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Senate Bill No. 863 WCIRB Cost Monitoring Report – 2016 Retrospective Evaluation

I. Executive Summary

On September 18, 2012, the Governor signed Senate Bill No. 863 (SB 863) into law. SB 863 increased benefits effective January 1, 2013 and January 1, 2014 and provided for a number of structural changes to the California workers' compensation benefit delivery system. The WCIRB's prospective evaluation of the cost impact of SB 863 was published on October 12, 2012.

The WCIRB's plan to retrospectively monitor the cost impact of SB 863 based on emerging post-reform costs was published on March 27, 2013. The WCIRB released retrospective evaluations pursuant to this plan in 2013, 2014, and 2015. This report includes the WCIRB's final comprehensive retrospective evaluation of the cost impact of SB 863 based on data emerging through the third quarter of 2016.

In total, based on the most current information available, the WCIRB estimates the impact of SB 863 is an annual net savings of $1.3 billion, or 7% of total system costs.

The WCIRB's principal findings based on emerging post-SB 863 costs are summarized below.

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

2. Changes to PD ratings related to the elimination of the future earning capacity (FEC) and PD add-ons were projected to increase average PD ratings by approximately 6% (prior to any impact from the Ogilvie[1] decision). This is comparable to the indicated impact based on data for accident year 2013 PD ratings from the California Disability Evaluation Unit (DEU) which suggests an increase in average PD ratings approximately 6% above the pre-reform rate of growth.

3. The changes to PD related to FEC were estimated to eliminate any increases to PD for the Ogilvie decision and included significant savings to frictional costs resulting from the elimination of Ogilvie. While specific information related to Ogilvie adjustments to PD ratings is not available, average PD ratings from WCIRB unit statistical data, the estimated proportion of claims involving Almaraz/Guzman[2] adjustments based on DEU information, and changes in total indemnity costs per claim do not suggest any significant post-SB 863 increases to PD costs. However, since the implementation of SB 863, average allocated loss adjustment expense (ALAE) costs per claim have not declined and in fact have increased significantly, suggesting no savings in ALAE from the elimination of Ogilvie have emerged.

4. Indemnity claim frequency was projected to increase modestly from 2012 to 2014, in part due to SB 863 changes to indemnity benefits. Indemnity claim frequency for accident years 2012 through 2014 is emerging somewhat higher than that projected by SB 863. However, prior WCIRB studies have shown that the recent increases in indemnity claim frequency are also driven by a number of factors that are not related to SB 863.

5. The number of lien filings was projected to decrease by 41% as a result of the SB 863 lien filing fee and statute of limitations. After a sharp decrease in lien filings in 2013 and 2014 during the transition period to SB 863, the number of liens filed increased significantly in 2015 and through the first two quarters of 2016. However, some of this increase was a result of temporary increases in lien filings due to the transition of the statute of limitations on filing liens from 36 months to 18 months for dates of service on or after July 1, 2013, and lien filings dropped significantly in the third quarter of 2016 to a level generally consistent with that suggested by the WCIRB's prospective estimate. As a result, the WCIRB's current estimate of the impact of the SB 863 lien provisions on the number of lien filings is consistent with the WCIRB's original prospective estimate.

[1] Ogilvie v. City and County of San Francisco.

[2] Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District.

6. SB 863's elimination of the duplicate payment for spinal surgical implants was originally estimated by the WCIRB to save approximately $20,000 per procedure, while WCIRB Medical Data Call (MDC) data shows a decrease of over $25,000, or 28%, reduction in the average cost of these procedures since 2013. In addition, the proportion of total inpatient services involving these procedures has reduced by approximately 40%.

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

8. The frequency of independent medical review (IMR) requests through the third quarter of 2016, even after eliminating duplicate and ineligible requests, is far above the levels initially projected. As a result, fees paid for IMRs are expected to increase ALAE costs by approximately 2.4%, as compared to a 1% increase prospectively estimated in 2012. Approximately half of IMR requests are for pharmaceutical services and over 85% of IMR decisions have upheld the original utilization review (UR) decision.

9. Expedited hearings related to medical treatment disputes were expected to be substantially eliminated by the new IMR process, while approximately 5,500 more expedited hearings have been held per year since the implementation of SB 863, the majority of which involve medical treatment disputes.

10. Medical-legal costs, UR costs, and litigation costs have continued to emerge at pre-reform levels or higher and average ALAE costs increased significantly through 2014, suggesting the prospectively estimated significant savings to frictional costs resulting from IMR and other SB 863 provisions have not materialized.

11. Temporary disability (TD) duration was projected to decrease by 5% as a result of SB 863 provisions related to IMR and medical provider networks (MPNs). California Workers' Compensation Institute (CWCI) information on average TD duration for accident years 2012 through 2014 show increases at approximately the pre-reform rate, while WCIRB PD Claim Survey and aggregate payment information also do not show any sign of a significant decrease in TD costs. As a result, there is no indication of any savings in TD costs resulting from SB 863 provisions.

12. Estimates of MPN usage through 2015 show that network utilization is continuing to emerge at pre-reform levels or higher and the impact of network utilization on cost levels is generally consistent with that for prior years.

13. Relatively few independent bill review (IBR) requests have been filed when compared to IMR filings, with information suggesting that the majority of decisions favor the provider and result in additional payments. However, as with IMR, MPNs, and other SB 863 provisions, the IBR process may be having an impact on recent declines in overall medical severities.

14. The changes to convert the California physician fee schedule to a Resource-Based Relative Value Scale (RBRVS) basis were estimated to increase physician costs by a cumulative 6.5% for services provided through 2016 when compared to pre-reform levels. Estimates of medical payments through the first six months of 2016 suggest a total 9.0% decrease in physician payments per claim since 2013, largely driven by overall moderate declines in the number of transactions per claim with physician costs and more significant declines in special services and reports transactions and pathology and laboratory transactions.

15. SB 863 changes to liens, IMR, IBR, MPNs, and other areas have significantly impacted medical treatment levels, and overall medical claim severities declined in 2012 through 2014 with clear indications of reduced utilization levels. While it is very difficult to attribute changes in medical treatment levels to specific components of SB 863, the WCIRB estimates these SB 863 changes in combination have resulted in an

overall 10% decline in medical treatment costs beyond the impacts attributed to specific components previously discussed.

Table 1 presents a summary of the WCIRB's prospective cost estimates of SB 863's cost components along with the general impact on savings estimates based on the most recent information and the WCIRB's updated cost estimates.

Table 1: November 2016 Evaluation of SB 863 Cost Impact					
	WCIRB Prospective Evaluation		November 2016 Retrospective Evaluation		
	Total Cost Impact ($millions)	Total % Impact	General Impact on Cost Savings[3]	Updated Cost Impact ($millions)	Updated Total % Impact
Indemnity Cost Components					
Changes to Weekly PD Min & Max	+$650	+3.4%	=	+$650	+3.4%
SJDB Benefits	($10)	-0.1%	-	**+$20**	**+0.1%**
Replacement of FEC Factor	+$550	+2.9%	=	+$550	+2.9%
Elimination of PD Add-ons	($170)	-0.9%	=	($170)	-0.9%
Three-Tiered Weekly PD Benefits	($100)	-0.5%	=	($100)	-0.5%
Ogilvie Decision	($210)	-1.1%	-	**($130)**	**-0.7%**
Medical & LAE Cost Components					
Liens	($480)	-2.5%	=	($480)	-2.5%
Surgical Implant Hardware	($110)	-0.6%	+	($110)	-0.6%
ASC Fees	($80)	-0.4%	=	($80)	-0.4%
IMR – Impact on Frictional Costs	($180)	-0.9%	-	**+$70**	**+0.4%**
IMR – Impact on TD Duration	($210)	-1.1%	-	**$0**	**0.0%**
MPN Strengthening	($190)	-1.0%	=	($190)	-1.0%
IBR	N/A	N/A	+	---	---
RBRVS Fee Schedule	+$340	+1.8%	+	**($330)**	**-1.7%**
Indemnity Claim Frequency	Small Increase	—	=	—	—
Indemnity Severities (Incl. Trend)	Increases	—	=	—	—
Medical Severities (Incl. Trend)	Increases	—	+	**($1,040)**	**-5.5%**
ALAE & ULAE Severities	Signif. Declines	—	-	—	—
Total Estimate – All Items	**($200)**	**-1.1%**		**($1,340)**	**-7.1%**

[3] A "+" implies additional savings above those prospectively estimated by the WCIRB, a "-" implies less savings (or additional costs) and a "=" implies savings (or cost) estimates generally consistent with prospective estimates.

II. Background

SB 863, which was enacted on September 18, 2012, increased benefits effective January 1, 2013 and January 1, 2014 and provided for a number of structural changes to the California workers' compensation benefit delivery system. Following the enactment of SB 863, the WCIRB reviewed the impact of SB 863 on the cost of losses and loss adjustment expenses (LAE) underlying 2013 advisory pure premium rates. On a prospective basis, the WCIRB estimated that the net impact of the provisions of SB 863 quantifiable at the time of its prospective evaluation, once fully implemented in 2014, was a 2.7% reduction in the total cost of losses and LAE.[4] (SB 863 also included a number of amendments which the WCIRB was not able to prospectively evaluate at the time.)

On October 2, 2013, the Division of Workers' Compensation (DWC) adopted a new fee schedule for physician services based on a Resource-Based Relative Value Scale (RBRVS). The WCIRB's prospective evaluation of the RBRVS changes was included in its Amended January 1, 2014 Pure Premium Rate Filing. In total, the WCIRB estimated the new fee schedule would increase policy year 2014 costs by 1.8%.

These estimates of the cost impact of SB 863 were in part based on judgmental assumptions that may or may not materialize. In addition, a number of SB 863 provisions that could not be evaluated at the time of the WCIRB's prospective evaluation may ultimately have a significant impact on costs. As a result, the WCIRB developed a plan to proactively monitor and quantify post-SB 863 costs as they emerge. The *Senate Bill No. 863 WCIRB Cost Monitoring Plan* was submitted to the California Department of Insurance (CDI) on March 27, 2013.

The WCIRB's cost monitoring plan involves a multi-year retrospective measurement of the cost impact of key provisions of SB 863 and identifies the cost components to be measured, the data elements needed to measure these cost components, the general methodology used to measure these cost components, and the scheduled timeframe by which each of the cost components will be measured. As noted in the monitoring plan, the ultimate cost impact of many provisions of SB 863 will not be known for many years. The WCIRB published earlier reports on the impact of SB 863 based on emerging post-SB 863 costs in 2013, 2014, and 2015. This report represents the WCIRB's fourth and final comprehensive retrospective evaluation of emerging post-SB 863 costs pursuant to the monitoring plan and reflects emerging experience through the third quarter of 2016.

[4] *WCIRB Evaluation of the Cost Impact of Senate Bill. No 863*, WCIRB, updated October 12, 2012.

III. Cost Components Evaluated – Changes to Indemnity Benefits

A. Minimum and Maximum Permanent Disability Benefits

SB 863 provided for increases in the minimum and maximum weekly PD benefits for workers with injuries occurring on or after January 1, 2013, with an additional increase to maximum weekly PD benefits for injuries occurring on or after January 1, 2014. In total, the WCIRB's prospective evaluation estimated that these changes, after the estimated impact on claim frequency, would increase overall system costs by 3.5%. These estimates were primarily based on the WCIRB's legislative evaluation model, which estimates changes in indemnity benefits using distributions of claim costs by claim type and PD rating.[5]

In 2013, the most significant changes were to weekly PD benefit minimums, which increased for all PD claims regardless of PD rating, with increases to weekly PD benefit maximums only for claims with very high ratings. In 2014, increases to weekly PD benefit maximums became effective for the majority of PD claims. Table 2 shows the changes to weekly PD benefit minimums and maximums by PD rating interval.

Table 2: SB 863 Changes to Weekly PD Benefits

PD Rating Interval	Pre-SB 863		Effective 1/1/2013		Effective 1/1/2014	
	Min.	Max.	Min.	Max.	Min.	Max.
1 to 54.75	$130	$230	**$160**	$230	$160	**$290**
55 to 69.75	$130	$230	**$160**	**$270**	$160	**$290**
70 to 99.75	$130	$270	**$160**	**$290**	$160	$290

The WCIRB has compiled information on accident year 2013 and 2014 PD claims based on unit statistical reports. Based on the reported weekly wage and PD rating for each claim, the estimated incurred PD benefits were computed under the 2013 or 2014 level and pre-SB 863 (2012) statutory benefit level. The estimated change in average PD benefits using this approach is compared to the WCIRB's prospective estimates by PD rating interval in Tables 3 and 4. The results for the changes are generally comparable to prospective estimates.

Table 3: Changes in Average PD Benefits for AY 2013 Based on WCIRB Unit Statistical Data at 2nd Report Level

PD Rating Interval	Prospective Estimate[6]	Retrospective Estimate[7]	Percent of 2nd Report Claims
1 to 14.75	+1.2%	+1.1%	62.2%
15 to 24.75	+1.0%	+1.2%	24.7%
25 to 69.75	+2.7%	+3.0%	12.7%
70 to 99.75	+7.0%	+6.9%	0.4%

[5] The model is based on WCIRB unit statistical data and other sources of claim characteristic information and the parameters underlying the model are periodically reviewed and updated by the WCIRB's Actuarial Committee.

[6] Based on 200,000 indemnity claims that occurred on policies incepting in 2008 and 2009, restated to 2013 wage and benefit levels.

[7] Based on 58,000 accident year 2013 PD claims.

Table 4: Changes in Average PD Benefits for AY 2014 Based on WCIRB Unit Statistical Data at 1st Report Level			
PD Rating Interval	Prospective Estimate[8]	Retrospective Estimate[9]	Percent of 1st Report Claims
1 to 14.75	+20.8%	+19.1%	69.2%
15 to 24.75	+21.4%	+19.7%	21.8%
25 to 69.75	+20.1%	+18.9%	8.7%
70 to 99.75	+0.0%	+0.0%	0.3%

B. Supplemental Job Displacement Benefits

SB 863 provided that a supplemental job displacement benefit (SJDB) of up to $6,000 shall be offered to an injured worker who has not received a qualified return-to-work-offer. SB 863 also modified the basis upon which the SJDB is paid and the types of expenses that are reimbursed. These changes are effective on injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation estimated that these changes would reduce costs by 0.1%.

Table 5 shows calendar year paid vocational rehabilitation-related benefits—which include SJDB—that are reported on the WCIRB's annual Aggregate Indemnity and Medical Costs Call through 2014. While vocational rehabilitation-related benefits paid in calendar year 2014 were somewhat lower than that of the immediate prior years, benefits paid in 2015 are significantly higher than for the pre-reform level.

Table 5: Calendar Year Paid Vocational Rehabilitation Benefits		
Calendar Year	Voc. Rehab. Paid ($millions)	% of Total Indemnity Paid
2010	$32.0	1.1%
2011	$32.3	1.1%
2012	$36.2	1.1%
2013	$37.2	1.1%
2014	$30.0	0.9%
2015	$45.8	1.4%

Table 6 shows the proportion of PD claims with a paid or incurred SJDB and the average paid or incurred SJDB based on WCIRB PD Claim Survey data by accident year. Some of the recent increase in vocational rehabilitation payments for accident year 2013—the first year in which the SB 863 SJDB applied—is driven by an increased utilization of the SJDB while some if it is driven by an increase in the average SJDB payment.

Table 6: Supplemental Job Displacement Benefits Based on WCIRB PD Claim Survey Data at First Survey Level						
Accident Year	% of Claims w/ Incurred SJDB	% of Claims w/ Paid SJDB	Average Incurred SDJB	% Change	Average Paid SDJB	% Change
2008	26.1%	3.3%	$6,028	---	$4,013	---
2009	20.3%	3.3%	$5,965	-1%	$3,945	-2%
2010	16.6%	3.2%	$5,948	0%	$4,097	4%
2011	14.7%	3.0%	$5,995	1%	$4,241	3%
2012	11.9%	2.5%	$5,845	-3%	$4,227	0%
2013	16.1%	4.2%	$5,796	-1%	$5,054	20%

[8] Based on 200,000 indemnity claims that occurred on policies incepting in 2008 and 2009, restated to 2014 wage and benefit levels.

[9] Based on 50,000 accident year 2014 PD claims.

Some of the recent increases in the SJDB may also be a result in the $120 million return-to-work (RTW) fund created by SB 863 and administered by the Division of Workers' Compensation (DWC). The WCIRB did not provide a prospective estimate of the cost impact of the new RTW fund inasmuch as it is funded by employer assessments outside of insurer pure premiums. However, the final regulations for the RTW fund adopted by the DWC provided that the trigger for requesting the additional benefit be the acquisition of a SJDB.

As a result of the recent increases in vocational rehabilitation benefits and utilization of the SJDB, the WCIRB has updated its estimate of the cost impact of SB 863 on this benefit. Based on an estimated 4 percentage point increase in the number of PD claims that receive this benefit, an estimated ultimate number of PD claims for accident year 2013 of 70,000, and an estimated $5,000 paid per SJDB, the WCIRB estimates the SB 863 provisions affecting the SJDB increased insured system costs by approximately $14 million, which equates to an increase of 0.1% or $20 million in total insured and self-insured system costs.

C. Changes in Permanent Disability Ratings

SB 863 provided that the PD impairment produced in accordance with the American Medical Association (AMA) Guides will not be modified for FEC as in the 2005 Permanent Disability Rating Schedule (PDRS).[10] In addition, SB 863 provided that a uniform adjustment factor of 1.4 will be applied to the whole person impairment determined pursuant to the AMA Guides. Additionally, by eliminating the application of the FEC factor, SB 863 in effect eliminates the impact of PD adjustments made in accordance with the 2009 Workers' Compensation Appeals Board (WCAB) decision in Ogilvie.[11] These changes to PD ratings were effective on injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation of SB 863 estimated that these changes, after the estimated impact on claim frequency, would increase costs by 1.8%. These estimates were primarily based on analysis of PD ratings issued by the DEU and judgmental assumptions. In the WCIRB's 2015 SB 863 Cost Monitoring Report, the estimated litigation cost savings resulting from the Ogilvie decision were eliminated based on the significant increases in ALAE costs that have occurred after the enactment of SB 863 (approximately 0.4% of total costs).

The WCIRB has compiled the latest information on PD ratings based on claims available from the DEU through mid-2016. Exhibit 1 shows average PD ratings by accident year and age of rating based on the DEU database. Prior to SB 863, PD ratings had been increasing at rate of 2% to 4% per year. PD ratings issued within the first 39 months after the injury increased by 6% to 11% for 2013 injuries and has increased at approximately the pre-reform rate of growth for 2014 and 2015 injuries. The 2013 increases in average PD ratings combined with the pre-reform rates of growth are generally consistent with the WCIRB's prospective estimates.[12]

Using the information in the DEU database, the WCIRB is able to estimate the impact of the elimination of the FEC factor and the additional 1.4 adjustment factor directly by restating the ratings from 2013 and later injuries using the pre-SB 863 FEC factor. For each claim, the PD rating was calculated based on the FEC factor implied by the 2005 PDRS and compared to the actual rating determined for the claim. Table 7 shows the average PD ratings based on this approach, which are generally comparable to the WCIRB's prospective estimates.

Table 7: Average DEU Ratings with Changes to FEC

Estimate	Accident Years Used	Number of Ratings	Average Rating w/ FEC Factor (Pre-SB 863)	Average Rating w/ 1.4 Factor (Post-SB 863)	Impact of Change
Prospective	2005-2012	20,000	21.1	22.9	+8.5%
Retrospective	2013-2014	8,300	17.0	18.5	+8.8%

Adjustments to PD for Ogilvie are typically not reflected in the DEU database. However, the WCIRB can review the DEU data and other PD data to assess whether the elimination of Ogilvie as well as other SB 863 provisions has an indirect impact on PD ratings, such as an increase in adjustments for the Almaraz/Guzman WCAB decisions.

[10] Prior to SB 863, the FEC factor ranged from 1.1 to 1.4 depending on the injury.

[11] Ogilvie allowed for the PD rating on a claim to be adjusted based on a finding that the FEC component of the PD rating did not appropriately describe the loss of future earning capacity.

[12] The WCIRB projected an additional 6% increase in average PD ratings as a result of the combined SB 863 changes to the FEC factor and elimination of PD add-ons.

Table 8 shows the estimated prevalence of Almaraz/Guzman adjustments in the DEU database pre- and post-SB 863 based on information identified by the DEU rater, which have been overall fairly consistent since the enactment of SB 863 in 2013. In addition, review of average PD ratings from WCIRB unit statistical data suggests some moderation in growth in average PD ratings which may include the elimination of Ogilvie.

Table 8: Percentage of Ratings Involving Almaraz Adjustments

Period	Quarter Final Rating was Issued	"Almaraz"[13]	"Potential Almaraz"[14]	Combined
Pre-SB 863	4Q 2011 to 4Q 2012	10.8%	7.7%	18.5%
Post-SB 863	1Q 2013 to 3Q 2016	7.0%	10.5%	17.5%

The WCIRB's evaluations of the cost impact of the Ogilvie decision reflected the significant litigation costs associated with the WCAB decision. Exhibit 2 shows changes in ultimate ALAE per indemnity claim by accident year, which has increased significantly since 2012. The impact of Ogilvie on ALAE costs cannot be isolated from other factors affecting ALAE. However, since overall ALAE severities have increased rather than declined as projected since the enactment of SB 863, the WCIRB continues to recommend no savings to ALAE costs related to the Ogilvie decision.

D. Permanent Disability Add-Ons

SB 863 eliminated increases in impairment ratings for psychiatric impairment, sleep disorder and sexual dysfunction arising out of a compensable physical injury, with the exception of psychiatric add-ons for catastrophic injuries or injuries that resulted from a violent act. These changes became effective for injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation estimated that these changes, after the estimated impact on claim frequency, would decrease costs by 0.9%. This projection included an estimated 10% offset to the estimated savings for psychiatric add-ons as a result of catastrophic injuries or injuries that resulted from a violent act.

PD ratings computed by the DEU include the impairment information to determine if the claim included a PD add-on. Exhibit 3 shows the proportion of claims in the DEU database that included an add-on for psychiatric impairment, sleep disorder, or sexual dysfunction by age of rating. Although ratings involving add-ons typically do not appear until much later, the proportion of ratings involving add-ons dropped significantly for accident year 2013 PD claims rated between 27 and 39 months and only approximately 1% of ratings were identified to involve these add-ons after SB 863. In addition, the proportion of DEU ratings involving these add-ons for older accident years is also declining. As a result, the WCIRB believes the most recent information from the DEU is generally consistent with its prospective estimates.

A potential indirect impact of SB 863 is the increased use of other types of PD add-ons in lieu of those eliminated by SB 863 such as pain, gastrointestinal disorder, diabetes, or hypertension. DEU data suggests that prevalence of these add-ons in post-SB 863 claims through 39 months is consistent with the pre-reform level and only affects approximately 1% of final ratings in this period.

E. Three-Tiered Weekly PD Benefits

SB 863 eliminated the provision for a 15% increase or decrease in weekly PD benefits depending on whether the employer provides a qualified return-to-work offer to the injured worker, effective on injuries occurring on or after January 1, 2013. The WCIRB's prospective evaluation estimated that this change, after the estimated impact on claim frequency, would decrease costs by 0.5%.

[13] Refers to ratings where Almaraz/Guzman is cited directly in the rating notes.

[14] Refers to ratings where terms related to Almaraz/Guzman are cited in the rating notes, such as "per AMA Guides."

Since the three tiers of weekly PD benefits were eliminated by SB 863, the WCIRB is unable to directly measure the post-SB 863 PD benefits that would have been paid at the different tiers if not for the enactment of SB 863. However, the WCIRB's PD Claim Survey does collect information as to whether a qualified RTW offer was made by the employer. Table 9 shows the percentage of surveyed claims for which a qualified RTW offer was made. After the enactment of SB 863 in 2013, there was a moderate decrease in the proportion of claims with a qualified RTW offer. However, it is not yet clear whether the indicated change is attributable to the elimination of the three-tiered system of weekly permanent disability benefits.

Table 9: Proportion of Claims with Qualified Offer of Permanent Return-to-Work Based on WCIRB PD Claim Survey Data

Accident Year	% with Qualified Offer at First Survey Level
2009	17.6%
2010	20.8%
2011	20.1%
2012	21.2%
2013	16.0%

F. Indemnity Claim Frequency

The WCIRB's prospective evaluation of SB 863 included provisions for changes in indemnity claim frequency (utilization) as a result of the changes to PD benefits and other types of indemnity benefits since frequency changes have historically accompanied changes in indemnity benefit levels. These provisions were based on a WCIRB econometric analysis of the effect of a number of economic, demographic and claims-related variables on the frequency of indemnity claims.[15] The study showed that changes in indemnity claim frequency are related, in part, to indemnity benefit changes. Specifically, the model shows that for every 1% change in average indemnity benefits, the frequency of indemnity claims changes by approximately 0.2%.[16] In total, the WCIRB's prospective evaluation estimated that the changes in frequency as a result of SB 863 changes to indemnity benefits would increase costs by 1.1%.

Exhibit 4 summarizes the WCIRB's latest estimates of accident year indemnity claim frequency changes through June 30, 2016. Table 10 compares the changes from 2012 through 2014 with those projected based on the WCIRB's econometric claim frequency model.[17] Current estimates for accident years 2012 through 2014 show increases greater than the changes projected by the WCIRB's frequency model. However, WCIRB research has shown that the recent increases in indemnity claim frequency are driven by a number of factors in addition to SB 863.[18]

[15] Brooks, Ward, *California Workers' Compensation Benefit Utilization – A Study of Changes in Frequency and Severity in Response to Changes in Statutory Workers Compensation Benefit Levels*, Proceedings of the Casualty Actuarial Society, Volume LXXXVI, 1999, pp. 80-262.

[16] This utilization provision is assumed to apply to TD and permanent partial disability claims but not to medical-only, permanent total disability, death, or vocational rehabilitation claims.

[17] The indemnity benefit level in the WCIRB's econometric frequency model is a leading variable. That is, a change in indemnity benefit levels for a year is assumed to also impact indemnity claim frequency for the prior year. In addition to changes in indemnity benefit levels, the WCIRB's frequency model also projects frequency changes based on a number of economic and other claims-related factors.

[18] For more information regarding the WCIRB's analysis of the recent indemnity claim frequency increases, see *Analysis of Changes in Indemnity Claim Frequency—January 2016 Update Report* (WCIRB, January 7, 2016).

Table 10: Indemnity Claim Frequency Changes		
Accident Year	WCIRB Prospective Estimate Indemnity Claim Frequency Change[19]	Current Estimate of Actual Indemnity Claim Frequency Change[20]
2012	+0.1%	+3.6%
2013	+1.0%	+1.4%
2014	-1.0%	+2.2%

Claim frequency patterns can be influenced by many diverse factors including changes in benefit levels. Exhibit 5 shows the distribution of PD claims by the injured worker average weekly wage reported in WCIRB unit statistical data. Wages are adjusted to a common (accident year 2015) basis. In 2013 and 2014, there does not appear to be a significant increase in the proportion of PD claims which would have received increases in minimum or maximum weekly PD benefits (see Table 2).

[19] See Part A, Section B, Appendix B, Exhibit 2 of the WCIRB's January 1, 2014 Pure Premium Rate Filing.

[20] See Exhibit 4. Estimates are based on indemnity claim counts compared to payroll adjusted to a common wage level from WCIRB unit statistical data.

IV. Cost Components Evaluated – Changes to Medical Benefit Delivery System

A. Liens

SB 863 included a number of provisions related to liens. Liens filed on or after January 1, 2013 are required to be filed with the WCAB using an approved form and be filed with a $150 filing fee. In addition, no liens may be filed more than three years from the date of service for services provided before July 1, 2013 or 18 months from the date of service for services provided on or after July 1, 2013. The WCIRB's prospective evaluation of the impact of SB 863 on lien-related costs estimated a 1.8% reduction in medical costs and a 7.8% reduction in LAE, resulting in a 2.5% reduction in total costs.[21]

In the WCIRB's prospective evaluation of SB 863, it was assumed that approximately 41% of liens would be eliminated by the SB 863 lien filing fee and statute of limitations. The DWC maintains lien filing information in its Electronic Adjudication Management System (EAMS). Exhibit 6 shows the number of liens filed by region and type of lien through the third quarter of 2016 based on DWC EAMS data. Following the passage of SB 863 in the third quarter of 2012, lien filings in the remainder of 2012 increased dramatically in anticipation of the implementation of the lien filing fee. In 2013 and 2014, the number of liens filed decreased by approximately 60% when compared to pre-reform levels. However, in 2015 and through the first two quarters of 2016, the number of liens filed increased significantly. A significant proportion of this increase appears to be attributable to a temporary phenomenon in which both the 36-month and 18-month statutes of limitations on liens were in effect during this period.[22] As shown in Exhibit 6, once the 36-month statute of limitations no longer applied starting in the third quarter of 2016, lien filings reduced significantly. In particular, lien filings decreased by over 25% from June of 2016 to July of 2016. While the number of lien filings in the third quarter of 2016 remains significantly higher than the lower levels experienced in 2013 and 2014, on an annual basis the third quarter 2016 lien filings represent a 34% decrease from the 2011 level, which is generally consistent with the WCIRB's prospective estimate of the lien filing reduction when combined with increases in the number of indemnity claims experienced since 2011.

Some detailed information on lien filings is included in the DWC EAMS data. Although the DWC EAMS data does not include the date of the service disputed on the lien, it does include the accident date information. Exhibit 7 shows the distribution of the difference between the year of injury and year of lien filing. The significant increase in the proportion of liens filed within the first two years from the date of injury in the third quarter of 2016 suggests that the elimination of the 36-month statute of limitations for liens filed in this period had a significant impact. Exhibit 8 shows the concentration of lien claimants by quarter, measured by the proportion of liens filed by the 10 largest lien claimants for that quarter. The concentration of lien filings decreased dramatically in 2013 and 2014, but increased significantly to the approximate pre-reform levels in 2015 and through 2016. Although the total volume of lien filings decreased in the third quarter of 2016, the concentration of lien filings in that quarter was consistent with the prior quarter, suggesting that not all of the recent increases in lien filings were a result of the statute of limitations changes and that the low lien filings experienced in 2013 and 2014 may have also been the result of a temporary transition period.

The WCIRB's prospective estimate of lien demand, settlement and administrative costs was based on its 2012 Lien Survey of a random sample of 1,000 PD claims. In 2013 and 2014, the WCIRB issued subsequent Lien Surveys on 1,000 additional PD claims for information on liens active in 2013 or 2014.[23] The results of the WCIRB's Lien Surveys were summarized in prior WCIRB SB 863 cost monitoring reports. These results were generally consistent with the estimated average costs of liens before and after SB 863 reflected in the WCIRB's prospective estimates.

Earlier this year, the WCIRB conducted a survey of PD claims in order to better understand ALAE costs in California which included a number of questions related to liens. The complete results of this survey as well as

[21] The WCIRB's prospective evaluation did not include any estimated impact of the lien activation fee since the lien activation fee is only effective on outstanding liens and would not affect post-January 1, 2013 injuries.

[22] Liens filed for dates of service prior to July 1, 2013 were subject to a 36-month statute of limitations, while liens filed for dates of service on or after July 1, 2013 are subject to an 18-month statute of limitations.

[23] The 2013 and 2014 Lien Surveys were conducted on accident year 2008 and 2009 claims, respectively. The 2012 Lien Survey was conducted on accident year 2007 and prior claims.

additional information on ALAE will be included in a WCIRB study of ALAE costs to be published later this year. Preliminary results from the survey indicate that average lien demand and settlement costs are consistent with prior WCIRB Lien Surveys and the factors driving recent changes in lien filings are consistent with the information provided by the DWC.

During the initial implementation of SB 863, there were concerns that some liens would be replaced by "petitions for costs" filings in an attempt to avoid payment of the lien filing or activation fees – particularly in areas such as interpreter and copy service fees. However, in mid-2013, the WCAB published an *en banc* decision clarifying that a claim for medical-legal expenses may not be filed as a petition for costs.[24]

Given that the number of liens filed in the third quarter of 2016—which is the first quarter subsequent to the transition period to an 18 month of statute of limitations—is generally consistent with the WCIRB's prospective estimate, the WCIRB believes its prospective estimates related to the savings from the SB 863 lien provisions are generally consistent with the emerging results. The WCIRB will continue to monitor future lien filing activity with the enactment of Senate Bill No. 1160 and Assembly Bill No. 1244 in 2016, which include a number of provisions related to liens.

B. Surgical Implant Hardware

SB 863 eliminated the separate reimbursement for implantable medical devices, hardware and instrumentation for spinal surgeries, beginning with services provided on or after January 1, 2013. Additionally, SB 863 required the Administrative Director to adopt a regulation specifying an additional reimbursement for certain diagnostic-related groups (DRGs) pertaining to spinal surgery to ensure that aggregate reimbursement is sufficient to cover costs, including implantable hardware.[25] On a prospective basis, the WCIRB estimated that the elimination of the multiple reimbursements would reduce total medical costs by 1% for a 0.6% reduction in total costs. (The WCIRB's prospective estimate did not include any provision for a potential change to the utilization of spinal implant procedures.)

The WCIRB's prospective estimate was, in part, based on a CWCI study estimating the savings from eliminating the multiple reimbursements on claims with spinal surgeries.[26] The study found that the duplicate payment for spinal instrumentation on these claims added an estimated $20,000 to each procedure.

The WCIRB has compiled information on spinal surgical implants performed through the first half of 2016 based on its Medical Data Call (MDC) data. Specifically, surgical implant services provided after January 1, 2013 were compared to the same services provided in 2012. The number and cost of surgical episodes involving these services[27] are shown in Table 11. The reduction in the average cost of these episodes was approximately 28% or $26,000 per episode. In addition, the utilization of these types of procedures measured by their proportion of total inpatient episodes has decreased by over 40%. However, the WCIRB MDC inpatient hospital data, which covers periods before and after the implementation of the surgical implant provisions of SB 863, suggests that there were fewer applicable inpatient episodes than the third party data baseline used in previous prospective estimates. As a result, the WCIRB believes the overall level of savings reflected in its prospective estimates continues to be appropriate.

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[24] Martinez v. Terrazas (2013) 78 Cal. Comp. Cases 444.

[25] The regulation was repealed on January 1, 2014.

[26] *Preliminary Estimate of California Workers' Compensation System-Wide Costs for Surgical Instrumentation Pass-Through Payments for Back Surgeries*, CWCI, June 2012.

[27] Includes payments for DRGs, the implant specific revenue code (0278), and other revenue codes on the same hospital bill (e.g., radiology, lab, pharmacy, supplies and physical training).

Table 11: Number and Cost of Surgical Episodes Involving Spinal Implants Based on WCIRB MDC Data		
Dates of Service	SB 863 Targeted DRGs[28]	
	Share of Total Inpatient Episodes	Average Paid per Episode
Pre-1/1/2013	7.3%	$93,616
Post-1/1/2013	4.3%	$67,542
% Change	**-41%**	**-28%**

C. Ambulatory Surgical Center Fees

SB 863 provides that the maximum facility fee for services performed in an ASC should not exceed 80% of the Medicare fee for the same service in a hospital outpatient department (the prior cap was set at 120% of the Medicare rate for hospitals). These amendments would have resulted in a one-third reduction in ASC facility fee payments if it was assumed that the change in the maximum fee schedule allowance would translate directly to ASC facility fee costs. However, many ASC fees are reimbursed under contract at levels different from those contemplated in the fee schedule. The WCIRB's prospective evaluation estimated the reduction in ASC facility fees would reduce total medical costs by 0.8% based on a judgmental reduction of 25% in ASC facility fees rather than the one-third indicated if the fee schedule reduction would be fully reflected in reduced costs, resulting in a 0.4% reduction in total costs. (The WCIRB's prospective estimate did not include any potential change in the utilization of ASCs or outpatient hospital services.) In 2014, the WCIRB in conjunction with CWCI released a comprehensive report detailing post-SB 863 outcomes for ASCs.[29] A follow-up study was published in 2015.[30] These reports showed that ASC costs in 2013 and 2014 are generally consistent with the WCIRB's prospective estimates and there is no evidence of cost shifting from ASCs to outpatient hospitals.

The WCIRB has compiled updated information on ASC facility fees paid on services provided through the first half of 2016 based on its MDC data. Table 12 shows the paid cost related to ASC facility fees on services provided after January 1, 2013 compared to the reimbursements on claims with pre-SB 863 dates of service. The average reimbursement to ASCs in 2013 and later is 21% lower than the average reimbursement on services provided prior to the implementation of SB 863, which is consistent with the WCIRB's prospective estimates and anticipated annual inflation in ASC facility fee rates since SB 863.

Table 12: ASC Facility Fee Results Based on WCIRB MDC Data	
Date of Service	Average Paid per Episode
Pre-1/1/2013	$1,974
Post-1/1/2013	$1,569
Change	**-21%**

Table 13 shows ASC costs compared to costs on outpatient hospital services for the same procedures provided both before and after SB 863. The proportion of total episodes utilized by outpatient hospitals has remained generally consistent after the implementation of SB 863, suggesting that no significant shift from ASCs to outpatient hospital facilities has occurred. Table 13 also shows that the relative cost per outpatient hospital episode compared to the average ASC cost has increased significantly after SB 863 and, as a result, outpatient hospitals represent a larger share of the total paid amounts after January 1, 2013.

[28] Spinal implant DRGs include: 028, 029, 030, 453, 454, 455 and 456.

[29] *Ambulatory Surgical Center Cost Outcomes: The Impact of California SB 863 Workers' Compensation Reforms*, WCIRB and CWCI, February 26, 2014.

[30] *Ambulatory Surgical Center Cost Outcomes: Follow Up Study on the Impact of California SB 863 Workers' Compensation Reforms*, WCIRB and CWCI, March 11, 2015.

Table 13: ASC and Outpatient Hospital Episodes Based on WCIRB MDC Data		
	Pre-1/1/2013 Services[31]	Post-1/1/2013 Services
ASC Episodes Share of Total	80%	82%
Outpatient Hospital Episodes Share of Total	20%	18%
ASC Avg. Paid/Episode	$1,974	$1,569
Outpatient Hospital Avg. Paid/Episode (Difference vs. ASC)	$2,483 **(+26%)**	$2,824 **(+80%)**

D. Independent Medical Review

SB 863 created a new IMR process for handling medical treatment disputes. IMR became effective on January 1, 2013 for new injuries and on July 1, 2013 for all injuries regardless of accident date. The WCIRB's prospective evaluation of the cost impact of IMR was segregated into several components, including savings attributable to lien costs, medical-legal reports, expedited hearings, temporary disability (TD) duration, and litigation costs. In total, the WCIRB estimated these IMR components would result in a 2.1% reduction in system costs. IMR also has the potential to significantly affect medical treatment costs. However, given the uncertainty as to how IMR will impact medical treatment, the WCIRB did not prospectively estimate the impact of IMR on medical treatment costs.[32] (See below for the WCIRB's estimated total impact of SB 863 including IMR on medical cost levels.) In the WCIRB's 2014 Cost Monitoring Report, based on the greater-than-projected number of IMR filings and no reductions in frictional costs or other LAE after the effective date of SB 863, the WCIRB updated its estimate to remove any savings to frictional or litigation costs resulting from the IMR process (0.9% of total costs). In the WCIRB's 2015 SB 863 Cost Monitoring Report, the WCIRB updated its estimate to include the additional cost of the greater-than-projected number of IMR filings and increased expedited hearings in ALAE costs (0.4% of total costs).

Table 14 shows the number of IMRs requested through the third quarter of 2016 based on information received from the DWC through the IMR vendor. Once IMR became effective for all injuries regardless of the accident date starting on July 1, 2013, the number of IMR requests increased significantly in the second half of 2013 and again in the second quarter 2014. The number of IMR requests have been generally consistent since that time. Although a number of requests have been identified as duplicate requests or requests ineligible for IMR, the total number of eligible IMRs as shown in Table 14 remains over three times greater than that projected by the WCIRB in its initial assessment of SB 863 cost impacts.[33]

[31] Reflects services in the third and fourth quarters of 2012.

[32] The CDI's decision on the January 1, 2013 and Premium Rate Filings reflected a projected 2.5% reduction in medical costs coming from the impact of IMR on medical treatment.

[33] The WCIRB prospectively estimated approximately 51,000 IMR requests to be filed per year when the SB 863 IMR process is fully in effect.

Table 14: IMR Filings			
Year & Quarter	Total IMRs Filed	Eligible IMRs	Four-Quarter Total Eligible IMRs
2013 1Q & 2Q	878	---	---
2013 3Q	31,950	---	---
2013 4Q	51,092	---	---
2014 1Q	49,928	---	---
2014 2Q	59,983	---	---
2014 3Q	59,606	---	---
2014 4Q	58,567	---	---
2015 1Q	61,142	38,752	---
2015 2Q	65,418	42,761	---
2015 3Q	65,889	43,036	---
2015 4Q	61,327	41,060	165,609
2016 1Q	60,772	41,023	167,880
2016 2Q	64,852	44,287	169,406
2016 3Q	62,411	43,892	170,262

The fees for IMR requests are paid by the insurer or self-insured employer and are a component of ALAE. Table 15 shows the WCIRB's prospective estimate of annual IMR costs in ALAE and the IMR fees incurred on requests made after SB 863 was enacted. While the number of eligible IMR requests has increased since 2014, there have been reductions in the average fee for an IMR resulting in an estimated total system-wide incurred cost of approximately $60 million annually for each of 2014 through 2016.

Table 15: Cost of IMRs			
Application Year	Eligible Requests (A)	Avg. Paid per IMR[34] (B)	Total IMR Fees Incurred (C) = (A) x (B)
Prospective Estimate	51,000	$500	$25.5M
2013[35]	52,563	$514	$27.0M
2014	141,703	$427	**$61.0M**
2015	165,609	$367	**$60.1M**
2016 (Est. Annual)	170,262	$367	**$62.5M**

Table 16 shows the distribution of IMR disputed treatments and Table 17 shows results of IMR decisions based on DWC data. Approximately half of IMR disputes are for pharmaceutical services while approximately 86% of IMR decisions uphold the original utilization review (UR) decision.

[34] Based on DWC data.

[35] IMR did not go into effect for all open claims until July 1, 2013.

Table 16: Distribution of IMR Disputed Treatments Based on DWC Data	
Treatment Type	% of Total Disputes
Pharmaceuticals – Injections	6%
Pharmaceuticals	43%
Rehabilitation	14%
Diagnostic Testing	11%
Medical Supplies & Equipment	7%
Surgery	6%
Evaluation & Management	2%
Psych Services	1%
All Others	10%

Table 17: Results of IMR Decisions Based on DWC Data				
IMR Filing Year	Number of IMR Decisions	% w/ UR Upheld	% w/ UR Overturned	% w/ UR Partially Overturned
2013	46,163	86.4%	6.9%	6.7%
2014	132,349	87.2%	6.7%	6.1%
2015	154,431	83.7%	8.9%	7.4%
2016	91,588	87.0%	8.9%	4.1%
Total	**424,531**	**85.8%**	**8.0%**	**6.2%**

The WCIRB's prospective evaluation of SB 863 assumed that liens related to UR disputes would be replaced by IMR reports. Although the number of liens filed decreased after the effective date of SB 863 (see Exhibit 6), it is uncertain as to what proportion of the eliminated liens were a result of IMR compared to other SB 863 provisions impacting liens. Based on DWC data and WCIRB survey data, a significant number of liens related to medical treatment disputes continue to be filed after 2013. The WCIRB's recent ALAE claim survey also showed that the majority of these liens are related to disputed body parts or self-procured medical treatment.

The WCIRB's prospective evaluation of SB 863 also assumed that Qualified Medical Evaluator (QME) reports related to medical treatment issues would be replaced by IMR reports. Table 18 shows the number and average cost of medical-legal reports based on WCIRB MDC data. Even after IMR became effective on all injuries starting in the second quarter of 2013, the number and cost of medical-legal reports has not shown any decline and has in fact continued to increase, particularly in the most recent six months.

Table 18: Number and Cost of Medical-Legal Reports		
Service Year & Half	% of Claims with Med-Legal Payments	Average Paid per Med-Legal Report
2012 2H	11.1%	$1,329
2013 1H	10.4%	$1,402
2013 2H	10.8%	$1,458
2014 1H	11.6%	$1,588
2014 2H	11.2%	$1,575
2015 1H	12.0%	$1,575
2015 2H	11.6%	$1,614
2016 1H	13.2%	$1,664

The WCIRB's prospective evaluation of SB 863 assumed that expedited hearings related to medical necessity disputes would be eliminated by IMR. Table 19 shows the number of expedited hearings by year. After SB 863 was enacted in 2013, the number of expedited hearings increased rather than decreased and has remained at the higher level through the first three quarters of 2016. In addition, the majority of expedited hearings held in 2014 through 2016 were related to medical treatment disputes. Although the number of expedited hearings increased significantly again in the second half of 2016, this period is over three years after the enactment of SB 863 and may be related to factors other than SB 863. The WCIRB estimates that 5,500 more expedited hearings were held annually after the implementation of SB 863 than in the years immediately prior to SB 863, resulting in an increase of approximately 0.1% in total costs.

Table 19: Number of Expedited Hearings

Calendar Year	Expedited Hearings Held	% Related to Medical Treatment Disputes
2011	9,502	---
2012	11,464	---
2013	15,217	---
2014	16,606	74%
2015	16,243	71%
2016 (3 Quarters)	17,308	72%

IMR requests follow execution of a valid UR. Exhibit 9 shows estimates of the proportion of medical payments (including medical cost containment program (MCCP) costs) related to UR, IMR, and independent bill review (IBR) based on information from CWCI. The proportion of these costs increased in 2014 and 2015, likely a result of IMR fees being paid for those years. Exhibit 9 also shows calendar paid MCCP costs as a percentage of other medical costs based on WCIRB aggregate data calls. The increase in the proportion of MCCP costs in 2014 and 2015 is likely in part a result of IMR fees included in MCCP costs, which were not paid in significant volumes until 2014.[36]

The WCIRB's prospective evaluation of SB 863 estimated significant savings in LAE as a result of fewer frictional costs (as discussed above) in addition to reduced litigation related to medical treatment disputes. Exhibit 10 shows the estimated percentage of PD claims represented by an attorney based on the WCIRB's PD Claim Survey. Representation rates have been increasing for claims in both Northern and Southern California regions.

Table 20 compares projected changes from 2012 to 2014 in average ULAE and ALAE costs per indemnity claim based on the WCIRB's prospective SB 863 estimates, projections based on current estimates of SB 863 costs and LAE severity trends, and what has actually emerged. While actual ALAE costs have emerged at a significantly greater level than current projections, average ULAE costs have emerged at a lower than projected level. As discussed in the WCIRB's prospective evaluation of SB 863, for many SB 863 provisions impacting frictional costs, it is difficult to separate the impact on ALAE or ULAE. Although ALAE costs are emerging greater than projected, a preliminary study of recent increases in ALAE costs suggests that factors other than SB 863's provisions may be impacting the greater-than-anticipated ALAE costs. As a result, the WCIRB is not recommending any adjustment to its SB 863 cost estimates for the higher-than-projected ALAE costs. The WCIRB will publish its findings on drivers of recent increases in ALAE costs in a report later this year.

[36] Beginning with IMRs paid in 2016, these costs are no longer reported as MCCP costs but continue to be reported as a component of ALAE.

Table 20: Change in Calendar/Accident Year LAE Costs Per Indemnity Claim from 2012 to 2014		
	ULAE	ALAE (Excl. MCCP)
Prospective Estimate[37]	-7.6%	-2.6%
Updated Projection[38]	-0.6%	+4.5%
Actual Emergence	-6.3%	+16.5%

The WCIRB's prospective evaluation of SB 863 assumed the new IMR process would reduce delays in medical treatment and as a result reduce the duration of TD payments. Exhibit 11 shows the average number of paid days of TD based on CWCI data. The number of paid TD days for accident years 2013 and 2014 at 12 months and accident year 2012 at 24 months continues to increase at approximately the pre-reform rate. While data from the WCIRB's PD Claim Survey (also shown in Exhibit 11) shows a small decline in TD duration for accident year 2013, these declines were occurring in this data source prior to SB 863 and in fact have moderated in the most recent years. Finally, Table 21 shows aggregate calendar year TD payments compiled from WCIRB aggregate financial data calls increasing at a steady rate over the last several calendar years with no sign of a decline resulting from SB 863. As a result, the WCIRB has eliminated the prospectively estimated savings in reduced TD duration from the IMR process, which was equal to $210 million or 1.1% of total costs.

Table 21: Calendar Year TD Payments	
Calendar Year	Total TD Paid (in Billions)
2010	$1.36
2011	$1.47
2012	$1.53
2013	$1.59
2014	$1.65
2015	$1.75

As discussed above, IMR has the potential to significantly affect medical treatment costs. As shown in Exhibit 14, medical severities have declined following the implementation of SB 863. However, it is very difficult to isolate the direct impact of the IMR process on medical treatment levels from other SB 863 provisions affecting medical treatment such as those related to liens, fee schedules, MPNs, and IBR. The WCIRB's analysis of the impact of SB 863 on the overall utilization of medical services is discussed in Section I below.

E. Medical Provider Networks

SB 863 made changes to MPNs to provide that reports prepared by a consulting or attending physician chosen by the injured worker and outside the MPN should not be the sole basis of compensation. In addition, SB 863 provided that the employer is not liable for treatment or the consequences of treatment obtained outside a valid MPN. The WCIRB's prospective evaluation estimated these changes to MPNs would reduce total costs by 1.0%, which included savings to PD costs, TD costs, and medical costs.

As discussed in the WCIRB's SB 863 Cost Monitoring Plan, the WCIRB is retrospectively monitoring the utilization of MPNs before and after the SB 863 changes to assess whether any changes in the utilization of networks has occurred. Table 22 shows the percentage of visits and medical payments made to MPNs through 2015 based on CWCI data compared to the proportion of visits and payments for prior years. Network penetration since 2013 has continued to increase at a rate generally consistent with that of the immediate prior years.

[37] Includes the WCIRB's prospective estimates of the impact of SB 863 on calendar/accident years 2013 and 2014 in addition to the projected severity trends for 2013 and 2014 reflected in the WCIRB's January 1, 2013 Pure Premium Rate Filing.

[38] Includes the WCIRB's current estimates of the impact of SB 863 (see Table 1) in addition to the projected severity trends for 2013 and 2014 reflected in the WCIRB's January 1, 2017 Pure Premium Rate Filing.

Table 22: MPN Utilization Based on CWCI Data		
Accident Year	Percent of First Year Visits to Network Providers	Percent of First Year Payments to Network Providers
2010	78.2%	67.0%
2011	79.7%	68.9%
2012	80.3%	68.8%
2013	79.9%	69.6%
2014	80.2%	71.3%
2015 (9 Months)	84.2%	76.4%

As discussed in the WCIRB's SB 863 Cost Monitoring Plan, the WCIRB will also monitor cost differentials related to MPNs to assess if any change in the cost of services provided within an MPN compared to out-of-network services has occurred. CWCI estimates the average medical cost per MPN managed claim is approximately $500, or 4%, less than a non-network claim through 24 months based on services provided through 2013.[39] This is generally consistent with estimates from prior years.

F. Independent Bill Review

SB 863 created a new process of IBR to handle bill payment disputes effective on medical services provided on or after January 1, 2013. Specifically, for disputes not resolved after the employer's second review, the provider may request an IBR within 30 days of the second review or the bill will be deemed satisfied. The WCIRB did not include a prospective cost estimate for IBR in its SB 863 evaluation since, at the time, there were a number of outstanding issues related to the IBR process that needed to be resolved through regulation.

Information on the number of IBRs requested through mid-2016 is available from the DWC through the IBR vendor and is summarized in Table 23. While the total volume of IBRs has increased each year, it still remains relatively low. Information on IBR decisions suggests that the majority of the decisions favor the provider and result in additional payments. Although the total volume of IBRs is low, the IBR process may be having an impact on the overall utilization of medical services (discussed in Section I below).

Table 23: IBR Filings	
Year	IBRs Filed
2013	991
2014	1,964
2015	2,310
2016 (3 Quarters)	1,773

G. Conversion of the OMFS to a RBRVS Basis

SB 863 provided that the DWC Administrative Director shall adopt a fee schedule based on a Resource-Based Relative Value Scale (RBRVS) basis for physician services, with the maximum reasonable fees paid set at a level not to exceed 120% of Medicare. The amendments adopted by the Administrative Director provide for a four-year transition period beginning in 2014. The WCIRB's prospective evaluation of the RBRVS changes were included in the WCIRB's Amended January 1, 2014 Pure Premium Rate Filing. Once fully implemented in 2017, the WCIRB estimated that the RBRVS changes would increase physician costs by 8.5% resulting in a 2.1% increase in total costs. As noted in prior WCIRB SB 863 cost monitoring reports and in the WCIRB's January 1, 2017 Pure Premium Rate Filing, information on paid physician costs for the 2014 and 2015 service years suggested that overall utilization of physician services has decreased, particularly for special services and reports and pathology and laboratory services. As a result, the WCIRB attributed significant savings from the RBRVS-based fee schedule to these service years.

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[39] *Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System*, CWCI, July 2014.

The WCIRB's retrospective evaluation of the RBRVS changes for service years 2014 through 2016 based on data through the first six months of 2016 is shown in Exhibits 12.1 through 12.3, respectively. As shown in Exhibit 12.1, the WCIRB retrospectively estimates physician payments per claim on 2014 services decreased by approximately 5.7% (compared to a decrease of 4.8% reflected in the WCIRB's January 1, 2017 Pure Premium Rate Filing). This change was in large part driven by greater-than-anticipated decreases in payments for special services and reports. As shown in Exhibit 12.2, the WCIRB retrospectively estimates physician payments per claim on 2015 services decreased by approximately 4.5% (compared to a decrease of 2.5% reflected in the WCIRB's January 1, 2017 Pure Premium Rate Filing). This change was driven in large part by greater-than-anticipated decreases in payments for pathology and laboratory services. However, the decreases in both the 2014 and 2015 service years were also in large part attributable to reductions in the utilization in physician services across most categories as measured by the number of transactions per fee schedule claim. The WCIRB has reflected these updates in its overall cost estimate of SB 863.

As shown in Exhibit 12.3, based on data through the first half of 2016, the WCIRB estimates physician payments per claim on 2016 services increased by approximately 1.0%, which is somewhat lower than its prospective cost estimate for 2016 services of an increase of 2.1%. However, inasmuch as the estimates for the 2014 and 2015 service years have continued to decrease over time as more transactions are paid on these service years, and the WCIRB expects this trend to continue, at least in part, for 2016, the WCIRB is not projecting any cost increase for the RBRVS changes for the 2016 service year. The WCIRB will continue to monitor the development of the 2016 service year as well as the changes for the 2017 service year—the final year of the four-year RBRVS phase-in—with its Actuarial Committee and reflect any appropriate changes to its cost estimates in future pure premium rate filings.

H. New Copy Services Fee Schedule

SB 863 directed the DWC to adopt a fee schedule for copy services. The new fee schedule was adopted starting July 1, 2015. The WCIRB prospectively estimated the new copy services fee schedule would not have a material impact on overall cost levels inasmuch as copy services represented a small proportion of total costs and the reimbursement rates provided by the fee schedule were at the approximate average of rates currently being paid for these services.

Table 24 shows the average reimbursement rates for copy services over the first year of the new fee schedule. Copy services have been paid at a rate of approximately $100 per transaction, which is consistent with data on paid costs prior to the new schedule from the DWC as well as WCIRB survey data. In addition, WCIRB summaries of aggregate payment information shows that copy services were only 0.3% of total paid medical in calendar year 2015.[40] As a result, the WCIRB continues to not recommend any cost adjustment for the new copy services fee schedule.

Table 24: Copy Service Fee Schedule Payments

Service Period	Paid per Copy Service Set
2015 3Q	$105
2015 4Q	$100
2016 1Q	$99
2016 2Q	$98

I. Impact of SB 863 on the Utilization of Medical Services

Many of the provisions of SB 863 affected medical treatment costs. For a number of SB 863 components including the elimination of duplicate reimbursements for spinal implant hardware, MPN strengthening, fee schedule reductions for ASCs, provisions related to liens, and the physician fee schedule transition to a RBRVS basis, the WCIRB was able to prospectively estimate the impact of the SB 863 provisions on average medical costs and

[40] *Report on 2015 California Workers' Compensation Losses and Expenses*, WCIRB, June 29, 2016.

those estimates have been reflected in the WCIRB's subsequent pure premium rate filings and have been separately re-assessed as part of this report and earlier SB 863 cost monitoring efforts.

Other provisions of SB 863 impact medical costs, many of which impact the utilization of medical services rather than the average cost of services. The potential cost impact of these provisions was heavily dependent on future regulations required by the legislation, how the WCAB interprets certain new provisions, the result of potential legal challenges to components of the legislation, and changes in medical treatment and other system practices and patterns. As a result, the WCIRB did not reflect estimates for these provisions in its initial prospective evaluation of SB 863, but indicated that cost evaluation of these components would require additional time and data. In particular, the WCIRB did not include a prospective evaluation of the impact of IMR on medical treatment levels in its prospective evaluation of SB 863.

Now, more than three years have elapsed since IMR and other SB 863 provisions impacting medical costs have been implemented. Prior to SB 863, medical costs per indemnity claim had risen by approximately 45%, or approximately 6.5% per year since 2005.[41] A CWCI report in 2013 analyzed increases in medical severities based on detailed medical transactional payment data through December 31, 2012.[42] The CWCI analysis showed sharp increases in medical payments per claim following the full implementation of the reforms of 2002 through 2004 in 2005 in a broad range of medical treatment categories such as pharmaceutical costs, costs of medical cost containment programs, and medical-legal costs. These increases were attributable to increases in the number of visits per claim, the number of procedures per visit, and the average cost of procedures.

Exhibits 13.1 through 13.7 summarize post-SB 863 medical cost trends by type of service for services performed in six month periods at six month payment intervals. Theses exhibits summarize the average cumulative paid per claim, the average number of transactions per claim, and the average cumulative paid per transaction. The data is shown for all medical services in Exhibit 13.1 and separately for physician services (Exhibit 13.2), pharmaceuticals (Exhibit 13.3), inpatient services (Exhibit 13.4), outpatient services (Exhibit 13.5), procedures coded under the Health Care Procedure Coding System (HCPCS) (Exhibit 13.6), and medical-legal (Exhibit 13.7). Exhibits 13.1 through 13.7 are based on the WCIRB's analysis of its medical transaction data covering services from July 2012 through June 2016.

As shown in Exhibit 13.1, rather than increasing at a level near the pre-SB 863 rate of inflation, medical costs per claim have been flat to declining since the pre-SB 863 levels as represented by the second half of 2012. The very modest growth in medical costs per claim in 2013 was driven in part by very little growth in the average cost of procedures, as many of the SB 863 reforms took effect (e.g., ASC fee schedule reductions, elimination of duplicate reimbursement for spinal implants). However, with the implementation of IMR on a broad basis as well as RBRVS in late 2013 through 2014, the reduction in medical cost levels was driven by significant reductions in the number of procedures per claim. Exhibits 13.2 through 13.7 show that this pattern was generally consistent for most components of medical treatment. As shown in Exhibit 13.3 for pharmaceuticals in particular, which had been growing at a double-digit annual rate of inflation prior to SB 863,[43] there were significant reductions in the average cost per claim beginning in 2014 and continuing through the first half of 2016 driven by significant reductions in the number of pharmaceutical transactions by claim. (Pharmaceuticals have been subject to IMR more frequently than other medical components.)

It is not possible to isolate the impact of IMR on the utilization of medical services from the impact of other components of SB 863, as well as other phenomena impacting medical costs such as a general slowing of medical inflation countrywide. However, as discussed above, it is clear that IMR as well as the other SB 863 components have had a significant impact on medical treatment levels and medical costs.

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[41] See the Executive Summary of the WCIRB's January 1, 2013 Pure Premium Rate Filing submitted on August 21, 2012.

[42] *Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System*, CWCI, July 2013.

[43] *Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System*, CWCI, July 2013.

J. Changes to Overall Claim Severities

As discussed above, there have been significant reductions in in the utilization of medical services producing post-SB 863 medical levels well below those reflected in the WCIRB's initial prospective evaluation of SB 863. As shown in Exhibit 14, projected ultimate medical severities for accident years 2012 through 2014 also show declines.

Table 25 compares projected post-SB 863 changes in average indemnity and medical costs per indemnity claim based on the WCIRB's prospective SB 863 estimates and projections based on current estimates of SB 863 costs and severity trends to what has actually emerged. As discussed above, the majority of SB 863 provisions impacting indemnity benefits only affect PD claims occurring after January 1, 2013 or January 1, 2014, and PD claims are often late-developing. As a result, after reflecting the WCIRB's most recent cost estimates for SB 863 and estimated residual indemnity severity trends, the WCIRB believes overall indemnity claim severities are emerging generally consistent with projections. However, even after reflecting the most current estimates of the impact of the various SB 863 provisions affecting medical costs (which were typically on a date of service basis), overall medical severities are still emerging at a level approximately 10% lower than projected. Given the impact of SB 863 on medical utilization levels discussed above, the WCIRB believes it is reasonable to assume this differential represents the approximate impact of SB 863 on overall medical treatment levels. As a result, the WCIRB has reflected an estimated 10% decrease in overall medical severities as a result of changes to medical utilization levels resulting from SB 863, which represents an approximate 6.0% decrease in total costs.

Table 25: Change in Post-SB 863 Accident Year Claim Severities

	Indemnity (2012 to 2014)	Medical (2011 to 2014)
Prospective Estimate[44]	+15.7%	+22.0%
Updated Projection[45]	+12.3%	+0.4%
Actual Emergence	+8.7%	-9.9%

K. Other System Components

In addition to the areas discussed above, the WCIRB's SB 863 Cost Monitoring Plan includes new fee schedules for home health services and interpreter services that have not yet been adopted by the DWC. The WCIRB will continue to monitor the status of these new fee schedules and will evaluate their estimated cost impact on pure premium rates once they are adopted.

[44] Includes the WCIRB's prospective estimates of the impact of SB 863 on accident years 2013 and 2014 in addition to the projected severity trends for 2013 and 2014 reflected in the WCIRB's January 1, 2013 Pure Premium Rate Filing. For the medical severity estimate, the projected medical severity trend for accident year 2012 is also included inasmuch as the majority of SB 863 provisions affecting medical benefits came into effect on a date of service basis and also impact a significant proportion of accident year 2012 medical costs.

[45] Includes the WCIRB's current estimates of the impact of SB 863 (see Table 1, excluding the estimated changes to overall medical severities) in addition to the projected severity trends for 2013 and 2014 reflected in the WCIRB's January 1, 2017 Pure Premium Rate Filing. For the medical severity estimate, the projected medical severity trend for accident year 2012 is also included inasmuch as the majority of SB 863 provisions affecting medical benefits came into effect on a date of service basis and also impact a significant proportion of accident year 2012 medical costs.

Average Permanent Disability Ratings Based on DEU Data
Claims with Final Rating Before September 26, 2016

Average Final Rating

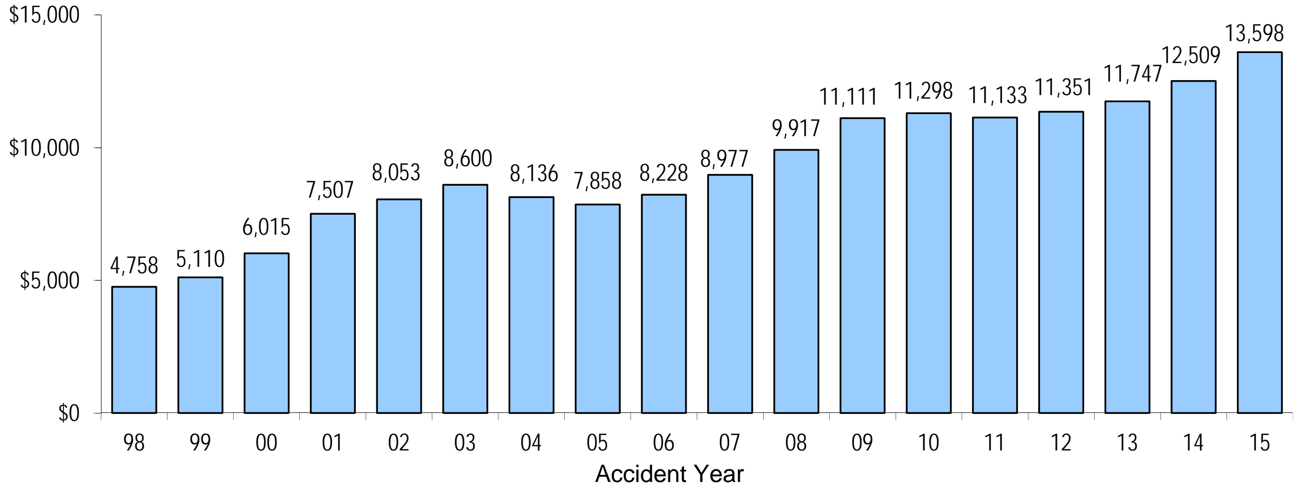
Age at Final Rating (Months)		Accident Year										
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
0	15	11.6	12.1	12.4	12.6	12.7	13.4	13.4	13.7	15.2	15.3	15.7
15	27	14.7	15.2	15.8	16.2	17.0	18.2	18.5	19.0	20.9	20.6	
27	39	18.8	19.8	20.6	22.2	22.6	23.8	23.8	24.3	25.8		
39	51	23.0	24.0	25.7	26.7	28.2	28.5	27.8	27.9			
51	63	26.7	28.6	30.4	31.7	31.6	30.6	31.6				
63	75	29.8	31.5	32.3	33.7	31.6	33.7					
75	& Over	35.2	36.4	35.2	34.4	35.7						

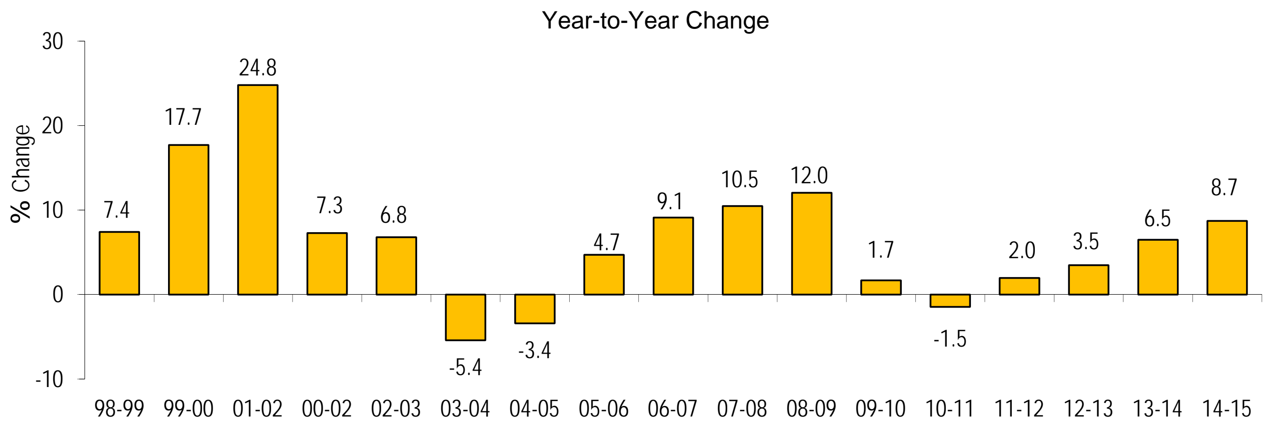
Change in Average Rating

Age at Final Rating (Months)		Accident Year										
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
0	15	---	3.7%	2.4%	2.0%	0.7%	5.6%	-0.4%	2.8%	11.0%	0.6%	2.7%
15	27	---	3.5%	4.0%	2.4%	5.2%	6.8%	2.1%	2.5%	10.1%	-1.6%	
27	39	---	5.1%	4.4%	7.9%	1.8%	5.1%	0.1%	2.0%	6.3%		
39	51	---	4.3%	7.1%	4.1%	5.5%	1.1%	-2.3%	0.3%			
51	63	---	7.3%	6.2%	4.1%	-0.2%	-3.3%	3.3%				
63	75	---	5.6%	2.6%	4.4%	-6.4%	6.7%					
75	& Over	---	3.2%	-3.4%	-2.1%	3.8%						

Source: DEU database.

California Workers' Compensation
Estimated Ultimate ALAE per Indemnity Claim[1] by Accident Year
As of March 31, 2016





[1] Based on data submitted by private insurers only.

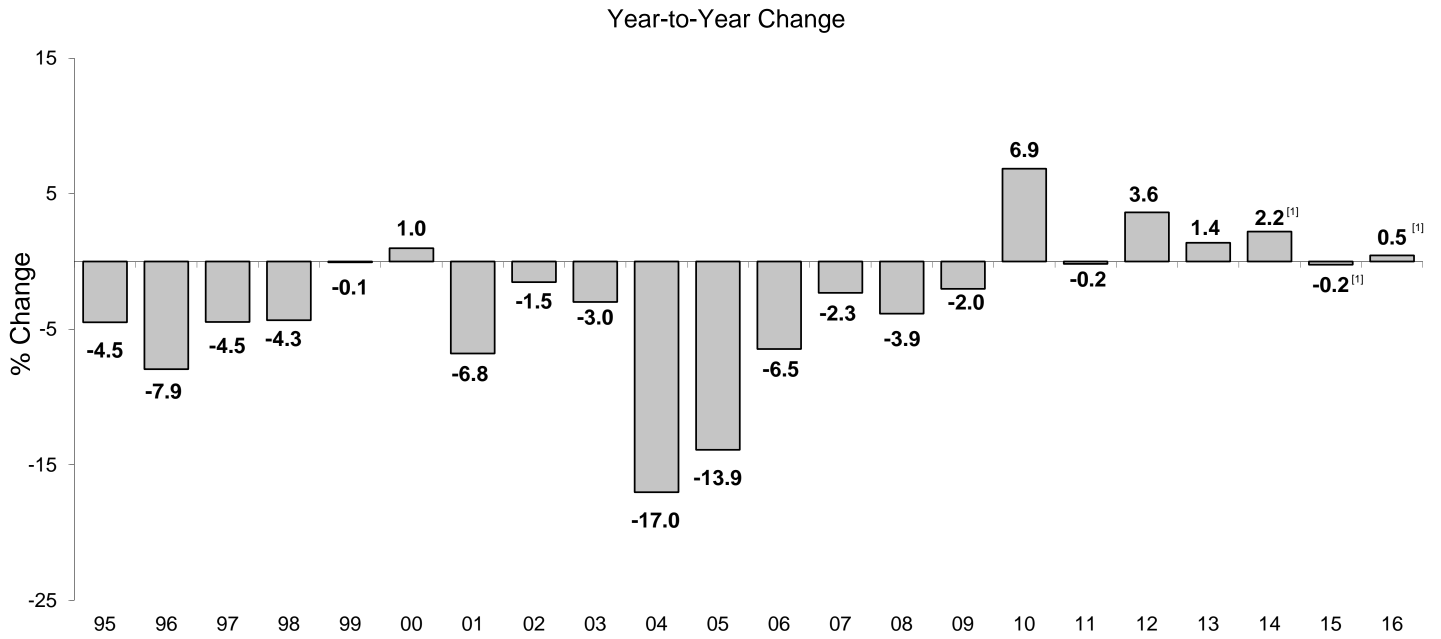
Percentage of DEU Ratings Involving Add-ons
Claims with Final Rating Before September 26, 2016

Add-on for: Psychiatric Impairment, Sleep Disorder, or Sexual Dysfunction

Age at Final Rating (Months)		Accident Year										
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
0	15	0.2%	0.4%	0.6%	0.7%	0.6%	0.5%	0.7%	0.8%	0.7%	0.4%	0.3%
15	27	0.8%	1.3%	1.4%	1.1%	1.6%	1.6%	1.6%	1.4%	0.7%	0.4%	
27	39	3.0%	2.6%	2.8%	3.8%	3.5%	4.4%	3.3%	3.2%	1.2%		
39	51	4.4%	4.1%	5.2%	6.5%	6.5%	6.5%	4.9%	3.9%			
51	& Over	6.9%	9.9%	10.9%	10.7%	9.4%	7.4%	6.3%				

Source: DEU database.

California Workers' Compensation
Estimated Indemnity Claim Frequency by Accident Year



[1] The 2013-2014 estimate is based on partial year unit statistical data. The 2014-2015 and 2015-2016 estimates are based on comparison of claim counts based on WCIRB accident year experience as of June 30, 2016 relative to the estimated change in statewide employment. Prior years are based on unit statistical data.

Distribution of Indemnity Claims by Average Weekly Wage
Based on WCIRB Unit Statistical Data at 1st Report Level

Permanent Disability Claims

Average PD Wage* Interval		Accident Year							
Lower	Upper	2008	2009	2010	2011	2012	2013	2014	2015
[$0	$160]	6.0%	7.8%	8.5%	9.1%	10.0%	9.9%	10.4%	*10.4%*
($160	$230)	4.7%	5.2%	5.8%	6.8%	7.5%	11.0%	9.4%	*7.0%*
[$230	$270)	7.7%	7.6%	9.6%	10.8%	11.5%	9.0%	10.4%	*15.1%*
[$270	& Up	81.6%	79.4%	76.1%	73.3%	71.0%	70.1%	69.8%	*67.5%*

All Indemnity Claims

Average PD Wage* Interval		Accident Year							
Lower	Upper	2008	2009	2010	2011	2012	2013	2014	2015
[$0	$160]	18.6%	18.8%	19.6%	20.4%	20.3%	17.5%	14.7%	*11.8%*
($160	$230)	4.6%	5.3%	5.9%	6.9%	7.6%	10.8%	10.0%	*8.3%*
[$230	$270)	7.2%	7.1%	8.6%	9.9%	10.3%	8.0%	9.3%	*12.6%*
[$270	& Up	69.6%	68.8%	65.9%	62.8%	61.8%	63.7%	66.0%	*67.3%*

*PD wage is 2/3 the reported average weekly wage. Wages are adjusted to a 2015 wage level.
Note: 2015 (italics) is preliminary and is based on policies incepting in 2014.

Liens Filed Counts*

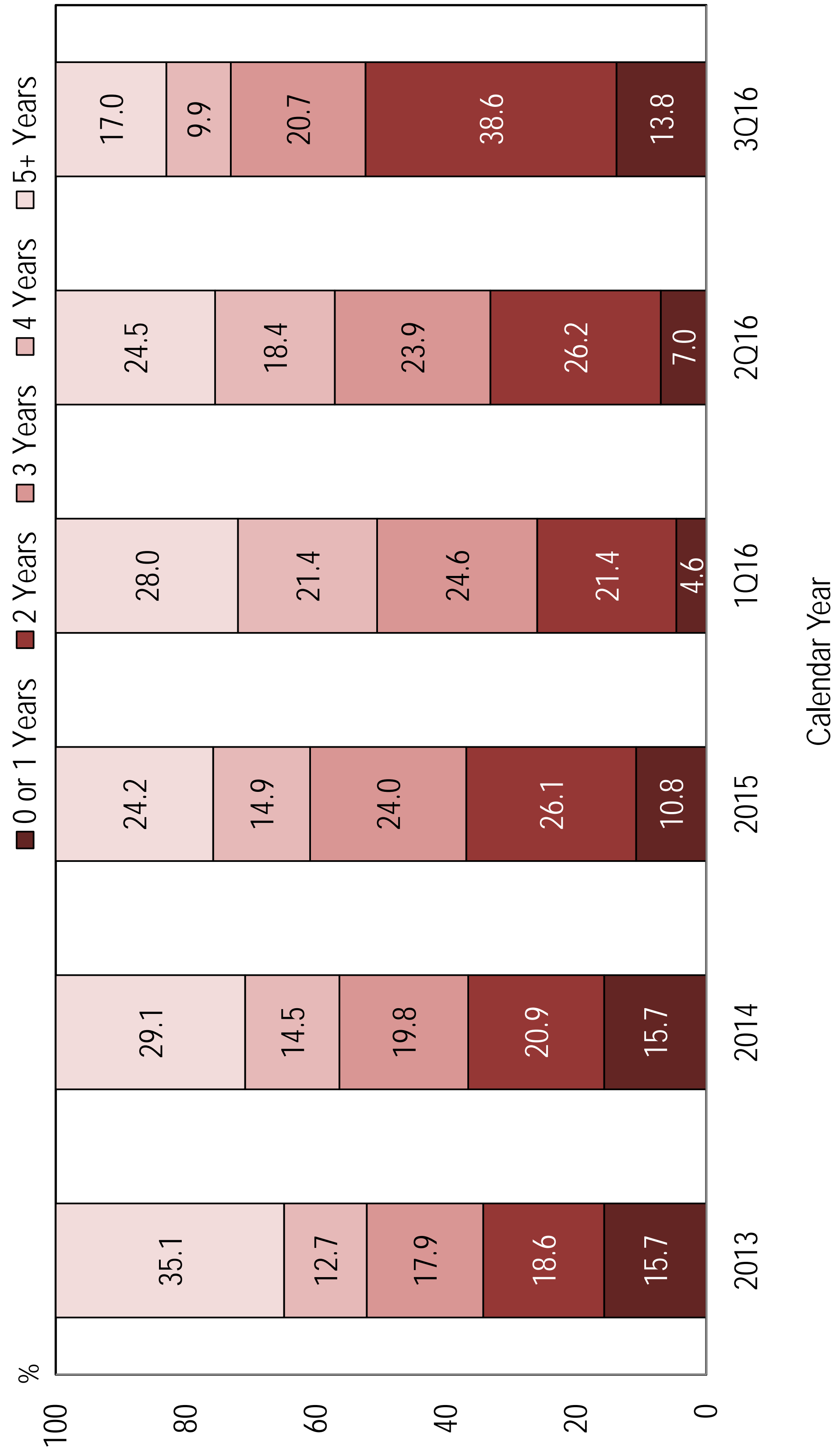
Counts by Region

Time Period	Bay Area	Central Coast/ Valley	Los Angeles County	Remainder of LA Basin	Remaining CA Zip Codes	Sacramento	San Diego County	**Total**
2011	18,723	24,414	283,774	114,554	2,535	3,934	15,922	**463,856**
1st Qtr 2012	5,490	7,245	97,245	38,034	895	1,248	4,936	**155,093**
2nd Qtr 2012	5,467	8,970	122,040	44,065	1,102	1,322	4,991	**187,957**
3rd Qtr 2012	6,434	15,289	207,639	85,152	698	1,407	6,611	**323,230**
4th Qtr 2012	10,397	25,730	342,549	123,129	1,119	1,557	8,523	**513,004**
1st Qtr 2013	1,232	2,193	46,830	17,032	230	268	1,312	**69,097**
2nd Qtr 2013	1,450	1,562	18,947	6,917	211	339	684	**30,110**
3rd Qtr 2013	1,607	1,795	25,999	9,855	247	410	991	**40,904**
4th Qtr 2013	1,928	2,025	29,537	10,893	276	358	1,136	**46,153**
1st Qtr 2014	1,841	2,029	25,668	10,117	239	384	1,165	**41,443**
2nd Qtr 2014	1,697	2,306	29,417	11,942	265	354	1,263	**47,244**
3rd Qtr 2014	1,941	1,996	29,665	12,198	355	424	1,378	**47,957**
4th Qtr 2014	1,690	2,371	34,772	12,469	374	384	1,488	**53,548**
1st Qtr 2015	2,071	3,058	45,827	18,016	431	488	2,133	**72,024**
2nd Qtr 2015	2,370	4,218	54,147	22,198	501	500	2,787	**86,721**
3rd Qtr 2015	2,428	4,977	61,619	24,827	691	526	3,047	**98,115**
4th Qtr 2015	2,338	4,991	68,843	26,571	686	495	3,085	**107,009**
1st Qtr 2016	2,884	5,410	67,259	27,326	672	538	3,931	**108,020**
2nd Qtr 2016	2,543	5,112	66,511	26,852	536	506	3,912	**105,972**
3rd Qtr 2016	2,243	4,167	45,707	20,136	420	462	3,404	**76,539**

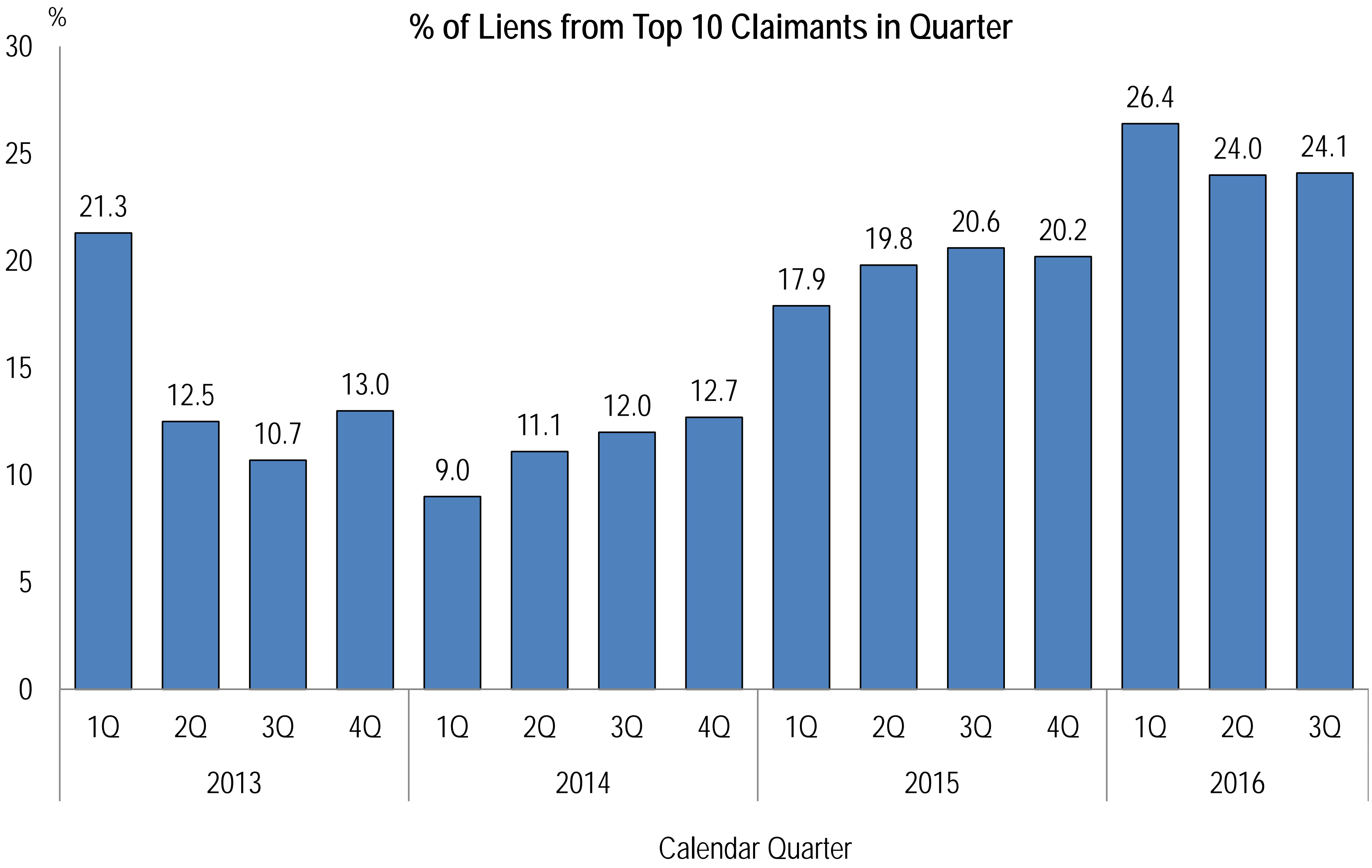
Counts by Type

Time Period	Interpreter	Medical	Medical-Legal	Copy Service	Other***	**Total**
2011	28,721	292,982	39,569	539	102,045	**463,856**
1st Qtr 2012	12,937	85,152	22,931	139	33,934	**155,093**
2nd Qtr 2012	17,162	106,336	37,440	65	26,954	**187,957**
3rd Qtr 2012	46,095	182,474	64,912	91	29,658	**323,230**
4th Qtr 2012	47,427	317,241	80,916	62	67,358	**513,004**
1st Qtr 2013	2,397	45,631	11,411	11	9,647	**69,097**
2nd Qtr 2013	831	22,480	587	20	6,192	**30,110**
3rd Qtr 2013	484	32,356	653	23	7,388	**40,904**
4th Qtr 2013	378	37,515	537	8	7,715	**46,153**
1st Qtr 2014	421	33,105	397	16	7,504	**41,443**
2nd Qtr 2014	275	38,534	320	10	8,105	**47,244**
3rd Qtr 2014	140	39,810	179	7	7,821	**47,957**
4th Qtr 2014	156	45,440	160	4	7,788	**53,548**
1st Qtr 2015	143	60,155	216	18	11,492	**72,024**
2nd Qtr 2015	152	74,037	268	7	12,257	**86,721**
3rd Qtr 2015	134	84,290	191	7	13,493	**98,115**
4th Qtr 2015	101	91,820	236	15	14,837	**107,009**
1st Qtr 2016	60	93,393	233	5	14,329	**108,020**
2nd Qtr 2016	90	89,781	467	6	15,628	**105,972**
3rd Qtr 2016	64	64,924	262	11	11,278	**76,539**

* Lien Counts exclude SDI/EDD Liens
** Regions reflect the following WCAB Office mapping: Bay Area - Oakland, San Jose, San Francisco; Central Coast/Valley - Bakersfield, Fresno, Goleta, Grover Beach, Salinas, Stockton; Los Angeles County - Long Beach, Los Angeles, Marina Del Rey, Pomona, Van Nuys; Remainder of LA Basin - Anaheim, Oxnard, Riverside, San Bernardino, Santa Ana; Remaining CA Zip Codes - Eureka, Redding, San Luis Obispo, Santa Barbara, Santa Rosa; Sacramento - Sacramento; San Diego County - San Diego
***Other includes Attorney Fees, Family Support, Living Expense, PFL, Transport, Wage Replace Liens
Source: EAMS Liens Data



Distribution of Liens Filed by Date of Injury
Difference between Year of Injury and Lien Filing Year
0 or 1 Years
2 Years
3 Years
4 Years
5+ Years
%
100
80
60
40
20
0
35.1
12.7
17.9
18.6
15.7
29.1
14.5
19.8
20.9
15.7
24.2
14.9
24.0
26.1
10.8
28.0
21.4
24.6
21.4
4.6
24.5
18.4
23.9
26.2
7.0
17.0
9.9
20.7
38.6
13.8
2013
2014
2015
1Q16
2Q16
3Q16
Calendar Year
Source: EAMS Liens Data


Liens Filed from Largest Lien Claimants
% of Liens from Top 10 Claimants in Quarter
%
30
25
20
15
10
5
0
21.3
12.5
10.7
13.0
9.0
11.1
12.0
12.7
17.9
19.8
20.6
20.2
26.4
24.0
24.1
1Q
2Q
3Q
4Q
2013
2014
2015
2016
Calendar Quarter
Source: EAMS Liens Data

Utilization Review Costs as a Percentage of Medical Payments
Based on CWCI 2016 Claims Monitoring Report

	Percent of Medical Cost Containment Payments by MCC Type			Medical Cost Containment as a Percentage of Medical Payments			UR/IMR/IBR* as a Percentage of Medical Payments		
	(1)	**(2)**		**(3)**	**(4)**	**(5)**	**= (3) X (1)**	**= (4) X (1)**	**= (5) X (1)**
Transaction Year	UR/IMR/IBR*	Medical Bill Review/PPO/MPN	Accident Year	9 Months	12 Months	24 Months	9 Months	12 Months	24 Months
2005	40.4%	59.6%	2005	11.7%	11.9%	11.2%	4.7%	4.8%	4.5%
2006	45.8%	54.2%	2006	14.4%	14.2%	12.5%	6.6%	6.5%	5.7%
2007	50.2%	49.8%	2007	15.2%	15.0%	13.6%	7.6%	7.5%	6.8%
2008	50.8%	49.2%	2008	16.4%	16.4%	14.6%	8.3%	8.3%	7.4%
2009	51.1%	48.9%	2009	16.8%	16.6%	14.8%	8.6%	8.5%	7.6%
2010	52.7%	47.3%	2010	16.6%	16.6%	14.7%	8.7%	8.7%	7.7%
2011	51.7%	48.3%	2011	17.3%	16.7%	14.3%	8.9%	8.6%	7.4%
2012	50.9%	49.1%	2012	16.7%	16.7%	14.4%	8.5%	8.5%	7.3%
2013	51.0%	49.0%	2013	17.3%	17.3%	15.2%	8.8%	8.8%	7.8%
2014	54.7%	45.3%	2014	16.4%	16.5%		9.0%	9.0%	
2015	56.2%	43.8%	2015	18.2%			10.2%		

Paid MCCP Costs as a Percentage of Paid Medical Costs
Based on WCIRB Aggregate Data

Calendar Year	
2007	7.1%
2008	9.6%
2009	9.1%
2010	9.2%
2011	9.4%
2012	9.2%
2013	9.2%
2014	10.1%
2015	11.2%

*IMR and IBR did not become effective until 2013 and few payments for IMR or IBR were made in 2013.

Percentage of Represented and Unrepresented Permanent Disability Claims by Region
First and Second Report Level

First Survey Level

	Northern California				
	AY2009	AY2010	AY2011	AY2012	AY2013
% Represented	61.4%	62.5%	63.3%	63.1%	70.3%
% Unrepresented	38.6%	37.5%	36.7%	36.9%	29.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

	Southern California				
	AY2009	AY2010	AY2011	AY2012	AY2013
% Represented	77.3%	78.8%	76.8%	80.6%	82.7%
% Unrepresented	22.7%	21.2%	23.2%	19.4%	17.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Second Survey Level

	Northern California				
	AY2008	AY2009	AY2010	AY2011	AY2012
% Represented	61.6%	65.6%	64.1%	65.5%	68.3%
% Unrepresented	38.4%	34.4%	35.9%	34.5%	31.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

	Southern California				
	AY2008	AY2009	AY2010	AY2011	AY2012
% Represented	79.1%	79.4%	79.4%	78.7%	81.7%
% Unrepresented	20.9%	20.6%	20.6%	21.3%	18.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Note: Claims are assigned to Northern and Southern California regions based on the WCAB office code reported on the Permanent Disability Claim Survey forms. If the WCAB office code was not reported, the zip code of the claimant's residence was used.

Source: WCIRB Permanent Disability Claim Survey at first survey level for each accident year (AY)

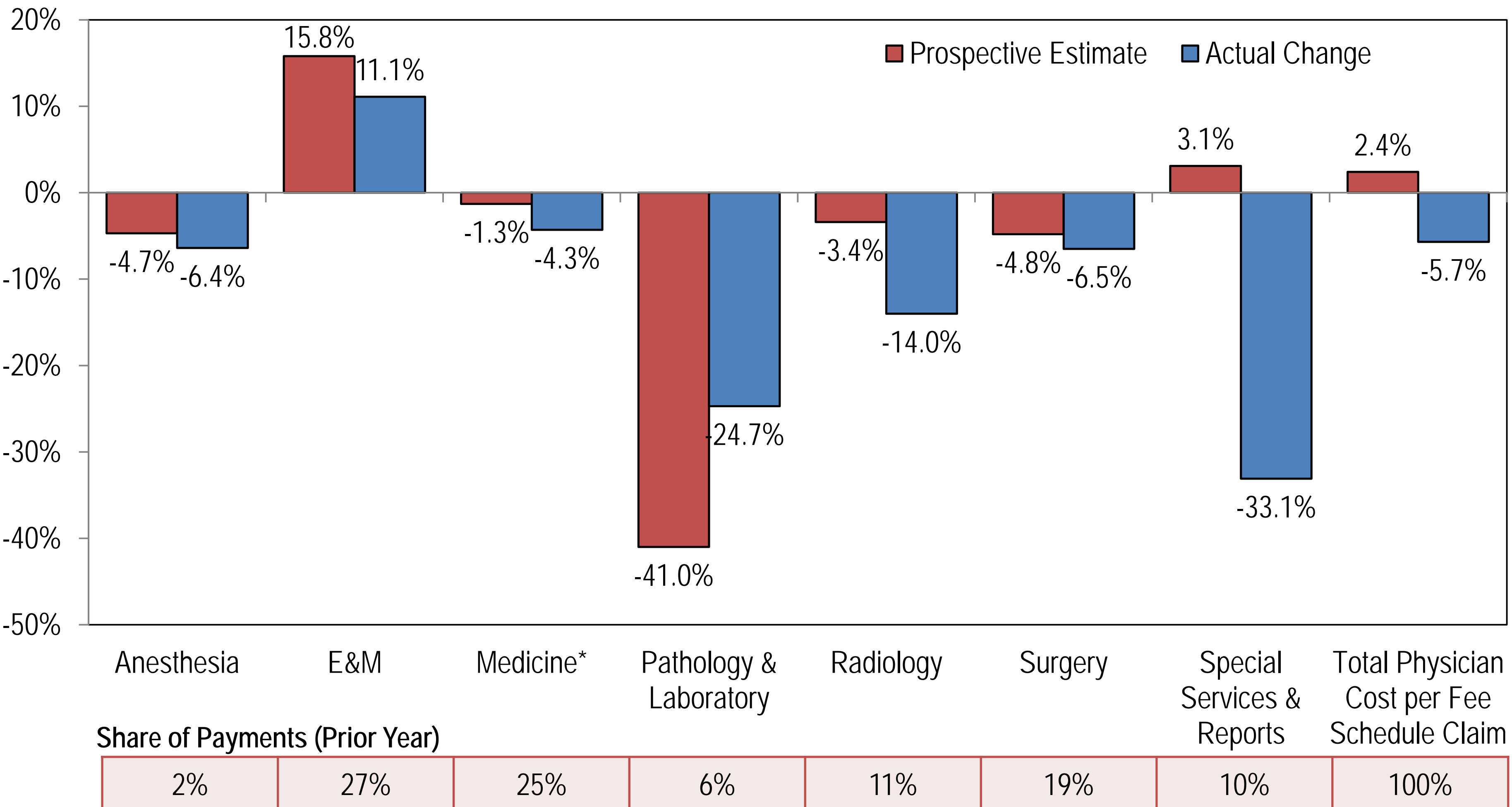
Temporary Disability Outcomes

Accident Year	Average Duration of TD Payments in Days Based on CWCI ICIS Data: 12 Months	24 Months	Average Duration of TD in Weeks Based on WCIRB PD Claim Survey: First Survey Level
2005	75.2	107.2	42.4
2006	78.8	111.0	44.2
2007	77.8	110.5	47.2
2008	79.6	115.8	50.4
2009	82.1	127.0	48.5
2010	89.9	130.1	46.2
2011	83.3	122.9	44.6
2012	85.6	128.1	43.8
2013	88.6	125.7	42.6
2014	89.0		

Annual Change

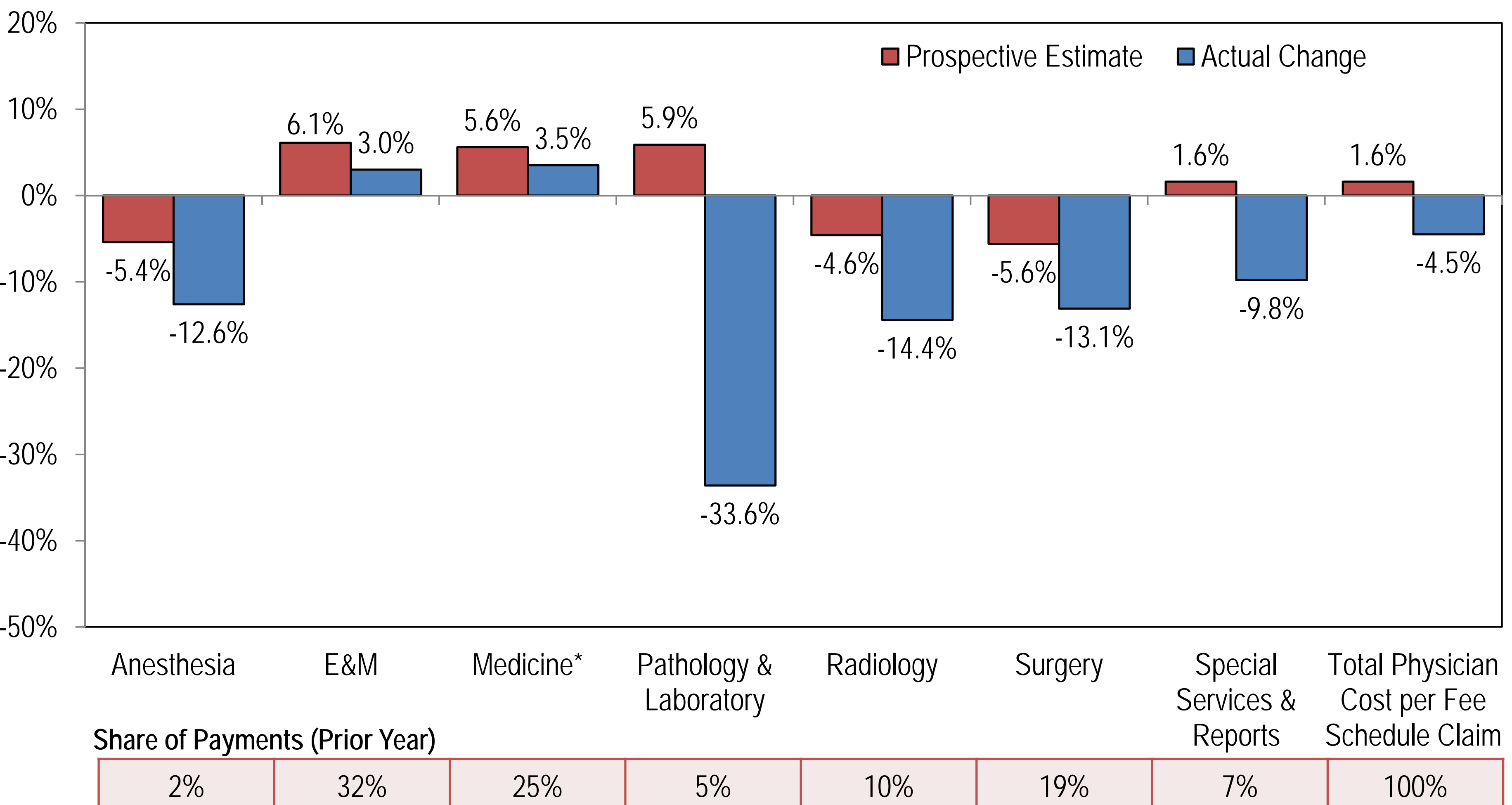
Accident Year	Average Duration of TD Payments in Days Based on CWCI ICIS Data: 12 Months	24 Months	Average Duration of TD in Weeks Based on WCIRB PD Claim Survey: First Survey Level
2006	4.8%	3.5%	4.2%
2007	-1.3%	-0.5%	6.9%
2008	2.3%	4.8%	6.8%
2009	3.1%	9.7%	-3.8%
2010	9.5%	2.4%	-4.7%
2011	-7.3%	-5.5%	-3.6%
2012	2.8%	4.2%	-1.8%
2013	3.5%	-1.9%	-2.7%
2014	0.5%		

Note: First Survey Level is valued at approximately 28 months.



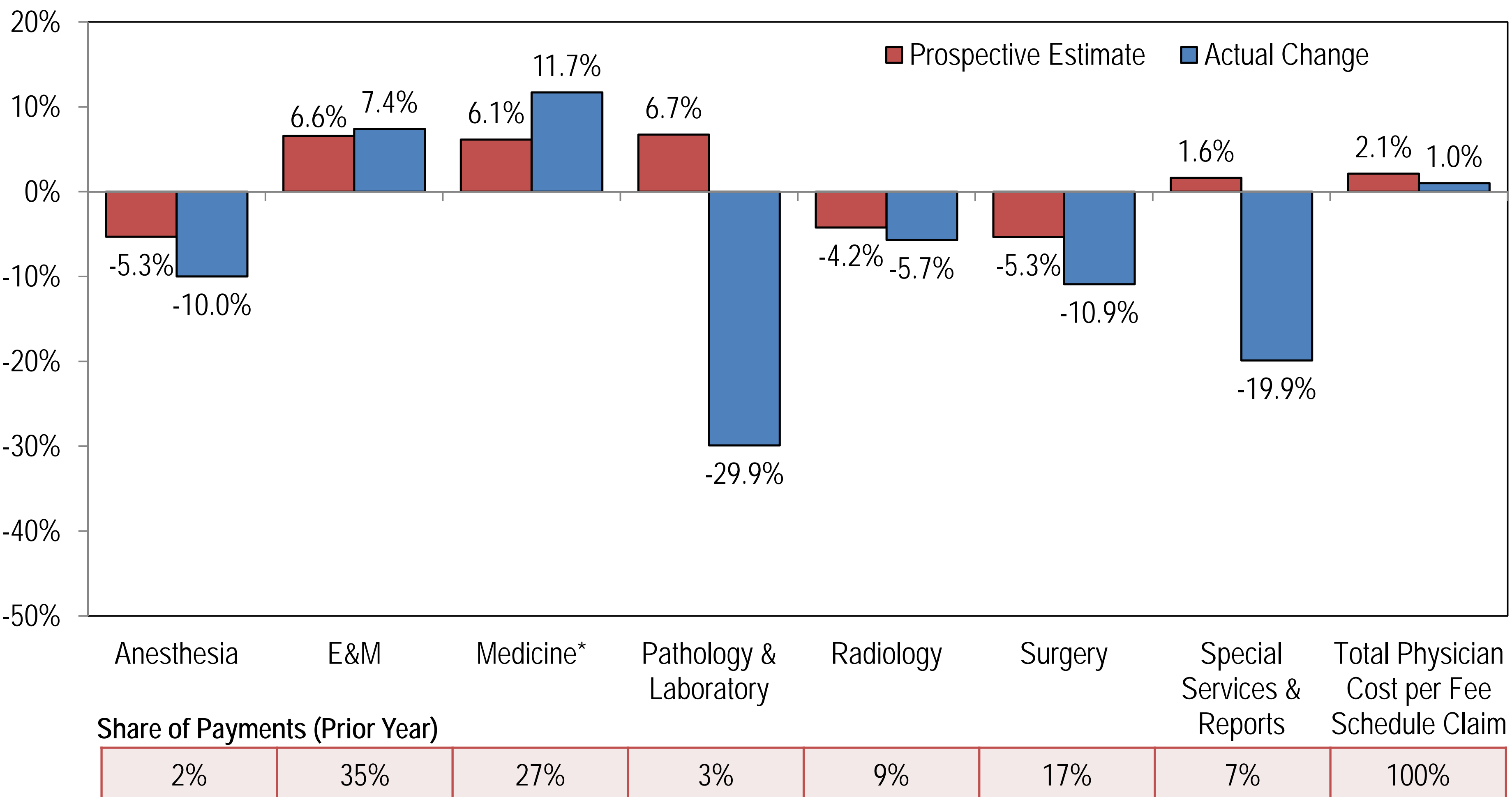
* Includes Physical Medicine, Chiropractic and Acupuncture

Source: WCIRB Medical Data Call.



Projected vs. Actual Change in Physician Fees – 2014 to 2015
Transactions through 2Q 2016 (18 Months)
Prospective Estimate
Actual Change
20%
10%
0%
-10%
-20%
-30%
-40%
-50%
-5.4%
-12.6%
6.1%
3.0%
5.6%
3.5%
5.9%
-33.6%
-4.6%
-14.4%
-5.6%
-13.1%
1.6%
-9.8%
1.6%
-4.5%
Anesthesia
E&M
Medicine*
Pathology & Laboratory
Radiology
Surgery
Special Services & Reports
Total Physician Cost per Fee Schedule Claim
Share of Payments (Prior Year)
2%
32%
25%
5%
10%
19%
7%
100%
* Includes Physical Medicine, Chiropractic and Acupuncture
Source: WCIRB Medical Data Call.

Exhibit 12.3



* Includes Physical Medicine, Chiropractic and Acupuncture

Source: WCIRB Medical Data Call.

Exhibit 13.1

Table 1: All: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	2,122		2,803		2,910		2,956		2,981		2,995		3,004		3,010
2013H1	2,152	1.01	2,809	1.00	2,891	0.99	2,921	0.99	2,943	0.99	2,953	0.99	2,960	0.99	
2013H2	2,144	1.01	2,714	0.97	2,783	0.96	2,813	0.95	2,825	0.95	2,832	0.95			
2014H1	2,144	1.01	2,718	0.97	2,782	0.96	2,805	0.95	2,818	0.95					
2014H2	2,038	0.96	2,553	0.91	2,613	0.90	2,634	0.89							
2015H1	2,117	1.00	2,581	0.92	2,631	0.90									
2015H2	1,994	0.94	2,494	0.89											
2016H1	2,093	0.99													

Table 2: All: Cumulative Paid Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	21.16		25.43		25.99		26.20		26.31		26.40		26.42		26.45
2013H1	21.34	1.01	26.18	1.03	26.64	1.03	26.81	1.02	26.97	1.02	27.01	1.02	27.04	1.02	
2013H2	21.21	1.00	25.33	1.00	25.77	0.99	25.99	0.99	26.04	0.99	26.08	0.99			
2014H1	19.02	0.90	23.59	0.93	24.04	0.92	24.14	0.92	24.21	0.92					
2014H2	19.35	0.91	22.91	0.90	23.27	0.90	23.39	0.89							
2015H1	19.45	0.92	22.41	0.88	22.74	0.87									
2015H2	18.23	0.86	21.43	0.84											
2016H1	18.66	0.88													

Table 3: All: Cumulative Paid/Paid Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	100		110		112		113		113		113		114		114
2013H1	101	1.01	107	0.97	109	0.97	109	0.97	109	0.96	109	0.96	109	0.96	
2013H2	101	1.01	107	0.97	108	0.96	108	0.96	108	0.96	109	0.96			
2014H1	113	1.12	115	1.05	116	1.03	116	1.03	116	1.03					
2014H2	105	1.05	111	1.01	112	1.00	113	1.00							
2015H1	109	1.09	115	1.04	116	1.03									
2015H2	109	1.09	116	1.06											
2016H1	112	1.12													

Source: WCIRB Medical Data Call

Table 4: Physician Fee Schedule: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	1,020		1,304		1,342		1,356		1,364		1,371		1,374		1,376
2013H1	1,001	0.98	1,288	0.99	1,319	0.98	1,333	0.98	1,345	0.99	1,350	0.98	1,354	0.98	
2013H2	974	0.96	1,226	0.94	1,256	0.94	1,273	0.94	1,279	0.94	1,282	0.94			
2014H1	960	0.94	1,214	0.93	1,243	0.93	1,251	0.92	1,257	0.92					
2014H2	951	0.93	1,163	0.89	1,185	0.88	1,193	0.88							
2015H1	991	0.97	1,179	0.90	1,199	0.89									
2015H2	933	0.91	1,122	0.86											
2016H1	990	0.97													

Table 5: Physician Fee Schedule: Cumulative Paid Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	15.36		18.74		19.14		19.27		19.35		19.41		19.43		19.44
2013H1	15.45	1.01	19.34	1.03	19.68	1.03	19.80	1.03	19.93	1.03	19.96	1.03	19.98	1.03	
2013H2	15.51	1.01	18.82	1.00	19.17	1.00	19.36	1.00	19.39	1.00	19.42	1.00			
2014H1	13.13	0.85	16.73	0.89	17.08	0.89	17.16	0.89	17.21	0.89					
2014H2	13.95	0.91	16.75	0.89	17.02	0.89	17.10	0.89							
2015H1	14.32	0.93	16.60	0.89	16.85	0.88									
2015H2	13.36	0.87	15.82	0.84											
2016H1	13.82	0.90													

Table 6: Physician Fee Schedule: Cumulative Paid/Paid Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	66		70		70		70		71		71		71		71
2013H1	65	0.98	67	0.96	67	0.96	67	0.96	67	0.96	68	0.96	68	0.96	
2013H2	63	0.95	65	0.94	65	0.93	66	0.94	66	0.94	66	0.94			
2014H1	73	1.10	73	1.04	73	1.04	73	1.04	73	1.04					
2014H2	68	1.03	69	1.00	70	0.99	70	0.99							
2015H1	69	1.04	71	1.02	71	1.01									
2015H2	70	1.05	71	1.02											
2016H1	72	1.08													

Source: WCIRB Medical Data Call

Exhibit 13.3

Table 7: Pharmacy Fee Schedule: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	396		436		448		454		458		460		462		463
2013H1	423	1.07	466	1.07	473	1.06	478	1.05	481	1.05	483	1.05	484	1.05	
2013H2	403	1.02	443	1.01	451	1.01	454	1.00	456	1.00	457	0.99			
2014H1	388	0.98	421	0.97	428	0.96	431	0.95	434	0.95					
2014H2	331	0.84	354	0.81	359	0.80	362	0.80							
2015H1	301	0.76	315	0.72	319	0.71									
2015H2	258	0.65	269	0.62											
2016H1	213	0.54													

Table 8: Pharmacy Fee Schedule: Cumulative Paid Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	3.84		4.18		4.24		4.27		4.29		4.30		4.30		4.30
2013H1	3.90	1.02	4.25	1.02	4.28	1.01	4.29	1.00	4.30	1.00	4.31	1.00	4.31	1.00	
2013H2	3.70	0.97	4.02	0.96	4.05	0.95	4.06	0.95	4.06	0.95	4.06	0.94			
2014H1	3.38	0.88	3.64	0.87	3.66	0.86	3.66	0.86	3.66	0.85					
2014H2	2.97	0.77	3.12	0.75	3.14	0.74	3.14	0.74							
2015H1	2.70	0.70	2.82	0.67	2.83	0.67									
2015H2	2.39	0.62	2.50	0.60											
2016H1	2.21	0.58													

Table 9: Pharmacy Fee Schedule: Cumulative Paid/Paid Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	103		104		106		106		107		107		107		108
2013H1	109	1.05	110	1.05	111	1.05	111	1.05	112	1.05	112	1.05	112	1.04	
2013H2	109	1.05	110	1.05	111	1.06	112	1.05	112	1.05	113	1.05			
2014H1	115	1.11	116	1.11	117	1.11	118	1.11	118	1.11					
2014H2	112	1.08	113	1.08	114	1.08	115	1.08							
2015H1	111	1.08	112	1.07	113	1.07									
2015H2	108	1.04	107	1.03											
2016H1	97	0.93													

Source: WCIRB Medical Data Call

Exhibit 13.4

Table 10: Inpatient Services: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	195		334		359		372		379		381		382		383
2013H1	208	1.07	327	0.98	342	0.95	346	0.93	348	0.92	349	0.92	349	0.91	
2013H2	233	1.20	336	1.01	346	0.96	349	0.94	348	0.92	349	0.92			
2014H1	222	1.14	313	0.94	320	0.89	323	0.87	325	0.86					
2014H2	220	1.13	314	0.94	326	0.91	329	0.88							
2015H1	223	1.15	308	0.92	315	0.88									
2015H2	211	1.09	312	0.94											
2016H1	223	1.15													

Table 11: Inpatient Services: Cumulative Paid Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	0.12		0.18		0.19		0.20		0.20		0.20		0.20		0.20
2013H1	0.12	1.03	0.18	0.98	0.19	0.97	0.19	0.96	0.19	0.96	0.19	0.96	0.19	0.95	
2013H2	0.13	1.10	0.19	1.02	0.19	0.99	0.19	0.98	0.19	0.97	0.19	0.97			
2014H1	0.14	1.19	0.19	1.04	0.19	1.00	0.19	0.99	0.20	0.98					
2014H2	0.14	1.17	0.18	1.00	0.19	0.97	0.19	0.95							
2015H1	0.13	1.15	0.18	0.99	0.18	0.95									
2015H2	0.14	1.20	0.19	1.04											
2016H1	0.13	1.12													

Table 12: Inpatient Services: Cumulative Paid/Paid Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	1,681		1,833		1,857		1,881		1,896		1,900		1,902		1,903
2013H1	1,750	1.04	1,822	0.99	1,826	0.98	1,817	0.97	1,819	0.96	1,820	0.96	1,822	0.96	
2013H2	1,830	1.09	1,799	0.98	1,800	0.97	1,799	0.96	1,800	0.95	1,802	0.95			
2014H1	1,610	0.96	1,656	0.90	1,657	0.89	1,661	0.88	1,664	0.88					
2014H2	1,625	0.97	1,723	0.94	1,735	0.93	1,742	0.93							
2015H1	1,679	1.00	1,714	0.94	1,721	0.93									
2015H2	1,522	0.91	1,657	0.90											
2016H1	1,720	1.02													

Source: WCIRB Medical Data Call

Exhibit 13.5

Table 13: Outpatient Services: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	121		201		217		222		225		226		227		228
2013H1	144	1.20	201	1.00	209	0.96	212	0.96	215	0.96	216	0.96	217	0.95	
2013H2	142	1.18	188	0.93	197	0.91	200	0.90	203	0.90	203	0.90			
2014H1	147	1.22	199	0.99	206	0.95	209	0.94	210	0.93					
2014H2	139	1.15	192	0.95	198	0.91	202	0.91							
2015H1	158	1.31	214	1.06	221	1.02									
2015H2	166	1.38	221	1.10											
2016H1	184	1.53													

Table 14: Outpatient Services: Cumulative Paid Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	0.24		0.39		0.41		0.42		0.43		0.43		0.43		0.43
2013H1	0.31	1.30	0.45	1.17	0.47	1.13	0.47	1.12	0.47	1.11	0.47	1.11	0.47	1.11	
2013H2	0.34	1.42	0.46	1.19	0.48	1.15	0.48	1.15	0.48	1.14	0.49	1.14			
2014H1	0.33	1.39	0.46	1.18	0.47	1.15	0.48	1.14	0.48	1.13					
2014H2	0.34	1.43	0.46	1.19	0.48	1.15	0.48	1.14							
2015H1	0.32	1.33	0.44	1.14	0.46	1.10									
2015H2	0.32	1.33	0.45	1.16											
2016H1	0.36	1.49													

Table 15: Outpatient Services: Cumulative Paid/Paid Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	504		522		527		528		529		530		532		532
2013H1	465	0.92	447	0.86	449	0.85	450	0.85	455	0.86	456	0.86	456	0.86	
2013H2	419	0.83	410	0.79	413	0.78	415	0.79	418	0.79	418	0.79			
2014H1	444	0.88	435	0.83	435	0.83	437	0.83	438	0.83					
2014H2	404	0.80	418	0.80	417	0.79	418	0.79							
2015H1	498	0.99	487	0.93	486	0.92									
2015H2	522	1.04	491	0.94											
2016H1	516	1.02													

Source: WCIRB Medical Data Call

Table 16: HCPCS Schedule: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	181		236		246		252		255		256		257		257
2013H1	173	0.95	229	0.97	244	0.99	247	0.98	249	0.98	250	0.98	251	0.98	
2013H2	176	0.97	223	0.94	229	0.93	232	0.92	234	0.92	235	0.92			
2014H1	172	0.95	217	0.92	226	0.92	230	0.91	231	0.91					
2014H2	159	0.88	206	0.87	214	0.87	217	0.86							
2015H1	183	1.01	220	0.93	226	0.92									
2015H2	174	0.96	216	0.91											
2016H1	173	0.96													

Table 17: HCPCS Schedule: Cumulative Paid Transactions/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	1.43		1.73		1.78		1.81		1.82		1.83		1.84		1.84
2013H1	1.41	0.98	1.75	1.01	1.81	1.02	1.83	1.01	1.84	1.01	1.85	1.01	1.85	1.01	
2013H2	1.37	0.96	1.63	0.94	1.67	0.94	1.68	0.93	1.69	0.93	1.70	0.93			
2014H1	1.87	1.30	2.34	1.36	2.39	1.35	2.41	1.34	2.43	1.33					
2014H2	1.79	1.25	2.18	1.26	2.22	1.25	2.24	1.24							
2015H1	1.81	1.26	2.14	1.24	2.17	1.22									
2015H2	1.79	1.25	2.14	1.24											
2016H1	1.84	1.29													

Table 18: HCPCS Schedule: Cumulative Paid/Paid Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	127		137		139		140		140		140		140		140
2013H1	123	0.97	131	0.96	135	0.97	135	0.97	135	0.97	135	0.97	135	0.97	
2013H2	129	1.02	137	1.00	138	0.99	138	0.99	138	0.99	138	0.99			
2014H1	92	0.73	93	0.68	94	0.68	95	0.68	95	0.68					
2014H2	89	0.70	95	0.69	96	0.69	97	0.69							
2015H1	101	0.80	103	0.75	104	0.75									
2015H2	97	0.77	101	0.74											
2016H1	94	0.74													

Source: WCIRB Medical Data Call

Exhibit 13.7

Table 19: Medical Legal Schedule: Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	200		278		284		285		286		286		287		287
2013H1	191	0.95	281	1.01	287	1.01	288	1.01	289	1.01	289	1.01	290	1.01	
2013H2	204	1.02	283	1.02	288	1.01	288	1.01	289	1.01	289	1.01			
2014H1	240	1.20	334	1.20	338	1.19	339	1.19	340	1.19					
2014H2	223	1.11	305	1.10	310	1.09	311	1.09							
2015H1	249	1.24	326	1.18	331	1.17									
2015H2	234	1.17	325	1.17											
2016H1	284	1.42													

Table 20: Medical Legal Schedule: Cumulative Paid Transactions/Claim by Service and Payment Half

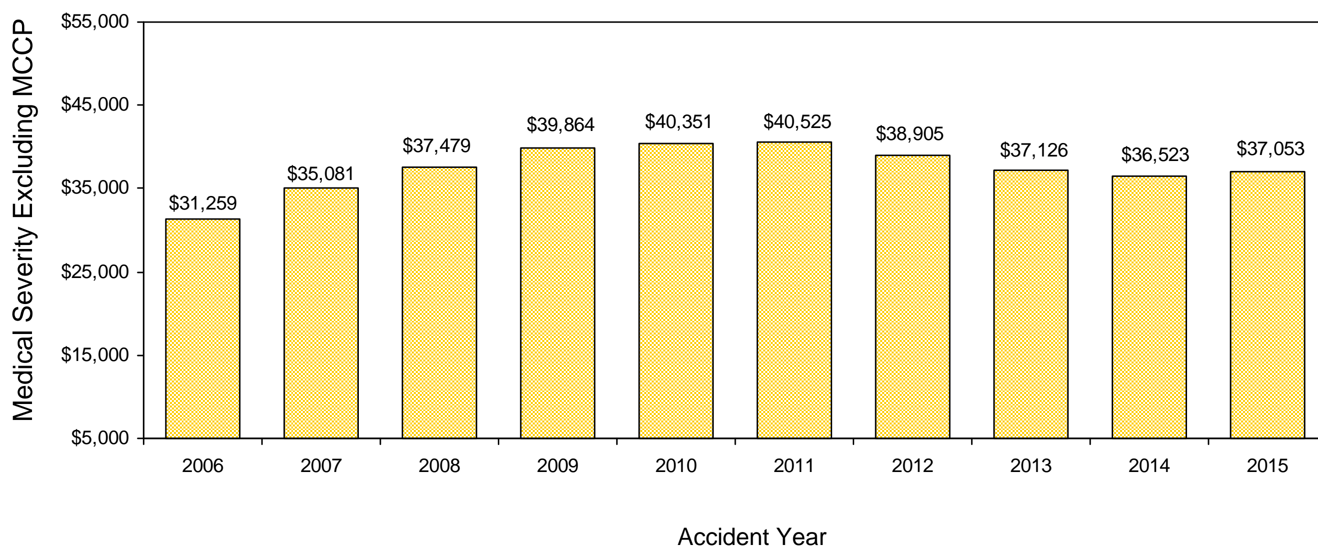
Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	0.15		0.19		0.20		0.20		0.20		0.20		0.20		0.20
2013H1	0.14	0.90	0.19	0.97	0.19	0.97	0.19	0.97	0.19	0.96	0.19	0.96	0.19	0.96	
2013H2	0.14	0.93	0.18	0.94	0.18	0.94	0.18	0.94	0.18	0.93	0.19	0.93			
2014H1	0.15	1.01	0.20	1.03	0.20	1.03	0.20	1.03	0.20	1.02					
2014H2	0.14	0.94	0.18	0.95	0.19	0.95	0.19	0.95							
2015H1	0.16	1.05	0.20	1.03	0.20	1.03									
2015H2	0.14	0.96	0.19	1.00											
2016H1	0.17	1.14													

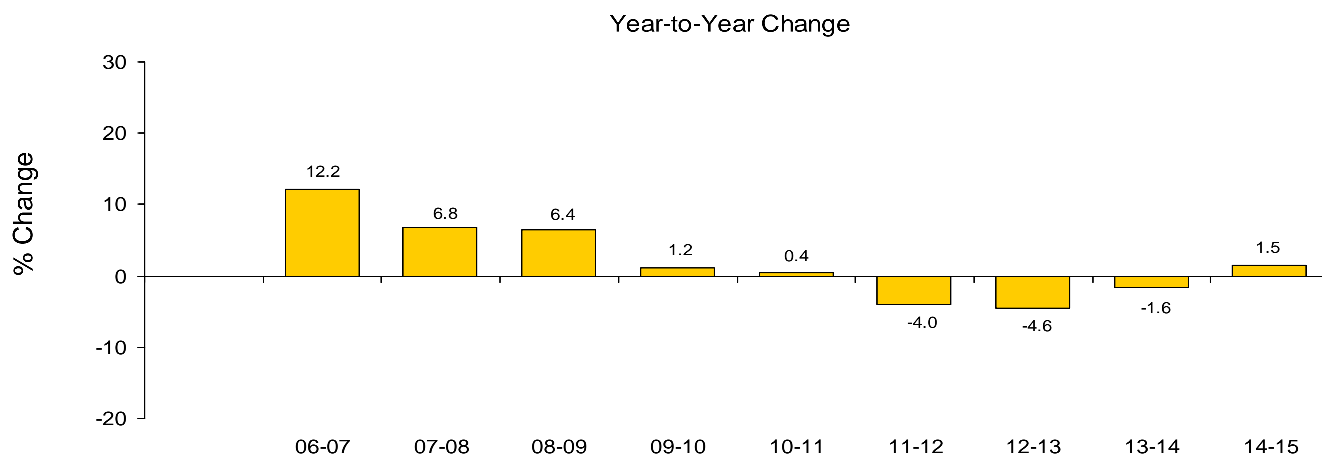
Table 21: Medical Legal Schedule: Cumulative Paid/Paid Transaction by Service and Payment Half

Service Half	Paid in Service Half	Ratio to 2012H2	Paid through SH + 1	Ratio to 2012H2	Paid through SH + 2	Ratio to 2012H2	Paid through SH + 3	Ratio to 2012H2	Paid through SH + 4	Ratio to 2012H2	Paid through SH + 5	Ratio to 2012H2	Paid through SH + 6	Ratio to 2012H2	Paid through SH + 7
2012H2	1,329		1,439		1,445		1,444		1,443		1,444		1,443		1,442
2013H1	1,402	1.05	1,511	1.05	1,515	1.05	1,514	1.05	1,514	1.05	1,514	1.05	1,512	1.05	
2013H2	1,458	1.10	1,557	1.08	1,561	1.08	1,562	1.08	1,562	1.08	1,561	1.08			
2014H1	1,588	1.19	1,679	1.17	1,680	1.16	1,677	1.16	1,677	1.16					
2014H2	1,575	1.18	1,659	1.15	1,656	1.15	1,653	1.15							
2015H1	1,575	1.18	1,641	1.14	1,643	1.14									
2015H2	1,614	1.21	1,692	1.18											
2016H1	1,664	1.25													

Source: WCIRB Medical Data Call

California Workers' Compensation
Estimated Ultimate Medical* Excluding MCCP per Indemnity Claim**
as of June 30, 2016





Source: WCIRB quarterly calls for experience

* Estimated ultimate severities for all accident years were derived by dividing ultimate medical losses on indemnity claims by ultimate indemnity claim counts.

** MCCP excluded from accident years 2010 and prior is estimated based on WCIRB's Annual Calls for Direct California Workers' Compensation Aggregate Indemnity and Medical Costs.

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