Material Dealer – New Materials Only – All Other Employees & Yard, Warehouse, Drivers,* with cross reference to *Home Improvement Center – New Materials Only – All Other Employees & Yard, Warehouse, Drivers* applies to those employees, other than employees assigned to Code 8058.

- Similar to California, NCCI assigns Classification 8017, *Store – Retail – N.O.C.,* to retail stores that are engaged in selling merchandise that is not described by a specialty retail store classification.

Recommendation
Amend Classification 8232(2), *Building Material Dealers,* to (1) include the sale of stone materials, stone slabs or fabricated stone products, including but not limited to stone countertops, (2) provide direction to separately classify employees engaged in cashiering operations or selling, stocking, handling or delivering store merchandise when the sale of store merchandise at a single locations exceeds 25% of gross receipts, (3) provide direction as to how related operations should be classified and (4) for clarity.

PROPOSED

BUILDING MATERIAL DEALERS – commercial – including counterpersons **8232(2)**

This classification applies to the sale of building materials, including but not limited to sand, gravel, cement, drilling mud, brick, fencing wire, wallboard, doors, roofing ~~paper~~materials, paneling, ~~decorative stone and~~ foundation piers, stone materials, stone slabs and fabricated stone products. This classification also applies to the sale of countertops, including but not limited to granite, marble, limestone or other natural stone, quartz, engineered stone, laminate or solid surface countertops. This classification includes handling, stocking or delivery of building materials.

This classification also applies to the sale of used building materials, including incidental cleaning, trimming or cutting operations to prepare items for sale.

~~The operation of a store for~~When, at a single location, the sale of store merchandise, including but not limited to tile, cabinets or hardware, electrical or plumbing supplies exceeds 25% of gross receipts, employees engaged in selling, stocking, handling or delivery of store merchandise shall be separately classified ~~as 8010, *Stores – hardware, electrical or plumbing supplies*~~to the applicable *Stores* Industry Group classification; refer to Section IV, *Special Industry Classification Procedures*, Rule 6, *Stores*. Cashiers who ~~work in support of hardware, electrical or plumbing supplies~~process store merchandise sales in addition to building material sales shall also be ~~classified as 8010~~assigned to the applicable *Stores* Industry Group classification.

The cutting or fabrication of stone materials, stone slabs or fabricated stone products shall be separately classified as 1803, *Stone Cutting or Fabrication.*

* * * * * * *

Recommendation
Amend Classification 8059, *Stores – tile,* which is part of the *Stores* Industry Group, to (1) include the sale of cabinets, (2) provide direction to separately classify employees engaged in handling, stocking or delivering lumber or building materials when lumber or building material sales exceed 10% of gross receipts and (3) provide direction as to how related operations should be classified.

PROPOSED

STORES

STORES – tile or cabinets – wholesale or retail **8059**

This classification applies to stores engaged in the sale of ~~decorative~~ tile, including but not limited to ceramic, stone, porcelain and glass tile. This classification also applies to stores engaged in the sale of cabinets that are designed to be affixed to building walls or floors, including but not limited to kitchen or bath cabinets.

~~Dealers in stone slabs or countertops~~When lumber or building material sales, including but not limited to ~~marble, granite, quartz and lime~~stone countertop or stone slab materials exceed 10% of gross receipts, employees, other than store salespersons or cashiers, engaged in handling, stocking or delivering lumber or building materials shall be separately classified as 8232(1), *Lumberyards*, or 8232(2), *Building Material Dealers.* When lumber or building material sales do not exceed 10% of gross receipts, such employees are included in Classification 8059.

~~The installation of tile shall be separately classified as 5348, *Tile, Stone, Mosaic or Terrazzo Work.*~~

Stores engaged in the sale of hardware, electrical or plumbing supplies shall be classified as 8010, *Stores – hardware, electrical or plumbing supplies – wholesale or retail.*

Stores engaged in the sale of furniture, including but not limited to couches, chairs, tables, dressers, bed frames, desks and bookcases shall be classified as 8015, *Stores – furniture – wholesale or retail.*

Stores engaged in the sale of vinyl, linoleum, asphalt, laminate or rubber tile floor coverings shall be classified as 8042, *Stores – floor covering.*

The installation of tile shall be separately classified as 5348, *Tile, Stone, Mosaic or Terrazzo Work.*

The installation of cabinets, fixtures, or wood or laminate countertops shall be separately classified as 5146(1), *Cabinet, Fixture or Trim Installation.*

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Recommendation
Amend Classification 8232(1), *Lumberyards*, to separately classify employees engaged in cashiering operations or selling, stocking, handling or delivering store merchandise when the sale of store merchandise at a single location exceeds 25% of gross receipts.

PROPOSED

LUMBERYARDS – commercial – including counterpersons **8232(1)**

This classification applies to commercial lumberyards engaged in the sale of lumber, plywood, moldings, paneling or incidental building materials. This classification includes incidental cutting of lumber to length and handling, stocking or delivery of lumber.

~~The operation of a store for~~When, at a single location, the sale of store merchandise, including but not limited to tile, cabinets or hardware, electrical or plumbing supplies exceeds 25% of gross receipts, employees engaged in selling, stocking, handling or delivery of store merchandise shall be separately classified ~~as 8010, *Stores – hardware, electrical or plumbing* supplies~~to the applicable *Stores* Industry Group classification; refer to Section IV, *Special Industry Classification Procedures*, Rule 6, *Stores*. Cashiers who ~~work in support of hardware, electrical or plumbing supplie~~process store merchandise sales in addition to ~~lumber~~building material sales shall also be ~~classified as 8010~~assigned to the applicable *Stores* Industry Group classification.

The sale of building materials, including secondhand building materials, shall be classified as 8232(2), *Building Material Dealers*.

Dealers of solid combustible fuel materials or soil amendments shall be classified as 8232(3), *Fuel and Material Dealers.*

The processing of logs into shingles or rough lumber shall be separately classified as 2710(1), *Sawmills or Shingle Mills*.

Planing of lumber to produce finished lumber, flooring or unassembled millwork shall be separately classified as 2731, *Planing or Moulding Mills*.

The application of preservative treatments to logs or lumber shall be separately classified as 2710(3), *Wood Treating or Preserving*.

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Recommendation
Amend Classification 8010, *Stores – hardware, electrical or plumbing supplies,* which is part of the *Stores* Industry Group, for consistency with other proposed changes.

PROPOSED

STORES

STORES – hardware, electrical or plumbing supplies – wholesale or retail **8010**

This classification applies to the sale of hardware, electrical or plumbing supplies, including but not limited to nails, screws ~~and~~or threaded fasteners; hand or power tools; door or lock hardware; electrical wire, conduit, switches, outlets ~~and~~or circuit breakers; new or used gas or water fittings, pipe, valves, faucets ~~and~~or filters; bathroom fixtures~~,~~; water heaters~~,~~ or boilers~~,~~; insulation; and ventilating ducts. This classification also applies to the sale of oil, gas or water well supplies, such as pipe (new or used), tubing, flanges, fittings and valves, and includes incidental cleaning operations to prepare the pipe for sale.

This classification also applies to locksmith operations performed at fixed or outside locations.

~~When lumber sales exceed 10% of gross receipts, employees, other than store cashiers, engaged in handling or delivering lumber shall be separately classified as 8232(1), *Lumberyards*.~~

When lumber or building material sales exceed 10% of gross receipts, employees, other than store salespersons or cashiers, engaged in handling, stocking or delivering lumber or building materials shall be separately classified as 8232(1), *Lumberyards*, or 8232(2), *Building Material Dealers*. When lumber or building material sales do not exceed 10% of gross receipts, such employees are included in Classification 8010.

Dealers of oil or gas well machinery or equipment shall be classified as 8107, *Machinery and Equipment Dealers – N.O.C.*, or 8267, *Machinery and Equipment Dealers – secondhand.*

* * * * * * *

Recommendation
Amend Classification 8042, *Stores – floor covering,* which is part of the *Stores* Industry Group, for consistency with other proposed changes.

PROPOSED

STORES

STORES – floor covering – wholesale or retail – carpet, rugs, vinyl or linoleum – including showroom sales **8042**

This classification applies to stores engaged in the sale of floor coverings, including but not limited to carpet ~~and~~or rugs; vinyl, linoleum, asphalt ~~and~~or rubber sheets, planks ~~and~~or tile; prefinished hardwood ~~and~~or bamboo strips ~~and~~or planks; and laminate ~~and~~or cork planks ~~and~~or tiles. This classification also applies to floor covering auctioneers.

The installation of linoleum, vinyl, laminate, carpet, rugs or asphalt or rubber tile shall be separately classified as 9521(2), *Floor Covering – installation.*

The installation or refinishing of hardwood or bamboo flooring shall be separately classified as 5436, *Hardwood Floor Laying.*

Dealers of building materials, including unfinished hardwood flooring, shall be classified as 8232(2), *Building Material Dealers*.

Stores engaged in the sale of ceramic ~~floor~~, stone, porcelain or glass tile shall be classified as 8059, *Stores – tile or cabinets – wholesale or retail*.

* * * * * * *

Recommendation
Amend Classification 8015, *Stores – furniture,* which is part of the *Stores* Industry Group, for consistency with other proposed changes.

PROPOSED

STORES

STORES – furniture – wholesale or retail **8015**

This classification applies to stores engaged in the sale or rental of furniture, including but not limited to couches, chairs, tables, dressers, bed frames, desks and bookcases. This classification also applies to furniture auctioneers.

This classification also applies to the operation of furniture galleries or showrooms that display samples of furniture for viewing and direct sale to customers. Such operations include but are not limited to the sale of furniture by salespersons, interior decorators or designers retained by the employer, and furniture shipping, receiving and delivery. This classification includes travel to customers' locations by salespersons, interior decorators or designers to gather information or provide advice in support of furniture sales.

This classification does not apply to the operation of furniture galleries or showrooms that sell exclusively from samples to buyers for stores (no direct sales) and where no inventory (exclusive of showroom samples) is maintained at the gallery or showroom location. Such gallery or showroom salespersons shall be classified as 8742, *Salespersons – Outside,* provided they have no other duties of any kind in the service of the employer except clerical work or outside sales. See Part 3, Section IV, Rule 6, *Stores*.

Stores engaged only in the sale of mattresses or box springs shall be classified as 8017(1), *Stores – retail.*

Stores engaged in the sale of tile or cabinets, including but not limited to kitchen or bath cabinets shall be classified as 8059, *Stores – tile or cabinets – wholesale or retail.*

The installation, service or repair of household appliances shall be separately classified as 9519(1), *Household Appliances.*

The installation of linoleum, vinyl, cork, asphalt or rubber tile, or laminate (not hardwood) flooring within buildings, as well as the laying of carpets or rugs, shall be separately classified as 9521(2), *Floor Covering – installation.*

The installation of hardwood or bamboo floors, including baseboard molding installed in connection therewith, shall be separately classified as 5436, *Hardwood Floor Laying.*

The installation of window coverings, including associated hardware, within buildings shall be separately classified as 9521(3), *Window Covering.*

* * * * * * *

Recommendation
Amend Section VIII, *Abbreviated Classifications – Numeric Listing*, for consistency with other proposed changes.

Section VIII – Abbreviated Classifications – Numeric Listing

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8059 Stores–tile/cabinets

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Item III-E
Proposed Classification Enhancements to the *California Workers' Compensation Uniform Statistical Reporting Plan—1995*

The Committee was reminded that the WCIRB continually reviews the standard classifications contained in the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* to ensure that the intended application of each classification is comprehensive and clear. WCIRB staff identified several classifications that could be clarified and, therefore, recommended revisions for clarity, consistency and to provide direction about how related operations are classified.

The Committee was advised that staff was withdrawing the proposed changes to Classification 2585(1), *Laundries*, in order to make additional edits and will bring this item back to the Committee at a later meeting.

As there were no questions about the proposed changes, a motion was made, seconded and unanimously passed to recommend that the proposed changes be included in the September 1, 2022 Regulatory Filing.

Recommendation
Amend Classification 2589(2), *Dry Cleaning – N.O.C.,* to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

DRY CLEANING – ~~N.O.C.~~commercial – including repairing or pressing, and cash and carry departments on plant premises **2589(2)**

This classification applies to locations at which more than 50% of gross receipts are derived from the dry cleaning of garments, linens or other household items that are owned by commercial customers rather than the general public.

Locations at which 50% or more of gross receipts are derived from the dry cleaning or laundering of garments, linens or other household items that are owned by the general public shall be classified as 2589(1), *Dry Cleaning or Laundry*.

Commercial laundry operations, including the rental and laundering of clothing, towels, linens, diapers ~~and~~or similar items shall be classified as 2585(1), *Laundries*.

* * * * * * *

Recommendation
Amend Classification 3805(1), *Aircraft Engine Mfg. or Rebuilding,* to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

AIRCRAFT ENGINE MFG. OR REBUILDING **3805(1)**

This classification applies to manufacturing or rebuilding aircraft engines when such operations are not performed in connection with aircraft manufacturing.

~~Employers that remove or install engines or otherwise work~~The repair, rebuilding or modification of aircraft engines, when performed directly on the aircraft or in connection with the removal and reinstallation of engines, components or accessories by the same employer shall be classified as 7428(3), *Aircraft Remanufacture, Conversion, Modification and Repair Companies.*

The manufacture or repair of machined aircraft components ~~and~~or accessories (not aircraft engines) by employers approved by the Federal Aviation Administration, when such operations are not performed directly on the aircraft or in connection with the removal and reinstallation of engines, components or accessories by the same employer, shall be classified as 3831, *Machine Shops – aircraft components,* ~~in accordance with the provisions of the Multiple Enterprises rule~~.

* * * * * * *

Recommendation
Amend Classification 8388, *Rubber Tire Dealers,* which is part of the *Automotive* Industry Group, to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

AUTOMOTIVE INDUSTRY

RUBBER TIRE DEALERS ~~– wholesale or retail, or combined wholesale and retail~~ – including ~~inside salespersons,~~ estimators, service writers, customer service representatives ~~and~~, cashiers~~; repairing and adjusting tires away from the premises;~~, and accessories and spare parts departments **8388**

This classification applies to dealers that sell rubber tires to commercial customers or the general public. This classification also applies to automobile, truck or bus service or repair facilities at which the sale of rubber tires exceeds 10% of the total gross receipts. Automobile, truck or bus service or repair facilities at which the sale of rubber tires does not exceed 10% of the total gross receipts shall be assigned to the applicable *Automotive* Industry Group classification.

Recapping or retreading ~~of~~used tires shall be separately classified as 4420, *Rubber Tire Recapping or Retreading*.

* * * * * * *

Recommendation
Amend Classification 8839, *Dentists and Dental Surgeons,* which is part of the *Health and Human Services* Industry Group, to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

HEALTH AND HUMAN SERVICES

~~DENTISTS AND~~ DENTAL ~~SURGEONS~~OR ORTHODONTIA PRACTICES ~~– all employees —~~ including Clerical Office Employees and Clerical Telecommuter Employees **8839**

This classification applies to dental practices or clinics that provide general, restorative or cosmetic dental services or teeth whitening or straightening procedures. This classification also applies to ~~orthodontists and periodontists~~periodontal or oral surgery practices. This classification includes the manufacture or customization of dental products, including but not limited to crowns, dentures, inlays and bridges when performed in connection with the dental services provided.

~~This classification includes the manufacture or customization of dental products, including but not limited to crowns, dentures, inlays and bridges when such operations are primarily in support of the dental services provided~~Physicians' practices or clinics that provide outpatient medical services shall be classified as 8834, *Physicians' Practices and Outpatient Clinics*.

The manufacture ~~or customization~~ of dental products primarily for other concerns shall be separately classified as 4692, *Dental Laboratories*.

* * * * * * *

Recommendation
Amend Classification 8601(4), *Forest Engineers,* to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

FOREST ENGINEERS – including Clerical Office Employees, Clerical Telecommuter Employees and Outside Salespersons **8601(4)**

This classification applies to forest engineers performing forest management related duties in support of the employer's own operations or on a consulting basis. Such duties include but are not limited to developing or reviewing logging plans, computing the value of standing timber and planning extensions of fire roads constructed in connection with logging operations.

This classification includes timber cruising.

Commercial timber harvesting shall be separately classified as 2702(1), *Logging*.

* * * * * * *

Recommendation
Amend Classification 0096, *Nut Hulling, Shelling or Processing,* which is part of the *Food Packaging and Processing* Industry Group, to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

FOOD PACKAGING AND PROCESSING

NUT HULLING, SHELLING OR PROCESSING **0096**

This classification applies to the hulling, shelling, cleaning, drying, sorting or packaging of nuts, including but not limited to peanuts, almonds, walnuts, pecans, pistachios and cashews. This classification also applies to nut processing, including but not limited to roasting, smoking, salting ~~and~~or flavoring; the manufacture of peanut butter or other nut butters; or grinding nuts to produce meal or pastes for baking.

The manufacture of non-alcoholic juice or juice concentrates from fruit, vegetables, nuts or seeds shall be separately classified as 2116, *Juice or Juice Concentrate Mfg.*

The manufacture of food products shall be separately classified as 6504, *Food Products Mfg. or Processing,* unless the operations are more specifically described by another *Food Packaging and Processing* Industry Group classification.

Growing or harvesting, including field packing, of crops~~,~~ shall be assigned to the applicable *Farms* Industry Group classification.

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Recommendation
Amend Classification 4692, *Dental Laboratories*, for consistency with other proposed changes.

PROPOSED

DENTAL LABORATORIES – including foundry or casting operations **4692**

This classification applies to the manufacture of dental appliances or devices, including but not limited to crowns, dentures, inlays, bridges, braces and retainers in accordance with orders placed by dentists or orthodontists for individual patients.

~~Dentists, orthodontists and d~~Dental ~~surgeons~~, orthodontia, periodontal and oral surgery practices shall be separately classified as 8839, ~~*Dentists and Dental Surgeons*~~*or Orthodontia Practices*.

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Recommendation
Amend Classification 2585(2), *Dyeing*, to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

DYEING – including yarn or thread dyeing or finishing – no yarn or thread manufacturing **2585(2)**

This classification ~~shall not be used for division of payroll in connection with any other classification (other than the Standard Exceptions or General Exclusions) unless the operations described by Classification 2585(2) constitute a separate and distinct enterprise having no connection with the operations covered by any other applicable classification~~applies to dyeing finished garments or other finished fabric products or dying or finishing yarn or thread. This classification also applies to stone washing, bleaching, sanding or dyeing clothing when performed for other concerns on a fee basis and not in connection with clothing manufacturing operations by the same employer.

Dyeing ~~of textile~~, bleaching, mercerizing or finishing fabric~~s~~ raw materials, not finished garments or other finished fabric products, shall be classified as 2413, *Textiles.*

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Recommendation
Amend Classification 2589(1), *Dry Cleaning or Laundry*, to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

DRY CLEANING OR LAUNDRY – retail – including alterations, repairing or pressing, and cash and carry departments on premises **2589(1)**

This classification applies to locations at which more than 50% of gross receipts are derived from the dry cleaning or laundering of garments, linens ~~and~~or other household items that are owned by the general public. This classification also applies to self-service laundries that retain attendants to perform ~~"fluff~~wash and fold~~"~~ activities.

Locations at which 50% or more of gross receipts are derived from the dry cleaning of garments, linens or other household items that are owned by commercial customers rather than the general public shall be classified as 2589(2), *Dry Cleaning – commercial.*

Self-service laundries that do not retain attendants to perform ~~"fluff~~wash and fold~~"~~ activities shall be classified 8017(1), *Stores – retail*.

Cash and carry facilities, situated away from the dry cleaning or laundry location, that solely engage in the receipt and distribution of items to be cleaned shall be classified as 8017(1), *Stores – retail.*

~~Diaper service companies and uniform and linen rental or service companies~~Commercial laundry operations, including but not limited to the washing and pressing of fabric items, clothing, uniforms, draperies, diapers or linens for commercial customers on a fee basis or the rental and laundering of towels, linens, diapers or similar items shall be classified as 2585(1), *Laundries*.

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Recommendation
Amend Classification 3830(1), *Aircraft or Spacecraft Mfg.*, to provide direction as to how related operations should be classified.

PROPOSED

AIRCRAFT OR SPACECRAFT MFG. – including foundry operations **3830(1)**

This classification applies to the manufacture of aircraft, including but not limited to fixed wing airplanes and helicopters. This classification also applies to the manufacture of aerospace products, including but not limited to missiles, rockets and other spacecraft. This classification also applies to the manufacture of light sport aircraft ~~and~~or hang gliders.

This classification includes foundry operations performed in connection with the aircraft or spacecraft manufacturing operations.

All members of the flying crew for aircraft operations, including but not limited to test flight operations performed by the manufacturer shall be classified in accordance with Section III, Rule 6, *General Exclusions*.

The manufacture of Unmanned Aircraft Systems (aerial drones) with a total combined weight of 55 pounds or heavier shall be classified as 3830(2), *Unmanned Aircraft System Mfg.*

The manufacture of Unmanned Aircraft Systems (aerial drones) with a total combined weight of less than 55 pounds shall be classified as 3681(1), *Instrument Mfg. – electronic.*

The manufacture of communication satellites shall be classified as 3681(3), *Telecommunications Equipment Mfg.*

Aircraft engine manufacturing or rebuilding not in connection with aircraft manufacturing by the same employer shall be classified as 3805(1), *Aircraft Engine Mfg. or Rebuilding*.

~~The~~Employers that are approved by the Federal Aviation Administration and manufacture or repair ~~of~~ machined aircraft components ~~performed by employers that are approved by the Federal Aviation Administration, when such operations are not performed directly on the aircraft or in connection with components that are removed from and later reinstalled on the aircraft,~~or accessories (not aircraft engines) shall be classified as 3831, *Machine Shops – aircraft components*, provided the employer does not perform such operations directly on the aircraft or remove and reinstall the components or accessories.

The repair, ~~and~~ rebuilding or modification of aircraft components ~~and parts~~or accessories, including aircraft engines, when ~~such operations are~~ performed directly on the aircraft or in connection with the removal and reinstallation of components ~~that are removed from and later reinstalled on the aircraft~~or accessories by the same employer~~,~~ shall be classified as 7428(3), *Aircraft Remanufacture, Conversion, Modification and Repair Companies.*

Aircraft operation, demonstration or flight testing shall be separately classified.

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Recommendation
Amend Classification 3831, *Machine Shops – aircraft components*, to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

MACHINE SHOPS – aircraft components **3831**

This classification applies to employers that are approved by the Federal Aviation Administration and ~~engage in the~~ manufacture or repair ~~of~~ machined aircraft components ~~and~~or accessories ~~provided the employer does not remove or install parts or otherwise work directly on the aircraft~~(not aircraft engines) when such operations are not performed directly on the aircraft or in connection with the removal and reinstallation of components or accessories by the same employer.

Aircraft engine manufacturing or rebuilding not in connection with aircraft manufacturing by the same employer shall be classified as 3805(1), *Aircraft Engine Mfg. or Rebuilding*.

~~Employers that remove or install parts or otherwise work directly on the aircraft~~The repair, rebuilding or modification of aircraft components or accessories, including engines, when performed directly on the aircraft or in connection with the removal and reinstallation of components

or accessories by the same employer, shall be classified as 7428(3), *Aircraft Remanufacture, Conversion, Modification and Repair Companies*.

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Recommendation
Amend Classification 7428(3), *Aircraft Remanufacture, Conversion, Modification and Repair Companies*, to clarify the intended application and provide direction as to how related operations should be classified.

PROPOSED

AIRCRAFT REMANUFACTURE, CONVERSION, MODIFICATION AND REPAIR COMPANIES – not engaged in the original manufacturing of aircraft **7428(3)**

This classification applies to the repair, ~~and~~ rebuilding or modification of aircraft. This classification includes the manufacture or repair of machined aircraft components ~~and parts~~, accessories or engines when ~~such operations are~~ performed directly on the aircraft or in connection with the removal and reinstallation of engines, components ~~that are removed from and later reinstalled on the aircraft~~or accessories by the same employer. This classification also includes but is not limited to aircraft cleaning, ~~and~~ detailing and ~~aircraft~~ fueling on a fee basis.

Employers that are approved by the Federal Aviation Administration and ~~engage in the~~ manufacture or repair ~~of~~ machined aircraft components ~~and~~or accessories (not aircraft engines) shall be classified as 3831, *Machine Shops – aircraft components*, provided the employer does not ~~remove or install parts or otherwise work directly on the aircraft~~perform such operations directly on the aircraft or remove and reinstall the components or accessories.

Aircraft engine manufacturing or rebuilding not in connection with aircraft manufacturing by the same employer shall be classified as 3805(1), *Aircraft Engine Mfg. or Rebuilding*.

The shop repair of Unmanned Aircraft Systems (aerial drones) with a total combined weight of 55 pounds or heavier by the manufacturer shall be classified as 3830(2), *Unmanned Aircraft System Mfg.*

Also refer to companion Classification 7424(1), *Aircraft Operation – other than agricultural or scheduled air carriers – members of the flying crew.*

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Recommendation
Amend Classification 3632, *Machine Shops – N.O.C.*, to provide direction as to how related operations should be classified.

PROPOSED

MACHINE SHOPS – N.O.C. **3632**

This classification applies to machining operations performed on a contract or proprietary basis when such operations are not specifically described by another machining, manufacturing or assembly classification. This classification includes the drilling of printed circuit boards on a contract basis.

Manufacturing screw machine products, including but not limited to connectors, fittings, spacers, pins and bushings, on a fee basis or as proprietary products using fully automatic screw machines for some or all of the machining operations shall be classified as 3152(3), *Screw Machine Products Mfg.*

Manufacturing nuts, bolts, screws or similar threaded fasteners shall be classified as 3152(2), *Nut, Bolt or Screw Mfg.*

~~The~~Employers that are approved by the Federal Aviation Administration and manufacture ~~of~~for repair machined aircraft ~~parts by employers that are approved by the Federal Aviation Administration~~components or accessories (not aircraft engines) shall be classified as 3831, *Machine Shops – aircraft components*, provided the employer does not perform such operations directly on the aircraft or remove and reinstall the components or accessories.

Manufacturing new automobile, truck or motorcycle parts shall be classified as 3840, *Automobile, Truck or Motorcycle Parts Mfg.*

The ~~machining or~~ rebuilding of ~~used automotive~~automobile, truck or motorcycle parts shall be classified as 3828, *Automobile or Truck Parts Rebuilding.*

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Recommendation
Amend Section VIII, *Abbreviated Classifications – Numeric Listing*, for consistency with other proposed changes.

PROPOSED

Section VIII – Abbreviated Classifications – Numeric Listing

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2116 ~~Fruit/Vegetable~~ Juice/Juice Concentrate Mfg

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2589(2) Dry Cleaning ~~N.O.C.~~ commercial
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8839 ~~Dentists/~~Dental ~~Surgeons~~/Orthodontia Practices
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Amend Appendix IV, *Classifications Including Clerical Office Employees, Clerical Telecommuter Employees or Outside Salespersons*, for consistency with other proposed changes.

PROPOSED

Appendix IV

Classifications Including Clerical Office Employees, Clerical Telecommuter Employees or Outside Salespersons

See Section III, *General Classification Procedures*, Rule 4, *Standard Exceptions*, Subrule c, *Standard Exception Classification Procedures*.

Code	Name	Including Clerical Office Employees / Clerical Telecommuter Employees	Including Outside Salespersons
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•			
•			
8839	~~Dentists/~~Dental ~~Surgeons~~/Orthodontia Practices	X	
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The meeting was adjourned at 11:40 AM.

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Note to Committee Members: These Minutes, as written, have not been approved. Please refer to the Minutes of the meeting scheduled for September 22, 2021 for approval and/or modification.

Item IV-B
September 1, 2021 Pure Premium Rate Filing

At the April 21, 2021 meeting, the Committee approved the filing of proposed advisory September 1, 2021 pure premium rates that averaged $1.50 per $100 of payroll and were on average 2.7% higher than the average January 1, 2021 approved advisory pure premium rates. On April 29, 2021, the WCIRB submitted its September 1, 2021 Pure Premium Rate Filing to the Insurance Commissioner.

The Commissioner held a public hearing to consider all matters in the September 1, 2021 Pure Premium Rate Filing on June 7, 2021 and the record was kept open following the hearing until the close of business on July 6, 2021. On July 21, 2021, the Commissioner issued his Decision (see attached).

In the Decision, the Commissioner approved advisory pure premium rates that average $1.41 per $100 of payroll. The average approved September 1, 2021 advisory pure premium rate is 3.4 percent below the average approved January 1, 2021 advisory pure premium rate. The approved September 1, 2021 advisory pure premium rates differ from the WCIRB's proposed pure premium rates due to somewhat different assumptions regarding medical loss development and future claim frequency and claim severity trends.

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
300 Capitol Mall, 17th Floor
Sacramento, CA 95814

DECISION AND ORDER

SEPTEMBER 1, 2021 WORKERS' COMPENSATION CLAIMS COST BENCHMARK AND ADVISORY PURE PREMIUM RATES

FILE NUMBER REG-2021-00003

In the Matter of: Proposed adoption or amendment of the Insurance Commissioner's regulations pertaining to the Workers' Compensation Insurance Claims Cost Benchmark and Advisory Pure Premium Rates. CDI File Number REG-2021-00003. The benchmark will be effective on **September 1, 2021**.

DECISION AND ORDER

I adopt the Proposed Decision and Order of Yvonne Hauscarriague dated July 21, 2021, and direct the WCIRB to adopt an average advisory claims cost benchmark of $1.41 per $100 of employer payroll and adjust the pure premium rates for individual classifications based upon this benchmark.

IT IS SO ORDERED THIS 21 DAY OF JULY, 2021.

RICARDO LARA
Insurance Commissioner

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
300 Capitol Mall, 17th Floor
Sacramento, CA 95814

PROPOSED DECISION AND ORDER

SEPTEMBER 1, 2021 WORKERS' COMPENSATION CLAIMS COST BENCHMARK AND ADVISORY PURE PREMIUM RATES

FILE NUMBER REG-2021-00003

In the Matter of: Proposed adoption or amendment of the Insurance Commissioner's ("Commissioner") regulations pertaining to the workers' compensation insurance claims cost benchmark and advisory pure premium rates. These regulations will be effective on September 1, 2021.

SUMMARY OF PROCEEDINGS

The California Department of Insurance ("Department") held a public hearing in the above-captioned matter on June 7, 2021 at the time and place set forth in the Notice of Proposed Action and Notice of Public Hearing, File Number REG-2021-00003, dated May 7, 2021 ("Notice"). A copy of the Notice is included in the record. The record closed on July 6, 2021.

The Department distributed copies of the Notice to the persons and entities referenced in the record. The Notice included a summary of the proposed changes and instructions for interested persons who wanted to view a copy of the information submitted to the Commissioner in connection with the proposed changes. The filing letter dated April 29, 2021, submitted by the Workers' Compensation Insurance Rating Bureau of California ("WCIRB"), and related documents were available for inspection by the public at the Oakland office of the Department and were available online at the WCIRB's website, www.wcirb.com.

The WCIRB's filing proposes a change in the workers' compensation claims cost benchmark and advisory pure premium rates ("benchmark") in effect since January 1, 2021, that reflects insurer loss costs and loss adjustment expenses ("LAE").

In its filing, the WCIRB requested that the Commissioner adopt a set of advisory pure premium rates for each classification to be effective September 1, 2021.

The WCIRB recommended an average pure premium rate of $1.50 per $100 of payroll, which is 2.7% more than the approved average pure premium rate as of January 1, 2021.

The Department accepted testimony and written comments at a hearing held on a virtual platform on June 7, 2021, and also received exhibits into the record. Members of the public submitted additional materials along with correspondence and documents prior to the hearing. The Commissioner announced that the record would remain open pending the receipt of additional information from the WCIRB and Bickmore Actuarial, the actuary representing the Public Members of the Workers' Compensation Insurance Rating Bureau's Governing Committee. The record closed on July 6, 2021. After the hearing and before the closure of the record, the Department received into the record additional comments from the WCIRB and Bickmore. The matter was submitted for decision at 5:00 p.m. on July 6, 2021. Having been duly heard and considered, the Department now presents the following review, analysis, Proposed Decision, and Proposed Order.

REVIEW OF WORKERS' COMPENSATION CLAIMS COST BENCHMARK AND ADVISORY PURE PREMIUM RATES FILING

Subdivision (b) of California Insurance Code Section 11750 states that the Commissioner shall hold a public hearing within 60 days of receiving an advisory pure premium rate filing made by a rating organization pursuant to subdivision (b) of Insurance Code Section 11750.3 and either approve, disapprove, or modify the proposed rate. Subdivision (b) of Section 11750.3 states a licensed rating organization, such as the WCIRB, shall collect and tabulate information and statistics for the purpose of developing pure premium rates for its insurance company members to be submitted to the Commissioner. Pure premium rates are the cost of workers' compensation benefits and the expense to provide those benefits.

The pure premium rates approved in this process by the Commissioner are only advisory. Insurers are permitted under California law to make their own determinations as to the pure premium rates each insurer will use, as long as the ultimate rates charged do not threaten the insurer's financial solvency, are not unfairly discriminatory, and do not tend to create a monopoly in the marketplace.

The Department's actuary, Mitra Sanandajifar, provides below in the Actuarial Evaluation a review and analysis based upon the filing information presented by the WCIRB and the public's comments about the filing. The Department's

actuarial review is consistent with the approach used for prior pure premium rate filings. The pure premium rate process serves as an important gauge or benchmark of the costs in the workers' compensation system, but must also reflect the reality of insurer rate filings and the premiums insurers charge to employers.

The pure premium rate process does not reflect an employer's final paid insurance rate or premium. Instead, the pure premium process is narrowly tailored to project a specific sub-component of an overall rate. For example, the pure premium rate does not include the costs associated with underwriting expenses, profit, or a return on an insurer's investments. The analysis of pure premium in California projects the cost of benefits and LAE for the upcoming policy period beginning September 1, 2021. The term "rate" can be confusing in the pure premium context since it is a measurement of average claim cost per $100 of employer payroll rather than the rates insurers may charge.

These figures are not predictive of an individual employer's insurance premium. That premium may fluctuate greatly from these figures based upon an employer's business, the mix of employees and operations, and the employer's actual claims experience. It is not possible to determine an individual employer's premium from these figures or from the Commissioner's pure premium determination because the review of pure premium rates represents just one component of insurance pricing.

ACTUARIAL RECOMMENDATION

The WCIRB has proposed an average advisory pure premium rate level of $1.50 per $100 of payroll in its September 1, 2021 filing. The $1.50 average pure premium rate does not include any provision for the estimated cost of the COVID-19 claims that will incur during the September 1, 2021 policy period, as the WCIRB has determined that in light of the current success of the COVID-19 vaccines and the research published by the sources that the WCIRB has relied on, inclusion of such a provision was not recommended for policies incepting on September 1, 2021 and later. The Department's staff actuaries' analysis, as set forth in the following Actuarial Evaluation section, results in an average pure premium rate level of $1.41 per $100 of payroll. The most recently available industry average level of pure premium rates filed by insurers with the Department is $1.86 per $100 of payroll as of January 1, 2021. While the indicated pure premium rate level represents our central estimate, and thus our recommendation, we note that both the WCIRB's estimate of $1.50 and the

middle estimate of $1.34 from the Public Members' Actuary (Bickmore) are within reasonable actuarial range.

With his decision on the January 1, 2021 advisory pure premium rates, the Commissioner approved pure premium rates that did not include a provision for COVID-19 estimated claims costs, and ordered that any provision in the rates filed by the insurers to cover the estimated costs of the COVID-19 claims, be accounted for and tracked separately.

In this filing, the WCIRB utilizes the data excluding COVID-19 claims, and January 1, 2021 industry filed pure premium rates excluding any provision for the estimated cost of the COVID-19 claims, as the basis for the determination of the proposed change in the average pure premium rate level.

The WCIRB's filing compares its proposed average pure premium rate level to the average industry-filed pure premium rate level. We believe this comparison is useful. It provides an appropriate basis for assessing both the industry's ability to adapt to the proposed pure premium rate level and the size of the potential market impact of such an adjustment. We note that under California law, the Insurance Commissioner's adopted pure premium rates are advisory, and insurers are free to make their own decisions as to what pure premium rates they will use in their rate filings and what rates to charge. The most recently filed pure premium rates by insurers are higher than the Insurance Commissioner's most recently adopted pure premium advisory rates.

The California workers' compensation market appears to be competitive and financially healthy. Collected premiums in 2020 produced an average charged rate of $1.86, which compares to $1.95[1] and $2.20[2] observed in 2019 and 2018 respectively, showing a continuation of a downward trend in charged market rates that has been in progress since the first half of 2015 when the average charged rate was $3.01. The average charged rate of $1.86 (which reflects all insurer expenses) was approximately 22% higher than the Insurance Commissioner's adopted January 1, 2020 average advisory pure premium rate of $1.52, and 27% more than the Insurance Commissioner's adopted January 1, 2021 average advisory pure premium rate of $1.46[3], which reflect loss and loss adjustment expense only. It was also approximately 30% less than the industry

[1] $2.05 if adjusted for new payroll limitations effective in 2020, to make it comparable to the $1.86 for 2020

[2] $2.31 if adjusted for new payroll limitations effective in 2020, to make it comparable to the $1.86 for 2020

[3] Revised from the Insurance Commissioner's adopted January 1, 2021 Pure Premium Rate of $1.45 based on updated exposure weights by classification.

average filed manual rate of $2.65, thus indicating the average effect of schedule rating and other rating plan credits.

As of December 31, 2020, the WCIRB estimates overall industry combined ratios at or below 86% for accident years 2014 through 2018, and a combined ratio of 95% for accident year 2019. For accident year 2020, the WCIRB projects a combined ratio of 102%, including the cost of COVID-19 claims, of which about six points are estimated for the COVID-19 costs, suggesting a preliminary estimate of the accident year 2020 combined ratio of about 96% excluding COVID-19, and comparable to 95% for 2019 accident year combined ratio. After a period of combined ratios in excess of 100% over the 2008 through 2012 accident years, the 2019 accident year is the seventh consecutive year for the industry with a projected combined ratio at or below 95%, and the higher accident year 2020 combined ratio is due to an extraordinary event, and is not expected to continue. However, current charged rate levels are somewhat lower than the charged rates that underlay the combined ratios for accident years 2015 through 2020.

Actuarial Evaluation

The actuarial evaluation will focus on the following main components of the analysis: (1) loss development; (2) loss trends; (3) loss adjustment expense ("LAE") provision, which includes allocated loss adjustment expense ("ALAE"), unallocated loss adjustment expense ("ULAE") and medical cost containment programs ("MCCP"); (4) impact of changes to the official medical fee and medical-legal fee schedules; and (5) the impact of reform legislation contained in Senate Bill 863 ("SB 863"), Senate Bill 1160 ("SB 1160"), Assembly Bill 1244 ("AB 1244"), and Assembly Bill 1124 ("AB 1124").

Table 1 shows the components of the WCIRB's pure premium rate indications over the past several years, separated into medical, indemnity, LAE, and for the January 1, 2021 filing, the COVID-19 components, along with a comparison to Bickmore's current indication based on its middle scenario. Table 2 displays the percentage impact of the various differences in assumptions and methods for both the Department's staff and the Public Members' Actuary, based on Bickmore's middle projection, as compared to the WCIRB's recommendation.

Table 1

	WCIRB Filed Rates										Bickmore		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
	7/1/15	1/1/16	7/1/16	1/1/17	7/1/17	1/1/18	7/1/18	1/1/19	1/1/20	1/1/21	9/1/21	9/1/21	1/1/21
Medical $	1.14	1.10	1.00	0.95	0.87	0.84	0.76	0.70	0.65	0.62	0.60	0.50	0.56
Indemnity $	0.72	0.69	0.70	0.67	0.64	0.63	0.58	0.54	0.51	0.50	0.53	0.49	0.50
LAE $	0.61	0.63	0.61	0.60	0.51	0.49	0.46	0.46	0.42	0.38	0.37	0.35	0.38
COVID-19 $	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.06	-	-	0.05
Total $	$ 2.47	$ 2.42	$ 2.30	$ 2.22	$ 2.02	$ 1.96	$ 1.80	$ 1.70	$ 1.58	$ 1.56	$ 1.50	$ 1.34	$ 1.49
Industry Avg Filed PP Rate								$ 1.99	$ 1.80	$ 1.86			
Industry Avg Filed Manual Rate (with expenses)								$ 2.82	$ 2.55	$ 2.65			
Industry Avg Charged Rate (net discounts)								$ 2.04	$ 1.90	$ 1.86			

Table 2

	Recommended 9/1/2021 Pure Premium Rates	Impact of Difference in Assumptions & Methods Between WCIRB and Alternative Recommendations					
		Total	Ultimate Medical	Claim Frequency	Indemnity Severity Trend	Medical Severity Trend	Inclusion of 2020 Year
WCIRB	$1.50						
CDI	$1.41	-6.0%	-2.0%	-3.4%	-0.7%	0.0%	0.0%
Bickmore (Middle)*	$1.34	-10.4%	-2.8%	-4.6%	-1.2%	-1.3%	-0.5%

*Bickmore percentage impacts is based on the information provided in May 21, 2021 written testimony.

1. Loss Development

Some form of the paid loss development method has consistently served as the basis for determining ultimate loss estimates for both indemnity and medical losses in the WCIRB's advisory pure premium rate filings for many years. While focusing on the paid method, the WCIRB has also reviewed the results of other methods, particularly the incurred development method, along with multiple variations on these basic methods. At the same time, Bickmore has been giving equal weight to both the paid and incurred development methods in its analysis of ultimate medical losses. The WCIRB's final selection, however, has always been based on the paid development method.

In the last several years, particularly after the implementation of SB 863 in 2013, the WCIRB has incorporated a Berquist-Sherman adjustment for changes in claim settlement rates to the historical paid loss triangles for both indemnity and medical losses in its filings. While the claim settlement rates had been mostly increasing during the pre-pandemic period, following the COVID-19 pandemic, and especially during the second quarter of 2020, claims settlement rates for more recent accident years have decreased sharply. If left unadjusted,

development factors will be overstated during periods of increase in claim settlement rates, and understated during periods of decrease in claim settlement rates.

In addition, the WCIRB has incorporated the impact of various reforms in the paid development factors. Similar to the January 1, 2021 filing, the cumulative paid medical development factors have been adjusted for the impact of SB 1160 and AB 1244 lien-related provisions, assuming a 70% decline in liens compared to the 2nd quarter of 2016, based on updated information and reflecting continued decline in the lien filings from the 60% level, utilized in the January 1, 2021 filing.

Based on a study performed in 2019, and similar to the latest two filings, the WCIRB has also made an adjustment to the paid losses underlying the paid medical development factors for the impact of the significant decline in pharmaceutical costs, which represent a much larger proportion of later period development compared to earlier periods (i.e., varies widely by maturity) and, if left unadjusted, would distort projected age-to-age medical development factors.

In 2020, the WCIRB conducted two studies that led to the implementation of changes in methodology and additional adjustments to late-term development factors and development tail for both indemnity and medical loss development. The results of these studies, discussed below, have been incorporated in the indemnity and medical loss development factors since the January 1, 2021 filing.

One of these studies was the WCIRB's retrospective study on late-term loss development, which showed that compared to the incurred method, the paid loss development method after 267 months was significantly more accurate at projecting recent emerging loss development for these late periods, and produced more stable tail factors. This study resulted in a change from the incurred method to the paid method for development after 267 months.

The second study involved an analysis of the impact of acceleration in claim settlement rates on later period loss development, which showed that there is a strong correlation between changes in the proportion of ultimate claims open at a point in time, and changes in later period loss development. This study resulted in an adjustment to the paid loss development being applied after 276 months for the post-SB 863 increases in claim settlement rates impacting later period loss development.

The Department appreciates the WCIRB's continued efforts to re-evaluate the impact of various reforms and the suitability of the methods underlying the projections, as well as conducting studies to monitor appropriateness of the

projections and proper implementation of adjustments to improve the accuracy of the estimates.

In this filing, the WCIRB reviewed the impact of the distortions caused by the COVID-19 pandemic on the paid loss development, and determined that the use of the Berquist-Sherman adjustment, which adjusts for the decline in claim settlement rates caused by the pandemic, substantially corrects for the impact of the distortions in the second quarter of 2020. In addition, in consideration of the recent volatility in loss development patterns emerging during the pandemic period, the WCIRB has relied on the two-year average claim settlement rate and reform adjusted paid method, compared to the latest year adjusted paid method used in prior filings. The estimated ultimate indemnity and medical loss ratios for 2019 are respectively about 1.3% and 1.9% higher based on the two-year adjusted paid method, compared to the latest year adjusted paid method.

In our review of filings prior to July 1, 2018, we had declined to give any weight to the incurred loss development method, noting that there were several drawbacks with the use of this method, especially on an industrywide basis for the workers' compensation line of insurance. While we had outlined the range of estimates produced by the various actuarial methods utilized by the WCIRB, and provided our commentary on the relative merits of the alternatives, we eventually concluded that the WCIRB's reliance on the paid development method, after adjustment for changes in settlement rates and for the effects of reforms, was appropriate.

However, in the review of the July 1, 2018 WCIRB proposed pure premium rate filing, we found it appropriate to give some weight to the incurred loss development method for projecting ultimate medical losses, despite the impediments to properly adjust the incurred method. Given the shortcomings identified with the incurred method stated below, we chose to give 75% weight to the WCIRB's paid development method, which included the adjustments for reforms and changes in claim settlement rates, and 25% weight to the unadjusted incurred development method. Our selection was made in consideration of the strong evidence that the paid development method had been overestimating ultimate medical losses and that the lower projections based on the incurred method—despite its shortcomings and distortions—could be utilized as an offset to moderate the overstatement in projected ultimate medical losses by the paid method.

The drawbacks with the use of the incurred method lie in the challenges associated with formulating the proper adjustments to make the incurred method more accurate, which include the difficulty of adjusting incurred losses for the

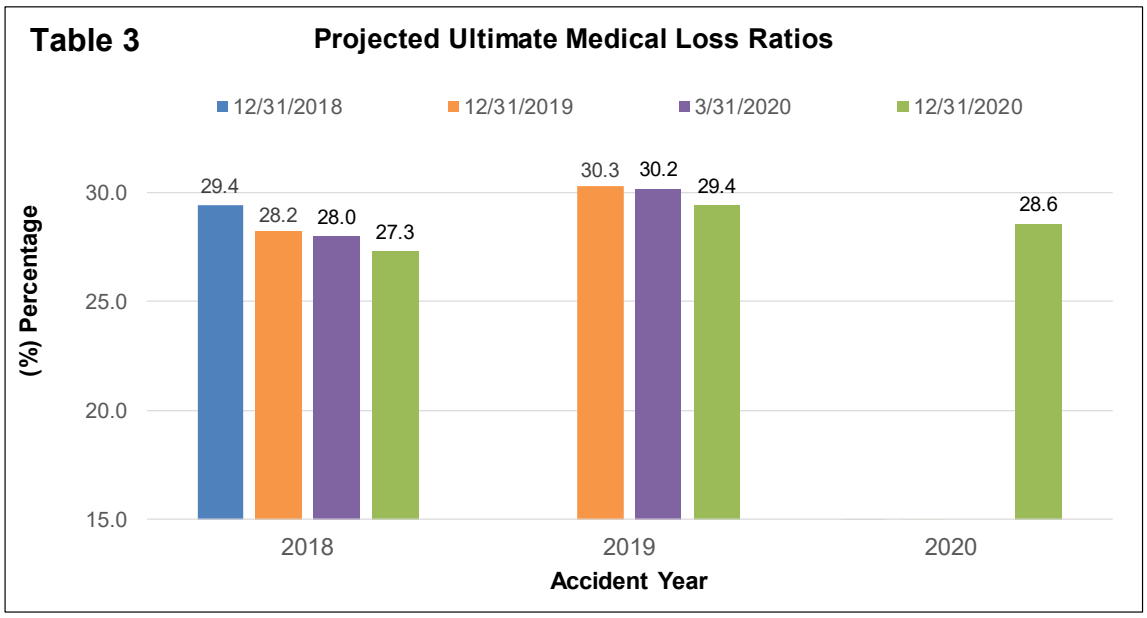
impacts of the various reforms that have affected the historical data. Making such adjustments to historical paid loss data is relatively straightforward, but knowing how much the reforms have influenced the setting of case reserves across the entire insurance industry would seem to be well-nigh impossible.

There is also difficulty in adjusting historical case reserve data to the current level of case reserve adequacy when there are likely to have been different claims handling procedures and case reserving philosophies across the industry, as well as a changing mix of insurers over time. Sorting these effects out would also be quite difficult.

On the other hand, as noted in Bickmore's written testimony, the WCIRB's retrospective evaluation of the performance of alternative loss development methodologies indicate that while the claims settlement and reform adjusted paid development method outperforms other methods, the latest-year incurred method has performed relatively well and significantly better than all other alternative methods for accident years 2014 through 2018 included in the study.

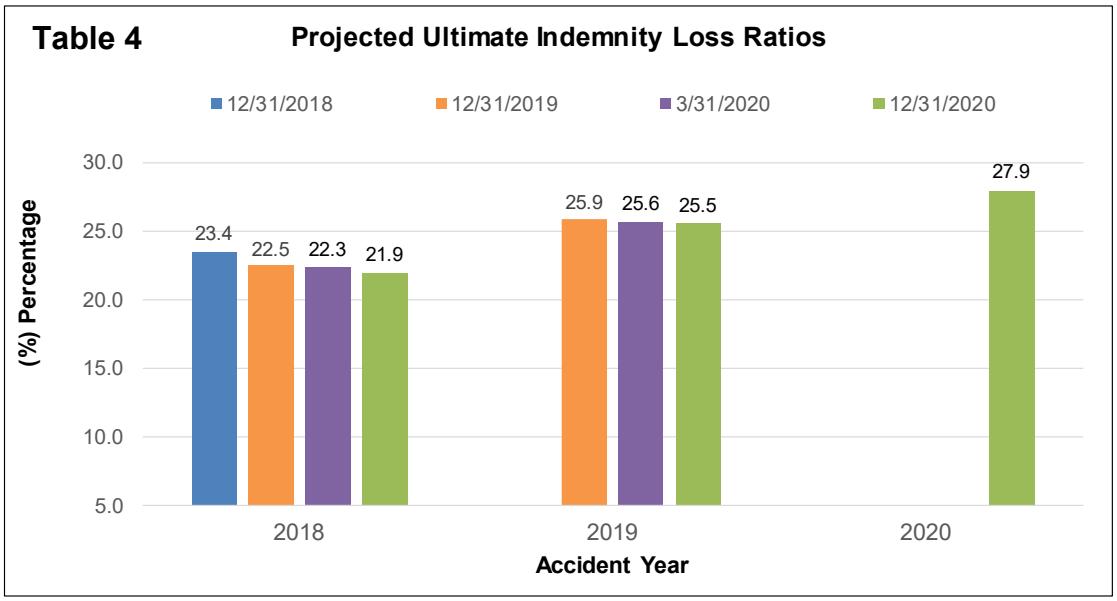
Moreover, the WCIRB's analysis of the distortions in loss development caused by the pandemic, especially during the second quarter of 2020, showed that while the paid loss development that emerged during the pandemic-affected periods was significantly distorted, the incurred development pattern was more stable and consistent with the pre-pandemic period.

Table 3, below, shows successive evaluations of the accident year ultimate medical loss ratios, which have shown continued downward development since December 2018. The accident year 2019 loss ratio has declined by about 2.9% between December 31, 2019 and December 31, 2020, and during the same period, the loss ratio for the more mature accident year 2018 also declined by about 3.2%. These loss ratios are all based on the 2-year average claim-settlement adjusted method utilized by the WCIRB in this filing, have been adjusted for the impact of pharmaceutical cost reductions to bring the historical payments to the current pharmaceutical cost level, as well as the impact of SB 1160, and AB 1244 provisions, and include changes in methodology and adjustments for the late-term loss development discussed above.



Note: All loss ratios are based on the loss development methodology presented in the WCIRB 9/1/2021 Filing, i.e. the 2-Year Average Claim Settlement-Adjusted Method

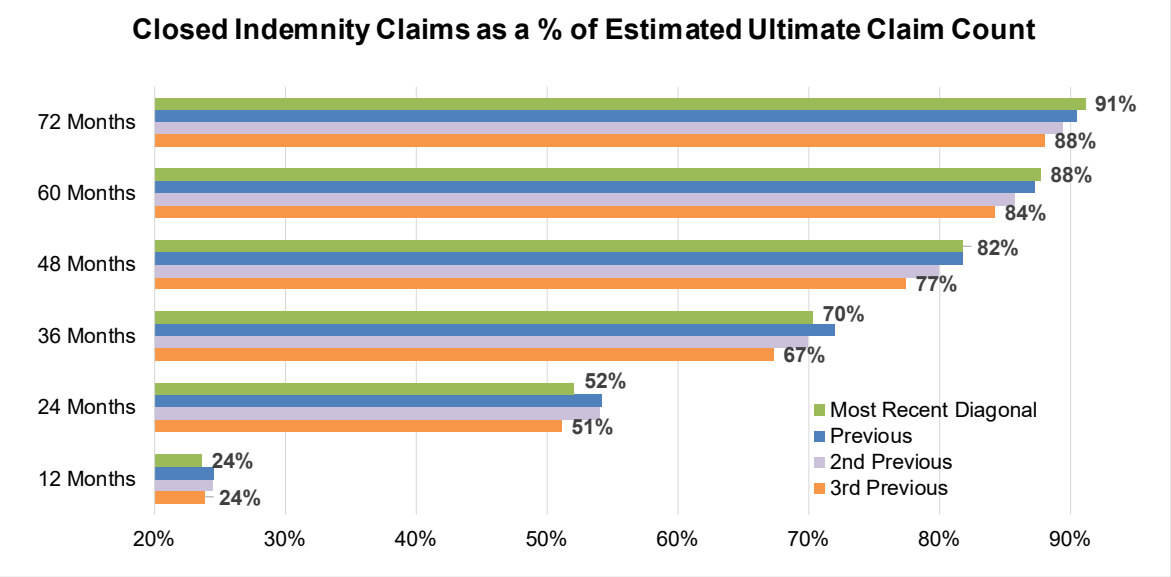
Similarly, as shown in Table 4, the successive estimates for indemnity loss ratios show that while the downward trend has moderated, the accident year 2019 loss ratio has declined by about 1.6% between December 31, 2019 and December 31, 2020, and the loss ratio for the more mature accident year 2018 declined by about 2.7% during the same period, despite utilization of a common more refined loss development methodology.



Note: All loss ratios are based on the loss development methodology presented in the WCIRB 9/1/2021 Filing, i.e. the 2-Year Average Claim Settlement-Adjusted Method

As shown in Table 5, claim settlement rates have declined in 2020 for the three least mature accident years. While prior to the onset of the pandemic the claim settlement rates for these accident years had plateaued, the decline in claim settlement rates appear to be due to a temporary slowdown affected by the COVID-19 pandemic, and are expected to return to the pre-pandemic levels once the operations return to a normal level. However, even with the pandemic, the trend of increase in claim settlement rates following the SB 863 has continued for 60-months-plus maturities.

Table 5



As noted above, the WCIRB has adjusted the development factors for the change in claim settlement rates to bring the historical claim settlement rates to the current level. The WCIRB does not forecast changes in the claim settlement rates, and makes adjustment to the development factors for known changes in claim settlement rates, as mentioned during the hearing.

Moreover, the WCIRB has adjusted the development factors for measurable impacts of the reforms such as the reduction in liens and the decline in pharmaceutical costs.

The continued decline in loss ratios, however, seem to be driven by the indirect impacts of the reforms such as the significant reduction in opioid use and other narcotics on future development of indemnity and medical losses, which have been difficult to quantify and are being allowed to work their way through the indications over time.

Consistent with the methodology used in the review of recent WCIRB pure premium rate filings since the July 1, 2018 filing, we believe it is appropriate to continue to give some weight to the incurred loss development method for projecting ultimate medical losses in this filing. However, given the fact that the incurred method has been proven to be more stable, and not affected by the distortions caused by the pandemic and rapid changes in the claim settlement patterns, for this filing, we choose to give 60% weight to the WCIRB's paid development method, which includes adjustments for the impact of pharmaceutical cost reductions to bring the historical payments to the current pharmaceutical cost level, change in claim settlement rates, and SB 1160 and AB 1244 provisions, and 40% weight to the unadjusted incurred development method. The 60/40% weight selection reflects the Department staff's continued higher reliance on the paid method compared to the incurred method. Furthermore, although the latest-year incurred development method has performed better than the 3-year average incurred development method based on the WCIRB retrospective study, in consideration of stability, and consistent with the methodology utilized in the review of recent filings, the projected ultimate incurred losses based on the 3-year average incurred development factors is used for this purpose.

2. Loss Trends

The WCIRB analyzes a range of trending assumptions to roll forward the estimates of ultimate losses developed above to the future time period during which the filing's proposed pure premium rates will be in effect.

The various trend assumptions differ in terms of (1) the particular historical time period used to determine severity and frequency trends, and (2) the experience period that these trends are applied to, in order to roll forward to the future time period of the filing.

The preferred method utilized by the WCIRB has been the use of separate trends for frequency and severity and the application of these trends to the latest two years of experience, giving 50% weight to the projections based on each of the latest two years. However, in this filing, the WCIRB has not found the experience for accident year 2020 appropriate to be used as the basis of projection of the September 1, 2021 pure premium rates, given significant and likely temporary impacts in various cost components, caused by the COVID-19 pandemic, affecting the 2020 accident year.

In contrast, Bickmore has selected to assign 25% weight to the 2020 accident year, based on the belief that despite the fact that the COVID-19 pandemic has resulted in distortions in the reported loss data, the 2020 accident year has some predictive value.

In terms of methodology, Bickmore has opted to make trend selections separately for frequency and severity, similar to the WCIRB, starting with the January 1, 2021 filing, prior to which Bickmore had used a loss ratio trend in past recent filings.

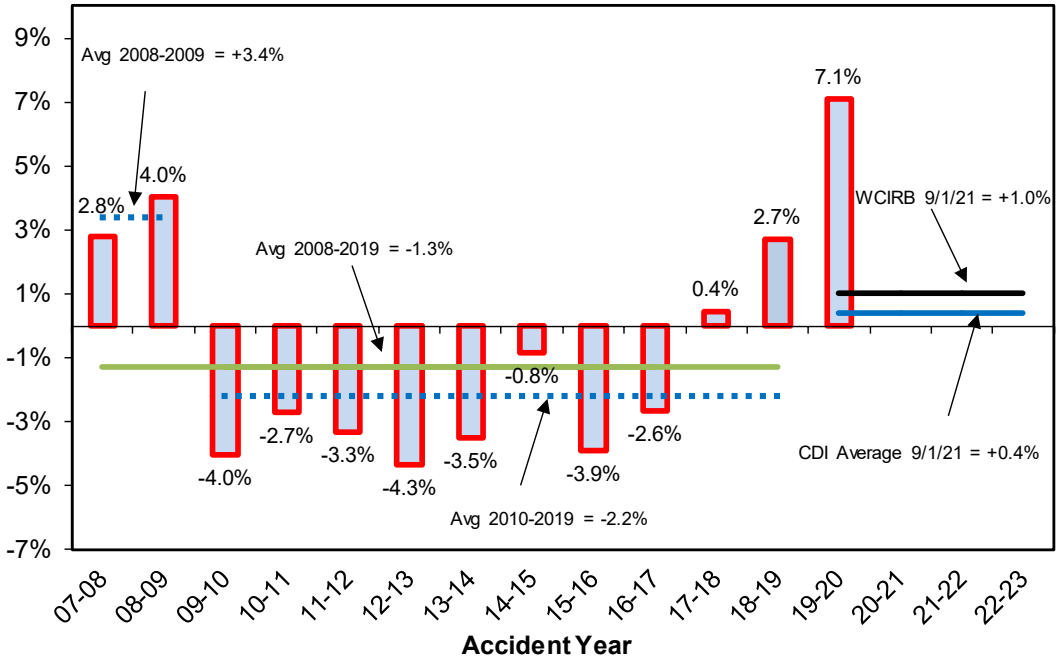
We agree with the WCIRB and Bickmore that the use of two years of experience for the application of the trend in general is appropriate, as it has also outperformed alternative assumptions based on the WCIRB's most recent study. In examining the merits of the loss ratio trend versus separate frequency and severity trends in various environments, we recognize that separate severity and frequency trends may better reflect the underlying causes in this changing environment. Furthermore, we agree with the WCIRB regarding not assigning any weight to the 2020 accident year as the basis for projecting the September 1, 2021 pure premium rates, given that known and unknown distortions caused by the pandemic, that may not be possible to adjust for, have been affecting the experience for this accident year.

Indemnity and Medical Severity Trend

As shown in Tables 6 and 7, indemnity and medical severities over the time period 2010-2019 have decreased relative to historical averages prior to 2010, discussed further following the charts.

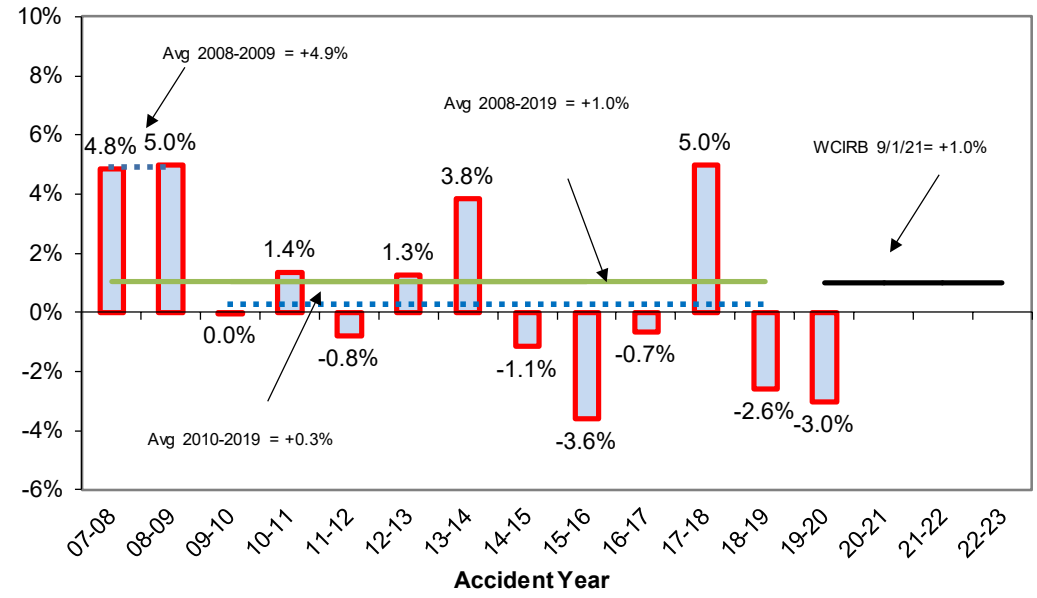
Table 6

On-Level Indemnity Severity Annual % Change*



*Ultimate Indemnity Loss Projections are Based on the Paid Method, and Data Evaluated as of December 31, 2020

Table 7 **On-Level Medical Severity Annual % Change***

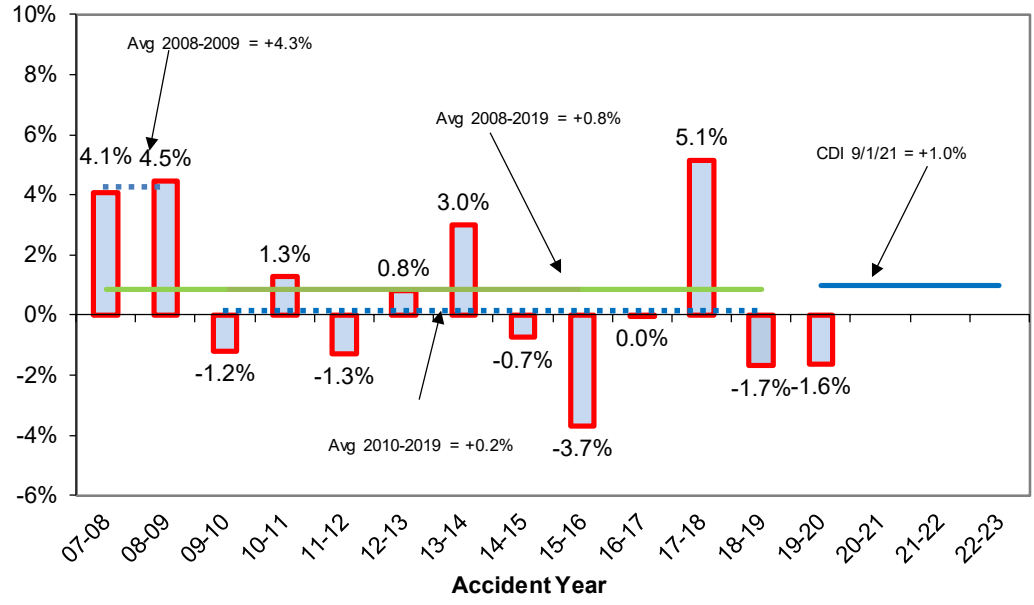


*Ultimate Medical Loss Projections are Based on the Paid Method, and Data Evaluated as of December 31, 2020

The changes in average medical severities in Table 7, as mentioned in the footnote, are based on ultimate medical losses that use the paid loss development method to project losses to ultimate. Table 8 shows the changes in average medical severities based on the Department-selected development method, discussed above, which relies on a combination of the paid and incurred development methods. While the individual data points may differ between Tables 7 and 8, the averages remain similar, especially for 2010 onward.

Table 8

On-Level Medical Severity Annual % Change*



*Ultimate Medical Loss Projections are Based on Mix of Paid and Incurred Methods, and Data Evaluated as of December 31, 2020

Following a period of year-over-year decreases in on-leveled indemnity severity between 2010 and 2017, sometimes with sharp declines, the 2018 and 2019 accident years show modest increases in indemnity severity based on data as of December 31, 2020. The 2020 increase is affected by mix shifts caused by the economic downturn due to the pandemic. In fact, if adjusted for class mix, the change in the indemnity severity for 2020 would have been about 1.5% lower at 5.6%. Both 2019 and 2020 increases are preliminary, given that at this stage in maturity, the underlying losses are mostly from temporary disability claims, which have higher indemnity benefits, but comprise about fifty percent of the indemnity claim counts. As an example, the increase in indemnity severity for 2018 has moderated from +3.0% as of March 31, 2019 to +0.4% as of the current valuation.

Consistent with the January 1, 2021 filing, the WCIRB-selected annual severity trend for indemnity in this filing is +1.0%. The average change in indemnity severities between accident years 2008 through 2019, which provides a longer-term view, is -1.3%, and the short-term average since 2015 is -0.9%.

The WCIRB's selection of indemnity severity trend is based on consideration of the general growth in on-level indemnity severities over the most recent three

years, as well as increased temporary disability duration and a slower claim settlement process in the short-term as a result of the gradual economic recovery in the post-pandemic period.

Bickmore's selection of indemnity severity trend, as noted in the public members' actuary's hearing testimony, takes into consideration the factors mentioned by the WCIRB, as well as the effects of the economy downturn and recovery, and selects separate annual trends of +3.5%, -0.2%, -2.5%, and -0.9%, for 2020 through 2023 accident years respectively, assuming return to more historical levels in 2023.

The Department's staff also agrees with considerations regarding the impact of the economic downturn and recovery on the indemnity severity, cited by the WCIRB and Bickmore, and based on separate selections for 2020 through 2023, which are similar to the annual trends selected by Bickmore, project indemnity severity trends that on average resemble a uniform annual indemnity severity trend of +0.4%. The Department's staff's selections for 2020 through 2023 are +3.5%, 0.0%, -2.0%, and -1.0% respectively.

The Department's staff notes that the medical severity trend of +1.0% selected by the WCIRB in this filing has been selected in consideration for both long-term and short-term trends, and is somewhat lower than the +2.5% selected by the WCIRB in the January 1, 2021 filing. The WCIRB also cites sharp growth of average medical costs in California absent of reforms, in combination with the length of time since implementation of the reforms that led to the decrease in medical costs, uncertainty in the impact of transition to the post-pandemic environment on medical costs, and inflationary pressures and advancements in new and improved medical technologies and processes, as the basis for the selected medical severity trend. As shown in Table 7, the ten-year average change in medical severities during the 2010-2019 period evaluated as of December 31, 2020 is +0.3.

Bickmore's selected annual medical severity trend is 0.0%, compared to the selected medical severity trend of +1.0% in the January 1, 2021 filing. Bickmore's selection is based on the average changes in medical severity for 2012-2020, which is -0.2%.

While the Department shares Bickmore's view that the observed trend in the recent ten years is on average flat, the Department is also sensitive to the WCIRB's concerns about the uncertainty in the impact of transition to the post-pandemic environment on medical costs.

The Department's actuarial staff believe that it is important to keep in mind that the workers' compensation system is an adaptive system where the various service providers respond to changes in the environment brought on by reform or court decisions. We recognize that particular attention needs to be paid to medical trends, as the belated recognition of increasing medical costs has been a major problem in the not-too-distant past. The average change in medical severities during the 2008-2019 period evaluated as of December 31, 2020, is about +1.0%, and the accident years included in this period strike a balance between pre- and post-SB 863 phases. The Department does not give any credence to the severity change observed for accident year 2020, due to existing distortions embedded in the data for this period. In consideration of the factors stated above, and consistent with the January 1, 2021 filing, the Department is selecting a +1.0% medical severity trend, as shown in Table 8, for this filing, which reflects considerations for both long-term and short-term changes in the average medical severity, as well as the uncertainty in the impact of current and prospective environments on the medical costs.

Frequency Trend

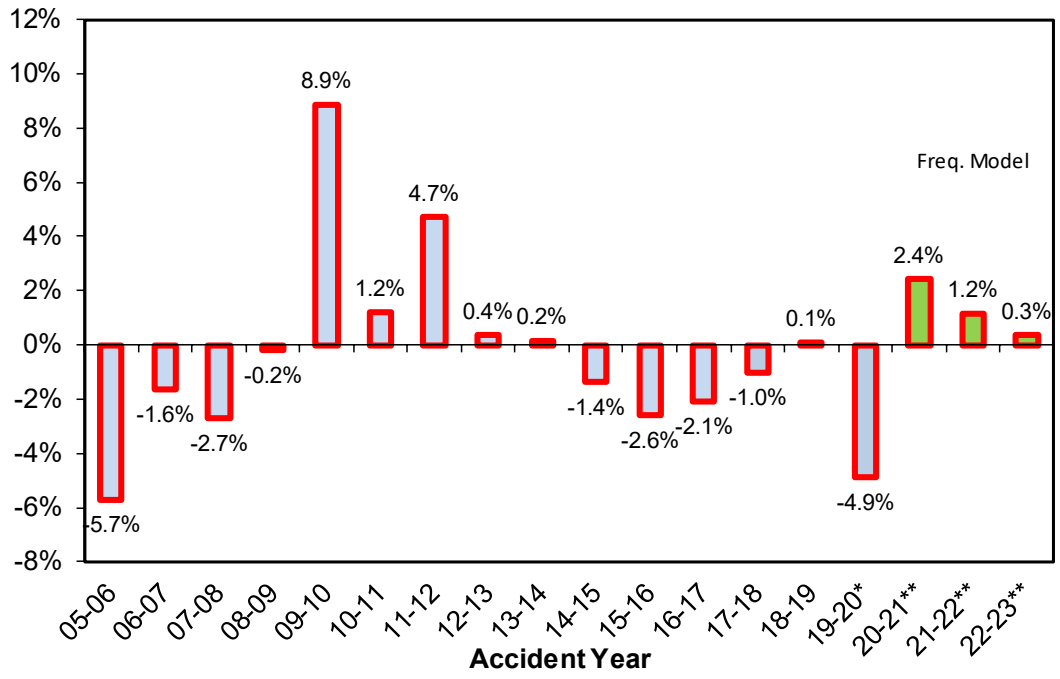
For many years, the WCIRB's econometric claim frequency model has been the primary source that the WCIRB has relied upon to project future changes in indemnity claim frequency. In addition, consistent with pure premium rate filings since January 1, 2014, the WCIRB relies on the preliminary estimate of the indicated frequency change for the most recent completed accident year as of twelve months (12-month frequency measure), based on preliminary measure of changes in actual reported claim counts compared to changes in statewide employment levels.

Table 9 below, shows the historical changes in indemnity claim frequency since 2005, as well as the WCIRB projected frequency changes based on the WCIRB econometric indemnity claim frequency model. The historical annual frequency changes shown in this table are based on unit statistical plan data for 2019 and earlier periods. For 2020, which is the latest complete accident year, the estimate relies on proxies for changes in frequency (i.e., changes in reported aggregate indemnity claim counts compared to changes in statewide employment).

Table 9

Intra-Class Indemnity Claim Frequency Annual % Changes

As of December 31, 2020



*The 2019-2020 estimate is based on comparison of claim counts based on WCIRB accident year experience as of December 31, 2020 relative to the estimated change in statewide employment. Prior years are based on unit statistical data.

**Projections based on Frequency Model.

The green bars in Table 9 reflect the WCIRB's forecast of changes in frequency, which are based on the WCIRB's econometric model developed using a long-term history of frequency changes in relation to changes in economic and other claims-related factors, including the proportion of cumulative trauma ("CT") claims, where claims are much more likely to involve multiple body parts, often include a psychiatric component, and are more concentrated to the Los Angeles Basin area.

Last year, the WCIRB published a study of the historical impact of prior economic slowdowns on claim frequency, which showed that during periods of economic slowdown, the accelerated decline in indemnity claim frequency is accompanied by an increase in the proportion of indemnity claims involving CT.

Due to the significant economic slowdown, caused abruptly by the pandemic, there was concern that the situation will give rise to an increase in CT claims, especially in 2020. Therefore, in the January 1, 2021 filing, the WCIRB had

incorporated a projected increase in the proportion of CT claims, consistent with that of the last two economic recessions, in the WCIRB's frequency forecast model.

The preliminary information for accident year 2020 suggests that an increase in the proportion of cumulative trauma claims has not occurred. Consequently, the WCIRB has not reflected any increase in the proportion of cumulative trauma claims either in the model frequency change forecasts, or as an adjustment to the 12-month frequency measure.

The projected frequency decline for accident year 2020 based on the WCIRB's econometric claim frequency model is 11.1%, which is consistent with the projection of the model in the January 1, 2021 filing, prior to the adjustment for the impact of the CT claims. On the other hand, the estimated frequency decline for accident year 2020 based on the 12-month frequency measure is 4.9%.

The WCIRB has used the 12-month frequency measure in its pure premium rate filings since 2014. Between 2014 and 2019, there has been a relatively modest difference between the 12-month frequency measure based on actual reported claim count and the initial estimate of indemnity frequency change based on the model at December 31 evaluation. The maximum absolute difference between the two was 2%. However, for accident year 2020, there is a significant difference between the results of the model which estimates a -11.1% change in the indemnity frequency, and the 12-month frequency measure, which reflects an estimate of 4.9% - both assessments adjusted for the estimated shifts in industrial mix.

Department's staff agrees with the WCIRB's comment during the hearing, that forecasting indemnity claim frequency during a major economic slowdown is incredibly challenging. Various distortions that have led to the WCIRB's finding that the accident year 2020 changes in severity are unreliable, such as the shift from medical-only to indemnity claims, have also had an effect on the preliminary indicated indemnity frequency change based on the 12-month frequency measure. Given that in calendar year 2020, the filing of medical-only claims declined by about 28%, compared to the indemnity claims, which declined by about 12.5%, the WCIRB believes that some of the medical-only claims have been actually filed as smaller indemnity claims, as workers with no job to return to may be more inclined to file an indemnity claim rather than a medical-only claim, where they would have to return to work right away. Such a shift in the type of claims filed would result in an overstatement of the reported indemnity claim count underlying the preliminary indicated frequency change for accident

year 2020 for the purpose of projections. However, as the WCIRB has explained in the hearing, the impact of such a shift could not be determined and accounted for, as measuring the impact would involve analysis of the characteristics of individual claims, as the claims mature.

As the WCIRB has noted in the filing, job losses in 2020 have disproportionately impacted lower wage industries, and lower wage workers within industries. The WCIRB has determined that the shifts in the industry mix have contributed by about 1.9% to the observed increase in the average wage level for 2020. In addition, the impact of the wage level shift within industries on the 2020 average wage level is about a 4.3% increase in the observed average wage for 2020. Therefore, the WCIRB has adjusted the 2020 average wage level for both the shifts in the industry mix and the shift in wage levels within industries. Given that the frequency is measured in relationship to payroll, both of these shifts have an impact on the accident year 2020 change in frequency.

The WCIRB, consistent with the methodology used in prior filings, has adjusted the preliminary indicated accident year 2020 indemnity claim frequency change for the impact of changes in the industrial mix. Furthermore, the WCIRB has also recognized that there may be several other factors that impact the ultimate 2020 claim frequency change such as shifts in wage levels within industries, potential future cumulative trauma claim filings, or other mix shifts. The WCIRB has not made adjustments for the impact of distortions due to known additional shifts in the underlying data, induced by the pandemic, given that they are not as well understood, and there is not a reliable basis to make these adjustments to the 12-month 2020 claim frequency measure. However, it appears that some of these shifts that could not be adjusted for, such as the shift in filed 2020 type of claims from medical-only claims to indemnity claims, result in an understatement of the frequency decline for accident year 2020, for the purposes of projection into future.

Information provided in the course of follow-up to the hearing discussions and in regards to the retrospective evaluation of the frequency projections, show that the 12-month frequency measure has performed better compared to the frequency change projected by the WCIRB's frequency model based on the three measures shown in the exhibit, i.e., Correlation with Actual Frequency, Mean Squared Error, and Directional Accuracy Percentage, and especially on the basis of Correlation with Actual Frequency. It is worth noting here that taking an average of the two estimates of frequency change, improves both the Directional Accuracy Percentage and the Mean Squared Error, while resulting in slightly lower Correlation with Actual Frequency, compared to the performance measures based on the 12-month frequency estimate.

Despite uncertainties around the accident year 2020 data, the WCIRB has found it appropriate to use the reported claim count for this period to determine the 12-month frequency measure, on the basis of not expecting the number of claims for 2020 to change dramatically as the year matures, and concluded that the preliminary frequency change based on 12 months continues to be a more reliable predictor of the actual accident year 2020 claim frequency than the WCIRB's frequency model projection.

While the WCIRB relies on the frequency model projections for 2021 through 2023 frequency changes, the WCIRB does not utilize the model's projection for accident year 2020 frequency change, given that the sharp unprecedented decrease in the economic variable for 2020 in the WCIRB's frequency model is well below that of any of the 40 years of economic information used to fit the model and results in a decrease significantly lower than any change experienced in the last 15 years as well as the preliminary actual 2020 change.

Bickmore has raised concerns regarding the disparity of using the results of the model for future years, while the indicated 12-month frequency measure for 2020 is significantly different from the model, stating that "If the recession in 2020 resulted in a frequency drop that was much less dramatic than projected (i.e., an actual drop of only 4.9% vs. the model predicted drop of 11.1%), then it stands to reason that frequency bouncing back up during the recovery will also be less dramatic than predicted." To that end, Bickmore is projecting frequency decreases for 2021 through 2023 of 0.6%, 1.0% and 0.1%, compared to frequency increases of 2.4%, 1.2%, and 0.3% projected by the WCIRB econometric claim frequency model. Bickmore's analysis assumes an annual 2% decline in frequency as the expected decline in frequency in a normal year (model's constant), and applies a formulaic adjustment based on the difference between the model prediction and the observed frequency change for AY 2020, to the model prediction for AYs 2021 through 2023 to determine the revised frequency change projection for these accident years.

Department's staff is also concerned about complete disregard of the model's projected 2020 decline in frequency on the basis that the results of the model for this period is significantly lower than any decrease in the last 15 years, especially as the WCIRB had noted in the January 1, 2021 filing, the WCIRB's review of indemnity claim frequency changes during prior recessions indicated that the economic variable in the WCIRB's frequency model was generally predictive of frequency decreases during these periods.

In addition, in view of the variety of unadjusted mix shifts and distortions embedded in the 2020 accident year data, the Department's staff does not find it appropriate to rely solely on the 12-month frequency measure for accident year 2020. However, we agree with the WCIRB, that the number of claims may not dramatically change for the 2020 period, and therefore this preliminary estimate should be given some weight.

Given the challenges associated with the projection of the frequency change for accident year 2020, the Department's staff believes that an average of the two estimates of frequency based on the model and the 12-month frequency measure would be more appropriate as a basis for projections.

Department staff's selection is based on concerns regarding the plausible distortions present in the 2020 preliminary indicated indemnity claim frequency, and in consideration of the fact that while the current WCIRB econometric model may need some enhancements, and the changes in the economic variable for accident years 2020 and 2021 are outside the usual range of observations that are the basis of the regression analysis, given the significant sudden increase in unemployment in 2020, the results of the model for accident year 2020 are within reasonable range, and as such, it would be appropriate to partially rely on those results. This approach will result in a projected frequency decline for accident year 2020 of about 8%.

Furthermore, the Department's staff finds the results of the model projections for 2021 through 2023 appropriate, as they can also be supported by the notion of the expected increase in frequency during economic rebound, as younger and less experienced workers that had become unemployed during the pandemic would enter the workforce again, and potentially start a different job.

The WCIRB is undertaking a comprehensive review of the econometric indemnity claim frequency model to determine potential enhancements to the model and the Department's staff appreciate the WCIRB's efforts to improve the model and the accuracy of its projections. In addition, the WCIRB has begun a study of wage inflation and frequency by wage levels, and plans to expand that study to look at differences between medical-only and indemnity claims to the extent reliable injured worker wage information on medical-only claims is available.

3. Loss Adjustment Expenses

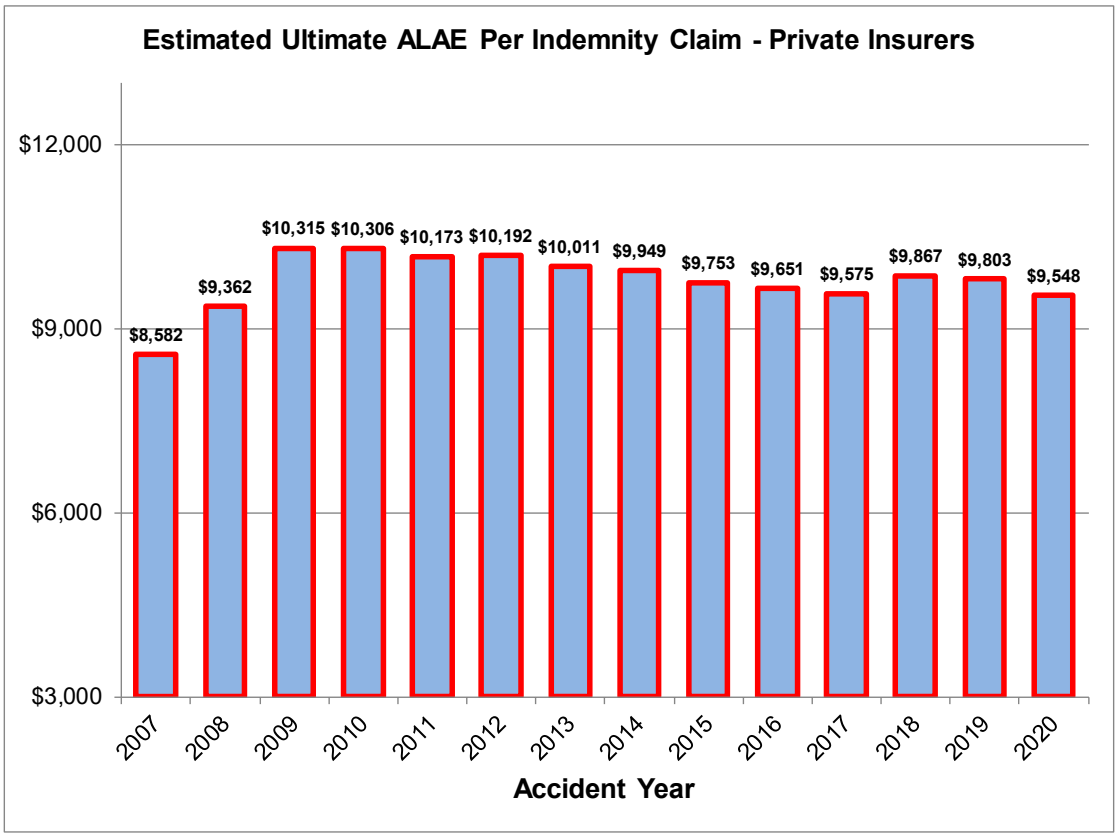
In its determination of the provision for LAE in the proposed rates, the WCIRB developed separate indications for the ALAE and ULAE, and medical cost containment programs ("MCCP").

Starting with the January 1, 2015 filing, the WCIRB adopted a change in its methodology to reflect only private carrier data in its evaluation of ALAE and ULAE to avoid distortion due to the impact of the higher expenses of the State Compensation Insurance Fund. The WCIRB has continued to apply this methodology in this current filing. The Department's staff concur with this methodology.

ALAE

Several evaluations underlying the past filings had shown that the estimated ultimate ALAE per indemnity claim increased steadily following the implementation of SB 863. Since the January 1, 2020 filing, this pattern has changed, and the estimated ultimate ALAE per indemnity claim shows slight decline between 2013 and 2017 (Table 10). While there is an expectation that ALAE costs decrease after the immediate periods following the reforms have elapsed, the ultimate ALAE per indemnity claim for 2018 and 2019 reverses the pattern of decline observed between the 2013 and 2017 accident years in the December 31, 2020 evaluation.

Table 10



Based on Data as of December 31, 2020.

In the review of the January 1, 2019 WCIRB pure premium rate filing, the Department noted that the projected ultimate ALAE per indemnity claim at successive quarterly evaluations had shown a downward trend with increased maturity, suggesting a consistent overstatement of the ultimate ALAE, and questioned whether an adjustment due to the speed-up in claims settlement rates would be needed to more accurately project ultimate ALAE.

The WCIRB performed a study to explore the potential impact of claim settlement rate changes on paid ALAE development in 2019, and determined that while the changes in claim settlement rates do not appear to significantly impact paid ALAE age-to-age development factors during the period of the change in settlement rates, there is a negative correlation between changes in claim settlement rates in earlier periods and the ALAE development that emerges in later periods for a given accident year. On the basis of that study, the one-year change in settlement rate was compared to cumulative development patterns from that age to ultimate for a given accident year. This approach created inconsistency in adjustments to various accident years, when settlement rates do not change consistently over time, or within a calendar year. As an example, in

the January 1, 2020 filing, the 2017 accident year age to ultimate ALAE development factor had been adjusted for higher claim settlement rates as of 27 months, but no adjustment had been made to the 2018 age to ultimate development factor, creating an inconsistency in the application of the concept underlying the adjustment.

As a follow-up to that study, prior to the January 1, 2021 filing, the WCIRB refined its approach for adjustment of the ALAE development factors to reflect incremental adjustments to age-to-age factors based on indicated cumulative adjustment per one point of change in claim settlement rates, applied only if the absolute value of the change for that accident year at that evaluation is at least 1.5%.

While in the January 1, 2021 filing this adjustment was incorporated to reflect increases in claim settlement rates, as discussed in the development section, the pandemic environment has resulted in a temporary decline in claim settlement rates, and consequently, in this filing the WCIRB has incorporated an adjustment to the ALAE age to ultimate development factor for the 2018 and 2019 accident years, which have shown more than 1.5% decline in claim settlement rates. This adjustment increases the age to ultimate development factors for 2018 and 2019 by 1.1% and 3.1% respectively, and essentially corrects for the distortions in the development factors caused by the pandemic. However, similar to the considerations for indemnity and medical loss development, the WCIRB has selected the ALAE development factors based on 2-year average age-to-age factors to account for the volatility that may have emerged during the pandemic period.

The Department appreciates the WCIRB's efforts in researching the impact of changes in settlement patterns on ALAE projections, and finding more appropriate ways to incorporate the results of the study.

Given that the ALAE development factors to ultimate are highly leveraged, the Department's staff recommend continued evaluation of the development patterns for the ALAE, as it appears that the persistent downward trend in successive evaluations of ALAE have continued at least for 2007 and later accident years, despite the adjustments that the WCIRB has made.

Moreover, the overstatement in the average ALAE per indemnity claim can also result in an overstatement of the implied annual trend, as the decline in average ALAE appears to be higher for less mature accident years.

Consistent with the January 1, 2021 filing, the Department's staff is selecting an average ALAE per indemnity annual trend based on the approximate average of the rates of growth in (a) estimated ultimate ALAE per indemnity claim for private insurers, and (b) incremental paid ALAE per open indemnity claim for private insurers, since 2013, which results in an annual trend of +0.8%, compared to +1.0% selected in the January 1, 2021 filing. The WCIRB-selected annual ALAE severity trend in this filing is +1.0%, compared to +1.5% selected in the January 1, 2021 filing.

While in prior filings the projections were based on the average of the recent two accident years, in this filing, the basis of the projection is the 2019 accident year, as the 2020 accident year projected ALAE may be distorted by the slowdown of the claim resolution process.

Similar to the January 1, 2021 filing, the WCIRB has adjusted the projected ALAE for the impact of the SB 1160 and AB 1244 reforms, based on an assumed 70% reduction in lien filings compared to the 3rd quarter of 2016. The full 11.2% estimate of the impact of the decline in liens is judgmentally tempered by 60% to 4.5% to reflect the impact of the reforms that is not yet reflected in the emerged ALAE data as of December 31, 2020.

While the projected ALAE has been adjusted for the impact of SB 1160 and AB 1244, the filing does not include any adjustment to the ULAE for the impact of these reforms, as medical bill disputes that would otherwise result in a filed lien are continuing to be pursued, and generate ULAE costs.

ULAE

Similar to the January 1, 2021 filing, the WCIRB has allocated national carriers' countrywide ULAE expenses on the basis of open indemnity claim count, in order to more completely reflect the additional complexity and duration of California workers' compensation claims. The allocation method uses the open indemnity claim count as a basis to apportion the ULAE, compared to the method utilized before the January 1, 2019 filing that had used paid losses to determine California's share of countrywide paid ULAE for national insurers.

Based on a study conducted by the WCIRB in 2020, starting with the January 1, 2021 filing, projections of open indemnity claim counts are based on incremental claim settlement rates, as opposed to estimated ultimate indemnity claim settlement rates used in prior filings. Given the impact of the COVID-19 on the claim settlement process in 2020, the incremental claim settlement rate from

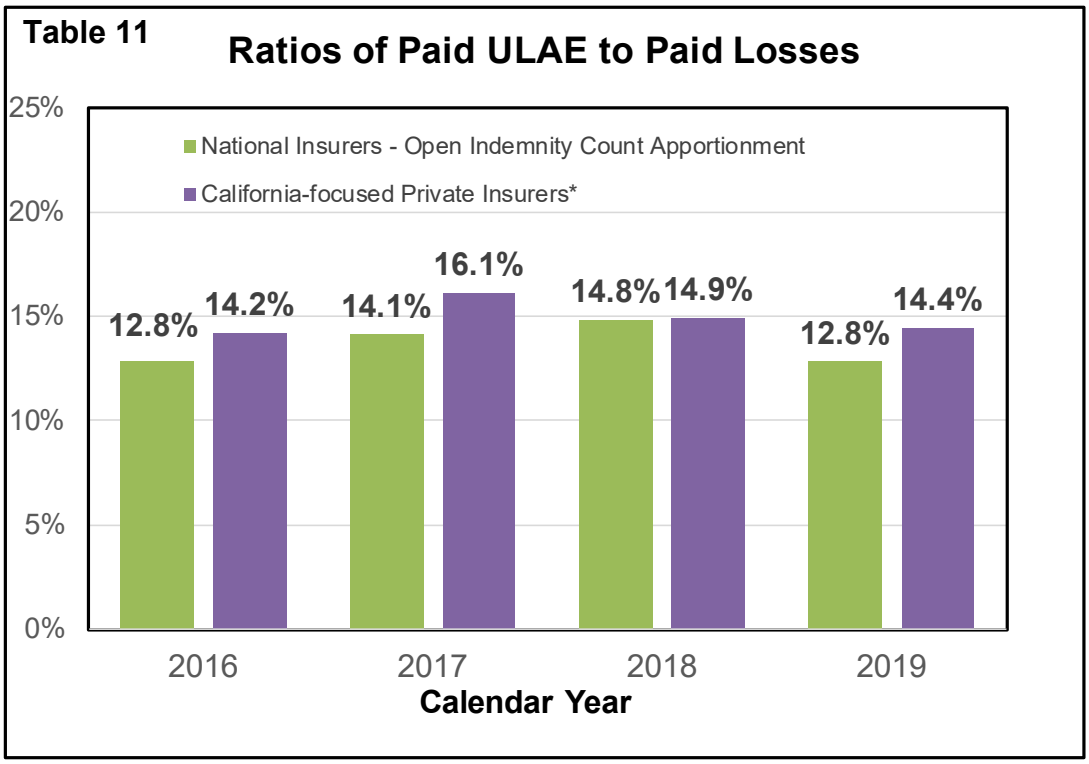
calendar year 2019 was utilized to determine the projections of open indemnity claim counts.

As shown in Table 11, using the open indemnity claim count as the basis of apportionment of the ULAE for national insurers' results in paid ULAE ratios that are comparable to the ULAE ratios for other private insurers that primarily write workers' compensation business in California. The rest of the difference could be attributed to economies of scale, as most of the national insurers tend to be much larger than the California-focused insurers.

Given that the 2020 calendar year information had not been available at the time of the filing, and even if available, it would have been impacted by the COVID-19 pandemic, the information used for this allocation is based on 12/31/2019 data.

Table 11

Ratios of Paid ULAE to Paid Losses



Source: WCIRB expense calls and quarterly calls for experience.
*California-focused Private Insurers are insurers with at least 80% of their workers' compensation writings in California.

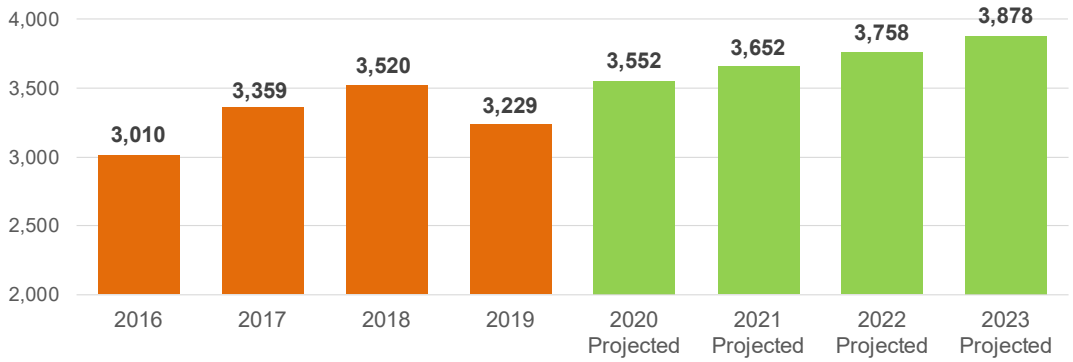
As shown in Table 12, following increases in the average paid ULAE per open indemnity claim in calendar years 2017 and 2018, the 2019 paid ULAE per open indemnity declined by about 8.3%. The WCIRB has attributed the decrease partly

to the effort from insurers to settle larger and more complex claims faster over the last several years.

The WCIRB projections based on the paid ULAE per open indemnity claim method account for wage inflation, with the assumption that the average ULAE costs grow at a rate comparable to that for statewide average wages. The ULAE costs have been trended to the prospective period by applying California average annual wage level changes based on UCLA and California Department of Finance forecasts, as adjusted for the impact of the pandemic-related slowdown on the mix of industries and mix of wage levels within industries. The projected average paid ULAE per open indemnity claim shown in Table 12, is based on the application of the wage trends to the ULAE severities for the 2018 and 2019 calendar years, and averaged to project average ULAE costs for calendar years 2021 through 2023.

Table 12

Paid ULAE per Open Indemnity Claim -- Private Insurers



Source: WCIRB aggregate financial data for private insurers only and projections.

As shown in Table 13 below, the decline in average ULAE costs in 2019 has tempered the recent increase of this component of the LAE as a percentage of losses. In addition, while the results based on the individual methods have changed between the January 1, 2021 and the current filing, the average of the two methods utilized by the WCIRB remain the same. Given that the January 1, 2021 filing used the same calendar years (2018 and 2019) as the basis of the paid ULAE to paid loss ratio, the change in the calendar year paid ULAE to paid losses between the January 1, 2021 and the current filing, is due to utilization of a more simplified approach, which is also more stable, on the basis of a WCIRB review conducted in 2020, and implemented in this filing.

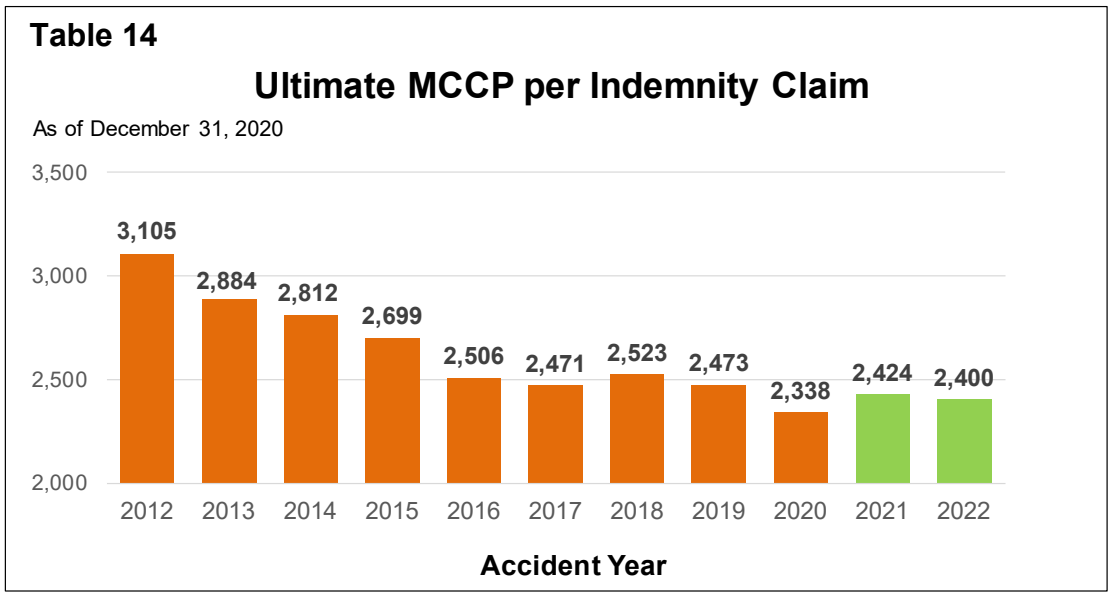
Table 13

Method	January 1, 2019 Filing ULAE Projection	January 1, 2020 Filing ULAE Projection	January 1, 2021 Filing ULAE Projection	September 1, 2021 Filing ULAE Projection
Paid ULAE per Open Indemnity Claim	14.9%	15.6%	14.1%	13.5%
Paid ULAE to Paid Losses	12.2%	13.8%	13.2%	14.0%
Average of Two Projection Methods	**13.6%**	**14.7%**	**13.7%**	**13.7%**

MCCP

The period between 2012 and 2019, as shown in Table 14, shows a steady decline in ultimate MCCP per indemnity claim, and the unusual spike for accident year 2018 has moderated as of the December 31, 2020 valuation.

Table 14



Source: WCIRB aggregate financial data and projections. Excludes the cost of IMR and IBR from all years.

The increase in ultimate MCCP cost per indemnity claim for accident year 2018 has subsided from +8.0% evaluated as of March 31, 2019 to +2.1% as of December 31, 2020. While it is not clear what the underlying driver of the initial significant increase has been, the subsequent moderations of the increase are reasonable, as an increase in MCCP costs in 2018 compared to 2017 is counterintuitive, given that SB 1160 has imposed some restrictions on utilization review ("UR") within the first 30 days of a claim beginning with 2018 injuries, and the new drug formulary, implemented as of January 1st 2018, restricts UR on

certain types of drugs, both of which were expected to lower the UR component of the MCCP costs.

The decline in ultimate MCCP cost per indemnity claim for accident year 2019, on the other hand, is in line with expectations, and while accident year 2020 may be distorted by the impact of the pandemic, a continued decline would have been expected.

Similar to the paid indemnity and medical loss development, the development factors to 108 months have been based on 2-year average development factors, to adjust for any distortions caused by the pandemic.

The WCIRB's projected MCCP per indemnity claim is based on the 2019 accident year, with -1.0% inflation going forward, which compares to 0.0% inflation assumed in the January 1, 2021 filing. Consistent with the January 1, 2021 filing, the Department's staff has selected an annual MCCP severity trend, based on the average of the annual rates of growth in (a) ultimate accident year MCCP costs per indemnity claim from 2015 through 2019 and (b) calendar year MCCP costs per open indemnity claim from 2013 through 2019. The selected MCCP annual severity trend of -1.3% is applied to the 2019 average MCCP per indemnity claim, as the basis for projections, disregarding the results for 2020.

A comparison of the components of LAE between the prior filing and the current filing based on the WCIRB projections is shown below in Table 15, which shows that compared to the January 1, 2021 filing, the ALAE and MCCP have decreased as a percentage of losses, while the ULAE has remained constant.

Table 15

LAE Provision Underlying WCIRB Pure Premium Rate Filings

	1/1/21 Filing		9/1/21 Filing	
(ALAE ex/MCCP)/Loss	16.1%		15.9%	
MCCP/Loss	4.2%		3.9%	
Total ALE/Loss	20.3%	$0.23	19.8%	$0.22
ULAE/Loss	13.7%	$0.15	13.7%	$0.15
Total LAE/Loss	34.0%	$0.38	33.5%	$0.37
Indicated Pure Premium Rate*		$1.50		$1.50

*Excluding COVID-19 Adjustment for 1/1/21 Filing

The projected LAE as a percentage of losses considered in the Department's analysis is 34.5% compared to the WCIRB's selection of 33.5%. The higher LAE percentage reflects slightly lower ALAE-to-loss and MCCP-to-loss projections based on the CDI trend assumptions for these components, and an adjustment for the differences in projected losses in the denominator of the LAE-to-loss ratio. The Department's assumed frequency changes, as reflected in the Frequency Trend section, have been incorporated in the projected claim count underlying the LAE cost determination.

Bickmore highlights differences in its assumptions from the WCIRB in the written testimony, as selection of lower ALAE per indemnity count based on the most recent three years, projection of lower ULAE per earned premium in consideration for how stable these ratios have been since 2017, projection of lower MCCP severity trend based on a five-year average, and projection of lower indemnity claim counts based on differences in indemnity claim frequency assumptions. The projected LAE cost, once normalized by the lower projected losses, results in a projected LAE-to loss ratio of 35.5%, compared to 33.5% assumed by the WCIRB.

The WCIRB's consistency in using the selected frequency trends, and the periods that the trends apply to in the projection of both the losses and the LAE components provides comparable bases for a determination of the LAE-to-loss ratio, and the Department's staff agrees with this approach.

The Department believes that the continued monitoring of direct and indirect impacts of recent reforms and legislation, as well as the economic environment, on LAE costs require particular attention and appreciates the WCIRB's and Bickmore's efforts in this regard.

4. Impact of changes to the Official Medical Fee and Medical-Legal Fee Schedules

In this filing the WCIRB has incorporated the cost impact of changes to the Evaluation and Management Section of the Official Medical Fee Schedule, as well as changes to the Medical-Legal Fee Schedule, adopted by the Division of Workers' Compensation effective March 1, 2021, and April 1, 2021 respectively, in the proposed pure premium rates.

The WCIRB has estimated the impact of the changes to these two Schedules, which have been incorporated in the September 1, 2021 advisory pure premium rates, to be an increase in the overall costs of +1.5%.

While the Schedule changes also impact the cost of medical and medical-legal services on open claims on policies incepting prior to September 1, 2021, the WCIRB has not proposed an adjustment to advisory pure premium rates applicable to the unexpired term of outstanding policies.

Official Medical Fee Schedule (OMFS)

The Division of Workers' Compensation (DWC) generally adopts regular updates made to the Medicare schedule values.

In 2021, the Centers for Medicare & Medicaid Services (CMS) made significant changes to reimbursement rules and rates in the Medicare payment system, including an increase in the reimbursement rates for Evaluation and Management (E&M) services, and effective March 1, 2021, the DWC made major changes to E&M billing, and posted new reimbursement rates for E&M services, to conform to relevant 2021 changes in the Medicare payment system.

The WCIRB has estimated the impact of the new DWC-adopted reimbursement rates for E&M services based on the distribution of the services in 2019 service year, and comparison of the March 1, 2021 OMFS values to the historical payments for those services, utilizing medical transaction data, and with a focus on the E&M office/outpatient visits which account for almost 90% of the payments for all E&M services.

Given that the E&M office/outpatient visits comprise about 15.9% of the overall medical costs, and based on an estimated 15% indicated increase in the E&M office/outpatient visits costs due to the implementation of the March 1, 2021 Schedule changes, the WCIRB has determined the impact of the Schedule change to be a +2.4% increase in overall medical costs. The 15% indicated increase is net of the typical Medicare inflationary increase of about 2.5% per year.

Medical-Legal Fee Schedule (ML)

Medical-Legal (ML) services which comprised about 6.5% of all medical costs in the California workers' compensation system in 2019, include services provided by a physician to resolve disputed issues in regards to evaluation of an injured worker, such as cause of injury, part of body injured, and temporary and permanent disability, which may be provided through a narrative medical report and/or expert testimony.

The new Medical-Legal Fee (ML) Schedule, adopted by the DWC effective April 1, 2021, reflects the first significant change to medical-legal reimbursement levels since 2006, and is intended to increase the reimbursement rate for medical-legal reports while eliminating the increased hourly billing provisions.

While in order to determine the cost impact of the ML Schedule change, the WCIRB essentially estimated the expected payments for ML services provided in 2018 and 2019 under the new Schedule and compared those to historical payments for those services based on medical transaction data, the estimation was more involved as there were changes in the ML codes, as well as additional modifiers for ML evaluations that have a primary focus of psychology/psychiatry, toxicology, and oncology, introduced with the new Schedule.

In addition, given that the new ML Schedule includes a provision that in lieu of billing for the time involved in conducting certain medical-legal evaluations, there is additional billing per page of records for reviewing records beyond the level specifically contemplated in the Schedule, evaluation of the cost impact of the new ML Schedule required estimation of the number of pages of records that physicians may review per hour.

Based on determination of the appropriate new code(s) to apply, the applicable fee(s) for the code(s), and application of the appropriate modifier and multipliers, as well as estimation of number of pages of records reviewed by physicians per hour, the WCIRB has estimated that the new ML Schedule increases the ML costs by about 22%, which translates to a 1.4% increase in overall medical costs, given that ML costs comprise approximately 6.5% of overall medical costs.

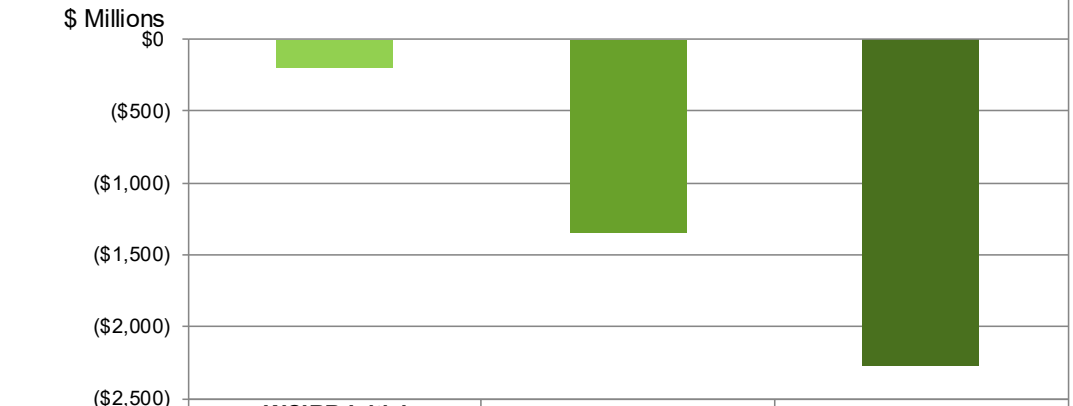
5. Impact of SB 863, SB 1160, AB 1244, and AB 1124

SB 863

The WCIRB issued its last retrospective evaluation of the effect of SB 863 in its October, 2019 SB 863 Cost Monitoring Report, where the WCIRB estimated that the various provisions of SB 863 have reduced annual system-wide costs by approximately $2.3 billion, as shown in Table 16. This estimate has been an update to the November 2016 estimate of $1.3 billion, and an initial assessment of overall savings of $200 million.

Table 16

Evaluation of SB 863 Cost Impact



	WCIRB Initial Proposective Estimate (October 2012)	WCIRB November 2016 Estimate	WCIRB October 2019 Estimate
All SB 863 Components Including Indirect Impacts	($200)	($1,340)	($2,270)

The substantial decreases in medical cost projections, which have been noted and reflected in filings over the last couple of years, have, in large part, been attributed to SB 863. In particular, the impact of IMR on medical costs is thought to represent a substantial portion of the "indirect impact" component discussed in the October 2019 retrospective evaluation. Assuming this to be true, it far outweighs the increase in frictional costs due to IMRs.

With the exception of the 2018 year, for which the number of eligible IMRs filed reached a record level high, the number of eligible IMRs filed has been relatively stable, around 172,500, between 2016 and 2019. However, in 2020 as a result of the environment caused by the pandemic, the number of IMRs decreased by about 19% to 140,070. It is worth noting here that greater than 20% of the filed IMRs in each year are determined to be duplicates, which could be the consequence of the automatic filing of IMRs, and impose unnecessary frictional costs on the system.

We appreciate the WCIRB's continuous efforts in re-evaluating the impacts of various reforms, some of which are discussed below.

Based on the analysis of the indirect impact of SB 863 on overall indemnity cost levels reflected in the October 2019 "SB 863 Cost Monitoring Updated" report, the WCIRB estimated that the decline in the average temporary disability duration and the average permanent disability ratings since the full

implementation of SB 863 have decreased the indemnity costs by about 4.5% on a combined basis. Given that several provisions of SB 863 impacted outstanding claims in addition to new claims, consistent with the approach employed since the January 1, 2020 filing, the WCIRB has distributed the 4.5% decrease in indemnity costs uniformly over the 2012 through 2015 accident years, and incorporated a 1.125% yearly decrease for these accident years in the calculation of indemnity on-level factors underlying the September 1, 2021 pure premium rate filing.

As mentioned in the Loss Development section, in 2019 the WCIRB studied the impact of the recent pharmaceutical cost declines on paid medical loss development factors, and since the January 1, 2020 filing, has reflected the results of this study in the adjustments made to the paid medical loss development.

SB 863 has also resulted in a significant reduction in the utilization of a number of types of medical services, particularly pharmaceuticals. In the January 1, 2019 pure premium rate filing, the WCIRB had reflected a 17% reduction in the utilization of medical services resulting from SB 863 in the medical on-level factors. The 17% decrease had been judgmentally spread to accident years 2011 through 2015, based on indications of the relative impact of SB 863 provisions impacting medical utilization on those years' medical costs.

Starting with the January 1, 2020 filing, given that the decline in pharmaceutical costs have been partially reflected in the adjustments to the paid medical losses underlying paid medical development factors, the WCIRB has judgmentally[4] reduced the total impact of SB 863 on medical utilization incorporated in the medical on-level factors from 17% to 13%, to avoid double counting for the portion of the decline that has been accounted for in adjustments to the paid medical development factors.

SB 1160, AB 1244, AB 1124

On September 30, 2016, SB 1160 and AB 1244 were signed into law. SB 1160 includes a number of provisions related to utilization review, while SB 1160 and AB 1244 include a number of provisions related to liens. In its January 1, 2017 filing, the WCIRB reviewed the impact of SB 1160 and AB 1244 on losses and loss adjustment expenses for policy year 2017 and estimated the impact at a 0.6% reduction in the indicated pure premium loss costs, which was an approximate savings of $135 million annually relative to the overall insured and

[4] Based on the differential in pharmaceutical cost declines in California compared to other states.

self-insured California workers' compensation system size of $22.5 billion. The 0.6% favorable impact was based on an estimated 10% reduction in number of liens filed.

Lien activity in 2017 and early 2018 indicated that the reduction in lien volume based on more recent data was in the ballpark of 40%. This reduction level assumed the 2nd quarter of 2016 to be the previous norm, before the transition period of late 2016 through early 2017 started, and the new environment was represented by the March 2017 through February 2018 period. The removal of the transition period from the calculations reflects the concern that the recent reform measures had resulted in many liens being filed before the January 1, 2017 reform effective date, potentially moving some of the 2017 volume into late 2016, and therefore the data for this period is distorted. Accordingly, in the July 1, 2018 pure premium rate filing, the WCIRB reflected a 40% reduction in lien volume in the adjustments applied to the medical loss development factors and the ALAE.

The number of liens filed continued to decline, and in the review of the January 1, 2019 pure premium rate filing, the Department incorporated a 50% reduction in its analysis, based on the comparison of lien filings in the 2nd quarter of 2018 to the 2nd quarter of 2016.

Due to a continued decline in the number of liens filed, the WCIRB incorporated a 60% reduction in lien volume in the January 1, 2020, and January 1, 2021 pure premium rate filings, on the basis of a comparison of the average number of liens filed during the July 2018 through June 2019 period, to the average level of filings shortly before the reforms.

However, the reduction in lien volume has continued, and reflect an approximate 70% decline based on the average number of liens filed during the July 2019 through June 2020 period. Consequently, in this filing, the WCIRB has made adjustments to the medical loss development factors and the ALAE reflecting the WCIRB's most recent review of lien filing information provided by the DWC, at a level of 70% reduction in liens.

A new medical treatment utilization schedule ("MTUS") drug formulary, as directed by AB 1124, was adopted by the Department of Industrial Relations, Division of Workers' Compensation, with an effective date of January 1, 2018. The primary goals of the formulary were to regulate the prescribing of opioids, reduce frictional costs from utilization review and IMR, and ensure medically necessary and timely medications for injured workers.

The prospective review of the MTUS drug formulary performed by the WCIRB estimated an overall reduction of 0.5% in loss and LAE costs, which were included in the WCIRB's July 1, 2018 and January 1, 2019 pure premium rate filings as an adjustment to the overall pure premium rate level. The 0.5% reduction was determined based on an estimated 10% decrease in pharmaceutical costs, amounting to 0.4% of total loss and LAE, and reduction in utilization review costs, estimated at 0.1% of total loss and LAE.

In 2019, the WCIRB performed its first retrospective analysis of the impact of the drug formulary based on pharmaceutical costs as of December 31, 2018, and found that the 10% reduction in pharmaceutical costs assumed in the prospective evaluation of the formulary has been reasonable in light of the emerged data, which showed that the pharmaceutical costs declined at an approximately 10% greater rate in 2018 compared to the rate of decrease observed in the immediate period before MTUS's implementation. Consistent with the filings since the January 1, 2020 filing, the WCIRB has reflected the -0.6% estimated impact of MTUS on medical costs, in the medical on-level factors applied to 2017 and prior accident years.

DETERMINATION OF WORKERS' COMPENSATION CLAIMS COST BENCHMARK BASED UPON CURRENT FILING

It is the determination of this Hearing Officer, based upon the current filing and public comments received, that the Commissioner should adopt an advisory pure premium rate of $1.41 per $100 of payroll. This recommended average pure premium rate is proposed to be effective with respect to new and renewal policies as of the first anniversary rating date of a risk on or after September 1, 2021. The change in the benchmark is based upon the hearing testimony and an examination of all materials submitted in the record as well as the Actuarial Recommendation and Evaluation set forth above by the Department's actuary, Mitra Sanandajifar.

ORDER

IT IS ORDERED, by virtue of the authority vested in the Insurance Commissioner of the State of California by California Insurance Code sections 11734, 11750, 11750.3, 11751.5, and 11751.8, that the WCIRB's filed advisory workers' compensation pure premium rates and Sections, 2353.1 and 2318.6 of Title 10 of the California Code of Regulations shall be amended and modified in the respects specified in this Proposed Decision;

IT IS FURTHER ORDERED that the advisory pure premium rates for individual classifications shall change based upon the classification relativities reflected in the WCIRB's filing to reflect an average workers' compensation claims cost benchmark and advisory pure premium rate of $1.41 per $100 of employer payroll, to be adjusted to the relative classifications consistent with this Proposed Decision;

IT IS FURTHER ORDERED that these advisory pure premium rates shall be effective September 1, 2021 for all new and renewal policies.

I CERTIFY that this is my Proposed Decision and Order as a result of the hearing held on June 7, 2021, as well as additional written comments entered into the record, and I recommend its adoption as the Decision and Order of the Insurance Commissioner of the State of California.

Date: July 21, 2021

Yvonne Hauscarriague

Yvonne Hauscarriague
Attorney IV

Item V-A
Summary of Current and Pending Legislative, Regulatory and Judicial Actions as of September 14, 2021

I. Legislation

A. The following are bills that have passed the Legislature and the Governor has until October 10th to sign or veto.

1. Assembly Bill No. 654 – COVID-19: Exposure: Notification
Under existing law, if an employer receives notice of potential exposure to COVID-19, within one business day the employer is required to provide written notice to all employees on the premises at the worksite that they may have been exposed to COVID-19. Existing law also requires that if an employer or the employer's representative is notified of enough COVID-19 cases to meet the definition of an "outbreak" – in a non-healthcare workplace, at least three COVID-19 cases among workers at the same worksite within a 14-day period – the employer must similarly notify the local public health agency. Existing law further requires the State Department of Public Health (DPH) to make workplace industry information received from local public health departments pursuant to these provisions available on its internet website in a manner that allows the public to track the number and frequency of COVID-19 outbreaks and the number of COVID-19 cases and outbreaks by industry reported by any workplace.

   This bill requires the employer to give notice to the local public health agency of a COVID-19 outbreak within 48 hours or one business day, whichever is later. The bill also requires the DPH to make workplace industry information received from local public health departments available on its internet website in a manner that allows the public to track the number of COVID-19 cases and outbreaks by workplace industry. It expands the employers exempt from the COVID-19 outbreak reporting requirement to various licensed entities, including but not limited to community clinics, adult day health centers, community care facilities and child daycare facilities. This bill takes effect immediately as an urgency statute and repeals these provisions on January 1, 2023.

2. Assembly Bill No. 1511 – Insurance: Omnibus
In addition to other provisions, this bill provides that if the required prior notice of cancellation for a workers' compensation policy is mailed, the period of notice required is extended by five calendar days if the place of mailing or the recipient's address is within California, ten calendar days if the place of mailing or the recipient's address is outside of California but within the United States and twenty calendar days if the place of mailing or the recipient's address is outside of the United States.

3. Senate Bill No. 788 – Workers' Compensation: Risk Factors
This bill prohibits consideration of race, religious creed, color, national origin, gender, marital status, sex, sexual identity or sexual orientation to determine the approximate percentage of the permanent disability caused by other factors before and after an employee's industrial injury for apportionment determinations. The bill also expresses the Legislature's intent to eliminate bias and discrimination in the workers' compensation system.

B. The following are bills that failed to pass the Legislature this year but may be of interest to the Committee.

1. Assembly Bill No. 1465 – Insurance: Liability Insurers
Existing law allows insured employers to create medical treatment provider networks, sets criteria for these networks and establishes exceptions for when an employee may be treated outside of the network. When this bill was initially introduced, it required the Division of Workers' Compensation to establish a statewide medical provider network called the California Medical Provider Network (CAMPN) to allow an employee to choose to be treated within their employer's network or the within CAMPN. The bill, however, was amended to require that the Commission on Health, Safety and Workers' Compensation submit a study by January 1, 2023 on delays and access to care issues in medical provider networks and compare data between those injured workers treated by a medical provider network and those treated by a provider that is not part of a medical provider network.

2. Senate Bill No. 335 – Workers' Compensation: Liability
Under existing law, if liability for a workers' compensation injury is not rejected within 90 days after the date the claim form is filed with the employer, the injury is presumed compensable. This bill reduced the 90-day investigatory time period to 45 days. For law enforcement and first responders with certain injuries or illnesses, the bill reduced the time to 30 days.

Under existing law, an employer must authorize treatment within one working day after an employee files a claim form and must continue to provide for treatment until the date that liability for the claim is accepted or rejected. While existing law limits liability for medical treatment to $10,000, this bill increased that amount to $17,000.

Existing law requires that when payment of compensation has been unreasonably delayed or refused, the amount of the unreasonably delayed or refused payment is required be increased up to 25% or up to $10,000, whichever is less. Under this bill, if payment of compensation has been unreasonably delayed or refused for law enforcement or first responder industrial injuries, the full amount is required to be increased by 10% without regard to whether the injury occurred before, on, or after the operative date of the bill.

II. Regulations

Recently Adopted Regulations

A. Updates to the Medical Treatment Utilization Schedule (MTUS)
The Division of Workers' Compensation (DWC) incorporated the American College of Occupational and Environmental Medicine (ACOEM) COVID-19 Guideline into the MTUS. This section contains the guideline for the evaluation, treatment and prevention of COVID-19.

Status: The regulations are effective for services rendered on or after June 28, 2021.

B. Updates to the MTUS Drug List
The DWC published updates to the MTUS Drug List that:

1. Include new drug recommendations for COVID-19;
2. Change the status of several drugs from non-exempt to exempt;
3. Delete drug recommendations for two COVID-related drugs; and
4. Change diclofenac potassium to non-exempt status due to higher risk profile evidence in ACOEM guidelines and recommendation of the Pharmacy and Therapeutics Committee.

Status: The updates to the MTUS Drug List became effective on August 1, 2021.

C. Medical-Legal Fee Schedule (MLFS) Billing Regulations

The DWC proposed several updates to the MLFS including the payment of $2,015 for a comprehensive medical-legal evaluation and review of up to 200 pages of records; reimbursement for reviewing additional records at $3 per page; and a follow-up evaluation of $1,316.25, which includes the review of 200 pages of records that were not reviewed as part of the initial evaluation. In addition, there is a $650 fee for supplemental medical-legal evaluations that include a supplemental report upon request. The supplemental evaluation fee includes review of 50 pages of records, beyond which reimbursement would be $3 per page. The updates to the MLFS also include a $455 hourly rate for medical-legal testimony and a $325 hourly rate for reviewing surveillance footage.

Additional changes to the MLFS create new modifiers increasing payments for certain evaluations:

1. "Modifier 96": Doubles the current payment for psychiatrists and psychologists. When an interpreter is needed, the modifier would increase payment by 110%. If the psychiatrist or psychologist is an agreed medical evaluator (AME), the modifier would increase payments by 135%. And if the modifier is used by an AME when an interpreter is necessary, payments would be increased by 145%.

2. Modifier "97": Increases payments by 50% when toxicology is the primary focus of an evaluation performed by a certified toxicologist or an internal medicine specialist. The modifier increases payment by 60% if an interpreter is needed, 85% if the provider is an AME, and 95% if the provider is an AME and needed an interpreter.

3. Modifier "98": Increases payments by 50% for oncology evaluations by oncologists and internal medicine specialists. The modifier increases payment by 60% if an interpreter is needed, 85% if the provider is an AME, and 95% if the provider is an AME and needed an interpreter.

Status: The changes to the regulation went into effect on April 1, 2021.

D. DWC Emergency Rulemaking Regulations for Medical-Legal Reporting in Response to COVID-19

On April 24, 2020, the DWC issued its Notice of Emergency Regulatory Action to address the ongoing need for medical-legal evaluations and to prevent a backlog resulting from stay-at-home orders throughout California. The regulations allow remote medical-legal evaluations while stay-at-home orders are in effect, indicate how payment for those evaluations can occur and provide alternative forms of service for required forms related to medical-legal evaluations and reports. The rules extend all time frames by 15 days for preparing and serving medical-legal reports and extend the 60-day scheduling requirements to 90 days. A party may also waive the 90-day requirement and schedule a qualified medical evaluator (QME) appointment within 120 days.

Other provisions in the rules will allow a QME or AME to interview an injured worker by telephone or video conference and schedule a face-to-face evaluation after the statewide and local stay-at-home orders are lifted. The rules also authorize medical-legal evaluations using telehealth services when:

- The worker is not required to travel outside the home for the evaluation;
- There is a medical issue in dispute that involves whether the injury arose out of employment and during the course of employment, or the physician is asked to address termination of indemnity benefits or a dispute over work restrictions;
- The injured worker, insurer or employer and the QME all agree in writing to the telehealth evaluation;
- The evaluation is consistent with appropriate and ethical medical practice; and

- The QME attests in writing that the evaluation does not require a physical exam.

Status: The DWC filed the emergency regulations with the Office of Administrative Law (OAL) on May 4, 2020 and received public comment on the regulations through May 12, 2020. Based on public comment and feedback from OAL, minor, non-substantive edits were made to the regulations. The emergency regulations became effective on May 14, 2020 and expired on January 12, 2021. The rules allow for two 150-day extensions. In October 2020, the rules were extended to stay in effect until March 12, 2021, and in February 2021, the rules were extended to stay in effect until October 12, 2021.

Rulemaking

A. Workers' Compensation Appeals Board (WCAB) Rules of Practice and Procedure
The WCAB has proposed amendments to several of its Rules of Practice and Procedure (Rules) to be effective January 1, 2022. The proposed amendments seek to formalize the processes for remote hearings, electronic filing and electronic services that were developed during the COVID-19 pandemic. The draft amendments also include several new rules to create processes for noticing and objecting to remote hearings, remote appearances and remote witness testimony.

Status: A public hearing is scheduled for September 24, 2021 via Zoom with written comments due on that day as well.

B. Copy Service Price Schedule
On July 30, 2021, the DWC announced proposed regulatory amendments to the Copy Service Price Schedule, which include the following:

1. An increase of the flat rate for copy services from $180 to $225 for records up to 500 pages, and including all associated services such as pagination, witness fees for delivery of records, and subpoena preparation;

2. Several provisions to address improper payments, such as a preclusion for medical providers to improperly charge for inspection of records, maximum witness fees from third party release of information services and an increase for bills not paid within 30 days of billing;

3. A procedure to object to copy services within 30 days of a request by an injured worker to an employer, claims administrator or workers' compensation insurer for copies of records in the employer's possession that are relevant to the claim;

4. Retrieval costs for records requested under the Public Records Act;

5. A limitation of four "certificates of no record" to limit fraud and abuse; and

6. Fees will no longer be provided for records from the WCIRB or the Employment Development Department (EDD).

Status: A public hearing took place on August 30, 2021 via Zoom with written comments due on that day. The next steps are for the DWC to file the proposed rules with the Office of Administrative Law for approval to be effective on January 1, 2022.

Pre-Rulemaking

A. Qualified Medical Evaluator (QME) Regulations
The DWC has posted proposed amendments to the QME regulations noting that the changes are necessary to bring existing regulations into compliance with amendments to the Labor Code and to

clarify the DWC Director's authority with respect to appointment and reappointment of QMEs. The draft regulations include provisions that:

1. Clarify definitions in conforming to changes made by Senate Bill No. 863;
2. Prohibit providing false information on the application or reapplication for appointment;
3. Amend regulations with proper gender pronouns;
4. Pertain to electronic service of medical-legal reports and use of electronic signatures in the QME program;
5. Revise the number of hours necessary for initial qualification of physicians as QMEs;
6. Revise continuing education and training requirements for QMEs;
7. Require a QME to comply with all DWC regulations in order to be reappointed;
8. Specify implementation for the Director's discretionary authority for reappointments;
9. Clarify the use of probation as a disciplinary sanction and allow the Director to designate hearing officers for adjudicating QME appointment and reappointment matters;
10. Make clerical changes to the regulation on QME unavailability; and
11. Allow QME reappointment hearings to be heard by other tribunals in addition to the Office of Administrative Hearings.

Status: The DWC posted the proposed amendments on April 29, 2021 and public comments were accepted until May 14, 2021. The next steps are for the DWC to open formal rulemaking for the proposed regulations.

III. Recent Judicial Decisions

A. Apportionment and Permanent Disability

Applied Materials v. WCAB (D.C.) – On May 7, 2021, the Sixth District Court of Appeal annulled and remanded a permanent total disability award to an injured worker who was sexually exploited by her treating physician. The decision was published on June 1, 2021 making it binding precedent for future cases.

Applicant worked as an administrative assistant at Applied Materials from 1996 until 2008; she sustained a specific injury in 2001, an additional specific injury in 2005 as well as a cumulative trauma injury ending in January 2008. It was revealed that the applicant was involved in a sexually exploitative relationship with her physician who controlled her medication, treatment and benefits causing her severe anxiety and depression. Applicant was examined by multiple medical-legal examiners for both her physical injuries as well as her psychological injuries. The QME determined that she was permanent and stationary with 100% total disability and suffering from post-traumatic stress disorder related principally to the treating physician as well as depression from her physical injuries. The QME also based his finding on her psychiatric condition alone, which he believed rendered her unable to work.

The WCJ found that the illegal conduct of the treating physician was a compensable consequence of the industrial orthopedic injuries. In addition, the WCJ determined that the Applicant sustained compensable specific injuries in 2001 and 2005, as well as cumulative trauma. He awarded two years of retroactive temporary disability and 100% permanent disability for the psychiatric injury alone and found that the injuries should be combined because "the psychiatric PD was largely caused by treatment events due to all three injuries." The insurers filed Petitions for Reconsideration with the WCAB who ultimately affirmed the award, finding joint and several liability. The parties then sought review by the 6th District Court of Appeal.

With respect to the relationship between the applicant and her physician, the Court held that it was non-consensual given her vulnerable state as well as pursuant to Business and Professions Code Section 729 (providing that physicians who engage in sexual intercourse or contact with a patient are

guilty of a criminal offense regardless of patient consent). Since it arose in the course of treating a workers' compensation injury, the Court found it was within the scope of a work-related injury and thus compensable.

The Court declined to disturb the WCAB finding of joint and several liability, reasoning that the events which caused the underlying orthopedic injuries occurred during insurance coverage by the insurers. However, the Court of Appeal found that the WCAB improperly applied Labor Code Sections 4660 and 4662 and improperly followed the psychiatric QME's analysis of the injured worker's ability to work. Section 4660 creates a rebuttable presumption that the Permanent Disability Rating Schedule is the proper means for assessing permanent disability. Section 4662(b) has been cited in some decisions as creating a second path for assessing total permanent disability where the disability is statutorily identified (e.g., total blindness), or where the injured worker proves an inability to compete in the open labor market due to loss of capacity to benefit from rehabilitation (as set out in the California Supreme Court LeBouef decision).

The Court determined that rather than creating two paths for rating disability, the Labor Code Sections must be harmonized. Section 4660 establishes the presumably correct method for rating all disabilities, including permanent total disability, using the Permanent Disability Rating Schedule, and 4662(b) describes the methods for rebutting the schedule. One of those methods is to prove through reliable evidence that the injured worker is incapable of benefitting from rehabilitation and therefore incapable of returning to work. Sufficient evidence of inability to benefit from rehabilitation must come from an expert in rehabilitation. A QME is an expert in medicine, but unless the QME is an established expert in rehabilitation as well, making such a determination is outside the doctor's expertise. In awarding 100% disability to the Applicant, the WCAB improperly accepted the QME's conclusions that the Applicant could not re-enter the job market. In the absence of expert evidence of this conclusion, the Applicant did not meet her burden of disproving the presumption. Therefore, the Court remanded the issue of permanent disability and apportionment to the WCAB for further consideration in light of this analysis.

B. Employment Status

Castellanos v. Hagen – On August 20, 2021, the Alameda County Superior court struck down Proposition 22, which was passed by California voters as a 2020 ballot initiative and defines rideshare and related gig workers as independent contractors instead of employees. The decision states that the California Constitution vests in the Legislature the "plenary power, unlimited by any provision of this Constitution, to create, and enforce a complete system of workers' compensation." The judge held that Proposition 22 illegally infringes on the California Legislature's constitutional authority and plenary power to decide coverage for worker injuries providing that, "if the People wish to use their initiative power to restrict or qualify a 'plenary' and 'unlimited' power granted to the Legislature, they must first do so by initiative constitutional amendment, not by initiative statute." As such, Proposition 22 was found to be unconstitutional and unenforceable. Immediately following publication of the decision, the gig companies stated their intent to file an appeal. In the interim, Proposition 22 remains in force.

C. Exclusive Remedy

Kuciemba v. Victory Woodworks – On May 10, 2021, the District Court for the Northern District of California dismissed a case in which a husband and his wife sued an employer for damages arising from COVID-19 infections. After contracting COVID-19, an employee who worked in the construction industry and his wife sued the employer in state court. In the complaint, the employee's wife brought claims for negligence, negligence per se and premises liability against the employer alleging that the employer's failure to maintain the workplace in safe conditions, implement a social distancing policy, and provide COVID-19 screening procedures caused the employee to contract COVID-19 and bring it home to his wife, who suffered severe injuries resulting from the virus. In addition, the employee's wife alleged that the employer created a public nuisance in violation of California law by substantially

and unreasonably spreading the transmission of a life-threatening disease. The employee, in turn, brought a claim for loss of consortium against the employer. On December 28, 2020, the employer removed the case to federal court and subsequently filed a motion to dismiss. In the motion to dismiss, the employer asserted that workers' compensation as an exclusive remedy barred the lawsuit. On February 22, 2021, the court granted the employer's motion to dismiss without a written opinion but allowed the employee and his wife to amend and refile the complaint. On May 10, 2021, the court dismissed the amended complaint filed by the employee and his wife, reasoning that claims that the wife contracted COVID-19 through direct contact with the employee were barred by workers' compensation as an exclusive remedy. The case has been appealed to the federal Ninth Circuit Court and is currently pending.