

March 30, 2007

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**Robert G. Mike**  
**President**

The Honorable Steve Poizner  
Insurance Commissioner  
California Department of Insurance  
45 Fremont Street, 23rd Floor  
San Francisco, CA 94105-2204

**RE: California Workers' Compensation Insurance  
Pure Premium Rates and Regulations  
Effective July 1, 2007**

Dear Mr. Poizner:

Pursuant to Article 2 of Chapter 2, and Articles 2 and 3 of Chapter 3, Part 3, Division 2, of the Insurance Code of the State of California, the Workers' Compensation Insurance Rating Bureau of California (WCIRB), a licensed rating organization and the designated statistical agent of the Insurance Commissioner, is submitting the recommendations and proposals contained in Parts A and B of the attached filing for your consideration.

**Part A. Pure Premium Rates**

The pure premium rates contained in Part A are proposed to be effective July 1, 2007 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after July 1, 2007. As compared to the approved pure premium rates effective January 1, 2007, the proposed pure premium rates reflect a decrease of 11.3%. The pure premium rates, which reflect loss costs (including loss adjustment expenses) per unit of exposure, are only advisory in that an insurer is not required to use either the proposed or the approved pure premium rates in establishing the rates it will charge.

The proposed pure premium rate decrease of 11.3% is based on (1) insurer losses incurred during 2006 and prior accident years valued as of December 31, 2006; (2) insurer loss adjustment expenses for 2005 and prior years; (3) the same loss ratio projection methodologies underlying the approved pure premium rates effective January 1, 2007; and (4) the same loss adjustment expense methodologies underlying the WCIRB's January 1, 2007 pure premium rate filing. These factors are discussed in Part A of this filing.

**Part B. Plans Subject to Insurance Commissioner Approval**

The proposed amendments to the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP) and the *California Workers' Compensation Experience Rating Plan—1995* (ERP) are contained in Part B of this filing. These amendments are proposed to become effective July 1, 2007 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after July 1, 2007.

The proposed amendments to the USRP effective July 1, 2007 are contained in Part B, Section A of this filing. These proposed amendments include (a) clarifying amendments related to the timing of required unit statistical submissions and the premium threshold above which an insurer is

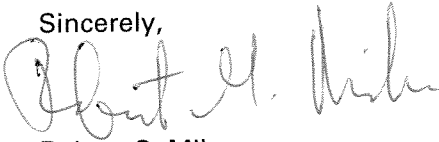
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California Department of Insurance  
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required to conduct a payroll audit and (b) amendments related to 2006 legislation (Assembly Bill No. 881), which requires each policy written for a C-39 licensed contractor (roofing contractor) to be audited.

The proposed amendments to the ERP effective July 1, 2007 are contained in Part B, Section B of this filing. These proposed amendments include (a) lowering the experience rating eligibility threshold from \$16,000 to \$14,192 to reflect the proposed 11.3% decrease in pure premium rates and (b) revisions to expected loss rates to reflect the most current loss experience available.

We shall endeavor to provide you with any additional information you may require.

Sincerely,



Robert G. Mike  
President

RGM:smd  
Enclosures

# WCIRB July 1, 2007 Pure Premium Rate Filing

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**Part A  
Pure Premium Rates**

The pure premium rates contained in Section A are proposed to be effective July 1, 2007 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after July 1, 2007. These pure premium rates have been computed based on an evaluation of accident year loss and premium experience as of December 31, 2006. The factors used to develop these proposed pure premium rates, including loss development and trending methodologies and loss adjustment expenses, are discussed in Section B.



**Part A**

**Section A — Proposed July 1, 2007 Pure Premium Rates**

This section sets forth the calculation of the pure premium rates proposed to be applicable to new and renewal policies as of the first anniversary rating date of a risk on or after July 1, 2007. The considerations used to develop these proposed pure premium rates are discussed in Section B.

As discussed in Section B, the indicated pure premium rate change based on aggregate loss and premium experience valued as of December 31, 2006 is a decrease of 11.3%. As a result, the pure premium rates proposed in this section to be effective on new and renewal policies as of the first anniversary rating date of a risk on or after July 1, 2007 are computed by multiplying the approved January 1, 2007 pure premium rate for each classification by a factor of 0.887.



**Pure Premium Rate Section (Proposed)**  
**Effective July 1, 2007 on New and Renewal Policies**  
**with Anniversary Rating Dates on or after July 1, 2007**

Legend:

(A) See immediately following page.

Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate
0005	3.81	2117	8.59	3082	6.35	3821	6.41	4558	3.66	5436	3.65	6834	4.51
0016	5.96	2121	4.67	3085	7.91	3828	4.44	4611	2.17	5443	4.46	7133	2.66
0034	5.05	2142	2.65	3099	3.82	3830	3.47	4623	5.02	5446	6.36	7198	6.84
0035	3.91	2150	5.76	3110	5.61	3831	1.98	4635	2.46	5447	3.06	7207	8.23
0036	6.35	2163	5.28	3131	3.26	3840	3.47	4665	5.76	5467	6.79	7219	6.84
0038	8.23	2211	8.85	3146	4.72	4000	3.18	4683	4.84	5470	4.68	7232	5.96
0040	2.92	2222	5.19	3152	2.87	4034	6.70	4691	3.04	5473	8.05	7248	2.79
0041	4.16	2362	6.48	3165	3.33	4036	1.84	4692	1.06	5474	6.16	7272	8.05
0042	4.63	2402	4.84	3169	4.86	4038	5.73	4717	5.45	5479	4.91	7332	3.56
0044	4.17	2413	6.50	3175	5.40	4041	4.71	4720	2.98	5482	2.76	7360	7.72
0045	3.99	2501	3.41	3178	2.85	4049	4.90	4740	1.42	5484	10.33	7365	8.62
0050	6.71	2570	5.77	3179	4.56	4111	2.12	4771	1.99	5485	5.18	7382	6.94
0079	3.01	2571	5.95	3180	5.00	4112	0.68	4828	2.79	5506	4.91	7392	6.11
0106	15.15	2576	5.46	3220	3.78	4114	4.71	4829	1.81	5507	3.10	7403	5.04
0171	6.55	2584	4.99	3241	4.67	4130	6.36	4831	4.07	5538	6.90	7405	1.36
0172	3.99	2585	6.48	3257	4.69	4150	2.71	4922	2.22	5542	2.46	7409	6.36
0251	3.22	2586	4.38	3300	8.01	4239	4.91	4983	5.00	5552	19.74	7410	3.77
0400	4.61	2589	4.38	3339	5.20	4240	5.42	5020	3.40	5553	8.63	7421	2.65
0401	5.17	2623	5.16	3365	7.27	4243	4.37	5027	6.64	5606	1.12	7424	1.96
1122	5.02	2660	3.46	3372	6.46	4244	4.23	5028	3.95	5630	11.53	7428	3.89
1123	10.79	2683	4.92	3383	2.13	4250	4.40	5040	6.55	5631	3.82	7429	4.58
1124	7.00	2688	4.88	3400	4.45	4251	3.45	5057	7.78	5632	11.53	7500	3.49
1320	2.31	2702	11.39	3401	4.78	4279	4.80	5059	15.89	5633	3.82	7515	1.30
1322	7.99	2710	7.89	3501	3.73	4283	4.18	5102	5.35	5645	11.53	7520	3.49
1330	7.18	2727	11.66	3507	5.93	4286	5.38	5107	3.69	5650	6.41	7538	8.60
1438	6.89	2731	6.79	3560	3.28	4295	4.96	5108	5.87	5697	3.82	7539	1.38
1452	3.03	2757	8.12	3568	2.15	4297	0.37	5128	1.24	5951	0.85	7580	3.01
1463	11.94	2759	5.86	3569	2.50	4299	3.58	5140	2.47	6003	5.69	7600	3.28
1624	5.02	2790	2.80	3570	4.56	4304	5.64	5146	4.19	6011	5.20	7601	6.83
1699	3.47	2797	6.96	3572	1.10	4312	4.39	5160	1.79	6204	8.17	7605	2.48
1701	7.59	2806	5.69	3573	1.62	4351	1.92	5183	4.72	6206	2.84	7606	2.68
1710	3.87	2812	4.98	3574	3.43	4354	1.73	5184	2.53	6213	2.83	7607	0.30
1741	4.72	2819	8.44	3577	1.17	4360	1.89	5185	5.43	6216	4.16	7610	0.70
1803	5.57	2840	6.88	3612	3.14	4361	2.47	5186	1.77	6218	5.01	7706	4.14
1925	7.60	2842	5.66	3620	6.62	4362	1.45	5187	2.34	6220	2.03	7707	(A)
2002	6.02	2852	6.59	3632	3.37	4410	5.83	5190	2.97	6233	2.82	7720	3.58
2003	5.36	2881	6.36	3634	3.28	4420	10.70	5191	1.77	6235	7.05	7721	3.83
2014	4.84	2883	7.89	3643	2.92	4432	2.10	5192	4.44	6237	4.04	7722	(A)
2030	5.63	2915	4.51	3647	4.60	4470	3.96	5195	4.13	6251	5.36	7855	2.76
2063	4.20	2923	4.74	3651	2.80	4478	4.88	5201	5.14	6254	3.95	8001	3.64
2081	8.57	3018	3.24	3681	1.12	4492	5.00	5205	3.20	6258	3.62	8004	2.96
2095	6.00	3022	4.03	3682	1.97	4494	4.57	5207	2.90	6307	8.53	8006	3.70
2102	3.98	3030	7.51	3683	2.36	4495	4.17	5212	4.19	6308	3.49	8008	2.51
2106	4.67	3039	9.07	3719	2.33	4496	3.73	5213	4.32	6315	5.79	8013	1.22
2107	4.49	3040	6.72	3724	3.70	4497	3.22	5214	4.70	6316	3.00	8015	3.66
2108	7.28	3060	5.98	3726	3.65	4498	4.44	5222	5.48	6325	3.93	8017	2.77
2109	5.76	3066	4.21	3805	1.41	4499	4.41	5225	6.39	6361	4.07	8018	4.76
2111	5.36	3070	0.73	3807	3.85	4511	1.13	5348	3.30	6364	5.89	8019	1.41
2113	8.07	3076	6.34	3808	2.60	4512	0.39	5403	11.53	6400	6.37	8021	7.48
2116	5.67	3081	6.65	3815	5.28	4557	2.53	5432	3.82	6504	5.22	8028	4.33

**Pure Premium Rate Section (Proposed)  
Effective July 1, 2007 on New and Renewal Policies  
with Anniversary Rating Dates on or after July 1, 2007**

(Continued)

Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate	Code No.	P.P. Rate
8031	4.99	8116	4.11	8393	2.97	8818	0.93	9011	3.56	9156	3.99	9620	3.02
8032	4.88	8117	5.15	8397	4.03	8820	0.43	9015	4.04	9180	2.97		
8039	4.58	8204	7.65	8400	1.97	8821	1.28	9016	3.81	9181	10.09		
8041	4.51	8209	6.42	8500	7.47	8822	0.68	9031	4.11	9182	2.24		
8042	2.78	8215	7.99	8601	0.52	8823	3.29	9033	5.05	9184	6.75		
8046	3.65	8227	5.32	8631	12.35	8827	3.63	9043	1.80	9185	15.46		
8057	4.04	8232	5.90	8720	2.79	8829	3.70	9048	4.51	9220	5.21		
8059	4.21	8264	7.22	8729	1.15	8830	1.80	9050	5.39	9402	3.50		
8060	2.47	8265	7.54	8740	1.06	8831	1.98	9053	1.82	9403	6.49		
8061	2.76	8267	5.10	8741	0.11	8834	1.06	9059	2.63	9410	1.61		
8062	1.19	8278	(B)	8742	0.50	8838	1.15	9060	3.14	9420	4.35		
8063	3.28	8286	6.70	8743	0.17	8839	0.94	9061	2.82	9422	4.01		
8064	3.50	8290	3.18	8745	4.70	8840	0.52	9066	3.07	9424	8.12		
8065	2.32	8291	4.20	8748	0.84	8846	0.82	9067	2.42	9426	7.25		
8066	1.32	8292	6.33	8749	0.43	8847	5.75	9069	3.46	9501	3.56		
8070	1.63	8293	15.03	8755	0.75	8850	2.23	9070	5.61	9507	3.11		
8071	1.21	8304	6.56	8800	3.00	8851	4.67	9079	2.68	9516	3.09		
8078	2.06	8324	3.21	8801	0.85	8852	2.94	9085	4.22	9519	4.63		
8102	2.08	8350	3.87	8803	0.20	8859	0.15	9092	2.18	9521	3.71		
8103	7.98	8387	3.72	8804	2.43	8868	0.94	9096	10.15	9522	3.95		
8106	5.63	8388	4.38	8806	3.94	8875	1.43	9097	3.39	9529	4.90		
8107	3.34	8389	4.08	8807	0.93	9007	3.83	9101	3.26	9549	6.34		
8110	1.66	8390	4.41	8808	0.75	9008	6.92	9151	0.83	9552	8.28		
8111	4.85	8391	2.55	8810	0.43	9009	3.67	9154	3.24	9586	2.32		
8113	7.65	8392	5.43	8813	0.66	9010	4.93	9155	1.46	9610	1.35		

	Code No.	Per Capita P.P. Rate
(A) Firefighters, Police, Police Deputies, etc.		
Firefighters - volunteers	7707	281.86
Police, Sheriffs - volunteers	7722	178.62

	Code No.	Per Race P.P. Rate
(B) Horse Racing		
Jockeys employed at a rate per race (See Classification 8631 - Racing Stables for instructions)	8278	57.66

**Part A**  
**Section B**  
**Computation of Projected Pure Premium Rate Level Change**  
**Applicable to Policies Effective on or after July 1, 2007**

The WCIRB's projection of the ratio of losses and loss adjustment expenses to premiums at the approved January 1, 2007 pure premium rate level for policies incepting between July 1, 2007 and December 31, 2007 is 88.7%. This generates an indicated 11.3% decrease in pure premium rates. This projection has been derived based on the considerations discussed below.

**A. Calendar-Accident Year Experience**

The projected loss to pure premium ratio is based on an evaluation of the experience of calendar-accident years 1977 through 2006, valued as of December 31, 2006. (The WCIRB's January 1, 2007 pure premium rate filing was based on calendar-accident year experience through 2005, valued as of June 30, 2006.)

Appendix A, Exhibit 1 is a summary of the calendar year premiums and accident year losses upon which this pure premium rate filing is based. Specifically, Appendix A, Exhibit 1 shows the earned premium, the indemnity paid losses and case reserves, and the medical paid losses and case reserves as of December 31, 2006 for accident years 1977 through 2006. The experience contained in this summary reflects the data reported by insurers representing approximately 86% of the California workers' compensation insurance market in 2005.<sup>1</sup> In addition, the December 31, 2006 experience of a number of insurers that were in liquidation by 2006 but may have written a significant portion of the market in prior years has not been reported to the WCIRB and is, therefore, not included in this summary.

**B. Loss Development**

The indemnity and medical losses paid and incurred (paid plus case reserves) shown in Appendix A, Exhibit 1 for each accident year are valued as of December 31, 2006. For example, the paid indemnity losses of \$272,342,586 shown for accident year 2006 reflect the total amount of indemnity benefits that have been paid on accidents that occurred during 2006 from the beginning of that year through December 31, 2006. However, the amount of losses reported for the accidents that occur in a particular year will change over time, and the final cost of these accidents will not be known for many years.

The pure premium rates are intended to reflect the estimated final or ultimate cost of losses and loss adjustment expenses on all accidents that will occur during the period that the rates will be in effect. Consequently, the losses reported for each historical accident year as of December 31, 2006 are adjusted, or developed, to reflect the ultimate cost of all accidents that have occurred during that year.

The historical incurred "age-to-age" development factors for each annual valuation period for indemnity losses and medical losses are shown in Appendix A, Exhibits 2.1 and 2.2, respectively. The historical paid "age-to-age" development factors for each annual valuation period for indemnity losses and medical losses are shown in Appendix A, Exhibits 2.3 and 2.4, respectively.

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<sup>1</sup> The December 31, 2006 experience of American International Group and Virginia Surety Company were not included in the statewide experience summary shown in Appendix A, Exhibit 1 due to WCIRB's concerns as to the accuracy of the information submitted.



These factors represent the historical year-to-year growth in the incurred and paid losses reported at consecutive December 31 valuation periods.

The methodologies used to develop each year's reported losses to their ultimate level are identical to those upon which the approved January 1, 2007 pure premium rates were predicated. These methodologies are summarized below.

#### Indemnity Loss Development

Prior to the WCIRB's July 1, 2006 pure premium rate filing, the WCIRB had been projecting future indemnity loss development based on historical accident year paid development. Appendix A, Exhibit 2.3 shows the historical annual indemnity paid loss development factors at successive December 31 valuations.<sup>2</sup> As reflected in Appendix A, Exhibit 2.3, over the last two years, paid indemnity loss development for the less mature evaluation periods has been significantly less than that of the prior years. However, for more mature evaluation periods, the latest two years of paid indemnity development have generally been comparable to prior years.

Assembly Bill No. 749 (AB 749) increased most classes of workers' compensation benefits over a four-year period beginning in 2003. Also, Assembly Bill No. 227 (AB 227), Senate Bill No. 228 (SB 228), and Senate Bill No. 899 (SB 899) included a number of reform provisions impacting indemnity benefits. The estimates of the overall cost impact of these various legislative provisions affecting indemnity benefits have been reflected in WCIRB pure premium rate filings for a number of years. In addition, these legislative provisions have affected not only the amount of indemnity benefits that will be paid on post-reform injuries, but also how quickly the losses will be paid.

The WCIRB's March 2007 report, *Impact of Reform Legislation on Loss Development Patterns—2007 Update*, summarizes the WCIRB's analysis of the impact of the recent reform legislation on indemnity paid loss development patterns. (This report is attached as Appendix B.) As discussed in the report, the WCIRB does not believe historical paid factors can be used as a reliable projector of future indemnity development in the post-reform environment. Instead, as in the WCIRB's July 1, 2006 and January 1, 2007 pure premium rate filings, the WCIRB is recommending that indemnity loss development for the 2003 through 2006 accident years be based on the findings included in this report. Specifically, projected post-reform indemnity paid loss development patterns for accident years 2003 through 2006 have been estimated from the pre-reform indemnity loss development pattern by (a) decomposing the pre-reform total indemnity payment pattern into benefit type and payment period; (b) reflecting each applicable AB 749, AB 227, SB 228 and SB 899 legislative change by benefit type and payment period; and (c) computing a post-reform total indemnity payment pattern based on the reform-adjusted estimated payment pattern by benefit type.<sup>3</sup>

The cumulative, "to-ultimate," paid development factors computed on this basis to develop accident years 2003 through 2006 are shown in Appendix A, Exhibit 2.3. Also shown in Appendix A, Exhibit 2.3 are projected "age-to-age" and cumulative factors for accident years 2002 and prior, which are based on the latest historical paid factor—the methodology used in the last several WCIRB pure premium rate filings.

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<sup>2</sup> Accident year 1979 and prior development factors for periods after 228 months have been adjusted for non-repeating permanent total and asbestos claim patterns.

<sup>3</sup> In the prior two pure premium rate filings, projected indemnity loss development for 2003 and 2004 were further adjusted to reflect the fact that the January 1, 2005 permanent disability rating schedule would apply to many pre-January 1, 2005 claims. However, in light of the recent WCAB Pendergrass decision, no such adjustments were made in this pure premium rate filing.

### Medical Loss Development

For many years, the WCIRB has also been relying on historical paid loss development to project future medical loss development.<sup>4</sup> Appendix A, Exhibit 2.4 shows the historical annual accident year medical paid loss development factors evaluated at successive December 31 valuations. As shown, paid development factors for the twelve-month periods ending December 31, 2004, December 31, 2005 and December 31, 2006 are generally well below those of prior twelve-month periods, particularly for the less mature valuation periods. Conversely, for more mature accident years, paid development continues to escalate. As discussed in Appendix B, many of the SB 228 reforms related to medical fee schedules and SB 228 and SB 899 reforms related to the utilization of medical services impacted the cost of future medical services on pre-existing claims as well as the cost of future claims. If no adjustment were made, emerging paid development factors would be artificially low for purposes of projecting future paid development.

As in the last several post-reform WCIRB pure premium rate filings, the WCIRB has attempted to eliminate this distortion in development patterns by adjusting pre-reform medical payments. The specific adjustments are described in detail in Appendix B. The WCIRB's recommended medical "age-to-age" and cumulative paid medical development factors, which have been adjusted for the impact of SB 228 medical fee schedule changes and SB 228 and SB 899 legislative provisions impacting the utilization of medical services, are shown in Appendix A, Exhibit 2.4.

### Estimated Ultimate Loss Ratios

The "age-to-age" development factors selected for each evaluation period are combined in Appendix A, Exhibit 3 to produce a cumulative development factor for each period. These factors reflect the ultimate amount of losses anticipated for each accident year relative to the reported paid losses as of December 31, 2006. These cumulative factors are then applied to the reported (undeveloped) paid indemnity and adjusted paid medical loss ratios as of December 31, 2006 to estimate an ultimate loss ratio for each accident year. (It should be noted that the estimated ultimate medical loss ratios shown in Appendix A, Exhibit 3 for accident years prior to 2004 have been adjusted to the current fee schedule and medical utilization levels for the sole purpose of computing the indicated July 1, 2007 pure premium rate level change and, as a result, do not reflect the actual WCIRB estimates of ultimate loss ratios for those years.) As shown in the last column of Appendix A, Exhibit 3, the WCIRB currently projects an ultimate loss ratio of 37.1% for accident year 2006.

### **C. Cost Level Adjustments to Losses**

Each year's historical losses, once developed to an ultimate basis, are adjusted to reflect various measurable economic or claims-related changes that have occurred since the time that year's claims were incurred. In this way, the accident year adjusted, or "on-level," ratios of losses to premium are on a comparable basis for purposes of projecting future ratios of losses to premium.

Appendix A, Exhibits 4.1 through 4.3 show the adjustments made to losses to reflect the changes in the cost of selected loss components that can be specifically measured. Appendix A, Exhibit 4.1 displays the average impact on indemnity benefits of legislative and regulatory changes as well as wage inflation. Specifically, Appendix A, Exhibit 4.1, column 1 shows the impact of statutory benefit changes through January 1, 2008 as estimated in legislative cost evaluations that were included in prior WCIRB pure premium rate filings. These factors represent the impact of legislative changes, including AB 749, AB 227, SB 228 and SB 899, on indemnity benefits.

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<sup>4</sup> Prior to the WCIRB's July 1, 2004 pure premium rate filing, the WCIRB had been projecting future medical development by applying an exponential trend to recent paid medical development factors.

As in prior WCIRB's pure premium rate filings, Exhibit 4.1 reflects the WCIRB's estimated impact of the January 1, 2005 permanent disability rating schedule (PDRS) adopted by the administrative director of the Division of Workers' Compensation (DWC) pursuant to SB 899. Specifically, the on-level adjustment in Exhibit 4.1 reflects the WCIRB's estimated 50% reduction in permanent disability benefits as a result of the implementation of the January 1, 2005 PDRS. As in the California Department of Insurance's decision on the WCIRB's January 1, 2007 pure premium rate filing,<sup>5</sup> this judgmental estimate was based on (a) the findings of the most current update to the UC Berkeley Survey/Research Center study of the cost impact of the January 1, 2005 PDRS (attached as Appendix C)<sup>6</sup> and (b) preliminary WCIRB unit statistical data on policy year 2005 permanent disability claims.<sup>7</sup>

Even without statutory benefit changes, wage inflation will impact the cost of indemnity benefits. Appendix A, Exhibit 4.1 shows the impact of wage inflation on indemnity benefits. The estimated wage inflation effects are based on (a) the most current UCLA Anderson School of Business estimates of changes in California annual wages included in Appendix A, Exhibit 5.1, (b) the distribution of the weekly wages of injured workers, and (c) the schedule of statutory benefits in effect for a particular year.

The Official Medical Fee Schedule (OMFS) regulates the amounts paid to physicians for many workers' compensation medical procedures. As of April 1, 1999, many inpatient hospital procedures became subject to the Inpatient Hospital Fee Schedule (IHFS). The administrative director of the DWC adopted changes to the IHFS in 2001. Appendix A, Exhibit 4.2 shows the impact of the OMFS and IHFS changes (pre-SB 228) on medical costs.<sup>8</sup> (The impact of the SB 228 changes related to medical fee schedules is reflected in adjustments to the medical paid development projections discussed in Appendix B.)

Some workers' compensation medical costs are not subject to fee schedules. As a result, the portion of each historical accident year's medical losses that is not subject to fee schedules is adjusted to reflect the anticipated cost level for the period the proposed pure premium rates will be in effect. The cost adjustments used in this analysis are shown in Appendix A, Exhibit 4.2. The historical values are based on the "Other Medical Services" and "Medical Care Services" components of the Consumer Price Index as published by the Bureau of Labor Statistics. Projected values are provided by Global Insight, Inc.

Legislative changes also impact the cost of medical benefits. Appendix A, Exhibit 4.3, column 5 shows the factor to adjust each year's medical costs to reflect the impact of subsequently-enacted legislation. The factors in column 5 reflect the impact on medical costs of (a) statutory reforms (excluding SB 228 fee schedule changes and SB 228 and SB 899 reform provisions impacting the utilization of medical services—the effects of which are reflected in the adjustments shown in Appendix A, Exhibit 2.4) and (b) changes in the frequency of indemnity claims as a result of benefit changes. Column 6 of Appendix A, Exhibit 4.3 shows the combined impact of (a) medical inflation on non-fee schedule components, (b) changes in the OMFS, (c) changes in the IHFS and (d) legislative changes on medical costs.

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<sup>5</sup> File Number Reg-2006-00002 issued on November 2, 2006.

<sup>6</sup> This report, which was based on a comparison of approximately 30,000 ratings computed by the Disability Evaluation Unit in accordance with the January 1, 2005 PDRS, suggested a reduction of approximately 50% in the permanent disability benefits on claims that were ratable under both the January 1, 2005 PDRS and the pre-January 1, 2005 PDRS.

<sup>7</sup> This analysis, based on preliminary unit statistical data, suggests a reduction in permanent disability benefits on claims with ratable permanent disabilities under both systems of approximately 31%.

<sup>8</sup> In accordance with SB 228, as of January 1, 2004, certain additional medical services, including pharmaceuticals and outpatient facility services, became subject to fee schedules, thereby reducing the proportion shown in Appendix A, Exhibit 4.2, column 2.

#### **D. Wage and Premium Adjustments**

Each historical year's earned premium is also adjusted to a common, or "on-level," basis. Appendix A, Exhibit 5.1 displays the adjustment made to historical premiums to reflect changes in wage level. Pure premium rates are expressed in terms of payroll. Consequently, the reported premium for each year reflects the wages paid during that year. To determine the level of pure premium needed to fund the cost of losses and loss adjustment expenses on July 1, 2007 through December 31, 2007 policies, the premium reported for each year is adjusted to reflect the wages anticipated to be paid during the period in which these policies will be in effect. Beginning with the WCIRB's January 1, 2004 pure premium rate filing, the WCIRB has based estimates of future wage inflation on changes in average annual California wages as published by UCLA's Anderson School of Business.

The amount of premium generated during a particular year reflects the rates in effect during that year. To test the adequacy of the approved January 1, 2007 pure premium rates, the premium generated for each year is adjusted to reflect the premium that would have been generated had the approved January 1, 2007 pure premium rates been charged during that year. This adjustment is shown in column 2 of Appendix A, Exhibit 5.2.<sup>9</sup> In addition, the premium reported for each year is adjusted for (a) the surcharge premium generated under the Minimum Rate Law, (b) the average experience modification and (c) the current experience rating off-balance correction factor of 1.030.

#### **E. Trending of On-Level Ratios**

The loss ratios shown for historical accident years, once adjusted to an ultimate, on-level basis, are used to project the July 1, 2007 through December 31, 2007 policy period loss ratio at the approved January 1, 2007 pure premium rates. Appendix A, Exhibits 6.1 through 7.2 summarize the computation of the projected "on-level" loss to pure premium ratio for this policy period. The WCIRB makes separate projections for indemnity and medical losses.

##### Indemnity On-Level Loss Ratios

Appendix A, Exhibit 6.1, column 1 displays the indemnity loss ratios developed to an ultimate level as shown in Appendix A, Exhibit 3. These developed loss ratios are adjusted for (a) the impact of changes in benefit levels and wage inflation on indemnity benefits shown in Appendix A, Exhibit 4.1 and (b) the premium level adjustments shown in Appendix A, Exhibit 5.2 to produce the on-level indemnity ratios shown in column 4 of Appendix A, Exhibit 6.1. These on-level ratios reflect the ratio of estimated ultimate indemnity losses to premium for each year as though (a) the January 1, 2007 statutory benefit level and wages projected for the July 1, 2007 through December 31, 2007 policy period had been in effect for each year and (b) the premium for each year had been generated at the January 1, 2007 pure premium rate level and at the average wage level projected for the July 1, 2007 through December 31, 2007 policy period.

The indemnity on-level loss ratios, which are displayed graphically in Appendix A, Exhibit 7.1, show a consistent upward trend through 2000, with the exception of the sharp declines in 1992 and 1993. Since accident year 2000, the indemnity on-level loss ratios have generally been declining. The projected accident year 2006 on-level loss ratio is, however, above the 2005 ratio. Given that two post-reform years of experience are now available and post-reform experience differs significantly from the pre-reform experience, the WCIRB is recommending, as in the last several WCIRB pure premium rate filings, that the projected loss ratio be based on the average of the latest two historical accident year on-level indemnity ratios.

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<sup>9</sup> The adjustments in this column reflect both (a) the impact of the average differential between insurer rates and the pure premium rates approved for each year and (b) changes in the approved pure premium rates.

### Medical On-Level Loss Ratios

Appendix A, Exhibit 6.2 shows accident year medical on-level loss ratios, which have been computed in a manner similar to those for indemnity. These on-level ratios, which are also displayed graphically in Appendix A, Exhibit 7.2, show a consistent upward trend through 1989, a dramatic acceleration of the trend in 1990 and 1991, and very sharp declines in 1992 and 1993. Since 1993, on-level medical loss ratios had been growing, with a sharp acceleration of the growth rate beginning in 1996. However, as with indemnity, the latest four accident year on-level ratios for medical are well below those of the prior accident years.

As discussed in the last several WCIRB pure premium rate filings, recent legislation was intended to significantly affect the utilization of medical services. While the WCIRB indicated that the impact of AB 749, SB 228 and SB 899 on the utilization of medical services will be significant, inasmuch as there was no credible statistical basis for directly estimating the impact of these legislative provisions on the utilization of medical services—either separately or in combination—no explicit adjustment for these reforms was reflected in prior WCIRB pure premium rate filings. Instead, several adjustments to the WCIRB's underlying rate filing methodology were made, including a significant reduction in the indicated on-level medical trend.<sup>10</sup> However, as discussed in Appendix B, estimates of the impact of these reforms based on post-reform data are now available; therefore, the WCIRB has recommended explicit adjustment to the medical paid loss development to reflect the impact of legislative reforms affecting medical utilization. As in the WCIRB's July 1, 2006 and January 1, 2007 pure premium rate filings, taking into consideration (a) the pre-Minnear-decision<sup>11</sup> average annual rate of growth in medical on-level ratios, (b) current estimates of general medical inflation and (c) the large proportion of medical costs currently subject to fee schedules, the WCIRB is again recommending that the projected medical loss to pure premium ratio be based on applying an annual medical on-level trend rate of 1% to the average of the latest two accident year on-level ratios.

### **F. February 15, 2007 Changes to the OMFS**

The administrative director of the DWC recently adopted changes to the OMFS values for 10 office visit codes. These changes were adopted effective February 15, 2007. A report by the California Workers' Compensation Institute (CWCI) that estimates the impact of the changes is attached as Appendix D. The analysis, which is based on 2005 medical procedure level data from CWCI's Industry Claim Information System (ICIS), indicates that the adopted changes will increase the cost of these office visit codes by approximately 23% (Appendix D, Table 8).

The CWCI report in Appendix D indicates that the current cost of the 10 office visit codes comprise 14.4% of total physician costs. The WCIRB's latest published summary of calendar year costs estimates that physician costs are 49.6% of total benefit costs.<sup>12</sup> Based on this information, the WCIRB estimates that the February 15, 2007 changes to the OMFS values for office visit codes will increase overall medical costs by 1.6%.<sup>13</sup>

### **G. March 1, 2007 Changes to the Pharmaceutical Fee Schedule**

The administrative director of the DWC also recently adopted changes to the Pharmaceutical Fee Schedule to that provide that pharmaceuticals directly dispensed by physicians are subject to the

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<sup>10</sup> In the WCIRB's July 1, 2005 and January 1, 2006 pure premium rate filings, a 0% medical inflation rate was assumed. In several filings prior to these, the indicated medical inflation rate was reduced by 75% to reflect the impact of recent reforms impacting the utilization of medical services.

<sup>11</sup> Minnear v. Mount San Antonio Community College District (1996) 61 Cal. Comp. Cases 1055 (Appeals Board en banc opinion).

<sup>12</sup> "2005 California Workers' Compensation Losses and Expenses," released June 23, 2006.

<sup>13</sup> The estimate assumes no change in the level of medical services provided.



same schedule values as are pharmaceuticals dispensed by pharmacies. These changes were adopted effective March 1, 2007. A Commission on Health and Safety and Workers' Compensation (CHSWC) report prepared by representatives of UC Berkeley Survey/Research Center, CWCI and the Rand Corporation on the cost of pharmaceuticals dispensed by physicians is attached as Appendix E. The CHSWC analysis, which is also based on medical procedure level data from the CWCI ICIS system, indicates that the adopted changes will decrease the cost of pharmaceuticals by approximately 40%.

The WCIRB's latest published summary of calendar year costs estimates that pharmacy costs are 11.4% of total benefit costs.<sup>14</sup> Based on this information, the WCIRB estimates that the March 1, 2007 changes to the Pharmaceutical Fee Schedule will decrease overall medical costs by 4.6%.<sup>15</sup>

#### **H. Computation of Projected Loss Adjustment Expenses**

The WCIRB's projection of the cost of loss adjustment expenses on policies incepting between July 1, 2007 and December 31, 2007 is computed in Exhibit 9. The methodology used to compute this ratio is consistent with that used in the WCIRB's January 1, 2007 pure premium rate filing. As shown in Exhibit 9, the WCIRB estimates that the ratio of loss adjustment expenses to losses on policies incepting between July 1, 2007 and December 31, 2007 is 23.6%.

#### **I. Computation of Pure Premium Rate Level Change**

Line 1 of Appendix A, Exhibit 8 displays the estimated ultimate indemnity and medical ratios of losses to premium at the approved January 1, 2007 pure premium rates for the July 1, 2007 through December 31, 2007 policy period. In total, the WCIRB estimates a loss to pure premium ratio of 0.732. These ratios do not reflect the impact of the February 15, 2007 changes to the OMFS and the March 1, 2007 changes to the Pharmaceutical Fee Schedule. The impact of these changes, as described in Sections F and G above, are shown on Appendix A, Exhibit 8, lines 2 and 3, respectively. The projected loss to pure premium ratio after adjustment for the impact of the adopted changes to the OMFS and Pharmaceutical Fee Schedule are shown on Appendix A, Exhibit 8, line 4. In total, the WCIRB projects a ratio of losses to premium at the approved January 1, 2007 pure premium rates of 0.718.

Appendix A, Exhibit 8, line 5 shows the estimated loss adjustment expenses for July 1, 2007 through December 31, 2007 policy period of 23.6% of losses. The estimated ultimate loss and loss adjustment expense ratio at the approved January 1, 2007 pure premium rate level for the July 1, 2007 through December 31, 2007 policy period, as shown on line 6, is 0.887. Appendix A, Exhibit 8, line 7 shows the indicated change in pure premium rates effective July 1, 2007 of -11.3%.

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<sup>14</sup> "2005 California Workers' Compensation Losses and Expenses," released June 23, 2006.

<sup>15</sup> The estimate assumes no change in the amount or type of pharmaceuticals prescribed.

**California Workers' Compensation  
Calendar-Accident Year Experience as of December 31, 2006**

<u>Year</u>	<u>Earned Premium</u>	<u>Paid Indemnity</u>	<u>Indemnity Reserves</u>	<u>Paid Medical</u>	<u>Medical Reserves</u>
1977	1,360,004,594	465,191,073	5,408,176	341,827,098	24,283,976
1978	1,602,622,620	483,707,844	6,032,838	368,459,274	25,531,710
1979	1,726,899,710	524,270,825	6,143,650	420,389,377	32,099,926
1980	1,851,998,197	540,467,372	5,911,681	443,960,258	28,023,006
1981	1,909,537,250	576,154,796	6,522,922	500,582,284	24,249,714
1982	1,805,223,389	584,783,611	6,526,809	525,420,741	32,557,929
1983	2,074,459,561	830,744,885	7,993,662	618,086,199	28,454,148
1984	2,440,569,554	1,087,960,185	9,167,500	783,710,036	30,318,842
1985	2,867,708,966	1,274,241,113	9,610,708	949,572,839	41,806,803
1986	3,501,584,334	1,373,264,360	12,136,352	1,070,197,651	49,234,258
1987	4,369,322,493	1,490,717,652	16,164,411	1,256,033,344	70,726,599
1988	5,170,382,107	1,682,185,330	17,275,058	1,452,694,919	72,553,386
1989	5,675,864,577	1,911,675,439	26,307,237	1,678,179,534	92,542,901
1990	5,704,876,442	2,230,414,238	27,294,461	1,934,782,455	96,720,501
1991	5,871,363,251	2,437,253,436	48,577,888	2,062,942,748	120,950,461
1992	5,691,551,825	1,939,786,354	42,577,321	1,622,441,964	116,896,440
1993	5,954,821,831	1,652,814,935	50,491,660	1,340,419,942	142,448,090
1994	5,061,974,472	1,574,188,785	68,592,961	1,284,802,183	170,880,027
1995	3,825,219,955	1,684,778,092	95,728,094	1,352,790,221	218,016,795
1996	3,786,087,612	1,854,890,157	129,480,036	1,430,523,124	233,745,277
1997	3,969,530,451	2,177,506,683	169,827,907	1,675,854,444	304,125,898
1998	4,373,070,153	2,548,889,966	246,589,821	2,107,771,708	438,202,499
1999	4,606,014,697	2,769,708,425	287,796,580	2,356,039,688	469,193,468
2000	5,997,128,272	3,010,069,147	362,745,805	2,726,661,448	548,762,280
2001	9,389,045,970	3,704,521,334	540,017,967	3,522,544,760	767,912,993
2002	12,769,141,871	3,482,441,970	624,486,426	3,518,468,152	805,436,331
2003	18,141,417,859	2,819,001,731	752,635,118	2,766,263,434	902,087,721
2004	20,957,057,327	1,521,776,913	726,313,597	1,666,637,022	835,156,326
2005	19,070,851,398	765,545,826	616,847,309	1,070,406,409	898,718,442
2006	14,934,480,164	272,348,586	572,472,136	476,132,195	952,863,024

Source: WCIRB calendar and accident year experience calls.

Incurred Indemnity Loss Development Factors

Age in Months	Reported as of									Latest Year	Cum.
	12/98	12/99	12/00	12/01	12/02	12/03	12/04	12/05	12/06		
24/12	1.709	1.861	1.910	1.931	1.873	1.952	1.782	1.447	1.501	1.501	2.092
36/24	1.213	1.230	1.260	1.291	1.276	1.325	1.263	1.187	1.158	1.158	1.394
48/36	1.077	1.092	1.109	1.117	1.118	1.123	1.106	1.069	1.070	1.070	1.204
60/48	1.031	1.048	1.062	1.071	1.068	1.068	1.052	1.035	1.034	1.034	1.125
72/60	1.014	1.031	1.038	1.047	1.042	1.045	1.034	1.020	1.023	1.023	1.088
84/72	1.008	1.016	1.022	1.031	1.030	1.026	1.021	1.014	1.011	1.011	1.064
96/84	1.005	1.009	1.013	1.020	1.016	1.022	1.013	1.007	1.011	1.011	1.052
108/96	1.004	1.006	1.007	1.015	1.013	1.017	1.011	1.002	1.008	1.008	1.041
120/108	1.001	1.002	1.008	1.008	1.006	1.009	1.007	1.003	1.007	1.007	1.033
132/120	1.001	1.002	1.003	1.004	1.005	1.005	1.007	0.998	1.001	1.001	1.026
144/132	0.999	1.001	1.003	1.004	1.003	1.003	1.004	1.000	1.003	1.003	1.025
156/144	1.001	1.001	1.004	1.001	1.003	1.002	1.006	1.001	1.002	1.002	1.022
168/156	1.000	0.999	1.001	1.001	1.002	1.001	1.001	1.002	1.002	1.002	1.020
180/168	1.000	0.999	1.001	1.001	1.000	1.001	1.000	1.000	1.002	1.002	1.018
192/180	1.001	0.999	1.002	1.001	1.000	1.001	1.002	1.001	1.002	1.002	1.016
204/192	1.000	1.000	1.001	1.000	1.001	1.000	1.000	1.000	1.001	1.001	1.014
216/204	0.999	1.000	1.001	1.000	1.000	1.000	1.002	1.001	1.003	1.003	1.013
228/216	0.999	1.001	1.003	1.000	1.001	1.001	1.001	1.002	1.001	1.001	1.010
240/228 (a)	<i>1.000</i>	1.002	1.001	1.000	1.001	1.001	1.001	1.000	1.000	1.000	1.009
252/240 (a)	<i>1.000</i>	<i>1.000</i>	0.998	1.002	1.002	1.001	1.001	1.000	1.000	1.000	1.009
264/252 (a)	<i>1.001</i>	<i>1.000</i>	1.000	1.002	1.001	1.000	1.002	1.000	1.001	1.001	1.009
276/264 (a)	<i>1.000</i>	<i>0.998</i>	1.000	1.000	1.001	1.002	1.002	1.002	1.001	1.001	1.008
288/276 (a)	<i>1.000</i>	1.000	1.000	1.000	1.000	1.001	1.003	1.000	1.001	1.001	1.007
300/288 (a)	<i>1.000</i>	1.000	1.000	1.000	<i>0.998</i>	1.000	1.001	1.002	1.001	1.001	1.006
312/300 (a)	<i>0.996</i>	1.000	0.999	1.000	1.000	1.000	1.000	1.001	1.001	1.001	1.005
324/312 (a)		1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.001	1.001	1.004
336/324 (a)			1.000	0.999	1.000	1.000	1.000	1.000	1.000	1.000	1.003
348/336 (a)				1.001	1.000	1.000	1.000	1.000	1.000	1.000	1.003
ULT/348 (b)						1.004	1.003	1.003	1.002	1.003 (c)	1.003
360/348 (a)							1.000	1.000	1.000	1.000	

- (a) Factors in italic format are adjusted for non-repeating permanent total and asbestosis claim patterns occurring in accident years 1979 and prior. These factors have been reflected at 20% of the reported factors.
- (b) To adjust for non-repeating asbestosis claim patterns in older accident years, these factors are reflected at 20% of the reported ULT/348 factors. The original factors were 1.021, 1.016, 1.014 and 1.008, respectively.
- (c) Three-year average ULT/348 factors are selected.



**Incurred Medical Loss Development Factors**

Age in Months	Reported as of									Latest Year	Cum.
	12/98	12/99	12/00	12/01	12/02	12/03	12/04	12/05	12/06		
24/12	1.339	1.443	1.517	1.598	1.658	1.632	1.565	1.349	1.389	1.389	2.263
36/24	1.084	1.113	1.169	1.219	1.226	1.274	1.203	1.118	1.131	1.131	1.629
48/36	1.018	1.067	1.087	1.112	1.125	1.131	1.107	1.059	1.058	1.058	1.440
60/48	1.010	1.037	1.050	1.070	1.095	1.097	1.072	1.047	1.039	1.039	1.361
72/60	1.009	1.032	1.038	1.053	1.072	1.081	1.060	1.038	1.041	1.041	1.310
84/72	1.005	1.011	1.028	1.047	1.052	1.062	1.042	1.032	1.029	1.029	1.258
96/84	1.008	1.010	1.021	1.033	1.036	1.046	1.048	1.022	1.027	1.027	1.223
108/96	1.007	1.005	1.013	1.028	1.034	1.044	1.028	1.021	1.024	1.024	1.191
120/108	1.002	1.004	1.009	1.017	1.024	1.029	1.026	1.019	1.015	1.015	1.163
132/120	1.002	1.003	1.011	1.010	1.014	1.021	1.025	1.018	1.019	1.019	1.146
144/132	0.996	1.002	1.009	1.008	1.012	1.021	1.022	1.011	1.011	1.011	1.125
156/144	1.000	1.005	1.010	1.009	1.012	1.009	1.010	1.012	1.018	1.018	1.113
168/156	1.002	1.001	1.003	1.006	1.009	1.012	1.008	1.011	1.009	1.009	1.093
180/168	1.004	1.006	1.004	1.008	1.008	1.015	1.006	1.006	1.002	1.002	1.083
192/180	1.006	1.004	1.006	1.007	1.007	1.009	1.003	1.001	1.009	1.009	1.081
204/192	0.990	1.005	1.005	1.003	1.007	1.016	1.005	1.002	1.004	1.004	1.071
216/204	1.007	1.006	1.005	1.005	1.009	1.009	1.004	1.004	0.999	0.999	1.067
228/216	1.004	1.009	1.016	1.007	1.006	1.007	1.007	0.998	1.004	1.004	1.068
240/228	1.003	1.015	1.008	1.012	1.008	1.003	1.008	1.004	1.006	1.006	1.064
252/240	1.002	1.016	1.003	1.009	1.009	1.009	1.007	1.008	1.001	1.001	1.058
264/252	1.009	1.007	1.011	1.003	1.011	1.009	0.998	1.002	1.004	1.004	1.057
276/264	1.005	1.008	1.009	1.009	1.020	1.003	1.009	1.001	1.004	1.004	1.053
288/276	1.004	1.003	1.005	1.014	1.014	1.009	1.007	1.000	1.005	1.005	1.049
300/288	1.012	1.007	1.005	1.014	1.014	1.010	1.014	1.003	1.000	1.000	1.044
312/300	1.007	1.002	1.010	1.011	1.013	1.008	1.004	1.003	1.002	1.002	1.044
324/312		0.996	1.011	1.004	1.010	0.993	0.992	1.006	1.005	1.005	1.042
336/324			1.016	1.004	1.005	1.007	1.011	1.009	1.007	1.007	1.037
348/336				1.014	1.011	1.007	1.008	1.002	1.007	1.007	1.030
ULT/348						1.035	1.029	1.027	1.013	1.023 (a)	1.023
360/348							1.017	1.008	1.007	1.007	

(a) Three-year average ULT/348 factors are selected.

Paid Indemnity Loss Development Factors

Age in Months	Reported as of										Selected	
	12/98	12/99	12/00	12/01	12/02	12/03	12/04	12/05	12/06	Age-to-Age	Cum.	
24/12	3.472	3.422	3.506	3.511	3.545	3.590	3.370	2.915	2.739	---	7.874 (a)	
36/24	1.691	1.661	1.692	1.724	1.744	1.796	1.782	1.699	1.524	---	2.336 (a)	
48/36	1.246	1.246	1.251	1.268	1.282	1.304	1.322	1.291	1.250	---	1.957 (a)	
60/48	1.120	1.116	1.129	1.130	1.133	1.146	1.151	1.145	1.128	---	1.575 (a)	
72/60	1.067	1.067	1.069	1.075	1.080	1.084	1.089	1.088	1.078	1.078	1.323	
84/72	1.039	1.040	1.042	1.049	1.047	1.052	1.054	1.055	1.047	1.047	1.227	
96/84	1.024	1.023	1.025	1.032	1.030	1.035	1.034	1.037	1.036	1.036	1.172	
108/96	1.015	1.014	1.016	1.021	1.020	1.023	1.027	1.025	1.027	1.027	1.131	
120/108	1.010	1.010	1.011	1.012	1.013	1.015	1.016	1.018	1.019	1.019	1.101	
132/120	1.008	1.006	1.006	1.008	1.010	1.010	1.014	1.010	1.014	1.014	1.080	
144/132	1.006	1.005	1.005	1.006	1.005	1.006	1.007	1.009	1.012	1.012	1.065	
156/144	1.004	1.004	1.004	1.004	1.004	1.004	1.007	1.004	1.008	1.008	1.052	
168/156	1.003	1.003	1.003	1.003	1.003	1.003	1.004	1.005	1.004	1.004	1.044	
180/168	1.002	1.002	1.003	1.002	1.002	1.002	1.002	1.003	1.004	1.004	1.040	
192/180	1.002	1.001	1.002	1.002	1.002	1.002	1.003	1.003	1.003	1.003	1.036	
204/192	1.002	1.002	1.001	1.001	1.001	1.002	1.002	1.005	1.002	1.002	1.033	
216/204	1.004	1.002	1.002	1.001	1.002	1.002	1.003	1.001	1.002	1.002	1.031	
228/216	1.001	1.002	1.002	1.002	1.001	1.001	1.001	1.001	1.001	1.001	1.029	
240/228 (b)	1.001	1.002	1.002	1.002	1.001	1.001	1.001	1.001	1.001	1.001	1.028	
252/240 (b)	1.002	1.002	1.002	1.002	1.002	1.001	1.001	1.001	1.001	1.001	1.027	
264/252 (b)	1.002	1.001	1.001	1.002	1.002	1.001	1.002	1.002	1.001	1.001	1.026	
276/264 (b)	1.001	1.001	1.001	1.001	1.001	1.002	1.002	1.003	1.001	1.001	1.025	
288/276 (b)	1.002	1.001	1.001	1.001	1.001	1.002	1.002	1.002	1.001	1.001	1.024	
300/288 (b)	1.002	1.002	1.002	1.002	1.001	1.001	1.002	1.002	1.002	1.002	1.023	
312/300 (b)	1.001	1.001	1.002	1.002	1.001	1.001	1.001	1.002	1.002	1.002	1.021	
324/312 (b)		1.002	1.002	1.002	1.001	1.001	1.001	1.001	1.001	1.001	1.019	
336/324 (b)			1.002	1.002	1.001	1.001	1.001	1.001	1.001	1.001	1.018	
348/336 (b)				1.001	1.001	1.001	1.001	1.001	1.001	1.001	1.017	
348Inc/348Pd						1.015	1.015	1.012	1.012	1.013 (d)	1.016	
ULT/348Inc (c)						1.004	1.003	1.003	1.002	1.003 (d)		
360/348 (b)							1.001	1.001	1.001	1.001		

- (a) The 12-to-ultimate, 24-to-ultimate, 36-to-ultimate and 48-to-ultimate development factors are based on the following cumulative post-reform indemnity payment patterns: 12.7% for accident year 2006 at 12 months, 42.8% for accident year 2005 at 24 months, 51.1% for accident year 2004 at 36 months and 63.5% for accident year 2003 at 48 months (see "Impact of Reform Legislation on Loss Development Patterns-2007 Update"). 60-to-ultimate factors are based on selecting the latest year age-to-age loss development factors.
- (b) Factors in italic format are adjusted for non-repeating permanent total and asbestosis claim patterns occurring in accident years 1979 and prior. These factors have been reflected at 66% of the reported factors.
- (c) To adjust for non-repeating asbestosis claim patterns in older accident years, these factors are reflected at 20% of the reported ULT/348 factors. The original factors were 1.021, 1.016, 1.014 and 1.008, respectively.
- (d) Three-year average ULT/348Inc and 348Inc/348Pd factors are selected.

**Paid Medical Loss Development Factors  
Adjusted for Impact of SB 228 and SB 899**

Age in Months	Reported as of									Adjusted(b)			Selected(b)	
	12/98	12/99	12/00	12/01	12/02	12/03	12/04	12/05	12/06	12/04	12/05	12/06	Latest Yr.	Cum.
24/12	2.271	2.342	2.476	2.666	2.842	2.887	2.590	2.288	2.254	2.930	2.367	2.254	2.254	7.168
36/24	1.265	1.286	1.328	1.378	1.430	1.472	1.416	1.318	1.343	1.494	1.388	1.351	1.351	3.180
48/36	1.124	1.142	1.159	1.181	1.207	1.222	1.212	1.168	1.170	1.246	1.207	1.197	1.197	2.354
60/48	1.067	1.081	1.097	1.105	1.118	1.133	1.127	1.109	1.113	1.143	1.130	1.134	1.134	1.967
72/60	1.042	1.048	1.058	1.071	1.080	1.093	1.089	1.079	1.076	1.099	1.091	1.089	1.089	1.735
84/72	1.028	1.034	1.038	1.051	1.055	1.065	1.066	1.059	1.056	1.072	1.065	1.063	1.063	1.593
96/84	1.021	1.020	1.025	1.035	1.040	1.049	1.052	1.047	1.044	1.058	1.052	1.048	1.048	1.499
108/96	1.013	1.014	1.017	1.025	1.028	1.037	1.038	1.036	1.039	1.042	1.039	1.042	1.042	1.430
120/108	1.013	1.010	1.012	1.015	1.021	1.029	1.031	1.029	1.033	1.034	1.032	1.036	1.036	1.372
132/120	1.010	1.008	1.010	1.012	1.016	1.020	1.025	1.020	1.025	1.027	1.022	1.027	1.027	1.324
144/132	1.009	1.009	1.008	1.009	1.011	1.013	1.020	1.017	1.024	1.022	1.019	1.026	1.026	1.289
156/144	1.008	1.010	1.007	1.008	1.010	1.009	1.011	1.014	1.018	1.012	1.015	1.020	1.020	1.256
168/156	1.007	1.006	1.007	1.009	1.007	1.010	1.008	1.013	1.012	1.009	1.014	1.013	1.013	1.231
180/168	1.005	1.007	1.007	1.008	1.007	1.008	1.006	1.007	1.011	1.007	1.007	1.012	1.012	1.215
192/180	1.006	1.005	1.005	1.006	1.006	1.007	1.009	1.005	1.007	1.010	1.006	1.008	1.008	1.201
204/192	1.007	1.007	1.005	1.005	1.007	1.009	1.005	1.007	1.005	1.006	1.007	1.006	1.006	1.191
216/204	1.008	1.006	1.006	1.005	1.006	1.006	1.007	1.005	1.005	1.008	1.006	1.006	1.006	1.184
228/216	1.008	1.007	1.007	1.004	1.005	1.006	1.006	1.007	1.006	1.007	1.008	1.007	1.007	1.177
240/228	1.008	1.006	1.006	1.006	1.005	1.005	1.004	1.006	1.006	1.004	1.007	1.007	1.007	1.169
252/240	1.007	1.008	1.007	1.007	1.008	1.006	1.005	1.005	1.004	1.005	1.006	1.005	1.005	1.161
264/252	1.009	1.009	1.005	1.007	1.008	1.008	1.007	1.004	1.005	1.007	1.005	1.006	1.006	1.155
276/264	1.009	1.008	1.007	1.008	1.007	1.006	1.007	1.004	1.004	1.008	1.004	1.004	1.004	1.148
288/276	1.007	1.009	1.008	1.007	1.007	1.008	1.009	1.006	1.005	1.010	1.007	1.006	1.006	1.143
300/288	1.012	1.011	1.008	1.008	1.009	1.009	1.008	1.005	1.008	1.009	1.006	1.009	1.009	1.136
312/300	1.010	1.009	1.010	1.010	1.009	1.009	1.007	1.006	1.006	1.008	1.007	1.006	1.006	1.126
324/312		1.008	1.009	1.008	1.009	1.009	1.008	1.006	1.006	1.008	1.007	1.007	1.007	1.119
336/324			1.011	1.010	1.008	1.010	1.008	1.008	1.007	1.008	1.009	1.008	1.008	1.111
348/336				1.009	1.009	1.007	1.008	1.008	1.007	1.009	1.009	1.007	1.007	1.102
348Inc/348Pd						1.063	1.074	1.069	1.065	1.074	1.069	1.065	1.069 (a)	1.094
ULT/348Inc						1.035	1.029	1.027	1.013	1.029	1.027	1.013	1.023 (a)	
360/348							1.007	1.005	1.009	1.008	1.005	1.010	1.010	

- (a) Three-year average ULT/348Inc and 348Inc/348Pd factors are selected.
- (b) These factors are based on reducing historical medical losses paid prior to January 1, 2004 by the estimated 9.4% cost savings due to SB 228 fee schedule changes. To correct development factors for the impact of the provisions related to the utilization of medical services on development, pre-July 1, 2004 payments are judgmentally reduced by the following percentages for purposes of computation of adjusted development factors: accident year 2004 by 25%, accident year 2003 by 20%, accident year 2002 by 15%, accident year 2001 by 10%, and accident year 2000 by 5%.

**Developed Loss Ratios Using Latest Year Loss Development Factors  
Adjusted for Impact of SB 228 and SB 899**

Accident Year	(1) Indemnity				(2) Medical					(10) Total Developed Loss Ratio(e) (4) + (9)
	Reported		Developed	Loss	Reported	Adjusted			Developed	
	Loss Ratio	Development Factors				Loss Ratio	Loss Ratio	Development Factors		
	Ex IBNR(a)	Annual(b) Cumulative	Ratio	Ex IBNR(a)	Ex IBNR(c)	Annual(d) Cumulative	Ratio(e)			
		(1) x (3)				(6) x (8)				
1977	0.342		1.015	0.347	0.251	0.228		1.083	0.247	0.594
1978	0.302	1.001	1.016	0.307	0.230	0.209	1.010	1.094	0.229	0.536
1979	0.304	1.001	1.017	0.309	0.243	0.221	1.007	1.102	0.244	0.553
1980	0.292	1.001	1.018	0.297	0.240	0.218	1.008	1.111	0.242	0.539
1981	0.302	1.001	1.019	0.308	0.262	0.238	1.007	1.119	0.266	0.574
1982	0.324	1.002	1.021	0.331	0.291	0.264	1.006	1.126	0.297	0.628
1983	0.400	1.002	1.023	0.409	0.298	0.270	1.009	1.136	0.307	0.716
1984	0.446	1.001	1.024	0.457	0.321	0.291	1.006	1.143	0.333	0.790
1985	0.444	1.001	1.025	0.455	0.331	0.300	1.004	1.148	0.344	0.799
1986	0.392	1.001	1.026	0.402	0.306	0.277	1.006	1.155	0.320	0.722
1987	0.341	1.001	1.027	0.350	0.287	0.261	1.005	1.161	0.303	0.653
1988	0.325	1.001	1.028	0.334	0.281	0.255	1.007	1.169	0.298	0.632
1989	0.337	1.001	1.029	0.347	0.296	0.268	1.007	1.177	0.315	0.662
1990	0.391	1.002	1.031	0.403	0.339	0.308	1.006	1.184	0.365	0.768
1991	0.415	1.002	1.033	0.429	0.351	0.319	1.006	1.191	0.380	0.809
1992	0.341	1.003	1.036	0.353	0.285	0.259	1.008	1.201	0.311	0.664
1993	0.278	1.004	1.040	0.289	0.225	0.205	1.012	1.215	0.249	0.538
1994	0.311	1.004	1.044	0.325	0.254	0.231	1.013	1.231	0.284	0.609
1995	0.440	1.008	1.052	0.463	0.354	0.323	1.020	1.256	0.406	0.869
1996	0.490	1.012	1.065	0.522	0.378	0.345	1.026	1.289	0.445	0.967
1997	0.549	1.014	1.080	0.593	0.422	0.387	1.027	1.324	0.512	1.105
1998	0.583	1.019	1.101	0.642	0.482	0.443	1.036	1.372	0.608	1.250
1999	0.601	1.027	1.131	0.680	0.512	0.472	1.042	1.430	0.675	1.355
2000	0.502	1.036	1.172	0.588	0.455	0.404	1.048	1.499	0.606	1.194
2001	0.395	1.047	1.227	0.485	0.375	0.324	1.063	1.593	0.516	1.001
2002	0.273	1.078	1.323	0.361	0.276	0.236	1.089	1.735	0.409	0.770
2003	0.155	---	1.575	0.244	0.152	0.135	1.134	1.967	0.266	0.510
2004	0.073	---	1.957	0.143	0.080	0.078	1.197	2.354	0.184	0.327
2005	0.040	---	2.336	0.093	0.056	0.056	1.351	3.180	0.178	0.271
2006	0.018	---	7.874	0.142	0.032	0.032	2.254	7.168	0.229	0.371

- (a) Based on Exhibit 1. Column 5 is shown for informational purposes only.
- (b) See Exhibit 2.3.
- (c) Based on experience evaluated as of December 31, 2006. These medical paid loss ratios reflect the following:
  - (i) adjusting pre-January 1, 2004 payments on all accident years by approximately -9.4% to reflect the SB 228 fee schedule changes; (ii) adjusting pre-July 1, 2004 payments on the following accident years: 2004 by -25%, 2003 by -20%, 2002 by -15%, 2001 by -10% and 2000 by -5% to reflect the SB 228 and SB 899 reforms related to medical services utilization.
- (d) See Exhibit 2.4.
- (e) The developed medical loss ratios shown for accident years 2004 and prior were derived based on an adjustment to reflect SB 228's fee schedule changes and medical services utilization. They are only for purposes of projecting future medical loss ratios and do not reflect true estimates of ultimate loss ratios for those accident years.

**Indemnity Benefit Level Factors**

Accident Year	(1) Annual Benefit Change (a)	(2) Factor to a PY 2007 Indemnity Benefit Level	(3) Annual Impact on Benefits due to Wage Inflation (b)	(4) Factor to 4/1/2008 Wage Level(c)	(5) Composite Indemnity Adjustment Factor (d)
1977	6.7	1.274	2.5	1.646	2.097
1978	0.0	1.274	2.6	1.604	2.043
1979	0.0	1.274	2.8	1.560	1.987
1980	0.0	1.274	3.5	1.507	1.920
1981	3.1	1.236	3.3	1.459	1.803
1982	0.0	1.236	1.9	1.432	1.770
1983	44.0	0.858	2.0	1.404	1.205
1984	8.2	0.793	2.1	1.375	1.090
1985	0.0	0.793	1.8	1.351	1.071
1986	0.0	0.793	1.5	1.331	1.055
1987	0.0	0.793	1.7	1.309	1.038
1988	0.0	0.793	1.7	1.287	1.021
1989	0.0	0.793	1.4	1.269	1.006
1990	2.6	0.773	1.1	1.255	0.970
1991	5.6	0.732	1.2	1.240	0.908
1992	1.1	0.724	1.1	1.227	0.888
1993	-1.1	0.732	0.2	1.225	0.897
1994	-6.1	0.780	0.4	1.220	0.952
1995	4.5	0.746	1.6	1.201	0.896
1996	3.3	0.722	1.7	1.181	0.853
1997	4.0	0.694	1.4	1.165	0.809
1998	0.8	0.688	2.2	1.140	0.784
1999	0.0	0.688	2.3	1.114	0.766
2000	0.0	0.688	3.4	1.077	0.741
2001	0.0	0.688	0.1	1.076	0.740
2002	0.0	0.688	0.2	1.074	0.739
2003	11.2	0.619	1.1	1.062	0.657
2004	-10.3	0.690	1.7	1.044	0.720
2005	-35.2	1.065	1.6	1.028	1.095
2006	5.8	1.007	1.2	1.016	1.023
2007	0.4	1.003	0.9	1.007	
4/1/2008	0.3 (Annual 0.4)	1.000	0.7		

- (a) Based on WCIRB evaluations of the average impact of legislative changes on the cost of indemnity benefits, including utilization impacts. These annual changes also include the effect of the 4/1/1997 changes in the PD schedule.
- (b) These impacts are based on the weekly wages of injured workers and the legislatively scheduled benefits for that year.
- (c) These factors bring the annual impacts shown in Column (3) to the 4/1/2008 level.
- (d) Column (2) x Column (4).

**Annual "Other Medical" Cost Level Changes  
Adjusted for Impact of SB 228 and SB 899**

Year	(1) Annual "Other Medical" Cost Level Change (a)	(2) % of "Other Medical" Cost Not Subject to Fee Schedules(b)	(3) Quantifiable IHFS Cost Level Change (c)	(4) % of "Other Medical" Cost Subject to Fee Schedules	(5) Adjusted "Other Medical" Cost Level Change	(6) Factor to a 4/1/2008 "Other Medical" Cost Level
1977	11.7	--	--	--	11.7	6.041
1978	9.6	--	--	--	9.6	5.512
1979	10.9	--	--	--	10.9	4.970
1980	12.5	--	--	--	12.5	4.418
1981	11.8	--	--	--	11.8	3.952
1982	17.1	--	--	--	17.1	3.375
1983	9.9	--	--	--	9.9	3.071
1984	3.7	--	--	--	3.7	2.961
1985	6.5	--	--	--	6.5	2.780
1986	9.1	--	--	--	9.1	2.548
1987	7.4	--	--	--	7.4	2.372
1988	7.7	--	--	--	7.7	2.202
1989	8.6	--	--	--	8.6	2.028
1990	10.4	--	--	--	10.4	1.837
1991	10.6	--	--	--	10.6	1.661
1992	8.1	--	--	--	8.1	1.537
1993	7.3	--	--	--	7.3	1.432
1994	4.3	--	--	--	4.3	1.373
1995	3.0	--	--	--	3.0	1.333
1996	3.0	--	--	--	3.0	1.294
1997	2.2	--	--	--	2.2	1.266
1998	2.2	--	--	--	2.2	1.239
1999	3.3	81.6	-8.3	18.4	1.2 (d)	1.224
2000	4.3	79.5	-4.1	20.5	2.6 (d)	1.193
2001	4.8	79.5	19.8	20.5	7.9 (d)	1.106
2002	5.1	79.5	7.7	20.5	5.6 (d)	1.047
2003	4.5	79.5	0.0	20.5	3.6 (d)	1.011
2004(e)	0.0	9.6	0.0	90.4	0.0 (d)	1.011
2005(e)	0.0	9.6	0.0	90.4	0.0 (d)	1.011
2006	4.1	9.6	0.0	90.4	0.4 (d)	1.007
2007	Projected: 3.8	9.6	0.0	90.4	0.4 (d)	1.003
4/1/2008	2.7 (Annual = 3.6)	9.6	0.0	90.4	0.3 (d)	

- (a) Values are based on a component of the Consumer Price Index furnished by Global Insight, Inc. (formerly DRI/McGraw-Hill).
- (b) Prior to 2004, these values reflect the portion not subject to Inpatient Hospital Fee Schedule (IHFS); subsequent to 1/1/2004, these values reflect cost estimates not subject to any fee schedule.
- (c) Based on WCIRB evaluations of the cost impact of changes to the Inpatient Hospital Fee Schedule.
- (d) Weighted average of columns (1) and (3), with columns (2) and (4) as weights.
- (e) Given the anticipated impact of recent legislative reforms, a 0% inflation rate has been assumed for 2004 and 2005; beyond 2005, inflation rates were based on a projection of the medical services cost component of the Consumer Price Index as computed by Global Insight, Inc.

**Composite Medical Fee and Other Medical Cost Level Factors  
Adjusted for Impact of SB 228 and SB 899**

Accident Year	(1) Proportion Subject to Fee Schedule(a)	(2) Proportion "Other Medical"(a)	(3) Factor to a 4/1/1999 Medical Fee Level(b)	(4) Factor to a 4/1/2008 "Other Medical" Cost Level(c)	(5) Factor to Reflect Legislative Changes(d)	(6) Factor to a 4/1/1999 Medical Fee and 4/1/2008 "Other Medical" Cost Level(e)
1977	0.508	0.492	1.938	6.041	0.856	3.387
1978	0.507	0.493	1.938	5.512	0.856	3.167
1979	0.506	0.494	1.831	4.970	0.856	2.895
1980	0.507	0.493	1.735	4.418	0.856	2.617
1981	0.575	0.425	1.578	3.952	0.852	2.204
1982	0.568	0.432	1.309	3.375	0.852	1.876
1983	0.595	0.405	1.197	3.071	0.815	1.594
1984	0.665	0.335	1.134	2.961	0.808	1.411
1985	0.665	0.335	1.096	2.780	0.808	1.341
1986	0.604	0.396	1.096	2.548	0.808	1.350
1987	0.610	0.390	1.080	2.372	0.808	1.280
1988	0.649	0.351	1.066	2.202	0.808	1.184
1989	0.647	0.353	1.066	2.028	0.808	1.136
1990	0.661	0.339	1.066	1.837	0.812	1.078
1991	0.631	0.369	1.066	1.661	0.820	1.054
1992	0.628	0.372	1.066	1.537	0.822	1.020
1993	0.565	0.435	1.066	1.432	0.828	1.014
1994	0.553	0.447	1.050	1.373	0.932	1.113
1995	0.583	0.417	1.050	1.333	0.928	1.084
1996	0.579	0.421	1.050	1.294	0.924	1.065
1997	0.573	0.427	1.050	1.266	0.922	1.053
1998	0.598	0.402	1.050	1.239	0.922	1.038
1999	0.602	0.398	1.012	1.224	0.922	1.011
2000	0.592	0.408	1.000	1.193	0.922	0.995
2001	0.605	0.395	1.000	1.106	0.922	0.961
2002	0.533	0.467	1.000	1.047	0.922	0.942
2003	0.547	0.453	1.000	1.011	0.915	0.920
2004	0.944	0.056	1.000	1.011	0.969	0.970
2005	0.916	0.084	1.000	1.011	1.009	1.010
2006	0.916	0.084	1.000	1.007	1.000	1.001

(a) From a Special Carrier Study through 1990. Based on WCIRB's Aggregate Indemnity and Medical Costs Calls for years subsequent to 1990.

(b) Based on the WCIRB's evaluation of the cost impact of changes in the Official Medical Fee Schedule.

(c) See Exhibit 4.2.

(d) The factors reflect the impact on medical costs of (i) statutory reforms, including the AB 749, AB 227, SB 228 and SB 899 provisions effective in 1/1/2003, 1/1/2004 and 1/1/2005; (ii) anticipated changes to the physician component of the OMFS to revert to the pre-SB228 schedule level effective 1/1/2006; and (iii) changes in the frequency of indemnity claims as a result of benefit changes. However, these factors do not reflect the estimated -9.4% impact of 1/1/2004 fee schedule changes in SB 228 or the impact of medical services utilization, as both were reflected in Exhibit 2.4.

(e) [(1)×(3) + (2)×(4)] × (5).

**Annual Wage Level Changes**

<u>Year</u>	<u>Annual Wage Level Change</u>	<u>Factor to a 4/1/2008 Wage Level</u>
1977	7.30	4.138
1978	7.70	3.842
1979	8.10	3.554
1980	10.10	3.228
1981	9.72	2.942
1982	5.61	2.786
1983	5.86	2.632
1984	6.00	2.483
1985	5.37	2.356
1986	4.28	2.259
1987	5.00	2.151
1988	4.91	2.050
1989	4.12	1.969
1990	3.19	1.908
1991	3.46	1.844
1992	3.09	1.789
1993	0.58	1.779
1994	1.18	1.758
1995	4.56	1.681
1996	4.82	1.604
1997	4.05	1.542
1998	5.85	1.457
1999	6.72	1.365
2000	10.60	1.234
2001	0.12	1.233
2002	0.43	1.228
2003	3.20	1.190
2004	4.99	1.133
2005	4.69	1.082
2006	3.53	1.045
2007	Projected: 2.58	1.019
4/1/2008	1.86 (Annual = 2.49)	



Source: Employment Cost Index for the western region for 1977 to 1980 as provided by Global Insight, Inc. (formerly DRI/McGraw-Hill). California average annual wage level changes for 1981 to 2008 derived from information published by the UCLA Anderson School of Business.



## Premium Adjustment Factors

Calendar Year	(1) Factor to a 4/1/2008 Wage Level(a)	(2) Factor to a 1/1/2007 Pure Premium Rate Level(b)	(3) Adjustment to Remove Surcharge Premium(c)	(4) Average Experience Modification(d)	(5) Off-Balance Correction in 1/1/2007 Pure Premium Rates	(6) Composite Premium Adjustment Factor(e)
1977	4.138	0.865	0.976	0.970	1.030	3.497
1978	3.842	0.826	0.978	0.966	1.030	3.119
1979	3.554	0.803	0.983	0.977	1.030	2.788
1980	3.228	0.798	0.987	0.982	1.030	2.514
1981	2.942	0.809	0.989	0.968	1.030	2.361
1982	2.786	0.824	0.991	0.957	1.030	2.308
1983	2.632	0.715	0.992	0.967	1.030	1.874
1984	2.483	0.740	0.992	0.980	1.030	1.806
1985	2.356	0.728	0.991	0.984	1.030	1.677
1986	2.259	0.665	0.991	0.983	1.030	1.470
1987	2.151	0.585	0.992	0.983	1.030	1.233
1988	2.050	0.523	0.993	0.963	1.030	1.073
1989	1.969	0.515	0.993	0.945	1.030	1.035
1990	1.908	0.502	0.991	0.942	1.030	0.978
1991	1.844	0.466	0.987	0.939	1.030	0.877
1992	1.789	0.446	0.982	0.940	1.030	0.809
1993	1.779	0.441	0.981	0.949	1.030	0.787
1994	1.758	0.505	0.986	0.948	1.030	0.896
1995	1.681	0.683	0.995	0.958	1.030	1.158
1996	1.604	0.727	1.000	0.935	1.030	1.211
1997	1.542	0.745	1.000	0.949	1.030	1.175
1998	1.457	0.783	1.000	0.959	1.030	1.155
1999	1.365	0.801	1.000	0.954	1.030	1.113
2000	1.234	0.697	1.000	0.970	1.030	0.861
2001	1.233	0.589	1.000	0.969	1.030	0.728
2002	1.228	0.470	1.000	0.991	1.030	0.566
2003	1.190	0.352	1.000	1.005	1.030	0.404
2004	1.133	0.318	1.000	0.981	1.030	0.356
2005	1.082	0.376	1.000	0.982	1.030	0.402
2006	1.045	0.475	1.000	0.957	1.030	0.504

(a) See Exhibit 5.1.

(b) Based on rate level changes approved by the insurance commissioner. (July 16, 1993 rate decrease was legislatively mandated.) This column adjusts premiums at insurer rate level to pure premium rate level.

(c) Based on unit statistical data.

(d) Based on average promulgated experience modifications. Calendar years 1996 through 2000 include adjustments for the impacts of Assembly Bill No. 1913 and Senate Bill No. 1217.

(e)  $(1) \times (2) \times (3) \div [(4) \times (5)]$ .

**Projected On-Level Accident Year  
Indemnity Loss to Pure Premium Ratios**

Accident Year	(1) Developed Loss Ratio(a)	(2) Composite Indemnity Adjustment Factor(b)	(3) Composite Premium Adjustment Factor(c)	(4) On-Level Indemnity to Pure Premium Ratio (1)×(2)÷(3)
1977	0.347	2.097	3.497	0.208
1978	0.307	2.043	3.119	0.201
1979	0.309	1.987	2.788	0.220
1980	0.297	1.920	2.514	0.227
1981	0.308	1.803	2.361	0.235
1982	0.331	1.770	2.308	0.254
1983	0.409	1.205	1.874	0.263
1984	0.457	1.090	1.806	0.276
1985	0.455	1.071	1.677	0.291
1986	0.402	1.055	1.470	0.289
1987	0.350	1.038	1.233	0.295
1988	0.334	1.021	1.073	0.318
1989	0.347	1.006	1.035	0.337
1990	0.403	0.970	0.978	0.400
1991	0.429	0.908	0.877	0.444
1992	0.353	0.888	0.809	0.387
1993	0.289	0.897	0.787	0.329
1994	0.325	0.952	0.896	0.345
1995	0.463	0.896	1.158	0.358
1996	0.522	0.853	1.211	0.368
1997	0.593	0.809	1.175	0.408
1998	0.642	0.784	1.155	0.436
1999	0.680	0.766	1.113	0.468
2000	0.588	0.741	0.861	0.506
2001	0.485	0.740	0.728	0.493
2002	0.361	0.739	0.566	0.471
2003	0.244	0.657	0.404	0.397
2004	0.143	0.720	0.356	0.289
2005	0.093	1.095	0.402	0.253
2006	0.142	1.023	0.504	0.288
				Projected (d)
2007				0.271
4/1/2008				0.271

(a) See Exhibit 3.

(b) See Exhibit 4.1.

(c) See Exhibit 5.2.

(d) These on-level ratios were projected using a two-year average of the 2005 and 2006 on-level ratios.

**Projected On-Level Accident Year  
Medical Loss to Pure Premium Ratio**

Accident Year	(1) Adjusted Developed Loss Ratio(a)	(2) Factor to a 4/1/1999 Medical Fee & 4/1/2008 "Other Medical" Cost Level(b)	(3) Composite Premium Adjustment Factor(c)	(4) On-Level Medical to Pure Premium Ratio (1)×(2)÷(3)
1977	0.247	3.387	3.497	0.239
1978	0.229	3.167	3.119	0.233
1979	0.244	2.895	2.788	0.253
1980	0.242	2.617	2.514	0.252
1981	0.266	2.204	2.361	0.248
1982	0.297	1.876	2.308	0.241
1983	0.307	1.594	1.874	0.261
1984	0.333	1.411	1.806	0.260
1985	0.344	1.341	1.677	0.275
1986	0.320	1.350	1.470	0.294
1987	0.303	1.280	1.233	0.315
1988	0.298	1.184	1.073	0.329
1989	0.315	1.136	1.035	0.346
1990	0.365	1.078	0.978	0.402
1991	0.380	1.054	0.877	0.457
1992	0.311	1.020	0.809	0.392
1993	0.249	1.014	0.787	0.321
1994	0.284	1.113	0.896	0.353
1995	0.406	1.084	1.158	0.380
1996	0.445	1.065	1.211	0.391
1997	0.512	1.053	1.175	0.459
1998	0.608	1.038	1.155	0.546
1999	0.675	1.011	1.113	0.613
2000	0.606	0.995	0.861	0.700
2001	0.516	0.961	0.728	0.681
2002	0.409	0.942	0.566	0.681
2003	0.266	0.920	0.404	0.606
2004	0.184	0.970	0.356	0.501
2005	0.178	1.010	0.402	0.447
2006	0.229	1.001	0.504	0.455
2007				Projected (d) 0.458
4/1/2008				0.461

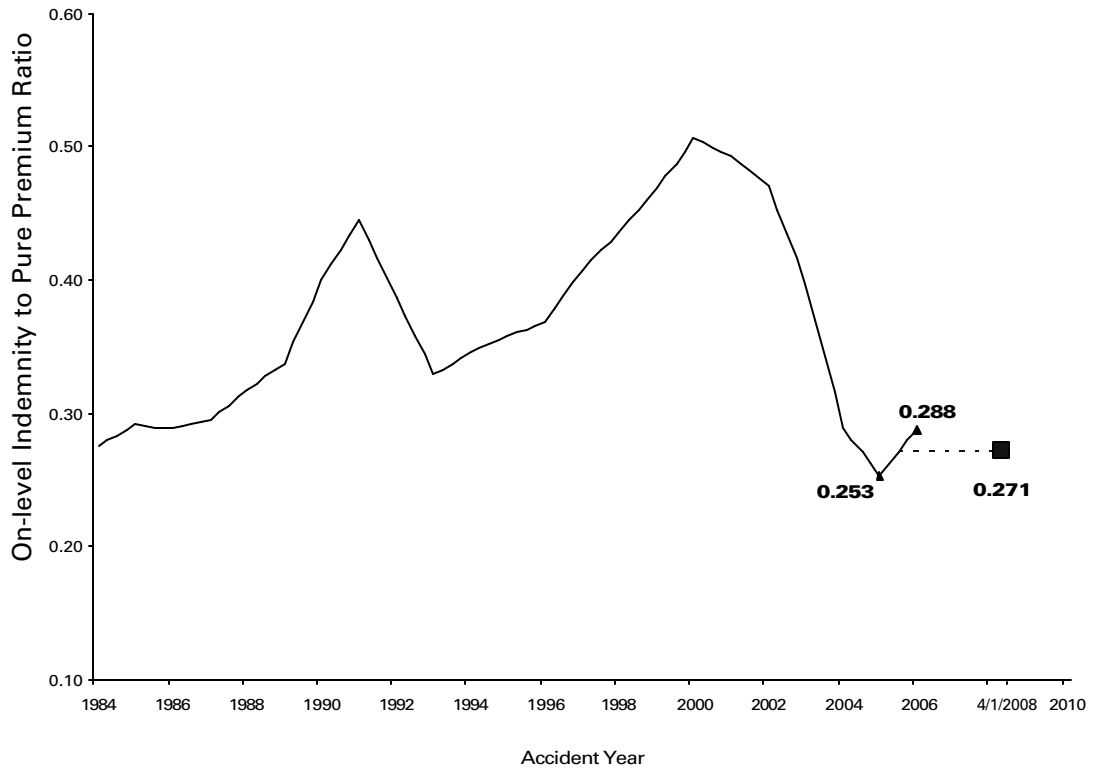
(a) See Exhibit 3.

(b) See Exhibit 4.3.

(c) See Exhibit 5.2.

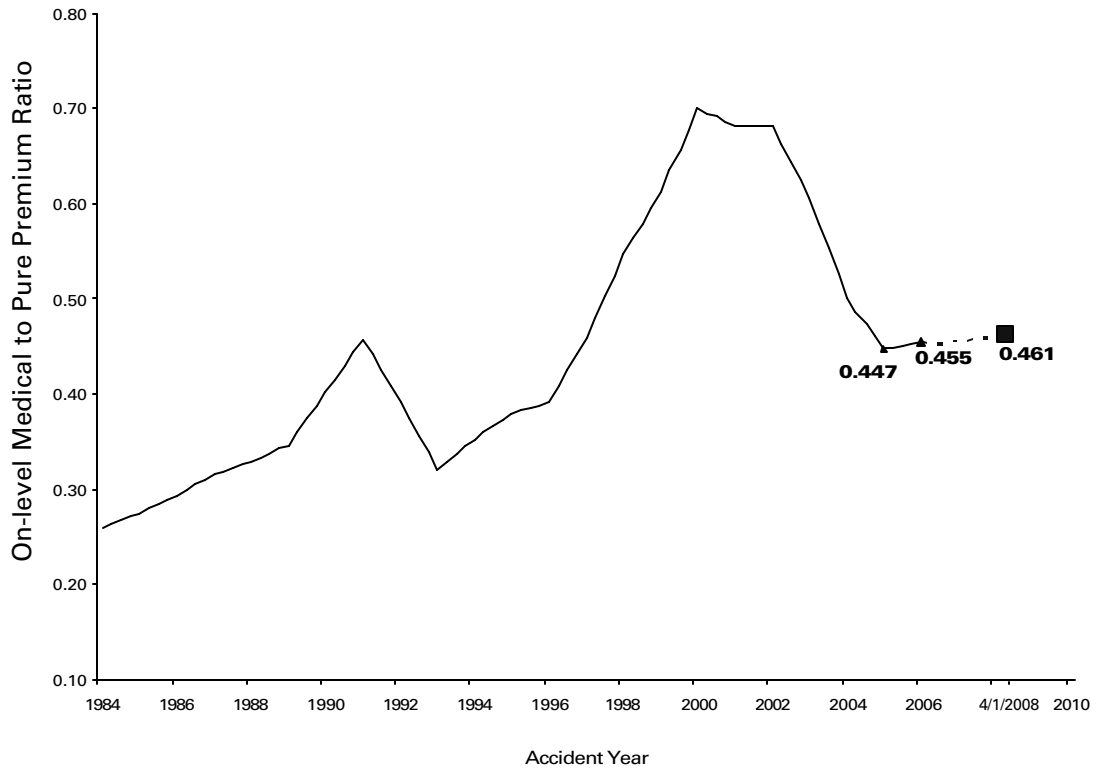
(d) These on-level ratios were projected using a two-year average of the 2005 and 2006 on-level ratios and trending by 1% per year.

**On-Level Indemnity to Pure Premium Ratios  
Using December 31, 2006 Valuations**



- ▲ On-level indemnity to pure premium ratios (see Exhibit 6.1).
- - Represents the 2-year (2005-2006) average used to project the 4/1/2008 indemnity to pure premium ratio.

**On-Level Medical to Pure Premium Ratios  
Using December 31, 2006 Valuations**



- ▲— On-level medical to pure premium ratios (see Exhibit 6.2).
- - Represents the 2-year (2005-2006) average, trended by 1% per year, and is used to project the 4/1/2008 medical to pure premium ratio.

**Indicated Total Loss to Pure Premium Ratio  
For Policies with Effective Dates between July 1, 2007 and December 31, 2007**

	<u>Indemnity</u>	<u>Medical</u>	<u>Total</u>
1. Projected Loss to Pure Premium Ratio (See Exhibits 6.1 and 6.2)	0.271	0.461	0.732
2. Average Impact of 2/15/2007 Medical Fee Schedule Change (OMFS)	0.0%	1.6%	1.0%
3. Average Impact of 3/1/2007 Pharmaceutical Fee Schedule Change	0.0%	-4.6%	-2.9%
4. Projected Loss to Pure Premium Ratio after Combined Impact of OMFS and Pharmaceutical Fee Schedule Changes (1) x [1.0 + (2)] x [1.0 + (3)]	0.271	0.447	0.718
5. Projected Loss Adjustment Expense Factor (See Exhibit 9.6)			1.236
6. Indicated Total Loss and Loss Adjustment Expense to Pure Premium Ratio (4) x (5)			0.887
7. Indicated Average Change from January 1, 2007 Approved Pure Premium Rates (6) - 1.0			-11.3%



**Historical Loss Adjustment Expense as a Percentage of Losses**

Calendar Year	ALAE as % of Losses	ULAE as % of Losses	Total LAE as % of Losses	Year-to-Year Change
	(1)	(2)	(3) = (1)+(2)	(4) = [(3)/prior(3)]-1
1985	---	---	12.6%	---
1986	---	---	12.7%	0.8%
1987	---	---	14.0%	10.2%
1988	---	---	15.2%	8.6%
1989	---	---	15.5%	2.0%
1990	---	---	15.7%	1.3%
1991	---	---	15.8%	0.6%
1992	10.6%	9.3%	19.9%	25.9%
1993	10.8%	12.7%	23.5%	18.1%
1994	14.2%	16.7%	30.9%	31.5%
1995	8.7%	18.2%	26.9%	-12.9%
1996	9.5%	13.9%	23.4%	-13.0%
1997	8.9%	13.2%	22.1%	-5.6%
1998	8.4%	14.3%	22.7%	2.7%
1999	9.9%	9.1%	19.0%	-16.3%
2000	7.3%	9.0%	16.3%	-14.2%
2001	4.1%	8.3%	12.4%	-23.9%
2002	5.9%	6.5%	12.4%	0.0%
2003	6.2%	7.4%	13.6%	9.7%
2004	8.6%	8.8%	17.4%	27.9%
2005	9.7%	11.6%	21.3%	22.4%

(5) Projected 4/1/2008 ULAE as Percent of Losses (Average of Latest 2 Years): 10.2%

## Notes:

(1), (2) Based on the WCIRB's annual calls for expense information.

(5) is the average of the latest 2 years in column (2).

# Paid Allocated Loss Adjustment Expense Development

Accident Year	Age-to-Age Development (in months):																												
	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-186	186-198	198-210	210-222	222-234	234-246	246-258	258-270	270-282	282-294	294-306	306-318	318-330	330-342	342-354	
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3-Year Arithmetic Average	2.111	1.417	1.210	1.132	1.091	1.067	1.045	1.035	1.025	1.018	1.013	1.008	1.006	1.006	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.008
Average Excluding High & Low	2.090	1.404	1.194	1.113	1.074	1.050	1.035	1.024	1.016	1.013	1.010	1.009	1.008	1.007	1.007	1.007	1.008	1.009	1.008	1.009	1.009	1.009	1.009	1.009	1.009	1.009	1.009	1.007	1.007
Latest Year	2.100	1.397	1.198	1.130	1.093	1.067	1.046	1.037	1.032	1.022	1.018	1.012	1.007	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.006	1.008

\* To adjust for non-repeating asbestosis claim pattern in older accident years, the 198-210 month and prior factors for pre-1980 accident years are reflected at 66% of the reported factors.



**Ultimate ALAE as a Percent of Ultimate Losses**  
Using Historical Development of Paid ALAE

Latest Year Development Factors

Accident Year	Paid ALAE as % of Premium at 6/30/2006 (1)	Age-to-Age Development Factors (2)	Cumulative Development Factors (3)	Ultimate ALAE as % of Premium (4)	Ultimate On-Level Indemnity as % of Premium (5)	Ultimate On-Level Medical as % of Premium (6)	Ultimate ALAE as % of Ultimate On-Level Loss (7)
1985	3.84	1.004	1.051	4.03	48.80	46.12	4.2
1986	3.68	1.005	1.056	3.89	42.48	43.22	4.5
1987	3.39	1.005	1.061	3.60	36.37	38.84	4.8
1988	3.40	1.006	1.068	3.63	34.12	35.30	5.2
1989	4.23	1.007	1.075	4.54	34.88	35.81	6.4
1990	5.41	1.006	1.082	5.86	39.12	39.32	7.5
1991	6.92	1.006	1.089	7.53	38.94	40.08	9.5
1992	5.52	1.006	1.095	6.04	31.31	31.71	9.6
1993	3.84	1.007	1.102	4.23	25.89	25.26	8.3
1994	4.11	1.012	1.116	4.59	30.91	31.63	7.3
1995	5.92	1.018	1.136	6.73	41.46	44.00	7.9
1996	6.95	1.022	1.161	8.06	44.56	47.35	8.8
1997	8.16	1.032	1.198	9.77	47.94	53.93	9.6
1998	9.35	1.037	1.242	11.61	50.36	63.06	10.2
1999	9.66	1.046	1.299	12.55	52.09	68.23	10.4
2000	8.64	1.067	1.386	11.98	43.57	60.27	11.5
2001	6.46	1.093	1.514	9.78	35.89	49.58	11.4
2002	4.60	1.130	1.712	7.87	26.66	38.54	12.1
2003	2.63	1.198	2.051	5.39	16.04	24.48	13.3
2004	1.29	1.397	2.866	3.70	10.29	17.84	13.2
2005	0.60	2.100	6.019	3.58	10.17	17.97	12.7

(8) Projected ALAE as a Percent of Ultimate On-Level Losses at 4/1/2008: 13.1

Notes:

- (1) Based on accident year paid ALAE and calendar year earned premium information reported by insurers.
- (2), (3) See Exhibit 9.2. Tail factors are based on powertail fit to the "Average Excluding High & Low" factors.
- (4) = (1) x (3).
- (5), (6) Based on Exhibits 6.1 and 6.2.
- (7) = (4) / [(5) + (6)], converted to a percentage basis.
- (8) Based on the average of the latest three years of Ultimate ALAE as % of Ultimate On-Level Loss shown in column (7).

# Development of Paid Allocated Loss Adjustment Expenses as a Percent of Paid Indemnity

Accident Year	Age-to-Age Development (in months):																												
	18-30	30-42	42-54	54-66	66-78	78-90	90-102	102-114	114-126	126-138	138-150	150-162	162-174	174-186	186-198	198-210	210-222	222-234	234-246	246-258	258-270	270-282	282-294	294-306	306-318	318-330	330-342	342-354	
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3-Year Arithmetic Average	0.992	0.971	1.006	1.019	1.022	1.022	1.014	1.013	1.010	1.007	1.006	1.003	1.003	1.003	1.003	1.004	1.002	1.003	1.006	1.004	1.003	1.006	1.007	1.008	1.008	1.010	1.009	1.010	1.006
Average Excluding High & Low	0.926	0.979	1.007	1.011	1.015	1.012	1.011	1.007	1.006	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.006	1.006	1.007	1.007	1.007	1.008	1.009	1.008	1.008	1.009	1.009	1.006	
Latest Year	1.116	0.995	1.012	1.026	1.026	1.023	1.014	1.014	1.014	1.011	1.010	1.008	1.002	1.003	1.004	1.001	1.003	1.008	1.005	1.003	1.004	1.007	1.007	1.007	1.007	1.007	1.006	1.013	1.006

3-Year Arithmetic Average	0.992	0.971	1.006	1.019	1.022	1.022	1.014	1.013	1.010	1.007	1.006	1.003	1.003	1.003	1.003	1.004	1.002	1.003	1.006	1.004	1.003	1.006	1.007	1.008	1.008	1.010	1.009	1.010	1.006
Average Excluding High & Low	0.926	0.979	1.007	1.011	1.015	1.012	1.011	1.007	1.006	1.005	1.005	1.005	1.005	1.005	1.005	1.005	1.006	1.006	1.007	1.007	1.007	1.008	1.009	1.008	1.008	1.009	1.009	1.006	
Latest Year	1.116	0.995	1.012	1.026	1.026	1.023	1.014	1.014	1.014	1.011	1.010	1.008	1.002	1.003	1.004	1.001	1.003	1.008	1.005	1.003	1.004	1.007	1.007	1.007	1.007	1.007	1.006	1.013	1.006

Note: Due to relatively sparse data and differing mixes of insurers represented in each factor, each factor shown is the ratio of the paid ALAE development factor in Exhibit 9.2 to the paid indemnity development factor in Part C, Section B, Appendix A, Exhibit 2.3 of the WCIRB's January 1, 2007 rate filing as amended on September 14, 2006.

**Ultimate ALAE as a Percent of Ultimate Losses**

Using Paid ALAE as a Percent of Paid Indemnity

Latest Year Development Factors

Accident Year	Paid ALAE as a Percent of Paid Indemnity at 6/30/2006 (1)	Age-to-Age Development Factors (2)	Cumulative Development Factors (3)	Ultimate ALAE as a Percent of Ultimate Indemnity (4)	Indemnity On-Level Factors (5)	Ultimate ALAE as a Percent of Ultimate On-Level Indemnity (6)
1977	6.9		1.007	6.9	2.097	3.3
1978	9.3	1.001	1.008	9.3	2.043	4.6
1979	6.8	1.001	1.009	6.9	1.987	3.5
1980	6.7	1.001	1.010	6.8	1.920	3.5
1981	7.3	1.002	1.012	7.4	1.803	4.1
1982	7.6	1.002	1.014	7.8	1.770	4.4
1983	6.9	1.002	1.016	7.0	1.205	5.8
1984	7.4	1.002	1.018	7.6	1.090	7.0
1985	8.6	1.002	1.020	8.8	1.071	8.2
1986	9.5	1.002	1.022	9.7	1.055	9.2
1987	9.9	1.002	1.024	10.2	1.038	9.8
1988	10.5	1.003	1.027	10.7	1.021	10.5
1989	12.5	1.003	1.030	12.9	1.006	12.8
1990	13.9	1.001	1.031	14.3	0.970	14.7
1991	16.7	1.004	1.036	17.3	0.908	19.1
1992	16.3	1.003	1.039	16.9	0.888	19.0
1993	13.9	1.002	1.041	14.5	0.897	16.1
1994	13.3	1.008	1.049	14.0	0.952	14.7
1995	13.5	1.010	1.060	14.3	0.896	16.0
1996	14.2	1.011	1.071	15.2	0.853	17.8
1997	15.0	1.014	1.086	16.3	0.809	20.1
1998	16.5	1.014	1.101	18.2	0.784	23.2
1999	16.3	1.014	1.117	18.2	0.766	23.8
2000	17.6	1.023	1.143	20.1	0.741	27.2
2001	17.1	1.026	1.172	20.0	0.740	27.0
2002	17.7	1.026	1.203	21.3	0.739	28.9
2003	18.5	1.012	1.217	22.5	0.657	34.3
2004	21.1	0.995	1.211	25.6	0.720	35.5
2005	21.1	1.116	1.352	28.5	1.095	26.0

- (7) Projected ALAE as a Percent of Ultimate On-Level Indemnity at 4/1/2008: 36.4
- (8) 4/1/2008 Indicated Indemnity to Pure Premium Ratio: 0.271
- (9) 4/1/2008 Indicated Medical to Pure Premium Ratio: 0.447
- (10) Projected ALAE as a Percent of Ultimate On-Level Losses at 4/1/2008: 13.7

Notes:

- (1) Based on accident year paid ALAE information reported by insurers.
- (2), (3) See Exhibit 9.4. Tail factors are based on powertail fit to the "Latest Year" factors.
- (4) = (1) x (3).
- (5) From Exhibit 4.1.
- (6) = (4) / (5).
- (7) This projection is the fitted value at 4/1/2008 based on an exponential trend of the post-1997 Ultimate ALAE as a Percent of Ultimate On-Level Indemnity shown in column (6).
- (8), (9) From Exhibit 8.
- (10) = (7) x (8) / [(8) + (9)].

**Indicated Ratio of Loss Adjustment Expenses to Losses**

For 2007 Policies with Effective Dates Between July 1, 2007 and December 31, 2007

1.	Selected Ratio of Unallocated Loss Adjustment Expenses to Losses from Exhibit 9.1:	10.2%
2.	Selected Ratio of Allocated Loss Adjustment Expenses to Losses:	
a.	Projected Ratio of Allocated Loss Adjustment Expenses to Losses from Exhibit 9.3:	13.1%
b.	Projected Ratio of Allocated Loss Adjustment Expenses to Losses from Exhibit 9.5:	13.7%
c.	Selected: Average of (2a) and (2b):	13.4%
3.	Projected Loss Adjustment Expense to Losses: (1) + (2c):	23.6%



Workers' Compensation Insurance Rating Bureau of California

**Impact of Recent Reform Legislation on  
Loss Development Patterns - 2007 Update**

**Workers' Compensation Insurance Rating Bureau of California**

**Released: March 30, 2007**



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## Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

### I. Executive Summary

Since 2002, three significant, comprehensive legislative reforms were enacted in California: Assembly Bill No. 749 (AB 749), Assembly Bill No. 227 (AB 227), Senate Bill No. 228 (SB 228) and Senate Bill No. 899 (SB 899). Legislative changes affecting benefit levels not only impact the cost of benefits, but also the rate at which accident year benefits or losses develop over time. This report summarizes the WCIRB's third annual analysis of the impact of the recent legislation on loss development patterns.

In addition to incorporating the findings of the studies performed in 2005 and 2006, this 2007 update (a) estimates a post-reform indemnity payout pattern for accident year 2006; (b) evaluates the accuracy of prior-year, reform-adjusted loss development factors based on the actual development that has emerged; (c) develops updated estimates of fee schedule-adjusted medical severity trends; and (d) compares post-reform paid loss development to pre-reform development in California and paid development in other jurisdictions.

The principal WCIRB findings that are summarized in this report include the following:

1. The legislative provisions in AB 749, AB 227, SB 228 and SB 899 have significantly accelerated the rate at which accident year indemnity losses will be paid.
2. The WCIRB is recommending that indemnity paid loss development projections for pure premium ratemaking purposes be based on the pre-reform payment pattern adjusted for the estimated impacts of the various legislative provisions impacting indemnity payments.
3. In light of recent court decisions, the WCIRB does not recommend any adjustment be made to pre-reform accident year indemnity loss development projections to reflect the impact of reforms.
4. The WCIRB's current estimated cumulative indemnity payment patterns for accident years 2005 and 2006 suggest that payments will be made at a generally comparable rate to the average rates of payments in other states.
5. Over the last 24 months, actual indemnity paid development has emerged at lower levels than that projected by the WCIRB. The WCIRB believes this may be in large part attributable to greater than anticipated declines in permanent partial disability claim frequency.
6. Many of the medical provisions of AB 749, SB 228, and SB 899 apply to future medical treatment on injuries that occurred prior to the effective date of the legislation. If no adjustment is made, the medical loss development factors can be significantly distorted.
7. The WCIRB is recommending that medical paid loss development projections for pure premium ratemaking purposes be adjusted to a common medical fee schedule level.
8. Recent legislation related to the utilization of medical services that applied to existing claims have impacted the development of more recent accident years, but not earlier years. As a result, the WCIRB is recommending that recent accident year paid loss development projections for pure premium ratemaking purposes be adjusted to a common medical utilization level.
9. While the WCIRB estimates that medical payments on the 2005 and 2006 accident years will be made more quickly than in the years immediately preceding the reforms, the rate of payments remains significantly below that of the countrywide average rate of medical payments and the rate of medical payments in California prior to the Minniear Decision.



10. Over the last 24 months, actual medical paid loss development has emerged at lower levels than that projected by the WCIRB. The WCIRB believes this may be attributable to a shortening of the average duration of medical treatment following the reforms.

## **II. Introduction and Background**

Over the last several years, three significant comprehensive legislative reforms were enacted: AB 749 was enacted in February of 2002; AB 227 and SB 228 were enacted in September of 2003; and, finally, SB 899 was enacted in April of 2004. Legislative changes affecting benefit levels not only impact the cost of benefits, but also the rate at which accident year benefits or losses develop over time.

In reviewing the loss development emerging subsequent to enactment of the reforms, the WCIRB's Actuarial Committee expressed concern over the potential impact of these recent legislative changes on loss development patterns. Additionally, in the decision on the WCIRB's January 1, 2004 pure premium rate filing,<sup>1</sup> the California Department of Insurance (CDI) also recommended that the WCIRB undertake a rigorous review of this issue.

In early 2005, the WCIRB performed a preliminary analysis of the potential impact of the recent legislation on loss development patterns. Specifically, the WCIRB reviewed the impact of the legislation in three areas. These included the following:

1. Impact of benefit changes and reform provisions on the indemnity payment pattern;
2. Impact of medical fee schedule changes on the medical payment pattern; and
3. Impact of medical service utilization provisions on the medical payment pattern.

The WCIRB's report that summarized this analysis was submitted to the CDI as part of the WCIRB's September 15, 2005 comprehensive report monitoring the cost impact of recent reforms.<sup>2</sup> Components of this study were also reflected in the WCIRB's July 1, 2005 and January 1, 2006 pure premium rate filings and in the CDI decisions on those filings.

In 2006, the WCIRB updated the 2005 study to incorporate the estimated cost impact of the January 1, 2005 Permanent Disability Rating Schedule (PDRS) on indemnity loss development patterns, both with respect to accidents incurred subsequent to the January 1, 2005 effective date of the PDRS as well as earlier claims.<sup>3</sup> In addition, the updated study recommended an adjustment to the WCIRB's medical loss development methodology to reflect the impact of the medical service utilization provisions of SB 228 and SB 899 on the development of pre-reform accident years. Results of the WCIRB's 2006 update to the study were reflected in the WCIRB's July 1, 2006 and January 1, 2007 pure premium rate filings and in the corresponding CDI decisions on those filings.

The WCIRB has prepared a 2007 update to this study. In addition to incorporating the findings of the 2005 and 2006 studies, the 2007 update is intended to: (a) estimate a post-reform indemnity payout pattern for accident year 2006; (b) evaluate the accuracy of prior-year reform-adjusted loss development factors based on the actual development that has emerged; (c) develop updated estimates of fee schedule-adjusted medical severity trends; and (d) compare post-reform paid loss development to pre-reform development in California and paid development in other jurisdictions.

<sup>1</sup> See CDI File Number 03031326 issued on November 7, 2003.

<sup>2</sup> See Attachment B of the WCIRB's "2005 Legislative Cost Monitoring Report," released on September 15, 2005.

<sup>3</sup> "Impact of Recent Reform Legislation on Loss Development Patterns — 2006 Update," released on April 4, 2006.

### III. Impact of Legislative Changes on Indemnity Paid Loss Development

#### A. Provisions of AB 749, AB 227, SB 228 and SB 899 Impacting Indemnity Benefits

AB 749 increased most classes of workers' compensation benefits over a four-year period—beginning in 2003. Also, AB 227, SB 228 and SB 899 included a number of provisions impacting indemnity benefits. These included the following:

1. AB 749 increased maximum temporary total and permanent total weekly benefits from \$490 to \$602 in 2003, \$728 in 2004, \$840 in 2005 and by the change in the state average weekly wage in 2006 and thereafter.
2. AB 749 increased the maximum permanent partial disability benefits for specified permanent disability rating intervals in 2003, 2004, 2005 and 2006.
3. AB 749 increased the scheduled number of weeks of payment of permanent disability benefits in 2004.
4. AB 749 increased the weekly benefit minimums in 2003, 2004 and 2006.
5. AB 749 increased death benefit and life pension benefit maximums in 2006.
6. AB 749 provided that weekly life pension and weekly permanent total benefits are subject to annual cost of living adjustments—beginning with injuries occurring in 2003.
7. AB 227 and SB 228 repealed mandatory vocational rehabilitation benefits effective on injuries occurring on or after January 1, 2004, and replaced it with a system of non-transferable education vouchers.
8. SB 899 limited temporary disability duration to two years, with specified exceptions, for injuries occurring on or after April 19, 2004.
9. SB 899 provided that effective April 19, 2004, apportionment of disability be based on causation for purposes of permanent disability determination.
10. SB 899 provided that for injuries occurring on or after the effective date of the revised PDRS, the number of weeks of permanent disability (a) decreases for each percentage point of disability up to 15% and (b) increases for each percentage point of disability above 70%.
11. SB 899 provided that for injuries occurring on or after the effective date of the revised PDRS, weekly permanent disability benefits could be adjusted either 15% up or down based on the return-to-work status of the injured worker.
12. SB 899 provided that on or before January 1, 2005, the Division of Workers' Compensation (DWC) Administrative Director shall adopt a new PDRS, based in part on the American Medical Association Guides. (The DWC Administrative Director adopted a new PDRS effective January 1, 2005.)

#### B. Estimation of Post-Reform Indemnity Payment Patterns

The WCIRB believes that the impact of these legislative reforms—while significantly impacting overall cost levels—have also impacted the rate of which indemnity losses will be paid. Rather than using historical payment patterns based primarily on pre-reform experience, the WCIRB is recommending a loss development methodology for pure premium ratemaking purposes that attempts to adjust paid development patterns for the impact of the legislative reforms.

The WCIRB has estimated the impact of the various reforms on the indemnity payment pattern by (a) decomposing the pre-reform indemnity loss payment pattern into benefit type, (b) reflecting the impact to the indemnity loss payment pattern of each legislative provision by benefit type and payment period, and (c) computing overall projected post-reform accident year indemnity loss payment patterns. It should be noted that this process reflected the specific indemnity-related

benefit changes and cost reforms in AB 749, AB 227 and SB 899. The payment patterns shown reflect the estimated impact of the legislation on severity. The WCIRB did not reflect any frequency utilization impacts resulting from the legislative changes in indemnity. Similarly, the WCIRB did not reflect any potential impact on indemnity payment patterns of the medical utilization legislative reforms.

The following process was used to estimate these post-reform indemnity payment patterns:

1. The proportion by indemnity dollars paid on each claim type (i.e., death, permanent total, major and minor permanent partial, and temporary) was compiled based on historical unit statistical report data. Exhibit 1.1 shows a separate distribution for each policy year from 1993 to 2001 at each available report level. Projections to policy year 2003 were also made based on the latest available historical distribution of policy years not affected by these legislative benefit changes.
2. The policy year distributions by claim type in Exhibit 1.1 were converted to an "accident year" basis at 12-month evaluations, as shown in Exhibit 1.2. The conversions were based on a linear interpolation/extrapolation of two consecutive report level values in Exhibit 1.1.
3. For each claim type, the proportion of indemnity dollars paid on each type of benefit (i.e., death, permanent total, permanent partial, temporary, and vocational rehabilitation) was derived based on historical individual case report (ICR) data. Exhibit 2.1 shows distributions by benefit type for each claim type and report level, based on the latest policy years available.
4. The policy year distributions by benefit type within claim type in Exhibit 2.1 were converted to an "accident year" basis at 12-month evaluations, as shown in Exhibit 2.2. The conversion was based on a linear interpolation/extrapolation of two consecutive report level values in Exhibit 2.1.
5. A summary of accident year indemnity payment patterns by evaluation period was compiled using the paid indemnity loss development factor summary as of December 31, 2003. (See Exhibit 3.) The indemnity payment pattern based on the payments made during calendar year 2002 was selected to be the representative indemnity payment pattern for all claims prior to the recent reforms—the first of which became effective in January 1, 2003.
6. Using (a) the accident year distribution at 12-month evaluations by claim type (Exhibit 1.2), (b) the accident year distribution at 12-month evaluations by benefit type within each claim type (Exhibit 2.2), (c) estimated permanent partial disability distribution based on information from the WCIRB's law evaluation model, and (d) the temporary disability distribution based on information from the California Workers' Compensation Institute (CWCI), the selected overall indemnity payment pattern from Exhibit 3 was segregated into separate payment patterns by benefit type. (See Exhibit 4.)
7. The first matrix shown in Exhibit 5 represents the selected payment pattern derived in Exhibit 4 for each benefit type prior to the recent reforms.
8. The pre-reform indemnity payment patterns by benefit type in Exhibit 5 were adjusted to reflect the estimable cost impacts of the various provisions contained in AB 749 that were effective January 1, 2003. Specifically, the impact of the AB 749 provisions affecting each type of benefit was applied to that benefit type, and the resulting adjusted payment patterns by benefit type were re-aggregated to derive an overall indemnity payment pattern after reflection of the new legislation. In Exhibit 5, the second matrix shows the payment patterns by benefit type after reflecting the cost impacts of the AB 749 provisions effective January 1, 2003. As shown, the total cost impact of these provisions is an increase of 9.6%. The third matrix included in Exhibit 5 shows the overall indemnity payment pattern for accident year 2003 after adjusting for the estimated impacts of AB 749.

9. Exhibit 6.1 shows the estimable cost impacts of the AB 749 provisions effective January 1, 2004 as applied to the post-AB 749, accident year 2003 indemnity payment pattern computed in Exhibit 5. As shown, the total cost impact of these provisions is an increase of 9.4%.
10. Exhibit 6.2 shows the estimable cost impacts of the AB 227 and SB 228 provisions effective January 1, 2004 as applied to the post-AB 749, accident year 2004 indemnity payment pattern computed in Exhibit 6.1. As shown, the total cost impact of these provisions is a decrease of 12.6%.
11. Exhibit 6.3 shows the estimable cost impacts of the SB 899 provisions effective April 19, 2004 as applied to the post-AB 749, AB 227 and SB 228, accident year 2004 (post-April 19, 2004 injuries) indemnity payment pattern computed in Exhibit 6.2. As shown, the total cost impact of these provisions is a decrease of 9.3%.
12. Exhibit 7.1 shows the estimable cost impacts of the AB 749 provisions effective January 1, 2005 as applied to the post-AB 749, AB 227, SB 228 and SB 899, accident year 2004 indemnity payment pattern computed in Exhibit 6.3. As shown, the total cost impact of these provisions is an increase of 4.9%.
13. Exhibit 7.2 shows the estimable cost impacts of the SB 899 provisions effective January 1, 2005 pertaining to changes involving the scheduled number of weeks of permanent disability benefits as applied to the post-AB 749, accident year 2005 indemnity payment pattern computed in Exhibit 7.1. As shown, the total cost impact of these provisions is a decrease of 4.5%.
14. Exhibit 7.3 shows the estimable cost impacts of the SB 899 provisions effective January 1, 2005 pertaining to changes involving multi-tiered permanent disability benefits as applied to the post-AB 749, SB 899 (number of weeks provision), accident year 2005 indemnity payment pattern computed in Exhibit 7.2. As shown, the total cost impact of these provisions is a decrease of 1.4%.
15. Exhibit 7.4 shows the estimable cost impacts of the SB 899 provisions effective January 1, 2005 pertaining to the new PDRS as applied to the post-AB 749, SB 899 (number of weeks and multi-tiered permanent disability provisions), accident year 2005 indemnity payment pattern computed in Exhibit 7.3. As shown, the total cost impact of these provisions is a decrease of 25.9%.<sup>4</sup>
16. Exhibit 8 shows the estimable cost impacts of the AB 749 provisions effective January 1, 2006 as applied to the post-AB 749 and SB 899, accident year 2005 indemnity payment pattern computed in Exhibit 7.4. As shown, the total cost impact of these provisions is an increase of 5.3%.

The resulting payment patterns applicable to accident years 2003 through 2006 are shown in Table 1 as follows:

<sup>4</sup> As discussed in the WCIRB's July 1, 2007 pure premium rate filing, this adjustment assumes a 50% reduction in permanent disability benefits resulting from the January 1, 2006 PDRS. Prior WCIRB analyses assumed a 38% reduction in permanent disability benefits.

**Table 1**  
**Projected Indemnity Post-Reform Payment Patterns**

Accident Year 2003

<b>% Paid at</b>	<b>Pre-2003 Reform (annual)</b>	<b>Pre-2003 Reform (cumulative)</b>	<b>Post-2003 Reform (annual)</b>	<b>Post-2003 Reform (cumulative)</b>
12 months	8.0%	8.0%	8.1%	8.1%
24 months	20.5%	28.5%	20.2%	28.3%
36 months	21.8%	50.3%	21.1%	49.4%
48 months	14.6%	64.9%	14.1%	63.5%
Ultimate	35.1%	100.0%	36.5%	100.0%

Accident Year 2004

<b>% Paid at</b>	<b>Pre-2004 Reform (annual)</b>	<b>Pre-2004 Reform (cumulative)</b>	<b>Post-2004 Reform (annual)</b>	<b>Post-2004 Reform (cumulative)</b>
12 months	8.1%	8.1%	9.4%	9.4%
24 months	20.2%	28.3%	22.0%	31.4%
36 months	21.1%	49.4%	19.7%	51.1%
48 months	14.1%	63.5%	12.3%	63.4%
Ultimate	36.5%	100.0%	36.6%	100.0%



Accident Year 2005

<b>% Paid at</b>	<b>Pre-2005 Reform (annual)</b>	<b>Pre-2005 Reform (cumulative)</b>	<b>Post-2005 Reform (annual)</b>	<b>Post-2005 Reform (cumulative)</b>
12 months	9.4%	9.4%	13.2%	13.2%
24 months	22.0%	31.4%	29.6%	42.8%
36 months	19.7%	51.1%	22.7%	65.5%
48 months	12.3%	63.4%	10.3%	75.8%
Ultimate	36.6%	100.0%	24.2%	100.0%

Accident Year 2006

<b>% Paid at</b>	<b>Pre-2006 Reform (annual)</b>	<b>Pre-2006 Reform (cumulative)</b>	<b>Post-2006 Reform (annual)</b>	<b>Post-2006 Reform (cumulative)</b>
12 months	13.2%	13.2%	12.7%	12.7%
24 months	29.6%	42.8%	28.7%	41.4%
36 months	22.7%	65.5%	22.1%	63.5%
48 months	10.3%	75.8%	10.0%	73.5%
Ultimate	24.2%	100.0%	26.5%	100.0%

As shown in Table 1, the measurable provisions of the legislation effective in January 2003 did not have a major effect on indemnity payment patterns. The 2004 provisions related to the elimination of vocational rehabilitation benefits (from AB 227) and the two-year limit on temporary disability benefits (from SB 899) are estimated to result in a significant reduction in the proportion of indemnity loss attributable to vocational rehabilitation and the shortening in duration of temporary disability payments beyond the second year. This translates into acceleration in the overall estimated accident year 2004 indemnity payment pattern in the first two years.

The 2005 provisions related to AB 749 benefit changes, the change to the number of weeks of permanent disability, and the establishment of the multi-tiered permanent disability benefits had only a minor impact on the indemnity claims payment pattern. However, the January 1, 2005 PDRS resulted in a significant acceleration in the payment pattern for accident year 2005.

The 2006 AB 749 provisions increasing death, life pension and maximum and minimum permanent partial weekly benefits resulted in a moderate slowing in the rate of payments relative to the 2005 accident year. This is primarily due to the AB 749 increases to life pension benefits effective January 1, 2006.

The WCIRB recommends that the projected future paid indemnity development for the 2003 through 2006 accident years be based on the adjusted cumulative paid distribution computed as described in Exhibits 5 through 8. Table 2 below shows the projected ultimate and on-level indemnity loss ratios for 2003 through 2006 as well as the projected April 1, 2008<sup>5</sup> on level loss ratios—both with and without the adjustment to paid loss development described in Exhibits 5 through 8.

**Table 2**  
**Projected Indemnity Ratios after Adjustment for Reforms**

Accident Period	Prior to Adjustment for Reforms		After Adjustment for Reforms <sup>6</sup>	
	Estimated Ultimate Loss Ratio	Projected On-Level Ratio	Estimated Ultimate Loss Ratio	Projected On-Level Ratio
2003	0.233	0.420	0.244	0.397
2004	0.136	0.305	0.143	0.289
2005	0.113	0.308	0.093	0.253
2006	0.140	0.271	0.142	0.288
April 1, 2008	—	0.290	—	0.271

**C. Impact of Indemnity Reforms on Pre-Reform Accident Year Loss Development**

Most of the provisions of AB 749, AB 227, SB 228 and SB 899 related to indemnity benefits impacted only the cost of claims incurred on or after the effective date of the legislative changes. However, several provisions, including the SB 899 provisions related to apportionment and the adoption of the January 1, 2005 PDRS, can also impact the cost of claims that were incurred prior to the effective dates of the legislative changes.

<sup>5</sup> April 1, 2008 represents the average date of experience on policies incepting between July 1, 2007 and December 31, 2007.

<sup>6</sup> See Part A, Section B, Appendix A, Exhibits 3 and 6.1 of the WCIRB’s July 1, 2007 pure premium rate filing.



The impact of the apportionment provisions of SB 899 on pre-2004 injuries is uncertain as the method of application is pending in the courts. Also, the overall cost impact of the retroactive impact of the apportionment provisions on pre-April 19, 2004 injuries is believed to be a relatively minor component of overall costs. As a result, the WCIRB has not computed an adjustment to reflect the retroactive impact of these provisions on pre-2004 accidents.

The WCIRB estimates that the January 1, 2005 PDRS will have a major impact on indemnity losses.<sup>7</sup> In the July 1, 2006 and January 1, 2007 WCIRB pure premium rate filings, a retroactive adjustment was made in projecting the development of accident years 2003 and 2004. This adjustment reflected the assumption that the January 1, 2005 PDRS would apply to all pre-2005 claims that did not have an initial comprehensive medical-legal report before January 1, 2005.<sup>8</sup>

In January of 2007, the Workers' Compensation Appeals Board (WCAB) held, in an en banc decision,<sup>9</sup> that because an employer's duty to provide notice under Labor Code section 4061 arises with the first payment of temporary disability indemnity, if the first date of compensable temporary disability occurred prior to January 1, 2005, the pre-January 1, 2005 PDRS applies to determine the extent of permanent disability. As a result, the WCIRB is no longer recommending any loss development adjustment to the 2003 and 2004 accident years to reflect the impact of the January 1, 2005 PDRS.

#### D. Comparison of Indemnity Payment Patterns

For informational purposes, Exhibit 9 shows the percentage of ultimate indemnity losses paid as of 12, 24 and 36 months under a number of alternative cumulative indemnity payment distributions. These include the following:

- (a) the pre-Minniear<sup>10</sup> decision period's California cumulative indemnity payment distribution estimated for accident year 1996;
- (b) the countrywide average cumulative indemnity payment distribution;<sup>11</sup>
- (c) the California accident year 2003 estimated cumulative indemnity payment distribution (pre-reform); and
- (d) the estimated California cumulative indemnity payment distribution based on accident year 2005 and 2006 development factors, after adjustment for the impact of the AB 749, AB 227, SB 228 and SB 899 provisions related to indemnity as described above.

Exhibit 9 shows that the rate of indemnity payments had decelerated in the years prior to the enactment of recent reforms, as illustrated by the slowdown in payment from the pre-Minniear years (which were already significantly slower than the rate of payment in other states) to the latest pre-reform 2003 accident year. However, current WCIRB estimates of cumulative payment

<sup>7</sup> The WCIRB's July 1, 2007 pure premium rate filing reflects an estimated 50% reduction in permanent disability benefits resulting from the January 1, 2005 PDRS.

<sup>8</sup> Based on CWCI information on the distribution of permanent disability claims by length of time from date of injury to first comprehensive medical-legal report, the WCIRB assumed the January 1, 2005 PDRS would apply to 80% of accident year 2004 permanent disability claims and 20% of accident year 2003 claims.

<sup>9</sup> Pendergrass v. Dugan Plumbing and State Compensation Ins. Fund (2007) 72 Cal. Comp. Cases 95 (Appeals Board en banc).

<sup>10</sup> Minniear v. Mount San Antonio Community College District (1996) 61 Cal. Comp. Cases 1055 (Workers' Compensation Appeals Board en banc opinion).

<sup>11</sup> Source: Exhibit IX, 2006 NCCI Annual Statistical Bulletin; excludes California, Massachusetts, Michigan, Minnesota, Nevada, New York, Texas and Wisconsin.

patterns for accident years 2005 and 2006 reflect faster payments than during the pre-Minnear period and generally comparable to the average payment pattern in other states.<sup>12</sup>

**E. Comparison of Actual and Projected Loss Development**

In the last two pure premium rate filings, the WCIRB has projected indemnity loss development based on the post-reform cumulative payment patterns generally derived as discussed above. Limited actual post-reform development factors are now available. Table 3 below compares the age-to-age indemnity paid loss development factors for accident years 2003, 2004 and 2005 based on the payment pattern estimated after adjustment for the impact of the reforms as described above with the development factors based on the experience that actually emerged for those years. Also shown are the factors that would have been projected based on the latest year development factors (the methodology used by the WCIRB during the years prior to the reforms).

**Table 3  
Comparison of Projected versus Actual Indemnity Paid Development Factors**

Accident Year	Age-to-Age (in months)	Actual	WCIRB Projected		Latest Year <sup>13</sup>	
		Factors	Factors	Difference	Factors	Difference
2005	12-to-24	2.739	3.242	18.3%	2.915	6.4%
2004	12-to-24	2.915	3.340	14.6%	3.370	15.6%
2004	24-to-36	1.524	1.627	6.8%	1.699	11.5%
2003	24-to-36	1.699	1.746	2.8%	1.782	4.9%
2003	36-to-48	1.250	1.285	2.8%	1.291	3.3%

As shown, actual loss development has emerged at significantly lower levels than projected by the WCIRB. Nevertheless, with the exception of the development of the 2005 accident year from 12 to 24 months of maturity, the projected factors are less than what would have been projected using the latest year paid development factor.

This difference between projected development and actual emergence could be in part attributable to greater than anticipated reform savings. The WCIRB also believes the reforms have had a significant impact on claim frequency.<sup>14</sup> While overall claim frequency has decreased significantly, the reforms have apparently impacted different injury types in different manners. Table 4 below compares the pre-reform indemnity claim distribution with a preliminary post-reform distribution. Specifically, Column 1 of Table 4 below shows the pre-reform distribution of indemnity claims by injury type that underlies the projection of post-reform indemnity loss development patterns. Column 2 shows a preliminary accident year 2005 indemnity claim distribution based on first unit statistical report level information that has been submitted as of the issuance of this report.

<sup>12</sup> Averages shown for other states are based on Exhibit IX of the 2006 NCCI Annual Statistical Bulletin.

<sup>13</sup> See Part A, Section B, Appendix A, Exhibit 2.3 of the WCIRB’s July 1, 2007 pure premium rate filing.

<sup>14</sup> See Attachment F of WCIRB’s “2006 Legislative Cost Monitoring Report,” published on September 27, 2006, for a discussion of the impacts of reform on overall claim frequency.



**Table 4**  
**Comparison of Indemnity Claim Distribution by Injury Type**

<b>Claim Type</b>	<b>Pre-Reform Claim Distribution</b>	<b>Preliminary (AY 2005) Claim Distribution</b>
Death	0.1%	0.2%
Permanent Total	0.1%	0.1%
Major	11.8%	4.0%
Minor	32.1%	30.7%
Temporary	55.9%	65.0%
All Indemnity	100.0%	100.0%

As shown in Table 4, there is a significant decrease in the proportion of major permanent partial disability claims<sup>15</sup> and a significant increase in the proportion of temporary-only disability claims.<sup>16</sup> Some, but not all, of this shift is contemplated in the WCIRB’s evaluation of the January 1, 2005 PDRS. In any case, shifts in the claim type distribution can impact loss development.

Inasmuch as it is unclear how indicative the preliminary first report level claim distribution shown in Table 4 will be of the ultimate post-reform claim distribution, it is premature to be able to fully assess the effect of the changes in claim frequency by injury type on loss development. As a result, the WCIRB did not reflect any frequency adjustments resulting from the legislative changes in indemnity loss development projections.

For informational purposes only, the WCIRB re-computed the indicated post-reform payment patterns for accident years 2005 and 2006 by replacing the pre-reform distribution of claims by injury type with the preliminary 2005 distribution shown in Table 4, and then reflecting the impact of the reforms by injury type and payment period. Table 5 below compares the indicated indemnity payment patterns for accident years 2005 and 2006 in Table 1 above to those computed using the preliminary accident year 2005 distribution of claims.<sup>17</sup> As shown in Table 5, if the preliminary accident year 2005 claim distribution was indicative of the ultimate distribution of indemnity claims, then accident year 2005 and 2006 indemnity paid losses will develop more quickly than projected.

**Table 5**  
**Indemnity Payment Patterns after Reflecting Post-Reform Claim Distribution**

<b>% Paid as of</b>	<b>AY2005 Unadjusted</b>	<b>AY2005 Adjusted</b>	<b>AY2006 Unadjusted</b>	<b>AY2006 Adjusted</b>
12 months	13.2%	19.5%	12.7%	18.4%
24 months	42.8%	53.4%	41.4%	50.8%
36 months	65.5%	71.9%	63.5%	68.8%
48 months	75.8%	79.0%	73.5%	75.8%
Ultimate	100.0%	100.0%	100.0%	100.0%

<sup>15</sup> Major permanent partial disability claims are permanent partial disability claims with a permanent partial disability rating greater than or equal to 25%.

<sup>16</sup> Initial, very preliminary estimates for accident year 2006 suggest that this trend is continuing. Also, preliminary evaluations as of second unit statistical report level suggest a similar, though not as dramatic, shift in the distribution.

<sup>17</sup> The adjusted 2005 and 2006 distributions were derived by assuming the preliminary 2005 claim distribution shown in Table 4, average severities as implied in the WCIRB’s loss projections, and reform impacts on accident years 2003 through 2006 as described in Exhibits 1 through 8.

#### IV. Impact of Legislative Changes on Medical Paid Loss Development

##### A. SB 228 Provisions Impacting Medical Fee Schedules

SB 228 enacted a number of medical fee schedule changes that applied to all medical services provided on or after January 1, 2004, including those provided on pre-January 1, 2004 injuries. These included the following:

1. SB 228 provided that for physician services provided in calendar years 2004 and 2005, the existing Official Medical Fee Schedule rates for physicians are reduced by 5 percent.
2. SB 228 provided that effective January 1, 2004, the maximum reasonable fees for inpatient procedures are set at 120% of Medicare fees.
3. SB 228 provided that effective January 1, 2004, the scheduled payments for pharmaceuticals are set at 100% of the Medi-Cal Schedule amounts.
4. SB 228 provided that effective January 1, 2004, the maximum facility fee for services performed in an ambulatory surgical center may not exceed 120% of the Medicare fees for the same service performed in a hospital outpatient facility.

##### B. Adjustments to Medical Loss Development to Reflect Fee Schedule Provisions

The SB 228 fee schedule changes impact both the cost of injuries occurring on or after January 1, 2004 as well as the cost of medical services provided on or after January 1, 2004 on pre-2004 injuries. Thus, if no adjustment is made, age-to-age paid development factors for accident years prior to 2004 will reflect a mix of paid losses at the post-January 1, 2004 fee schedule level and those at prior fee schedule levels. These factors will then be applied to accident year paid-to-date loss ratios, which will either reflect purely post-SB 228 fee schedule change experience (accident years 2004 through 2006) or a mix of fee schedule experience.<sup>18</sup>

Beginning with the WCIRB's July 1, 2005 pure premium rate filing, the WCIRB has been correcting for this potential distortion in loss development projections. Specifically, the WCIRB has recommended that all pre-January 1, 2004 medical payments be adjusted to reflect the overall impact of the SB 228 fee schedule changes.<sup>19</sup> In this way, these adjusted medical age-to-age development factors will reflect payments as if they were all made in accordance with the SB 228 medical fee schedule level.

##### C. AB 749, SB 228 and SB 899 Provisions Impacting the Utilization of Medical Services

AB 749, SB 228 and SB 899 contained a number of provisions related to the utilization of medical services. Many of these provisions impact the cost of future medical on claims incurred prior to the effective date of the legislation as well as the cost of medical on future claims. These provisions included the following:

1. AB 749 repealed the presumption given to the primary treating physician (except when the worker has pre-designated a personal physician), effective for injuries occurring on or after January 1, 2003. (SB 228 and SB 899 later extended this to all future medical treatment on earlier injuries.)
2. SB 228 provided that beginning three months after the publication date of the updated American College of Occupational and Environmental Medical (ACOEM) Practice Guidelines

<sup>18</sup> In the WCIRB's January 1, 2005 and subsequent pure premium rate filings, the approved pure premium rates reflected an adjustment for the estimated cost impact of the fee schedule changes on medical loss development patterns.

<sup>19</sup> Pre-January 1, 2004 medical payments were reduced by 9.4%—which is the estimated overall impact of the fee schedule changes reflected in the WCIRB's January 1, 2005 and subsequent pure premium rate filings and in the approved January 1, 2005 and subsequent pure premium rates.

and continuing until such time as the DWC Administrative Director establishes an Official Medical Treatment Utilization Schedule, the ACOEM standards are presumed correct regarding the extent and scope of all medical treatment.

3. SB 228 provided that by December 1, 2004, the DWC Administrative Director is to establish an Official Medical Treatment Utilization Schedule meeting specified criteria.
4. SB 228 established a special process for resolving disputes over medical treatment related to spinal surgeries by providing for a second opinion by a qualified medical evaluator or an agreed-upon medical evaluator when there is a medical dispute over the need for spinal surgery.
5. SB 228 limited the number of chiropractic visits and the number of physical therapy visits to 24 each per claim, effective for injuries occurring on or after January 1, 2004.
6. SB 899 provided that effective April 19, 2004, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based on the utilization guidelines adopted by the DWC Administrative Director or, prior to the adoption of those guidelines, the ACOEM Guidelines.
7. SB 899 provided that after January 1, 2005, an employer or insurer may establish medical provider networks meeting certain conditions and, with limited exceptions, medical treatment can be provided within those networks.
8. SB 899 provided that the DWC Administrative Director shall develop a process of independent medical reviews within the medical provider network by which an injured employee can dispute the diagnosis or treatment after the opinion from the third physician from the medical network.

#### **D. Adjustments to Medical Loss Development to Reflect Medical Utilization Provisions**

As noted earlier, many of the provisions of AB 749, SB 228 and SB 899 impacting the utilization of medical services affect all medical benefits provided, including future medical treatment on injuries occurring prior to the effective date of the legislation. As with other legislative provisions that have a retroactive impact on earlier accident years, if no adjustment is made, the medical loss development factors—which would reflect a mix of medical utilization levels—could be distorted as payments made pursuant to later legislative medical utilization provisions are compared to earlier year payments that reflected different medical utilization provisions. As these legislative provisions related to the utilization of medical services are believed to have the potential to significantly reduce medical utilization levels, historical post-reform medical paid development factors could significantly understate actual future development.

As shown on Exhibit 10.1, quarterly medical development factors in calendar years 2004 through 2006 are generally well below those of the prior years—particularly for the earlier evaluation periods. Similarly, Exhibit 10.2 shows a similar pattern in the average medical paid during 2004, 2005 and 2006 per open or new indemnity claim.

As previously discussed, paid loss development factors that compare medical losses at two successive evaluations were adjusted such that all pre-January 1, 2004 medical payments were reduced by 9.4% to represent the estimated impact of the SB 228 fee schedule changes that became effective in January 1, 2004. However, the actual decline in loss development and average medical severities for the less mature valuation periods far exceed the estimated 9.4% cost savings attributed to the SB 228 fee schedule changes. Exhibit 11 shows quarterly medical severity information after adjustment to the common SB 899 fee schedule level. As shown, there is significant decline in post-reform severities for the less mature evaluation periods shown that is well beyond the estimated -9.4% fee schedule impact.

Exhibit 12 shows, for successive December 31 evaluation periods: (a) historical medical paid loss development factors for the pre-reform period (i.e., through December 31, 2003); (b) actual post-reform paid loss development factors for the December 31, 2004, 2005 and 2006 valuations; and (c) projected development for 2004 through 2006 with historical medical payments adjusted to a current (SB 228) medical fee schedule level. (Also shown on the dotted line is the projected development after reflecting the medical utilization adjustment discussed below.)

As shown in Exhibits 10 through 12, for development valuation periods through 72 months, actual post-reform development and post reform severities are well below those of the pre-reform period and, in most cases, those of the post-reform period adjusted to a common (SB 228) medical fee schedule level. Thus, the evidence suggests that the legislative provisions related to the utilization of medical services are significantly impacting historical medical paid loss development for the less mature valuations. Conversely, as also shown in Exhibits 10 through 12, there is no evidence that post-reform medical paid development beyond 72 months has been significantly affected by the legislative provisions related to the utilization of medical services.

In September of 2006, the WCIRB released a retrospective assessment of the impact of recent legislative reforms.<sup>20</sup> Based in part on a CWCI study completed on behalf of the WCIRB that measured reductions in medical utilization levels, the WCIRB estimated an approximate 25% reduction in utilization levels on 2004 injuries as compared to the pre-reform projected estimates. In light of the findings in this report as well as the patterns observed in Exhibits 10 through 12 suggesting that the impact of the provisions related to the utilization of medical services becomes less as valuation periods mature, the WCIRB recommends that projected medical loss development be adjusted to reflect the impact of the reforms affecting the utilization of medical services for the 2000 through 2004 accident years. (This adjustment is consistent with the adjustment recommended by the WCIRB in the July 1, 2006 and January 1, 2007 pure premium rate filings.) Specifically, the WCIRB recommends that in order to reflect the impact of the provisions related to the utilization of medical services on development through 72 months, pre-July 1, 2004 payments<sup>21</sup> be judgmentally reduced by the following percentages for purposes of computing adjusted development factors: 25% for accident year 2004, 20% for accident year 2003, 15% for accident year 2002, 10% for accident year 2001, and 5% for accident year 2000.<sup>22</sup>

Exhibit 12 also shows the annual age-to-age medical paid development factors adjusted on this basis. Shown in Table 6 below are the projected ultimate and on-level medical loss ratios for 2003 through 2006 as well as the projected April 1, 2008 on-level medical loss ratios, prior to and after adjustment to a common fee schedule level and level of medical utilization.

<sup>20</sup> 2006 Legislative Cost Monitoring Report," released September 27, 2006.

<sup>21</sup> Various provisions impacting the utilization of medical services became effective at different times. However, for relative simplicity of the calculation, the WCIRB assumed a July 1, 2004 effective date.

<sup>22</sup> These adjustments are in addition to the adjustments made to a common (SB 228) medical fee schedule level.

**Table 6**  
**Projected Medical Ratios Adjusted for SB228 Fee Schedule and**  
**Medical Utilization Changes**

Accident Period	Prior to Adjustment for Impact of SB 228 Fee Schedule or Medical Utilization Changes		After Adjustment for Impact of SB 228 Fee Schedule and Medical Utilization Changes	
	Estimated Ultimate Loss Ratio	Projected On-Level Ratio	Estimated Ultimate Loss Ratio	Projected On-Level Ratio
2003	0.282	0.587	0.266	0.606
2004	0.172	0.429	0.184	0.501
2005	0.162	0.407	0.178	0.447
2006	0.208	0.394	0.229	0.455
April 1, 2008	—	0.410	—	0.461

**E. Comparison of Medical Payment Patterns**

For informational purposes, Exhibit 13 shows the percentage of ultimate medical losses paid as of 12, 24 and 36 months under a number of alternative cumulative medical payment distributions. These include the following:

- (a) the pre-Minniear decision period’s California cumulative medical payment distribution estimated for accident year 1996 as of December 31, 1996;
- (b) the countrywide average cumulative medical loss payment distribution;<sup>23</sup>
- (c) the estimated California accident year 2003 cumulative medical loss payment distribution (pre-reform); and
- (d) the estimated California cumulative medical loss payment pattern based on accident year 2006 development factors, after adjustment for the retroactive impact of both the SB 228 fee changes<sup>24</sup> and the provisions related to medical utilization as described above.

As shown on Exhibit 13, while the WCIRB estimates medical payments on 2006 will be made more quickly than in the years immediately preceding the reforms, the rate of payments remains significantly below that of the countrywide average rate and the pre-Minniear California rate.

**F. Comparison of Projected and Actual Post-Reform Medical Development**

Table 7 below compares the medical loss development factors for accident years 2003, 2004 and 2005 after adjustment for the retroactive impact of both the SB 228 fee changes and the provisions related to medical utilization as described above with the development that actually emerged for those years.

<sup>23</sup> Source: Exhibit IX, 2006 NCCI Annual Statistical Bulletin; excludes California, Massachusetts, Michigan, Minnesota, Nevada, New York, Texas and Wisconsin.

<sup>24</sup> The adjustment of -9.4% to the medical dollars paid prior to January 1, 2004 in the derivation of paid medical loss development factors is the methodology adopted by the WCIRB in projecting loss to pure premium ratios proposed in its January 1, 2005 and subsequent pure premium rate filings.

**Table 7**  
**Comparison of Estimated versus Actual Medical Paid Development Factors**

Accident Year	Age-to-Age (in months)	Actual	Estimated	
		Factors	Factors	Difference
2005	12-to-24	2.254	2.367	5.0%
2004	12-to-24	2.288	2.930	28.1%
2004	24-to-36	1.343	1.388	3.4%
2003	24-to-36	1.318	1.494	13.4%
2003	36-to-48	1.170	1.207	3.2%

As shown in Table 7 above, the development emerging for each period is well below that projected by the WCIRB. The WCIRB's recommended medical loss development projection methodology, while correcting for certain reform impacts on earlier accident years, implicitly assumes no fundamental change to the rate at which medical losses are being paid. If the recent reforms have, in fact, shortened the average duration of medical treatment, actual paid medical loss development will be less than currently projected. The WCIRB recommends this issue be studied as additional post-reform medical information continues to emerge.



**V. Exhibits**





**Policy Year Distribution of Paid Indemnity by Claim Type**

Claim Type	Policy Year	Report Level				
		1st	2nd	3rd	4th	5th
Death	1993	1.1%	1.3%	1.4%	1.5%	1.5%
Death	1994	1.3%	1.5%	1.5%	1.6%	1.5%
Death	1995	1.4%	1.4%	1.4%	1.4%	1.5%
Death	1996	1.5%	1.4%	1.4%	1.4%	1.4%
Death	1997	1.5%	1.3%	1.3%	1.3%	1.3%
Death	1998	1.3%	1.1%	1.1%	1.1%	<b>1.3%</b>
Death	1999	1.1%	1.0%	1.0%	<b>1.1%</b>	<b>1.3%</b>
Death	2000	1.2%	1.1%	<b>1.0%</b>	<b>1.1%</b>	<b>1.3%</b>
Death	2001	0.9%	<b>1.1%</b>	<b>1.0%</b>	<b>1.1%</b>	<b>1.3%</b>
Death	2002	<b>0.9%</b>	<b>1.1%</b>	<b>1.0%</b>	<b>1.1%</b>	<b>1.3%</b>
Death	2003	<b>0.9%</b>	<b>1.1%</b>	<b>1.0%</b>	<b>1.1%</b>	<b>1.3%</b>
Perm. Total	1993	0.4%	1.1%	1.7%	2.8%	3.6%
Perm. Total	1994	0.7%	1.3%	1.9%	2.6%	3.5%
Perm. Total	1995	0.5%	1.3%	2.1%	3.0%	3.7%
Perm. Total	1996	0.4%	1.3%	2.2%	3.0%	4.1%
Perm. Total	1997	0.6%	1.5%	2.1%	3.3%	4.5%
Perm. Total	1998	0.7%	1.7%	2.4%	3.4%	<b>4.5%</b>
Perm. Total	1999	0.4%	1.2%	2.6%	<b>3.4%</b>	<b>4.5%</b>
Perm. Total	2000	0.6%	1.5%	<b>2.6%</b>	<b>3.4%</b>	<b>4.5%</b>
Perm. Total	2001	0.8%	<b>1.5%</b>	<b>2.6%</b>	<b>3.4%</b>	<b>4.5%</b>
Perm. Total	2002	<b>0.8%</b>	<b>1.5%</b>	<b>2.6%</b>	<b>3.4%</b>	<b>4.5%</b>
Perm. Total	2003	<b>0.8%</b>	<b>1.5%</b>	<b>2.6%</b>	<b>3.4%</b>	<b>4.5%</b>
Major	1993	29.2%	46.2%	53.4%	56.6%	57.6%
Major	1994	29.5%	47.2%	55.7%	57.8%	59.0%
Major	1995	31.0%	50.2%	57.0%	59.3%	60.9%
Major	1996	34.7%	52.6%	59.3%	62.9%	63.9%
Major	1997	34.8%	54.0%	61.4%	64.3%	65.2%
Major	1998	34.7%	54.0%	62.2%	64.8%	<b>65.2%</b>
Major	1999	35.3%	56.2%	62.6%	<b>64.8%</b>	<b>65.2%</b>
Major	2000	43.1%	55.2%	<b>62.6%</b>	<b>64.8%</b>	<b>65.2%</b>
Major	2001	35.7%	<b>55.2%</b>	<b>62.6%</b>	<b>64.8%</b>	<b>65.2%</b>
Major	2002	<b>35.7%</b>	<b>55.2%</b>	<b>62.6%</b>	<b>64.8%</b>	<b>65.2%</b>
Major	2003	<b>35.7%</b>	<b>55.2%</b>	<b>62.6%</b>	<b>64.8%</b>	<b>65.2%</b>
Minor	1993	50.6%	41.1%	35.5%	32.2%	31.1%
Minor	1994	50.2%	39.7%	33.2%	31.3%	29.6%
Minor	1995	48.7%	37.4%	32.3%	29.7%	27.5%
Minor	1996	46.9%	36.1%	30.2%	26.6%	24.8%
Minor	1997	44.6%	34.3%	28.0%	24.6%	22.9%
Minor	1998	43.5%	33.3%	26.5%	23.3%	<b>22.9%</b>
Minor	1999	41.3%	30.5%	24.6%	<b>23.3%</b>	<b>22.9%</b>
Minor	2000	32.6%	28.7%	<b>24.6%</b>	<b>23.3%</b>	<b>22.9%</b>
Minor	2001	39.3%	<b>28.7%</b>	<b>24.6%</b>	<b>23.3%</b>	<b>22.9%</b>
Minor	2002	<b>39.3%</b>	<b>28.7%</b>	<b>24.6%</b>	<b>23.3%</b>	<b>22.9%</b>
Minor	2003	<b>39.3%</b>	<b>28.7%</b>	<b>24.6%</b>	<b>23.3%</b>	<b>22.9%</b>
Temporary	1993	18.7%	10.3%	8.0%	6.9%	6.3%
Temporary	1994	18.2%	10.3%	7.7%	6.7%	6.3%
Temporary	1995	18.4%	9.7%	7.3%	6.6%	6.3%
Temporary	1996	16.4%	8.6%	7.0%	6.2%	5.9%
Temporary	1997	18.6%	8.9%	7.1%	6.5%	6.1%
Temporary	1998	19.9%	9.9%	7.8%	7.3%	<b>6.1%</b>
Temporary	1999	21.9%	11.0%	9.3%	<b>7.3%</b>	<b>6.1%</b>
Temporary	2000	22.6%	13.5%	<b>9.3%</b>	<b>7.3%</b>	<b>6.1%</b>
Temporary	2001	23.2%	<b>13.5%</b>	<b>9.3%</b>	<b>7.3%</b>	<b>6.1%</b>
Temporary	2002	<b>23.2%</b>	<b>13.5%</b>	<b>9.3%</b>	<b>7.3%</b>	<b>6.1%</b>
Temporary	2003	<b>23.2%</b>	<b>13.5%</b>	<b>9.3%</b>	<b>7.3%</b>	<b>6.1%</b>
All	1993	100.0%	100.0%	100.0%	100.0%	100.0%
All	1994	100.0%	100.0%	100.0%	100.0%	100.0%
All	1995	100.0%	100.0%	100.0%	100.0%	100.0%
All	1996	100.0%	100.0%	100.0%	100.0%	100.0%
All	1997	100.0%	100.0%	100.0%	100.0%	100.0%
All	1998	100.0%	100.0%	100.0%	100.0%	100.0%
All	1999	100.0%	100.0%	100.0%	100.0%	100.0%
All	2000	100.0%	100.0%	100.0%	100.0%	100.0%
All	2001	100.0%	100.0%	100.0%	100.0%	100.0%
All	2002	100.0%	100.0%	100.0%	100.0%	100.0%
All	2003	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Unit Statistical Reports.

Note: Bold figures are projections based on latest available report levels.



**Accident Year Distribution of Paid Indemnity by Claim Type**

Claim Type	Accident Year	Evaluated at				
		12 mos.	24 mos.	36 mos.	48 mos.	60 mos.
Death	1994	1.1%	1.3%	1.4%	1.5%	1.5%
Death	1995	1.3%	1.4%	1.4%	1.5%	1.5%
Death	1996	1.4%	1.4%	1.4%	1.4%	1.4%
Death	1997	1.6%	1.4%	1.4%	1.3%	1.3%
Death	1998	1.5%	1.3%	1.2%	1.2%	1.2%
Death	1999	1.2%	1.1%	1.0%	1.1%	1.2%
Death	2000	1.2%	1.1%	1.0%	1.0%	1.2%
Death	2001	1.0%	1.1%	1.0%	1.0%	1.2%
Death	2002	0.8%	1.0%	1.0%	1.0%	1.2%
Death	2003	0.8%	1.0%	1.0%	1.0%	1.2%
Perm. Total	1994	0.2%	0.9%	1.5%	2.3%	3.1%
Perm. Total	1995	0.3%	1.0%	1.7%	2.4%	3.2%
Perm. Total	1996	0.0%	0.9%	1.7%	2.5%	3.5%
Perm. Total	1997	0.1%	0.9%	1.8%	2.6%	3.7%
Perm. Total	1998	0.1%	1.1%	1.9%	2.8%	3.9%
Perm. Total	1999	0.1%	1.0%	2.0%	2.9%	4.0%
Perm. Total	2000	0.1%	0.9%	2.0%	3.0%	4.0%
Perm. Total	2001	0.2%	1.1%	2.1%	3.0%	4.0%
Perm. Total	2002	0.4%	1.2%	2.1%	3.0%	4.0%
Perm. Total	2003	0.4%	1.2%	2.1%	3.0%	4.0%
Major	1994	20.7%	38.0%	50.6%	55.9%	57.8%
Major	1995	21.1%	39.5%	52.5%	57.5%	59.3%
Major	1996	23.6%	42.1%	54.8%	59.6%	61.8%
Major	1997	25.5%	44.0%	56.8%	62.0%	64.1%
Major	1998	25.1%	44.4%	57.9%	63.2%	64.9%
Major	1999	24.9%	45.1%	58.8%	63.6%	65.0%
Major	2000	30.9%	47.5%	59.2%	63.7%	65.0%
Major	2001	31.5%	47.3%	58.9%	63.7%	65.0%
Major	2002	26.0%	45.5%	58.9%	63.7%	65.0%
Major	2003	26.0%	45.5%	58.9%	63.7%	65.0%
Minor	1994	55.4%	45.4%	37.4%	33.0%	31.0%
Minor	1995	54.9%	44.0%	35.6%	31.6%	29.5%
Minor	1996	53.3%	42.3%	34.0%	29.7%	27.1%
Minor	1997	51.0%	40.5%	32.2%	27.4%	24.7%
Minor	1998	49.1%	38.9%	30.5%	25.6%	23.4%
Minor	1999	47.6%	37.1%	28.7%	24.4%	23.1%
Minor	2000	40.6%	33.3%	27.1%	24.0%	23.1%
Minor	2001	39.6%	32.3%	26.6%	24.0%	23.1%
Minor	2002	44.6%	34.0%	26.6%	24.0%	23.1%
Minor	2003	44.6%	34.0%	26.6%	24.0%	23.1%
Temporary	1994	22.6%	14.4%	9.1%	7.3%	6.5%
Temporary	1995	22.5%	14.2%	8.7%	7.1%	6.5%
Temporary	1996	21.5%	13.3%	8.1%	6.7%	6.2%
Temporary	1997	21.9%	13.1%	7.9%	6.7%	6.1%
Temporary	1998	24.1%	14.3%	8.5%	7.2%	6.5%
Temporary	1999	26.1%	15.7%	9.5%	7.9%	6.7%
Temporary	2000	27.2%	17.2%	10.8%	8.3%	6.7%
Temporary	2001	27.6%	18.2%	11.4%	8.3%	6.7%
Temporary	2002	28.1%	18.4%	11.4%	8.3%	6.7%
Temporary	2003	28.1%	18.4%	11.4%	8.3%	6.7%
All	1994	100.0%	100.0%	100.0%	100.0%	100.0%
All	1995	100.0%	100.0%	100.0%	100.0%	100.0%
All	1996	100.0%	100.0%	100.0%	100.0%	100.0%
All	1997	100.0%	100.0%	100.0%	100.0%	100.0%
All	1998	100.0%	100.0%	100.0%	100.0%	100.0%
All	1999	100.0%	100.0%	100.0%	100.0%	100.0%
All	2000	100.0%	100.0%	100.0%	100.0%	100.0%
All	2001	100.0%	100.0%	100.0%	100.0%	100.0%
All	2002	100.0%	100.0%	100.0%	100.0%	100.0%
All	2003	100.0%	100.0%	100.0%	100.0%	100.0%

**Policy Year Distribution of Paid Indemnity by Benefit Type for Each Claim Type**

Policy Year 1996-1st

<u>Claim Type</u>	<u>Benefit Type</u>					<u>Total</u>
	<u>TD</u>	<u>PPD</u>	<u>PT</u>	<u>Death</u>	<u>VR</u>	
Death	0.7%	3.3%	0.0%	96.0%	0.0%	100.0%
Perm. Total	52.1%	18.2%	24.9%	0.0%	4.8%	100.0%
Major	58.0%	28.3%	0.0%	0.0%	13.7%	100.0%
Minor	67.8%	23.4%	0.0%	0.0%	8.7%	100.0%
Temporary	97.8%	1.4%	0.0%	0.0%	0.8%	100.0%

Policy Year 1995-2nd

<u>Claim Type</u>	<u>Benefit Type</u>					<u>Total</u>
	<u>TD</u>	<u>PPD</u>	<u>PT</u>	<u>Death</u>	<u>VR</u>	
Death	0.8%	7.4%	0.0%	91.7%	0.1%	100.0%
Perm. Total	32.4%	33.3%	29.7%	0.0%	4.5%	100.0%
Major	40.4%	41.3%	0.1%	0.0%	18.1%	100.0%
Minor	46.3%	38.0%	0.0%	0.0%	15.7%	100.0%
Temporary	95.1%	2.8%	0.3%	0.1%	1.7%	100.0%

Policy Year 1994-3rd

<u>Claim Type</u>	<u>Benefit Type</u>					<u>Total</u>
	<u>TD</u>	<u>PPD</u>	<u>PT</u>	<u>Death</u>	<u>VR</u>	
Death	1.5%	5.9%	0.0%	92.6%	0.0%	100.0%
Perm. Total	35.3%	30.8%	30.1%	0.2%	3.7%	100.0%
Major	34.8%	47.2%	0.0%	0.0%	18.0%	100.0%
Minor	39.5%	42.4%	0.0%	0.0%	18.0%	100.0%
Temporary	95.7%	2.6%	0.0%	0.1%	1.6%	100.0%

Policy Year 1993-4th

<u>Claim Type</u>	<u>Benefit Type</u>					<u>Total</u>
	<u>TD</u>	<u>PPD</u>	<u>PT</u>	<u>Death</u>	<u>VR</u>	
Death	1.4%	3.7%	1.0%	93.6%	0.3%	100.0%
Perm. Total	29.9%	28.8%	34.9%	0.6%	5.8%	100.0%
Major	30.7%	47.8%	0.1%	0.0%	21.4%	100.0%
Minor	36.0%	42.1%	0.0%	0.0%	21.9%	100.0%
Temporary	95.3%	2.5%	0.0%	0.0%	2.2%	100.0%

Policy Year 1992-5th

<u>Claim Type</u>	<u>Benefit Type</u>					<u>Total</u>
	<u>TD</u>	<u>PPD</u>	<u>PT</u>	<u>Death</u>	<u>VR</u>	
Death	1.9%	6.1%	1.2%	90.3%	0.6%	100.0%
Perm. Total	31.3%	36.3%	22.6%	0.1%	9.7%	100.0%
Major	30.5%	43.1%	0.2%	0.0%	26.1%	100.0%
Minor	33.8%	39.1%	0.2%	0.0%	26.9%	100.0%
Temporary	92.2%	4.6%	0.2%	0.0%	3.0%	100.0%

Source: Individual Case Reports.

**Selected Accident Year Distribution of Paid Indemnity by Benefit Type for Each Claim Type**

Benefit Type	Claim Type	Evaluated at				
		12 mos.	24 mos.	36 mos.	48 mos.	48+ mos.
TD	Death	0.7%	0.8%	1.1%	1.4%	1.5%
TD	Perm. Total	58.5%	40.2%	31.5%	32.0%	15.2%
TD	Major	58.9%	46.3%	38.4%	36.1%	29.7%
TD	Minor	71.1%	53.9%	43.8%	41.1%	34.1%
TD	Temporary	98.6%	96.2%	95.4%	95.9%	93.3%
PPD	Death	2.4%	7.4%	5.9%	3.8%	5.1%
PPD	Perm. Total	17.3%	30.8%	27.7%	23.5%	18.7%
PPD	Major	32.9%	41.3%	42.0%	42.0%	50.9%
PPD	Minor	25.0%	36.5%	38.1%	37.0%	45.8%
PPD	Temporary	1.0%	2.6%	2.5%	2.1%	4.1%
PT	Death	0.0%	0.0%	0.0%	0.6%	4.3%
PT	Perm. Total	20.4%	25.4%	36.6%	39.4%	62.8%
PT	Major	0.0%	0.1%	0.1%	0.1%	0.6%
PT	Minor	0.0%	0.0%	0.0%	0.1%	0.5%
PT	Temporary	0.0%	0.1%	0.2%	0.0%	0.5%
Death	Death	96.9%	91.7%	93.0%	94.0%	88.7%
Death	Perm. Total	0.0%	0.0%	0.1%	0.4%	0.2%
Death	Major	0.0%	0.0%	0.0%	0.0%	0.0%
Death	Minor	0.0%	0.0%	0.0%	0.0%	0.0%
Death	Temporary	0.0%	0.1%	0.1%	0.0%	0.0%
VR	Death	0.0%	0.1%	0.1%	0.1%	0.3%
VR	Perm. Total	3.8%	3.6%	4.0%	4.7%	3.1%
VR	Major	8.2%	12.3%	19.5%	21.8%	18.8%
VR	Minor	3.9%	9.5%	18.1%	21.9%	19.5%
VR	Temporary	0.3%	1.0%	1.7%	1.9%	2.1%
All	Death	100.0%	100.0%	100.0%	100.0%	100.0%
All	Perm. Total	100.0%	100.0%	100.0%	100.0%	100.0%
All	Major	100.0%	100.0%	100.0%	100.0%	100.0%
All	Minor	100.0%	100.0%	100.0%	100.0%	100.0%
All	Temporary	100.0%	100.0%	100.0%	100.0%	100.0%

Note: Based on Exhibit 2.1

**Indemnity Payment Pattern for all Claim Types Combined**

Accident Year	First 12 mos.	12 to 24 mos.	24 to 36 mos.	36 to 48 mos.	48 mos. to Ultimate
1993	11.0%	21.5%	23.0%	15.4%	29.2%
1994	10.6%	22.1%	23.3%	14.6%	29.5%
1995	10.0%	23.2%	23.0%	13.8%	29.9%
1996	9.9%	22.8%	22.6%	13.6%	31.2%
1997	9.4%	23.3%	21.6%	13.6%	32.0%
1998	9.2%	22.2%	21.7%	14.2%	32.6%
1999	8.6%	21.6%	21.8%	14.6%	33.4%
2000	8.3%	20.9%	21.8%	15.6%	
2001	8.0%	20.5%	22.6%		
2002	8.0%	20.5%			
2003	7.9%				

Note: Based on Part A, Section A, Exhibit 1, Exhibit 2, Sheet 3, and Exhibit 3 of the WCIRB's July 1, 2004 pure premium rate filing, which used aggregate financial data valued as of December 31, 2003.



**Accident Year 2003 Pre-Reform Indemnity Payment Pattern by Benefit Type**

(A) Selected Pre-Reform Indemnity Payment Pattern for Accident Year 2003

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>
(i) Indemnity	8.0%	20.5%	21.8%	14.6%	35.1%
(ii) Cum. Indemnity Ex. LP	8.0%	28.5%	50.3%	64.9%	97.5%

(B) Accident Year Distribution of Paid Indemnity by Claim Type

<u>Claim Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>
Death	0.8%	1.0%	1.0%	1.0%	1.2%
Perm. Total	0.4%	1.2%	2.1%	3.0%	4.0%
Major	26.0%	45.5%	58.9%	63.7%	65.0%
Minor	44.6%	34.0%	26.6%	24.0%	23.1%
<u>Temporary</u>	<u>28.1%</u>	<u>18.4%</u>	<u>11.4%</u>	<u>8.3%</u>	<u>6.7%</u>
All	100.0%	100.0%	100.0%	100.0%	100.0%

(C) Accident Year Distribution of Paid Indemnity by Benefit Type for Each Claim Type

<u>Claim Type</u>	<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>
Death	TD	0.7%	0.8%	1.1%	1.4%	1.5%
Perm. Total	TD	58.5%	40.2%	31.5%	32.0%	15.2%
Major	TD	58.9%	46.3%	38.4%	36.1%	29.7%
Minor	TD	71.1%	53.9%	43.8%	41.1%	34.1%
Temporary	TD	98.6%	96.2%	95.4%	95.9%	93.3%
Death	PPD	2.4%	7.4%	5.9%	3.8%	5.1%
Perm. Total	PPD	17.3%	30.8%	27.7%	23.5%	18.7%
Major	PPD	32.9%	41.3%	42.0%	42.0%	50.9%
Minor	PPD	25.0%	36.5%	38.1%	37.0%	45.8%
Temporary	PPD	1.0%	2.6%	2.5%	2.1%	4.1%
Death	PT	0.0%	0.0%	0.0%	0.6%	4.3%
Perm. Total	PT	20.4%	25.4%	36.6%	39.4%	62.8%
Major	PT	0.0%	0.1%	0.1%	0.1%	0.6%
Minor	PT	0.0%	0.0%	0.0%	0.1%	0.5%
Temporary	PT	0.0%	0.1%	0.2%	0.0%	0.5%
Death	Death	96.9%	91.7%	93.0%	94.0%	88.7%
Perm. Total	Death	0.0%	0.0%	0.1%	0.4%	0.2%
Major	Death	0.0%	0.0%	0.0%	0.0%	0.0%
Minor	Death	0.0%	0.0%	0.0%	0.0%	0.0%
Temporary	Death	0.0%	0.1%	0.1%	0.0%	0.0%
Death	VR	0.0%	0.1%	0.1%	0.1%	0.3%
Perm. Total	VR	3.8%	3.6%	4.0%	4.7%	3.1%
Major	VR	8.2%	12.3%	19.5%	21.8%	18.8%
Minor	VR	3.9%	9.5%	18.1%	21.9%	19.5%
Temporary	VR	0.3%	1.0%	1.7%	1.9%	2.1%

(D) Pre-Reform Indemnity Payment Pattern by Benefit Type for Accident Year 2003

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>
TD	6.0%	16.3%	23.1%	27.3%	32.4%
PPD	1.7%	9.3%	18.0%	23.6%	42.8%
LP	0.0%	0.0%	0.0%	0.0%	2.5%
PT	0.0%	0.1%	0.5%	0.9%	5.2%
Death	0.1%	0.2%	0.5%	0.7%	1.1%
VR	0.3%	2.6%	8.3%	12.4%	16.0%
All (Cumulative)	8.0%	28.5%	50.3%	64.9%	100.0%
All (Incremental)	8.0%	20.5%	21.8%	14.6%	35.1%

Notes: (A) Based on Exhibit 3.

(B) See Exhibit 1.2.

(C) See Exhibit 2.2.

(D) Matrix (A.ii) x Matrix (B) x Matrix (C) of the benefit type.

**Indemnity Payment Pattern Before and After Impact of AB 749 Provisions Effective January 1, 2003**

(A) Indemnity Payment Pattern by Benefit Type Before January 1, 2003 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	6.0%	10.4%	6.8%	4.3%	5.1%	32.4%
PPD	1.7%	7.6%	8.7%	5.6%	19.2%	42.8%
LP	0.0%	0.0%	0.0%	0.0%	2.5%	2.5%
PT	0.0%	0.1%	0.4%	0.5%	4.3%	5.2%
Death	0.1%	0.2%	0.2%	0.2%	0.4%	1.1%
VR	<u>0.3%</u>	<u>2.3%</u>	<u>5.7%</u>	<u>4.1%</u>	<u>3.6%</u>	<u>16.0%</u>
Total	8.0%	20.5%	21.8%	14.6%	35.1%	100.0%
Cum. Total	8.0%	28.5%	50.3%	64.9%	100.0%	

(B) Paid Indemnity Adjusted for January 1, 2003 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD (a)	6.4%	11.1%	7.3%	4.6%	5.4%	34.9%
PPD (b)	2.1%	8.5%	9.4%	6.0%	20.6%	46.5%
LP (c)	0.0%	0.0%	0.0%	0.0%	3.0%	3.0%
PT (d)	0.0%	0.1%	0.4%	0.5%	7.0%	8.0%
Death (a)	0.1%	0.2%	0.3%	0.2%	0.4%	1.1%
VR (a)	<u>0.3%</u>	<u>2.3%</u>	<u>5.7%</u>	<u>4.1%</u>	<u>3.6%</u>	<u>16.0%</u>
Total	8.9%	22.1%	23.1%	15.4%	40.0%	109.6%

AB 749 provisions effective 1/1/03 reflected above in (B) include:

- (a) Increasing payments on Temporary Disability, Death, and Vocational Rehabilitation benefits as a result of changes in maximum and minimum weekly Temporary Disability benefits.
- (b) Increasing payments on Permanent Partial Disability benefits as a result of changes in maximum and minimum weekly Permanent Partial Disability benefits.
- (c) Increasing payments on Life Pension benefits as a result of annual cost of living adjustments after the first year of Life Pension payments.
- (d) Increasing payments on Permanent Total Disability benefits as a result of changes in maximum and minimum weekly Permanent Total Disability benefits and annual cost of living adjustments after the first year of Permanent Total Disability payments.

(C) Indemnity Payment Pattern by Benefit Type After Adjustment for January 1, 2003 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	5.8%	10.2%	6.7%	4.2%	4.9%	31.8%
PPD	1.9%	7.7%	8.6%	5.4%	18.8%	42.5%
LP	0.0%	0.0%	0.0%	0.0%	2.7%	2.7%
PT	0.0%	0.1%	0.4%	0.5%	6.4%	7.3%
Death	0.0%	0.2%	0.2%	0.2%	0.4%	1.0%
VR	<u>0.3%</u>	<u>2.1%</u>	<u>5.2%</u>	<u>3.8%</u>	<u>3.3%</u>	<u>14.6%</u>
Total	8.1%	20.2%	21.1%	14.1%	36.5%	100.0%
Cum. Total	8.1%	28.3%	49.4%	63.5%	100.0%	

Notes: (A) Based on incorporating Exhibits 2, 3 and 4.

(B) Based on adjusting (A) for the cost impacts of the AB 749 provisions effective January 1, 2003.

(C) Restated (B) as a payment pattern.

**Indemnity Payment Pattern Before and After Impact of AB 749 Provisions Effective January 1, 2004**

## (A) Indemnity Payment Pattern by Benefit Type Before January 1, 2004 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	5.8%	10.2%	6.7%	4.2%	4.9%	31.8%
PPD	1.9%	7.7%	8.6%	5.4%	18.8%	42.5%
LP	0.0%	0.0%	0.0%	0.0%	2.7%	2.7%
PT	0.0%	0.1%	0.4%	0.5%	6.4%	7.3%
Death	0.0%	0.2%	0.2%	0.2%	0.4%	1.0%
VR	<u>0.3%</u>	<u>2.1%</u>	<u>5.2%</u>	<u>3.8%</u>	<u>3.3%</u>	<u>14.6%</u>
Total	8.1%	20.2%	21.1%	14.1%	36.5%	100.0%
Cum. Total	8.1%	28.3%	49.4%	63.5%	100.0%	

## (B) Paid Indemnity Adjusted for January 1, 2004 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD (a)	6.0%	10.4%	6.8%	4.3%	5.0%	32.5%
PPD (b)	2.3%	9.3%	10.3%	6.5%	22.5%	51.0%
LP (c)	0.0%	0.0%	0.0%	0.0%	2.7%	2.7%
PT (d)	0.0%	0.1%	0.4%	0.5%	6.6%	7.5%
Death (a)	0.1%	0.2%	0.2%	0.2%	0.4%	1.1%
VR (a)	<u>0.3%</u>	<u>2.1%</u>	<u>5.2%</u>	<u>3.8%</u>	<u>3.3%</u>	<u>14.6%</u>
Total	8.7%	22.0%	23.0%	15.3%	40.5%	109.4%

AB 749 provisions effective 1/1/04 reflected above in (B) include:

- Increasing payments on Temporary Disability, Death, and Vocational Rehabilitation benefits as a result of changes in maximum and minimum weekly Temporary Disability benefits.
- Increasing payments on Permanent Partial Disability benefits as a result of changes in maximum and minimum weekly Permanent Partial Disability benefits and increase in duration of Permanent Partial Disability payments.
- Decreasing payments on Life Pension benefits as a result of increase in duration of Permanent Partial Disability payments.
- Increasing payments on Permanent Total Disability benefits as a result of changes in maximum weekly Permanent Total Disability benefits.

## (C) Indemnity Payment Pattern by Benefit Type After Adjustment for January 1, 2004 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	5.5%	9.5%	6.3%	3.9%	4.6%	29.7%
PPD	2.1%	8.5%	9.4%	6.0%	20.6%	46.6%
LP	0.0%	0.0%	0.0%	0.0%	2.5%	2.5%
PT	0.0%	0.1%	0.3%	0.4%	6.0%	6.9%
Death	0.0%	0.2%	0.2%	0.2%	0.4%	1.0%
VR	<u>0.3%</u>	<u>1.9%</u>	<u>4.7%</u>	<u>3.4%</u>	<u>3.0%</u>	<u>13.4%</u>
Total	7.9%	20.1%	21.0%	14.0%	37.0%	100.0%
Cum. Total	7.9%	28.0%	49.0%	63.0%	100.0%	

Notes: (A) From Exhibit 5.

(B) Based on adjusting (A) for the cost impacts of the AB 749 provisions effective January 1, 2004.

(C) Restated (B) as a payment pattern.

**Indemnity Payment Pattern Before and After Impact of AB 227/SB 228 Provisions Effective January 1, 2004**

## (A) Indemnity Payment Pattern by Benefit Type Before January 1, 2004 AB 227 / SB 228 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	5.5%	9.5%	6.3%	3.9%	4.6%	29.7%
PPD	2.1%	8.5%	9.4%	6.0%	20.6%	46.6%
LP	0.0%	0.0%	0.0%	0.0%	2.5%	2.5%
PT	0.0%	0.1%	0.3%	0.4%	6.0%	6.9%
Death	0.0%	0.2%	0.2%	0.2%	0.4%	1.0%
VR	<u>0.3%</u>	<u>1.9%</u>	<u>4.7%</u>	<u>3.4%</u>	<u>3.0%</u>	<u>13.4%</u>
Total	7.9%	20.1%	21.0%	14.0%	37.0%	100.0%
Cum. Total	7.9%	28.0%	49.0%	63.0%	100.0%	

## (B) Paid Indemnity Adjusted for January 1, 2004 AB 227 / SB 228 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	5.5%	9.5%	6.3%	3.9%	4.6%	29.7%
PPD	2.1%	8.5%	9.4%	6.0%	20.6%	46.6%
LP	0.0%	0.0%	0.0%	0.0%	2.5%	2.5%
PT	0.0%	0.1%	0.3%	0.4%	6.0%	6.9%
Death	0.0%	0.2%	0.2%	0.2%	0.4%	1.0%
VR/Vouchers (a)	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>0.8%</u>
Total	7.7%	18.3%	16.5%	10.7%	34.2%	87.4%

AB 227 / SB 228 provisions effective 1/1/04 reflected above in (B) include:

- (a) Elimination of mandatory Vocational Rehabilitation benefits. Provision for Nontransferable Educational Vouchers was added to compensate qualified injured workers. (Payment pattern for Vouchers are assumed to be the same as that for Vocational Rehabilitation.)

## (C) Indemnity Payment Pattern by Benefit Type After Adjustment for January 1, 2004 AB 227 / SB 228 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	6.2%	10.8%	7.2%	4.5%	5.2%	34.0%
PPD	2.4%	9.7%	10.8%	6.8%	23.6%	53.3%
LP	0.0%	0.0%	0.0%	0.0%	2.8%	2.8%
PT	0.0%	0.1%	0.4%	0.5%	6.9%	7.9%
Death	0.1%	0.2%	0.3%	0.2%	0.4%	1.1%
VR/Vouchers	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>0.9%</u>
Total	8.8%	20.9%	18.9%	12.3%	39.1%	100.0%
Cum. Total	8.8%	29.7%	48.6%	60.9%	100.0%	

Notes: (A) From Exhibit 6.1.

(B) Based on adjusting (A) for the cost impacts of the AB 227 and SB 228 provisions effective January 1, 2004.

(C) Restated (B) as a payment pattern.



**Indemnity Payment Pattern Before and After Impact of SB 899 Provisions Effective April 19, 2004**

(A) Indemnity Payment Pattern by Benefit Type Before April 19, 2004 SB 899 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	6.2%	10.8%	7.2%	4.5%	5.2%	34.0%
PPD	2.4%	9.7%	10.8%	6.8%	23.6%	53.3%
LP	0.0%	0.0%	0.0%	0.0%	2.8%	2.8%
PT	0.0%	0.1%	0.4%	0.5%	6.9%	7.9%
Death	0.1%	0.2%	0.3%	0.2%	0.4%	1.1%
VR/Vouchers	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>0.9%</u>
Total	8.8%	20.9%	18.9%	12.3%	39.1%	100.0%
Cum. Total	8.8%	29.7%	48.6%	60.9%	100.0%	

(B) Paid Indemnity Adjusted for April 19, 2004 SB 899 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD (a)	6.2%	10.8%	7.2%	4.1%	1.6%	30.0%
PPD (b)	2.2%	8.7%	9.7%	6.2%	21.2%	48.0%
LP	0.0%	0.0%	0.0%	0.0%	2.8%	2.8%
PT	0.0%	0.1%	0.4%	0.5%	6.9%	7.9%
Death	0.1%	0.2%	0.3%	0.2%	0.4%	1.1%
VR/Vouchers	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>0.9%</u>
Total	8.5%	19.9%	17.8%	11.2%	33.2%	90.7%

SB 899 provisions effective 4/19/04 reflected above in (B) includes:

- (a) Decreasing payments on Temporary Disability benefits as a result of a 2-year cap from date of first payment, with exceptions. (Assumed 90%/10% savings distribution between the Year 5+ and Year 4 periods, respectively.)
- (b) Decreasing payments on Permanent Partial Disability benefits as a result of the apportionment provision.

(C) Indemnity Payment Pattern by Benefit Type After Adjustment for April 19, 2004 SB 899 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	6.9%	12.0%	7.9%	4.5%	1.8%	33.1%
PPD	2.4%	9.6%	10.7%	6.8%	23.4%	52.9%
LP	0.0%	0.0%	0.0%	0.0%	3.1%	3.1%
PT	0.0%	0.1%	0.4%	0.5%	7.6%	8.7%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.2%
VR/Vouchers	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>1.0%</u>
Total	9.4%	22.0%	19.7%	12.3%	36.6%	100.0%
Cum. Total	9.4%	31.4%	51.1%	63.4%	100.0%	

Notes: (A) From Exhibit 6.2.

(B) Based on adjusting (A) for the cost impacts of the SB 899 provisions effective April 19, 2004.

(C) Restated (B) as a payment pattern.

**Indemnity Payment Pattern Before and After Impact of AB 749 Provisions Effective January 1, 2005**

## (A) Indemnity Payment Pattern by Benefit Type Before January 1, 2005 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	6.9%	12.0%	7.9%	4.5%	1.8%	33.1%
PPD	2.4%	9.6%	10.7%	6.8%	23.4%	52.9%
LP	0.0%	0.0%	0.0%	0.0%	3.1%	3.1%
PT	0.0%	0.1%	0.4%	0.5%	7.6%	8.7%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.2%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>1.0%</u>
Total	9.4%	22.0%	19.7%	12.3%	36.6%	100.0%
Cum. Total	9.4%	31.4%	51.1%	63.4%	100.0%	

## (B) Paid Indemnity Adjusted for January 1, 2005 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD (a)	7.0%	12.1%	8.0%	4.6%	1.8%	33.6%
PPD (b)	2.6%	10.4%	11.6%	7.4%	25.2%	57.2%
LP	0.0%	0.0%	0.0%	0.0%	3.1%	3.1%
PT (c)	0.0%	0.1%	0.4%	0.5%	7.7%	8.8%
Death (a)	0.1%	0.2%	0.3%	0.2%	0.5%	1.2%
VR (a)	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>1.0%</u>
Total	9.7%	23.0%	20.7%	13.0%	38.5%	104.9%

AB 749 provisions effective 1/1/05 reflected above in (B) include:

- Increasing payments on Temporary Disability, Death, and Vocational Rehabilitation benefits as a result of changes in maximum and minimum weekly Temporary Disability benefits.
- Increasing payments on Permanent Partial Disability benefits as a result of changes in maximum and minimum weekly Permanent Partial Disability benefits.
- Increasing payments on Permanent Total Disability benefits as a result of changes in maximum weekly Permanent Total Disability benefits.

## (C) Indemnity Payment Pattern by Benefit Type After Adjustment for January 1, 2005 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	6.7%	11.6%	7.7%	4.4%	1.7%	32.0%
PPD	2.5%	9.9%	11.1%	7.0%	24.0%	54.5%
LP	0.0%	0.0%	0.0%	0.0%	3.0%	3.0%
PT	0.0%	0.1%	0.4%	0.5%	7.3%	8.4%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.2%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>0.9%</u>
Total	9.2%	21.9%	19.7%	12.4%	36.7%	100.0%
Cum. Total	9.2%	31.1%	50.9%	63.3%	100.0%	

Notes: (A) From Exhibit 6.3.

(B) Based on adjusting (A) for the cost impacts of the AB 749 provisions effective January 1, 2005.

(C) Restated (B) as a payment pattern.

**Indemnity Payment Pattern Before and After Impact of SB 899 Effective January 1, 2005  
Pertaining to Changes Involving Number of Weeks of Permanent Disability Benefits**

(A) Indemnity Payment Pattern by Benefit Type Before January 1, 2005 SB 899 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	6.7%	11.6%	7.7%	4.4%	1.7%	32.0%
PPD	2.5%	9.9%	11.1%	7.0%	24.0%	54.5%
LP	0.0%	0.0%	0.0%	0.0%	3.0%	3.0%
PT	0.0%	0.1%	0.4%	0.5%	7.3%	8.4%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.2%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>0.9%</u>
Total	9.2%	21.9%	19.7%	12.4%	36.7%	100.0%
Cum. Total	9.2%	31.1%	50.9%	63.3%	100.0%	

(B) Paid Indemnity Adjusted for January 1, 2005 SB 899 Impact Related to Change in Number of Weeks of PD Benefits

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	6.7%	11.6%	7.7%	4.4%	1.7%	32.0%
PPD (a)	2.5%	9.8%	10.7%	6.4%	20.9%	50.3%
LP (b)	0.0%	0.0%	0.0%	0.0%	2.7%	2.7%
PT	0.0%	0.1%	0.4%	0.5%	7.3%	8.4%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.2%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>0.9%</u>
Total	9.2%	21.8%	19.4%	11.7%	33.3%	95.5%

- (a) Decreasing payments on Permanent Partial Disability benefits as a result of changes in the scheduled number of weeks of permanent disability for each percentage point of permanent disability.
- (b) Decreasing payments on Life Pension benefits as a result of lengthening the duration of payment for the permanent disability in the 70 to 99.75 rating interval.

(C) Indemnity Payment Pattern by Benefit Type After Adjustment for January 1, 2005 SB 899 Impact Related to Change in Number of Weeks of PD Benefits

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	7.0%	12.1%	8.0%	4.6%	1.8%	33.5%
PPD	2.6%	10.3%	11.2%	6.7%	21.9%	52.7%
LP	0.0%	0.0%	0.0%	0.0%	2.8%	2.8%
PT	0.0%	0.1%	0.4%	0.5%	7.7%	8.8%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.2%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>1.0%</u>
Total	9.7%	22.9%	20.3%	12.3%	34.9%	100.0%
Cum. Total	9.7%	32.5%	52.8%	65.1%	100.0%	

Notes: (A) From Exhibit 7.1.

(B) Based on adjusting (A) for the cost impacts of the SB 899 provisions effective January 1, 2005 related to change in number of weeks of PD benefits.

(C) Restated (B) as a payment pattern.

**Indemnity Payment Pattern Before and After Impact of SB 899 Effective January 1, 2005  
Pertaining to Changes Involving Multi-Tiered Permanent Disability Benefits**

(A) Indemnity Payment Pattern by Benefit Type Before January 1, 2005 SB 899 Impact Related to Multi-Tiered PD Benefits

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	7.0%	12.1%	8.0%	4.6%	1.8%	33.5%
PPD	2.6%	10.3%	11.2%	6.7%	21.9%	52.7%
LP	0.0%	0.0%	0.0%	0.0%	2.8%	2.8%
PT	0.0%	0.1%	0.4%	0.5%	7.7%	8.8%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.2%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>1.0%</u>
Total	9.7%	22.9%	20.3%	12.3%	34.9%	100.0%
Cum. Total	9.7%	32.5%	52.8%	65.1%	100.0%	

(B) Paid Indemnity Adjusted for January 1, 2005 SB 899 Impact Related to Multi-Tiered PD Benefits

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	7.0%	12.1%	8.0%	4.6%	1.8%	33.5%
PPD (a)	2.6%	10.0%	10.9%	6.5%	21.3%	51.3%
LP	0.0%	0.0%	0.0%	0.0%	2.8%	2.8%
PT	0.0%	0.1%	0.4%	0.5%	7.7%	8.8%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.2%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>0.2%</u>	<u>1.0%</u>
Total	9.7%	22.5%	20.0%	12.1%	34.3%	98.6%

(a) Decreasing payments on Permanent Partial Disability benefits due to adjustment in benefit depending on whether or not the injured worker has been offered regular or modified work.

(C) Paid Indemnity Adjusted for January 1, 2005 SB 899 Impact Related to Multi-Tiered PD Benefits

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	7.1%	12.3%	8.1%	4.7%	1.8%	34.0%
PPD	2.7%	10.1%	11.1%	6.6%	21.6%	52.0%
LP	0.0%	0.0%	0.0%	0.0%	2.8%	2.8%
PT	0.0%	0.1%	0.4%	0.6%	7.8%	8.9%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.3%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>1.0%</u>
Total	9.8%	22.9%	20.3%	12.3%	34.8%	100.0%
Cum. Total	9.8%	32.7%	53.0%	65.2%	100.0%	

Notes: (A) From Exhibit 7.2.

(B) Based on adjusting (A) for the cost impacts of the SB 899 provisions effective January 1, 2005 related to multi-tiered PD benefits.

(C) Restated (B) as a payment pattern.

**Indemnity Payment Pattern Before and After Impact of SB 899 Effective January 1, 2005  
Pertaining to the New Permanent Disability Rating Schedule (PDRS)**

(A) Indemnity Payment Pattern by Benefit Type Before January 1, 2005 SB 899 Impact Related to the New PDRS

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	7.1%	12.3%	8.1%	4.7%	1.8%	34.0%
PPD	2.7%	10.1%	11.1%	6.6%	21.6%	52.0%
LP	0.0%	0.0%	0.0%	0.0%	2.8%	2.8%
PT	0.0%	0.1%	0.4%	0.6%	7.8%	8.9%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.3%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>1.0%</u>
Total	9.8%	22.9%	20.3%	12.3%	34.8%	100.0%
Cum. Total	9.8%	32.7%	53.0%	65.2%	100.0%	

(B) Paid Indemnity Adjusted for January 1, 2005 SB 899 Impact Related to the New PDRS

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	7.1%	12.3%	8.1%	4.7%	1.8%	34.0%
PPD (a)	2.6%	9.2%	7.6%	1.9%	4.8%	26.1%
LP	0.0%	0.0%	0.0%	0.0%	2.8%	2.8%
PT	0.0%	0.1%	0.4%	0.6%	7.8%	8.9%
Death	0.1%	0.2%	0.3%	0.2%	0.5%	1.3%
VR	<u>0.0%</u>	<u>0.1%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>0.2%</u>	<u>1.0%</u>
Total	9.8%	21.9%	16.8%	7.6%	17.9%	74.1%

(a) Decreasing payments on Permanent Partial Disability benefits due to the implementation of the new PDRS.

(C) Indemnity Payment Pattern by Benefit Type After Adjustment for January 1, 2005 SB 899 Impact of the New PDRS

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	9.6%	16.6%	11.0%	6.3%	2.5%	45.9%
PPD	3.5%	12.4%	10.3%	2.6%	6.4%	35.2%
LP	0.0%	0.0%	0.0%	0.0%	3.8%	3.8%
PT	0.0%	0.1%	0.6%	0.7%	10.5%	12.0%
Death	0.1%	0.3%	0.4%	0.3%	0.6%	1.7%
VR	<u>0.0%</u>	<u>0.2%</u>	<u>0.5%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>1.3%</u>
Total	13.2%	29.6%	22.7%	10.3%	24.2%	100.0%
Cum. Total	13.2%	42.8%	65.5%	75.8%	100.0%	

Notes: (A) From Exhibit 7.3.

(B) Based on adjusting (A) for the cost impacts of the SB 899 provision effective January 1, 2005 related to the new PDRS.

(C) Restated (B) as a payment pattern.

**Indemnity Payment Pattern Before and After Impact of AB 749 Provisions Effective January 1, 2006**

(A) Indemnity Payment Pattern by Benefit Type Before January 1, 2006 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	9.6%	16.6%	11.0%	6.3%	2.5%	45.9%
PPD	3.5%	12.4%	10.3%	2.6%	6.4%	35.2%
LP	0.0%	0.0%	0.0%	0.0%	3.8%	3.8%
PT	0.0%	0.1%	0.6%	0.7%	10.5%	12.0%
Death	0.1%	0.3%	0.4%	0.3%	0.6%	1.7%
VR	<u>0.0%</u>	<u>0.2%</u>	<u>0.5%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>1.3%</u>
Total	13.2%	29.6%	22.7%	10.3%	24.2%	100.0%
Cum. Total	13.2%	42.8%	65.5%	75.8%	100.0%	

(B) Paid Indemnity Adjusted for January 1, 2006 AB 749 Impacts

<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	9.6%	16.6%	11.0%	6.3%	2.5%	45.9%
PPD (a)	3.7%	13.0%	10.8%	2.7%	6.6%	36.8%
LP (b)	0.0%	0.0%	0.0%	0.0%	6.7%	6.7%
PT	0.0%	0.1%	0.6%	0.7%	10.5%	12.0%
Death (c)	0.1%	0.3%	0.5%	0.4%	1.3%	2.6%
VR	<u>0.0%</u>	<u>0.2%</u>	<u>0.5%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>1.3%</u>
Total	13.4%	30.2%	23.3%	10.5%	27.9%	105.3%

AB 749 provisions effective 1/1/06 reflected above in (B) include:

- (a) Increasing payments on Permanent Partial Disability benefits as a result of changes in maximum and minimum weekly Permanent Partial Disability benefits.
- (b) Increasing payments on Life Pension benefits as a result of changes in maximum weekly benefits at 99.75% disability rating.
- (c) Increasing payments on Death benefits as a result of changes in statutory maximum death benefits.

(C) Indemnity Payment Pattern by Benefit Type After Adjustment for January 1, 2006 AB 749 Impacts

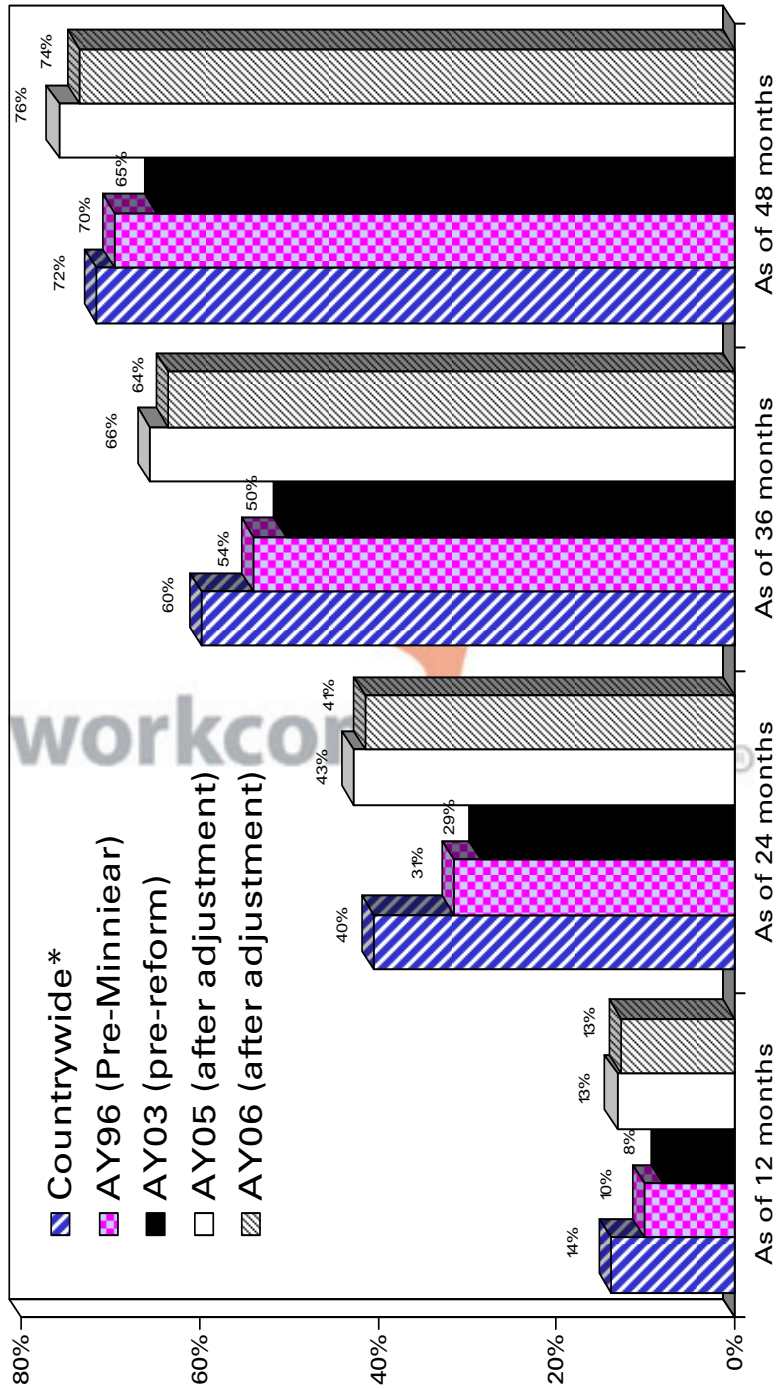
<u>Benefit Type</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5+</u>	<u>Ultimate</u>
TD	9.1%	15.7%	10.4%	6.0%	2.3%	43.6%
PPD	3.5%	12.3%	10.3%	2.5%	6.3%	34.9%
LP	0.0%	0.0%	0.0%	0.0%	6.4%	6.4%
PT	0.0%	0.1%	0.6%	0.7%	10.0%	11.4%
Death	0.1%	0.3%	0.4%	0.4%	1.2%	2.4%
VR	<u>0.0%</u>	<u>0.2%</u>	<u>0.4%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>1.3%</u>
Total	12.7%	28.7%	22.1%	10.0%	26.5%	100.0%
Cum. Total	12.7%	41.4%	63.5%	73.5%	100.0%	

Notes: (A) From Exhibit 7.4.

(B) Based on adjusting (A) for the cost impacts of the AB 749 provisions effective January 1, 2006.

(C) Restated (B) as a payment pattern.

# Comparison of Percent of Ultimate Indemnity Losses Paid



\* Based on all states except California, Massachusetts, Michigan, Minnesota, Nevada, New York, Texas and Wisconsin.

Quarterly Paid Medical Loss Development Factors  
Through December 31, 2006

Age in Months	Accident Years																
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
15/12	1.471	1.515	1.472	1.425	1.366	1.396	1.432	1.421	1.434	1.453	1.490	1.514	1.547	1.554	1.510	1.434	1.421
18/15	1.233	1.263	1.232	1.198	1.173	1.193	1.207	1.221	1.232	1.241	1.267	1.286	1.310	1.330	1.295	1.242	1.232
21/18	1.137	1.159	1.147	1.116	1.105	1.126	1.126	1.133	1.155	1.164	1.168	1.192	1.219	1.211	1.178	1.152	1.153
<b>24/21</b>	<b>1.104</b>	<b>1.117</b>	<b>1.104</b>	<b>1.081</b>	<b>1.108</b>	<b>1.088</b>	<b>1.094</b>	<b>1.109</b>	<b>1.128</b>	<b>1.132</b>	<b>1.124</b>	<b>1.149</b>	<b>1.159</b>	<b>1.154</b>	<b>1.124</b>	<b>1.115</b>	<b>1.117</b>
27/24	1.085	1.084	1.077	1.063	1.066	1.074	1.074	1.085	1.086	1.096	1.108	1.121	1.128	1.123	1.093	1.089	
30/27	1.068	1.065	1.059	1.051	1.053	1.062	1.069	1.062	1.070	1.077	1.088	1.101	1.108	1.103	1.077	1.084	
33/30	1.054	1.050	1.043	1.043	1.038	1.046	1.048	1.053	1.059	1.065	1.072	1.086	1.089	1.078	1.062	1.071	
<b>36/33</b>	<b>1.042</b>	<b>1.037</b>	<b>1.035</b>	<b>1.045</b>	<b>1.036</b>	<b>1.037</b>	<b>1.042</b>	<b>1.051</b>	<b>1.048</b>	<b>1.055</b>	<b>1.066</b>	<b>1.069</b>	<b>1.076</b>	<b>1.061</b>	<b>1.055</b>	<b>1.062</b>	
39/36	1.036	1.036	1.029	1.031	1.029	1.032	1.038	1.039	1.046	1.051	1.059	1.060	1.061	1.049	1.044		
42/39	1.029	1.027	1.028	1.031	1.026	1.028	1.029	1.036	1.038	1.044	1.049	1.055	1.054	1.042	1.044		
45/42	1.025	1.021	1.022	1.024	1.023	1.023	1.026	1.033	1.035	1.039	1.045	1.047	1.044	1.036	1.037		
<b>48/45</b>	<b>1.019</b>	<b>1.018</b>	<b>1.024</b>	<b>1.020</b>	<b>1.018</b>	<b>1.020</b>	<b>1.026</b>	<b>1.027</b>	<b>1.031</b>	<b>1.035</b>	<b>1.039</b>	<b>1.044</b>	<b>1.037</b>	<b>1.032</b>	<b>1.035</b>		
51/48	1.017	1.015	1.018	1.019	1.017	1.019	1.022	1.027	1.027	1.030	1.035	1.037	1.034	1.031			
54/51	1.015	1.014	1.017	1.017	1.016	1.017	1.019	1.026	1.026	1.031	1.036	1.032	1.027	1.030			
57/54	1.013	1.012	1.015	1.014	1.014	1.017	1.020	1.021	1.025	1.026	1.030	1.027	1.024	1.024			
<b>60/57</b>	<b>1.011</b>	<b>1.013</b>	<b>1.011</b>	<b>1.011</b>	<b>1.013</b>	<b>1.014</b>	<b>1.018</b>	<b>1.020</b>	<b>1.023</b>	<b>1.026</b>	<b>1.028</b>	<b>1.026</b>	<b>1.021</b>	<b>1.023</b>			
63/60	1.009	1.012	1.012	1.012	1.011	1.013	1.016	1.019	1.021	1.023	1.025	1.022	1.019				
66/63	1.009	1.010	1.010	1.011	1.011	1.013	1.014	1.019	1.021	1.026	1.021	1.020	1.020				
69/66	1.008	1.008	1.009	1.010	1.011	1.011	1.016	1.016	1.019	1.021	1.022	1.019	1.018				
<b>72/69</b>	<b>1.008</b>	<b>1.008</b>	<b>1.010</b>	<b>1.009</b>	<b>1.010</b>	<b>1.012</b>	<b>1.013</b>	<b>1.015</b>	<b>1.017</b>	<b>1.022</b>	<b>1.018</b>	<b>1.017</b>	<b>1.017</b>				
75/72	1.008	1.008	1.008	1.008	1.010	1.010	1.011	1.013	1.016	1.017	1.016	1.014					
78/75	1.007	1.008	1.006	1.007	1.007	1.011	1.013	1.014	1.017	1.018	1.015	1.014					
81/78	1.006	1.006	1.006	1.007	1.008	1.008	1.016	1.014	1.015	1.015	1.014	1.013					
<b>84/81</b>	<b>1.005</b>	<b>1.005</b>	<b>1.007</b>	<b>1.006</b>	<b>1.007</b>	<b>1.009</b>	<b>1.013</b>	<b>1.013</b>	<b>1.015</b>	<b>1.013</b>	<b>1.012</b>	<b>1.014</b>					
87/84	1.005	1.007	1.006	1.005	1.007	1.010	1.009	1.015	1.014	1.013	1.011						
90/87	1.005	1.004	1.005	1.005	1.006	1.010	1.010	1.012	1.018	1.013	1.012						
93/90	1.004	1.005	1.004	1.005	1.006	1.008	1.010	1.012	1.011	1.011	1.010						
<b>96/93</b>	<b>1.003</b>	<b>1.004</b>	<b>1.005</b>	<b>1.005</b>	<b>1.006</b>	<b>1.007</b>	<b>1.011</b>	<b>1.011</b>	<b>1.010</b>	<b>1.010</b>	<b>1.011</b>						

Source: WCIRB accident year experience calls.



**Average Growth Rate in Quarterly Paid Medical Loss Development Factors**

Age in Months	Evaluation Years															Annualized Growth in Development Through 2003	Actual Annual Change from 2003
	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006		
15/12	1.472	1.425	1.366	1.396	1.432	1.421	1.434	1.453	1.490	1.514	1.547	1.554	1.510	1.434	1.421	2.7%	-9.4%
18/15	1.232	1.198	1.173	1.193	1.207	1.221	1.232	1.241	1.267	1.286	1.310	1.330	1.295	1.242	1.232	4.9%	-11.8%
21/18	1.147	1.116	1.105	1.126	1.126	1.133	1.155	1.164	1.168	1.192	1.219	1.211	1.178	1.152	1.153	5.9%	-10.6%
<b>24/21</b>	<b>1.104</b>	<b>1.081</b>	<b>1.108</b>	<b>1.088</b>	<b>1.094</b>	<b>1.109</b>	<b>1.128</b>	<b>1.132</b>	<b>1.124</b>	<b>1.149</b>	<b>1.159</b>	<b>1.154</b>	<b>1.124</b>	<b>1.115</b>	<b>1.117</b>	<b>5.6%</b>	<b>-8.6%</b>
27/24	1.084	1.077	1.063	1.066	1.074	1.074	1.085	1.086	1.096	1.108	1.121	1.128	1.123	1.093	1.089	5.4%	-12.8%
30/27	1.065	1.059	1.051	1.053	1.062	1.069	1.062	1.070	1.077	1.088	1.101	1.108	1.103	1.077	1.084	5.9%	-9.9%
33/30	1.050	1.043	1.043	1.038	1.046	1.048	1.053	1.059	1.065	1.072	1.086	1.089	1.078	1.062	1.071	7.1%	-8.7%
<b>36/33</b>	<b>1.037</b>	<b>1.035</b>	<b>1.045</b>	<b>1.036</b>	<b>1.037</b>	<b>1.042</b>	<b>1.051</b>	<b>1.048</b>	<b>1.055</b>	<b>1.066</b>	<b>1.069</b>	<b>1.076</b>	<b>1.061</b>	<b>1.055</b>	<b>1.062</b>	<b>7.2%</b>	<b>-6.9%</b>
39/36	1.036	1.036	1.029	1.031	1.029	1.032	1.038	1.039	1.046	1.051	1.059	1.060	1.061	1.049	1.044	6.1%	-10.9%
42/39	1.029	1.027	1.028	1.031	1.026	1.028	1.029	1.036	1.038	1.044	1.049	1.055	1.054	1.042	1.043	6.3%	-9.4%
45/42	1.025	1.021	1.022	1.024	1.023	1.023	1.026	1.033	1.035	1.039	1.045	1.047	1.044	1.036	1.037	7.6%	-8.8%
<b>48/45</b>	<b>1.019</b>	<b>1.018</b>	<b>1.024</b>	<b>1.020</b>	<b>1.018</b>	<b>1.020</b>	<b>1.026</b>	<b>1.027</b>	<b>1.031</b>	<b>1.035</b>	<b>1.039</b>	<b>1.044</b>	<b>1.037</b>	<b>1.032</b>	<b>1.035</b>	<b>8.2%</b>	<b>-8.0%</b>
51/48	1.018	1.017	1.015	1.018	1.019	1.017	1.019	1.022	1.027	1.027	1.030	1.035	1.037	1.034	1.031	6.9%	-4.4%
54/51	1.017	1.015	1.014	1.017	1.017	1.016	1.017	1.019	1.026	1.026	1.031	1.036	1.032	1.027	1.030	7.9%	-6.9%
57/54	1.014	1.013	1.012	1.015	1.014	1.014	1.017	1.020	1.021	1.025	1.026	1.030	1.027	1.024	1.024	8.3%	-7.6%
<b>60/57</b>	<b>1.011</b>	<b>1.011</b>	<b>1.013</b>	<b>1.011</b>	<b>1.011</b>	<b>1.013</b>	<b>1.014</b>	<b>1.018</b>	<b>1.020</b>	<b>1.023</b>	<b>1.026</b>	<b>1.028</b>	<b>1.026</b>	<b>1.021</b>	<b>1.023</b>	<b>9.7%</b>	<b>-7.7%</b>
63/60	1.011	1.011	1.009	1.012	1.012	1.012	1.011	1.013	1.016	1.019	1.021	1.023	1.025	1.022	1.019	7.5%	-6.8%
66/63	1.010	1.011	1.009	1.010	1.010	1.011	1.011	1.013	1.014	1.019	1.021	1.026	1.021	1.020	1.020	8.8%	-8.0%
69/66	1.009	1.008	1.008	1.008	1.009	1.010	1.011	1.011	1.016	1.016	1.019	1.021	1.022	1.019	1.018	9.6%	-5.9%
<b>72/69</b>	<b>1.007</b>	<b>1.007</b>	<b>1.008</b>	<b>1.008</b>	<b>1.010</b>	<b>1.009</b>	<b>1.010</b>	<b>1.012</b>	<b>1.013</b>	<b>1.015</b>	<b>1.017</b>	<b>1.022</b>	<b>1.018</b>	<b>1.017</b>	<b>1.017</b>	<b>10.3%</b>	<b>-8.0%</b>

Source: WCIRB accident year experience calls.

**Ratio of Quarterly Paid Medical to Indemnity Claims Inventory\*  
 At Common Fee Schedule Level\*\***

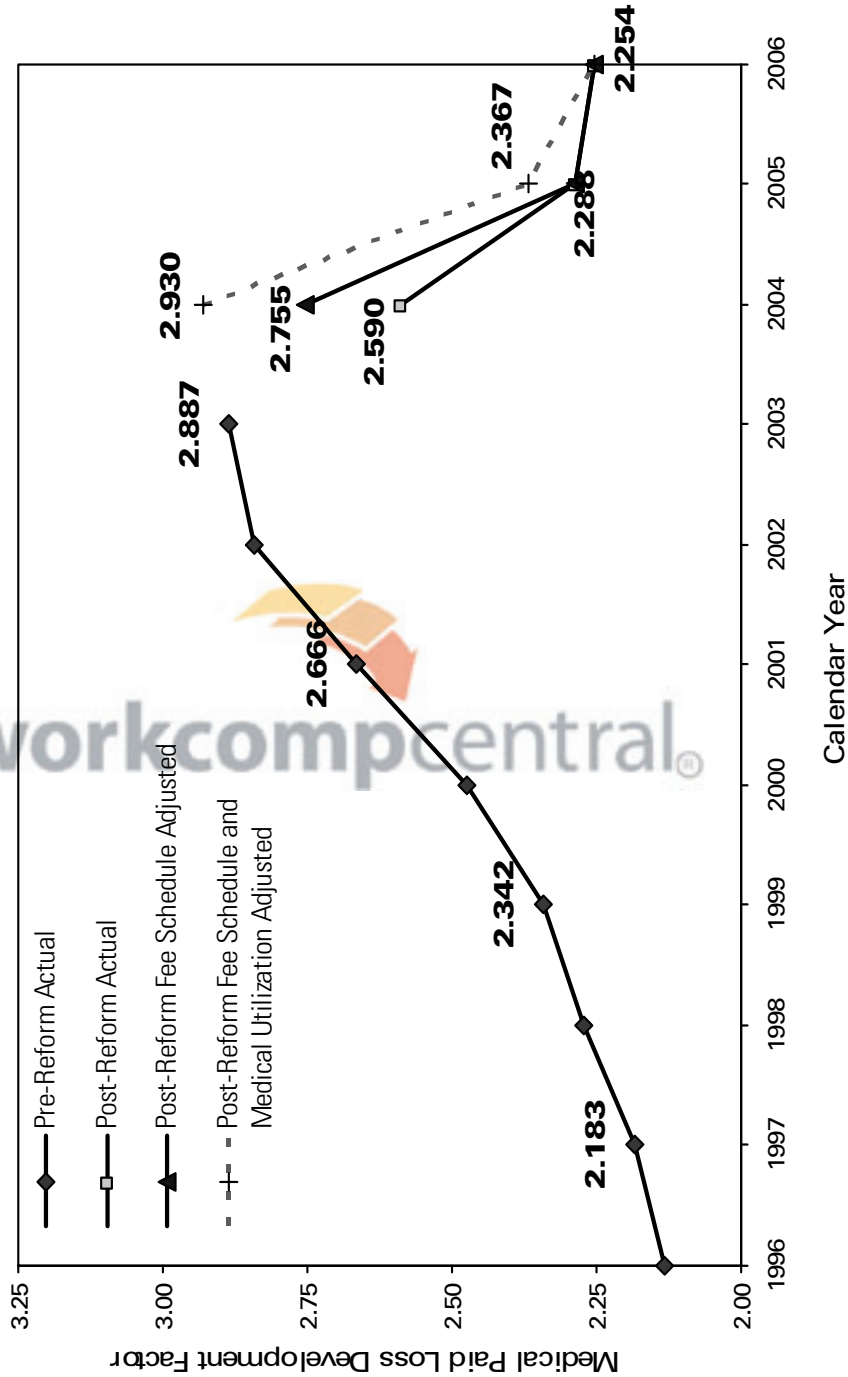
Development Period	Evaluation Years							Annualized Growth CY00-CY03	CY06 / CY03
	2000	2001	2002	2003	2004	2005	2006		
24/12	5,595	6,079	7,039	7,614	7,725	5,945	5,943	11.3%	-22%
36/24	4,585	5,148	6,765	7,164	7,408	5,615	5,189	17.5%	-28%
48/36	4,276	4,888	6,569	6,431	6,855	5,661	5,325	16.4%	-17%
60/48	4,786	4,895	5,893	6,626	6,980	6,063	6,218	12.3%	-6%
72/60	4,848	5,061	5,821	7,100	7,695	6,864	6,479	13.7%	-9%
84/72	5,106	5,603	5,726	6,842	7,928	7,348	7,046	9.4%	3%
96/84	5,763	5,422	5,483	7,136	8,482	7,789	7,819	6.7%	10%
108/96	6,027	5,645	5,057	7,260	7,697	7,435	8,523	4.6%	17%
120/108	6,798	5,355	5,283	7,441	8,196	7,437	8,247	2.6%	11%



\* The sum of indemnity claims open at the beginning of the development period and newly-reported indemnity claims during that period.  
 \*\* Historical medical losses paid prior to January 1, 2004 were reduced by the estimated 9.4% cost savings due to SB228 fee schedule changes which impact the cost of injuries occurring in 2004 and later years.

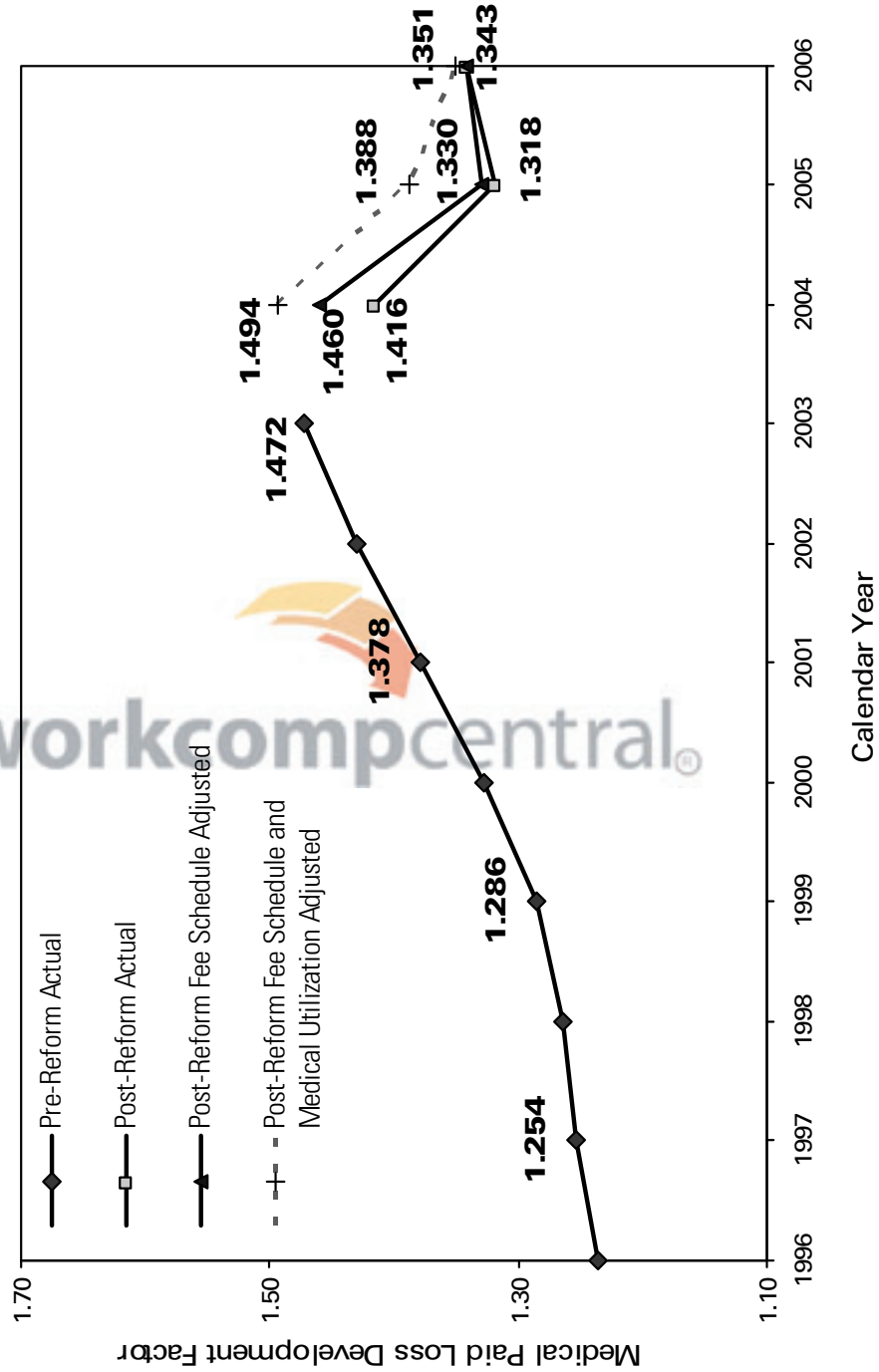
Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

# Comparison of Paid Medical 12-to-24 Month Development Factor

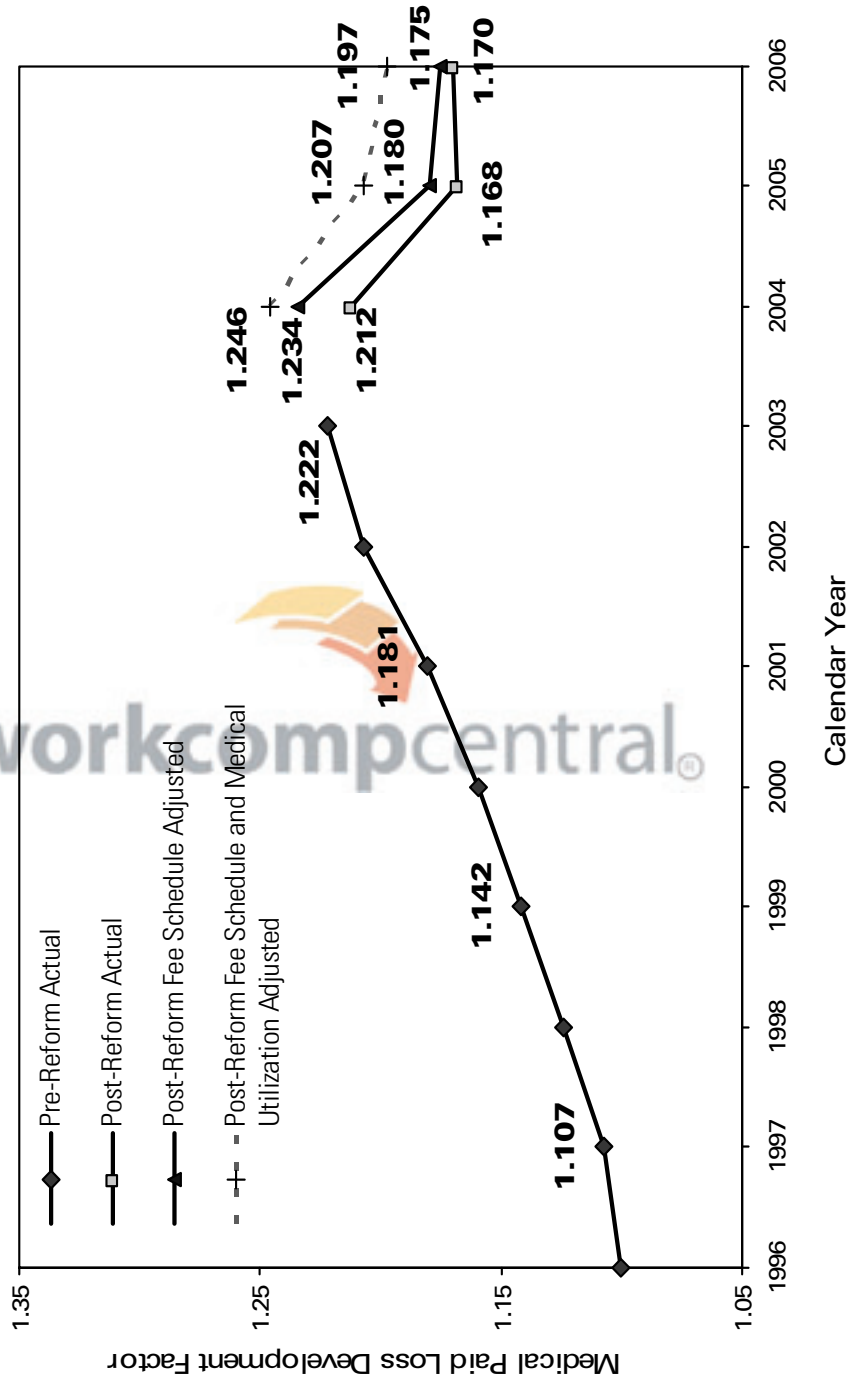


Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

## Comparison of Paid Medical 24-to-36 Month Development Factor

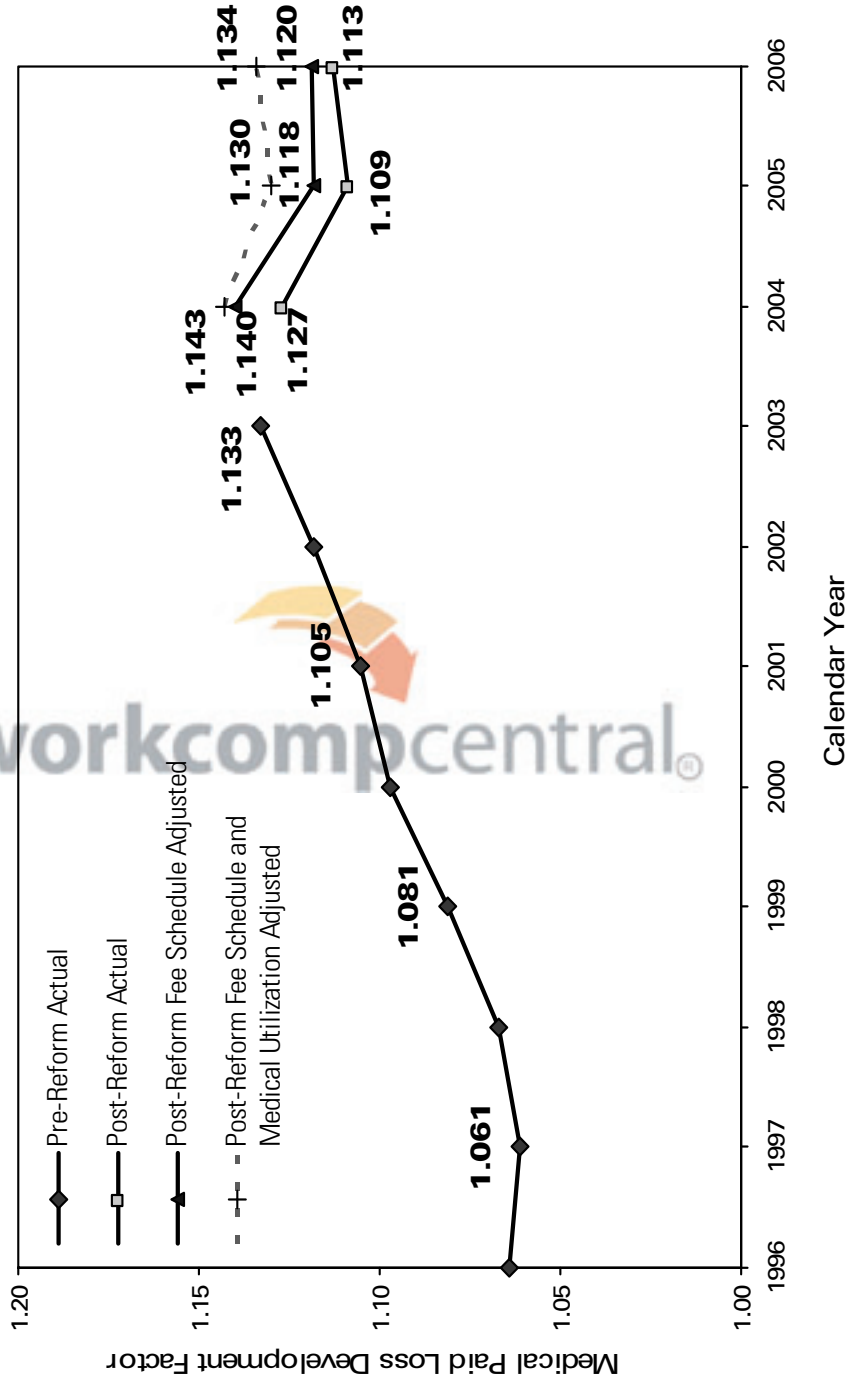


## Comparison of Paid Medical 36-to-48 Month Development Factor



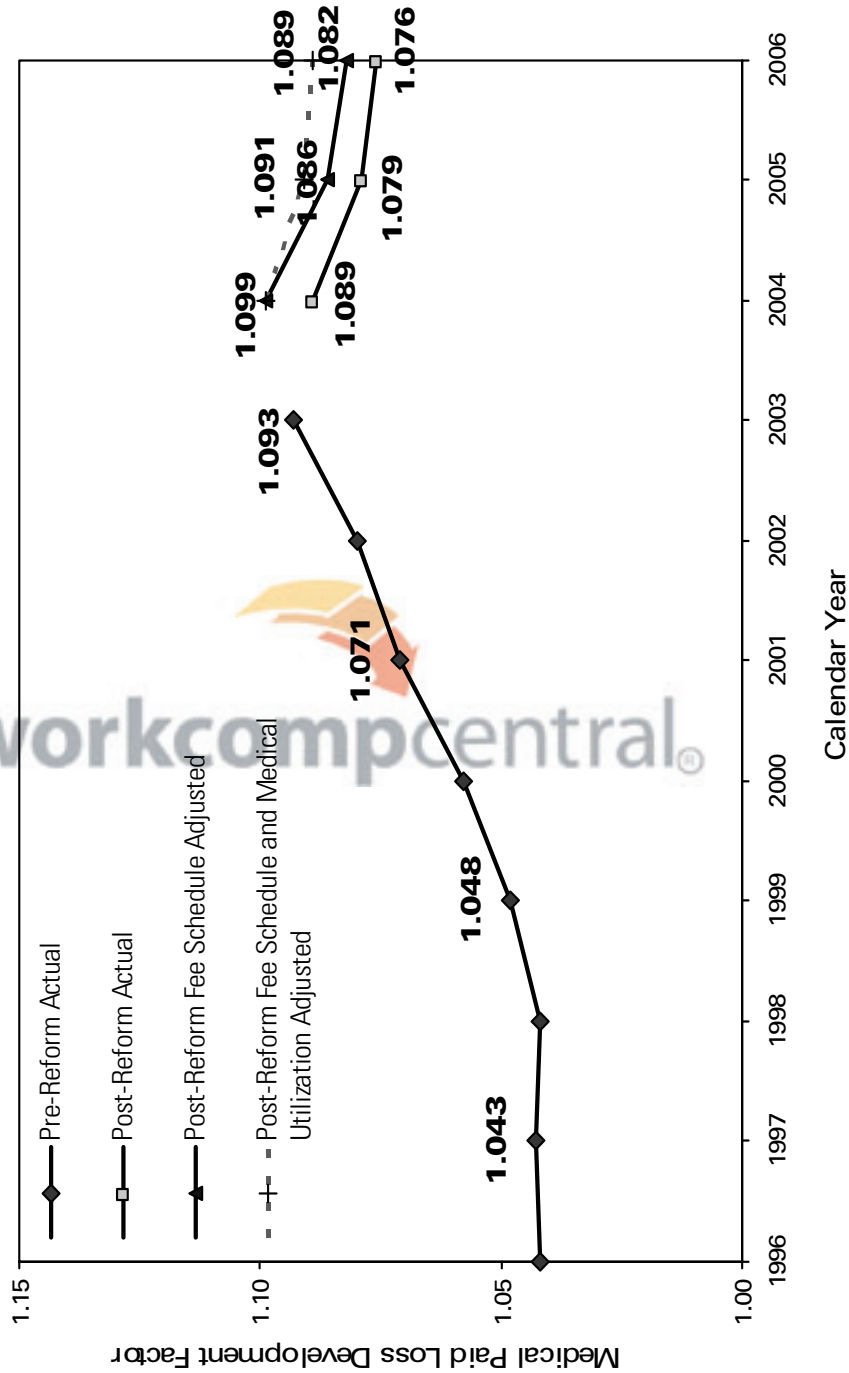
Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

## Comparison of Paid Medical 48-to-60 Month Development Factor



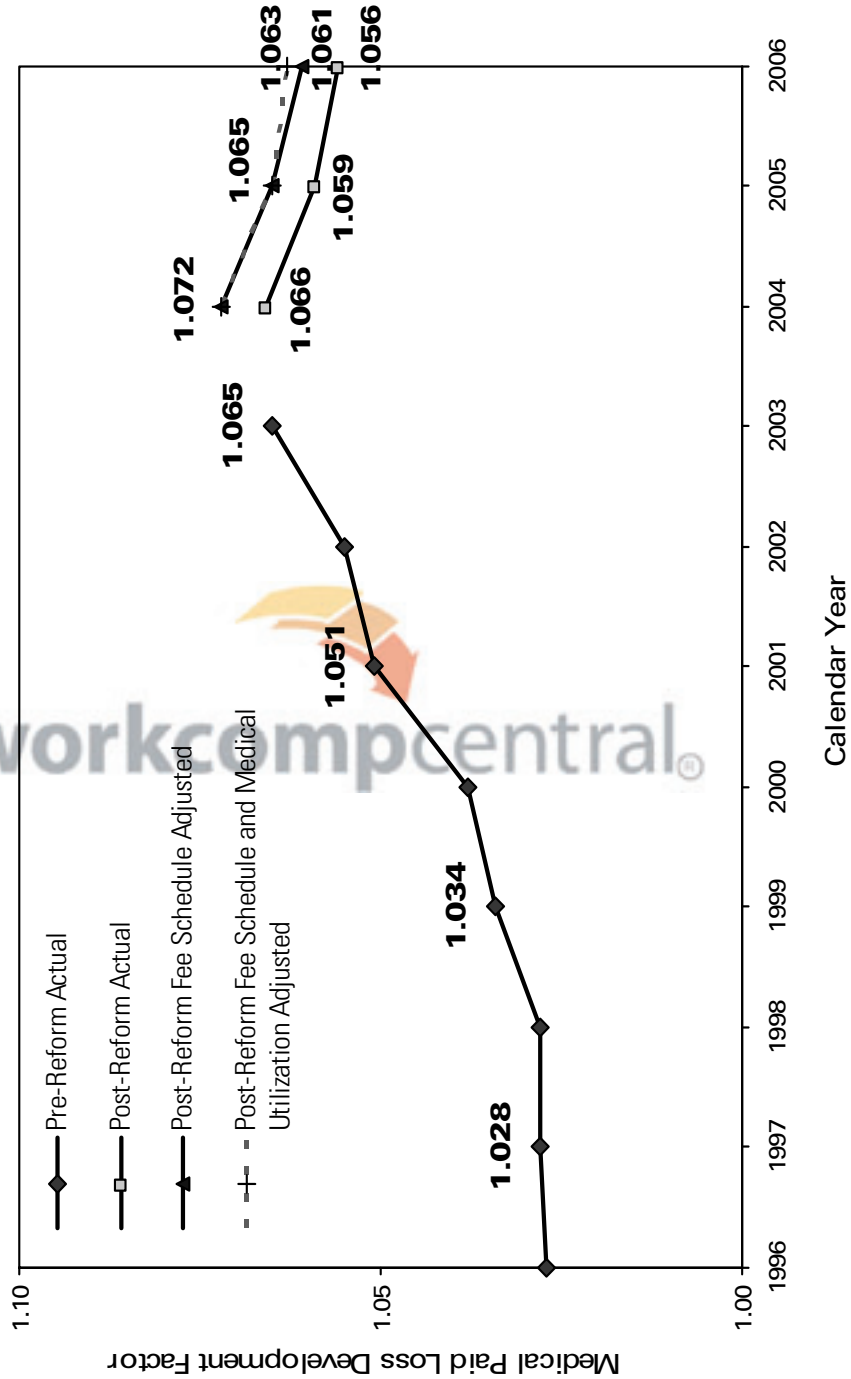
Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

## Comparison of Paid Medical 60-to-72 Month Development Factor



Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

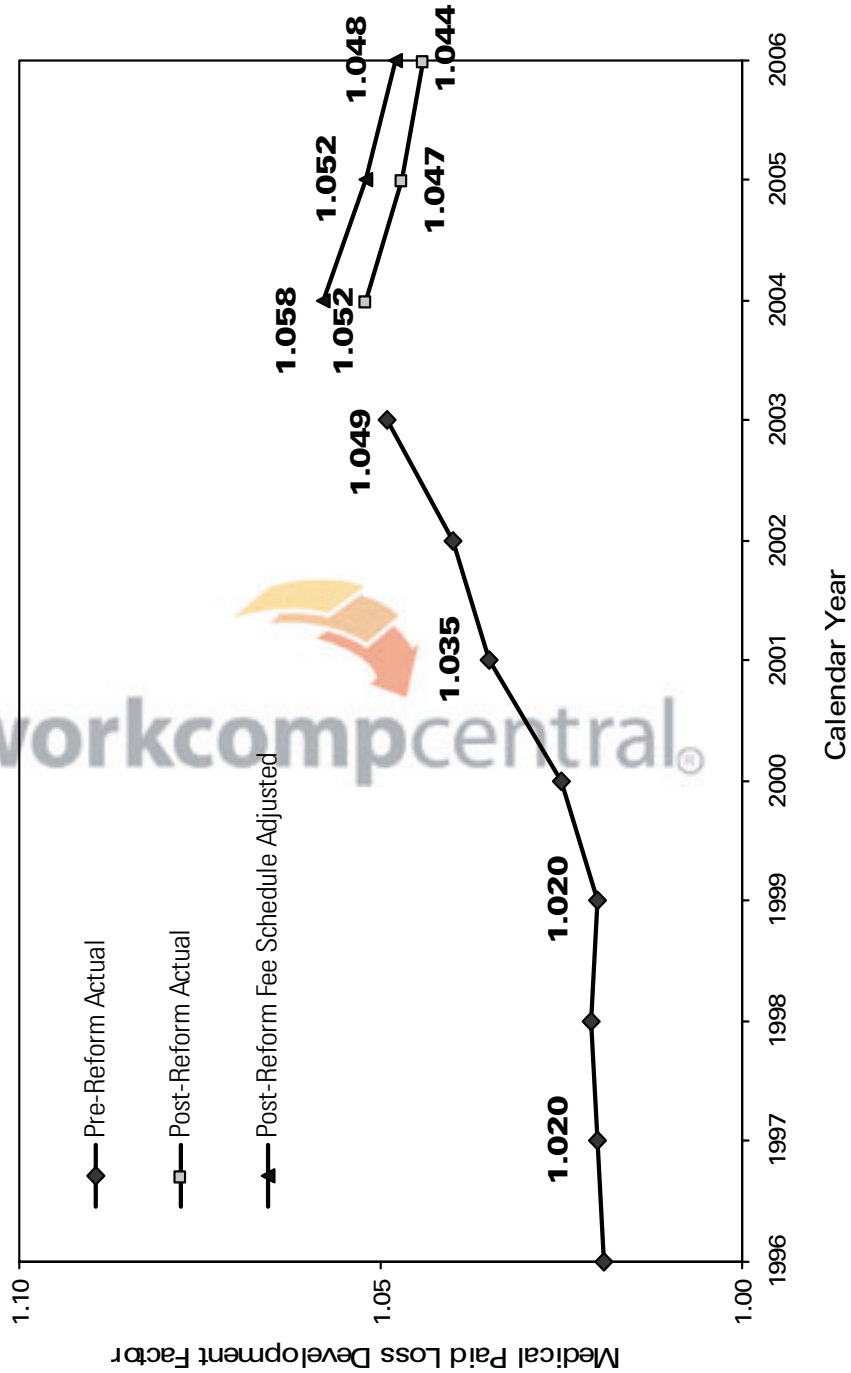
## Comparison of Paid Medical 72-to-84 Month Development Factor





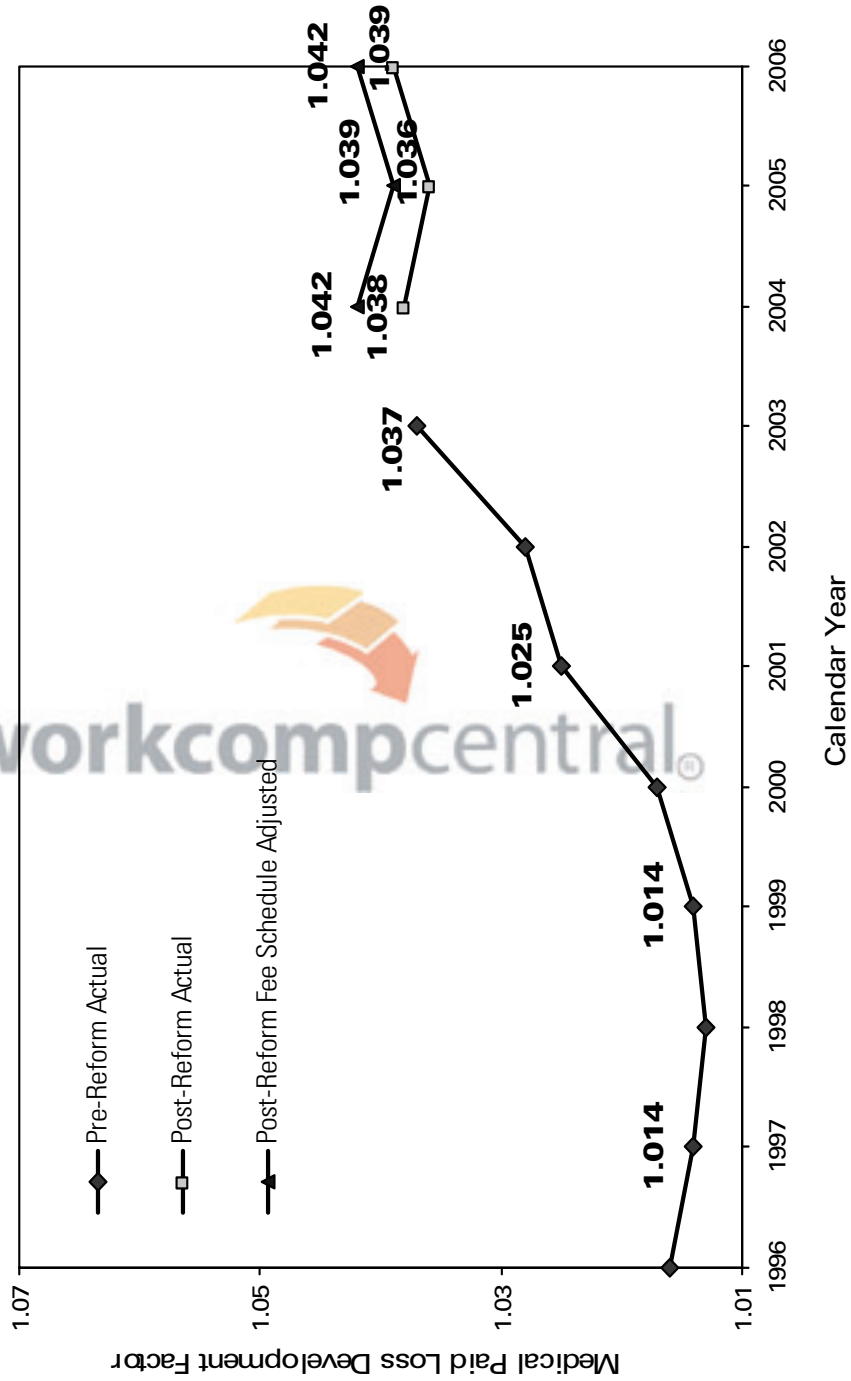
Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

## Comparison of Paid Medical 84-to-96 Month Development Factor



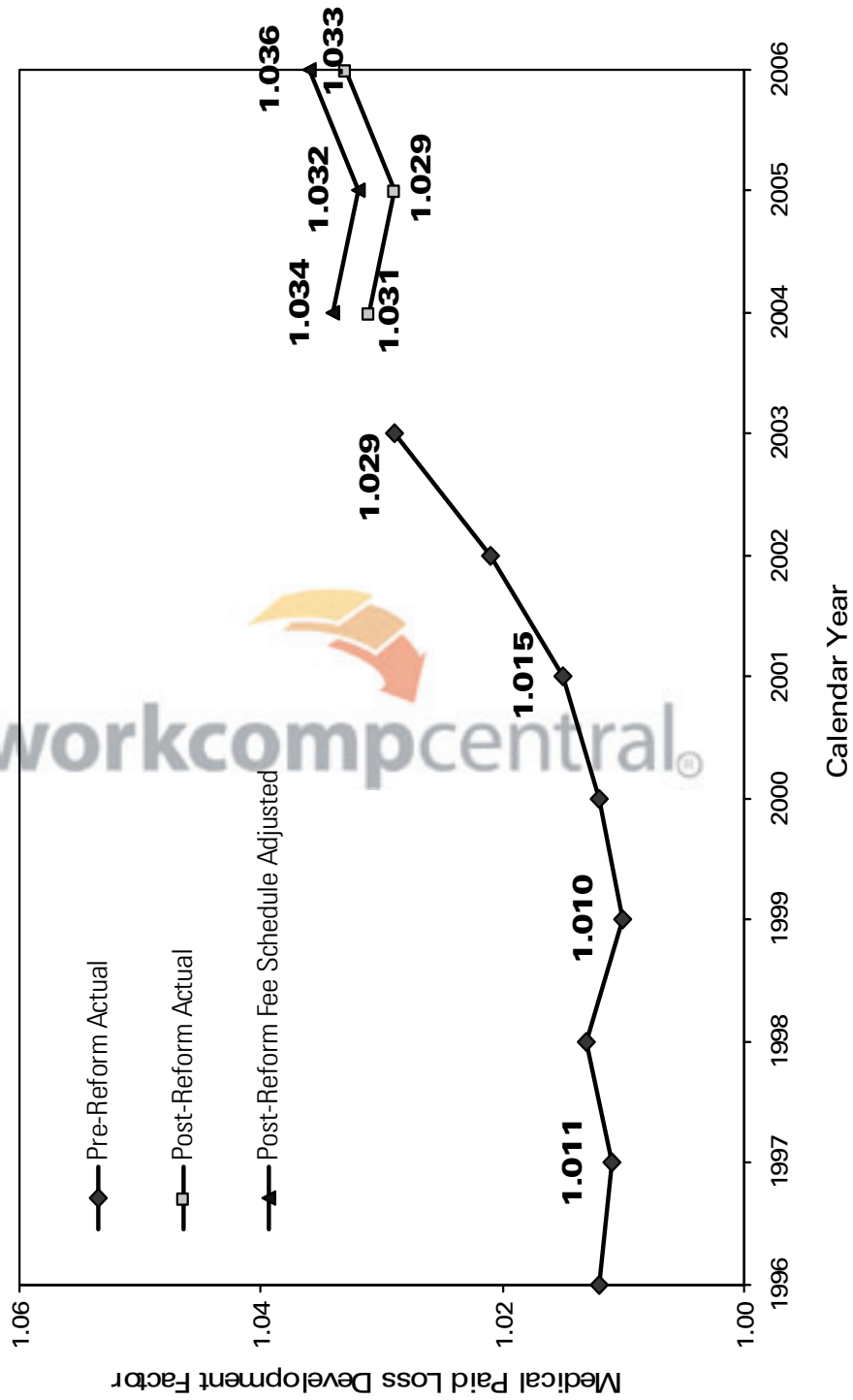
Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

## Comparison of Paid Medical 96-to-108 Month Development Factor



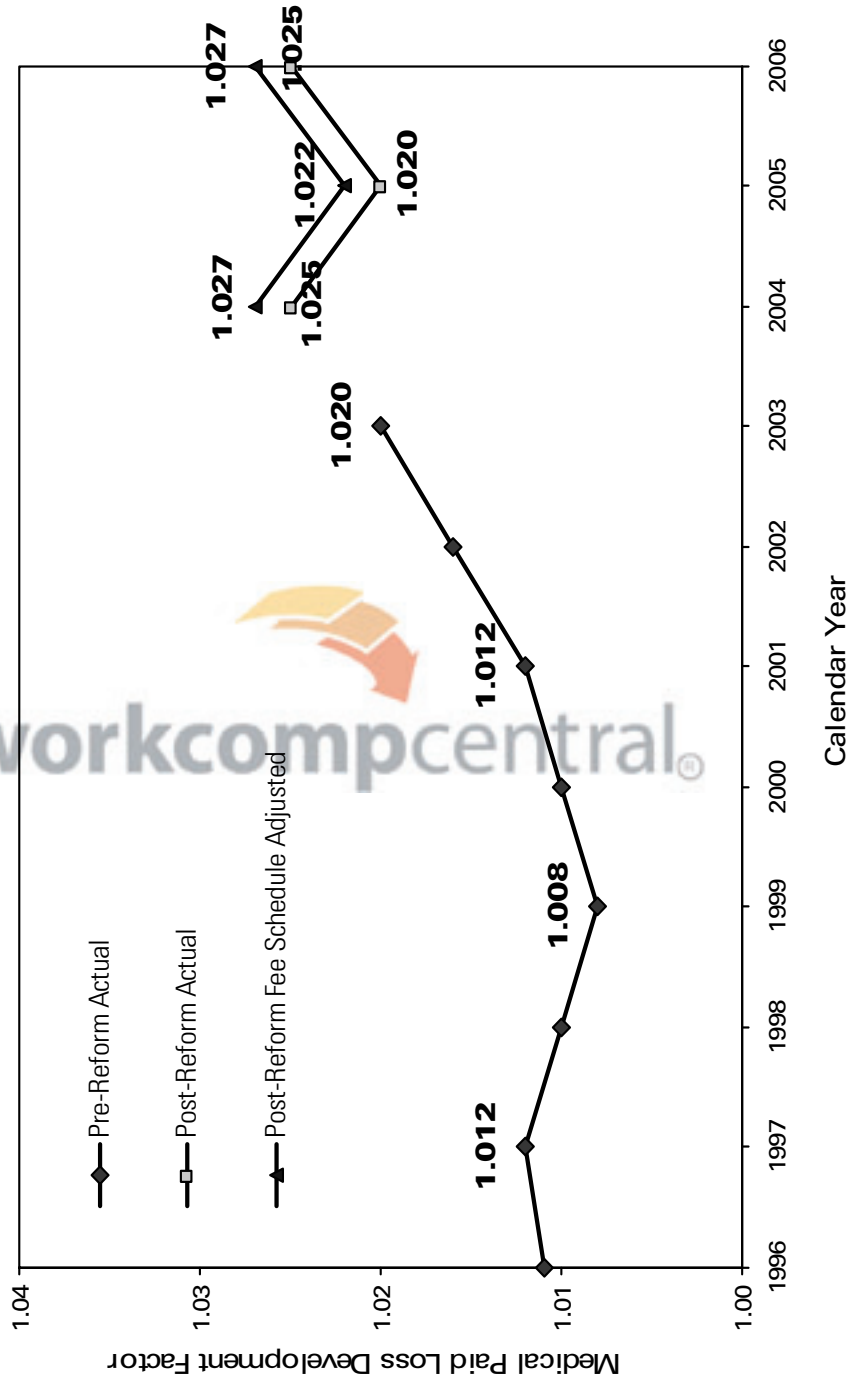
Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

## Comparison of Paid Medical 108-to-120 Month Development Factor

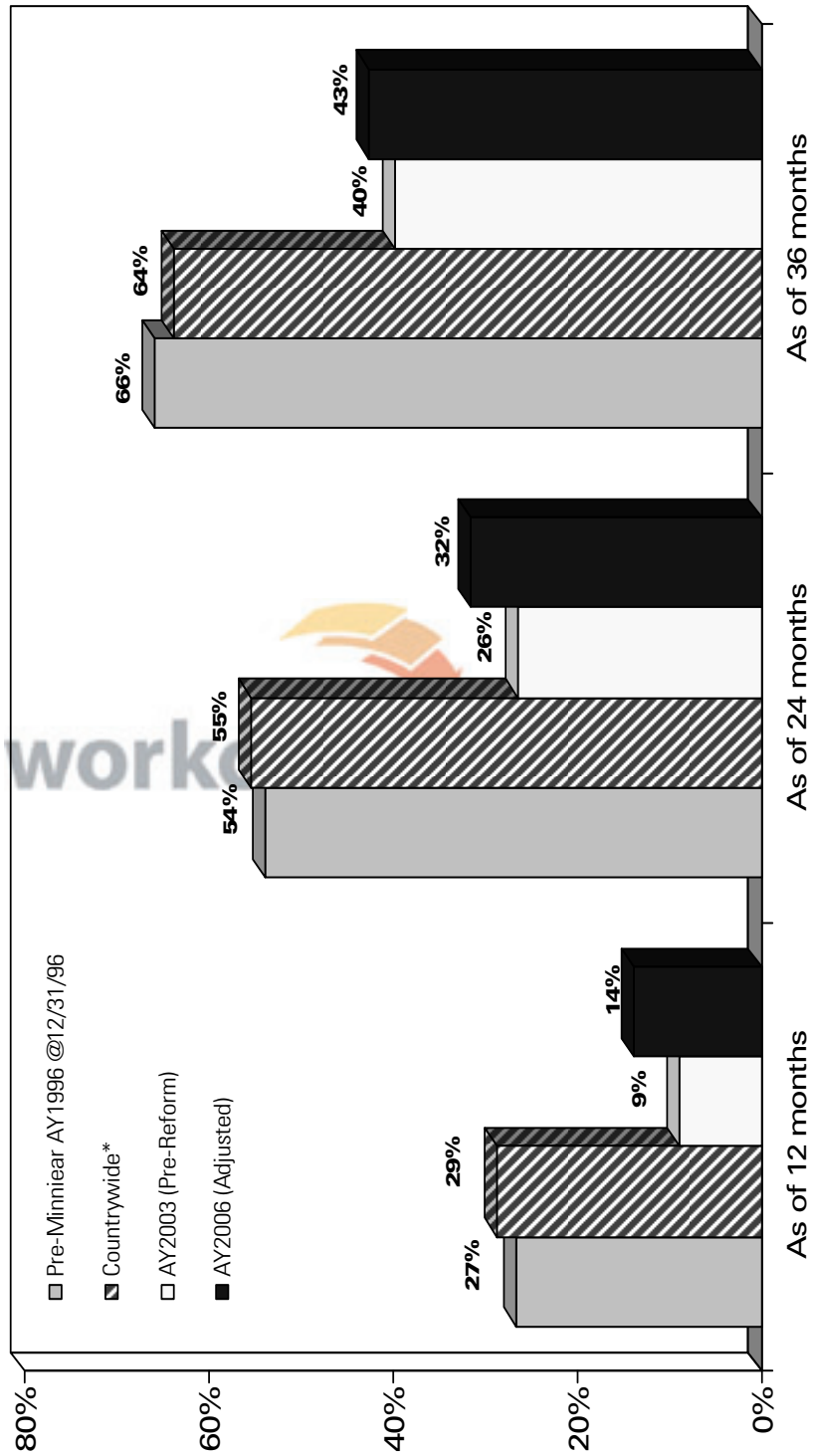


Impact of Recent Reform Legislation on Loss Development Patterns - 2007 Update

# Comparison of Paid Medical 120-to-132 Month Development Factor



## Comparison of Percent of Ultimate Medical Losses Paid



\* Based on all states except California, Massachusetts, Michigan, Minnesota, Nevada, New York, Texas and Wisconsin.



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**Memorandum**

**Date:** February 24, 2007  
**To:** Christine Baker, Executive Officer, CHSWC  
Dave Bellusci, Senior VP & Chief Actuary, WCIRB  
**CC:** Ward Brooks, WCIRB  
**From:** Frank Neuhauser  
**Re:** Analysis of ratings under the new PD schedule, through January 2007

At the request of the Commission on Health and Safety and Workers' Compensation (CHSW) and the Workers' Compensation Insurance Rating Bureau (WCIRB) I compare the average ratings under the 2005 PDRS to comparable groups of ratings under the pre-2005 PDRS. The comparison includes all ratings done under the 2005 PDRS through January, 2007. This includes 30,537 ratings under the new schedule.

**Current estimates:**

- Through January 17, 2007 there were 30,537 reports rated under the 2005 PDRS, excluding reports where no ratable impairment was found. A very small number of cases rated under the new schedule had missing data, such as incomplete impairment category numbers, and were excluded from these analyses.
- 13,832 of these ratings were "summary" ratings and are included in the primary estimate.
- 16,705 of the ratings were for "consults" where the comparison between the two schedules should be considered more carefully.

The data in this report were weighted to correct for the slightly less mature nature of claims under the new schedule. These data should reflect the ultimate average ratings.

**Average ratings**

- The average rating on Summary ratings was 11.95% compared to an average of 20.50% for a comparable group of claims under the pre-2005 PDRS. This represents a decline of 41.7% in the average rating
- The average rating for Consults was 19.72% compared to an average of 33.50 for a comparable group of cases rated under the pre-2005 PDRS, a decline of 41.1%.

<b>Average Ratings (Sept. 2006 estimate in parentheses)</b>			
	<b>2005 PDRS</b>	<b>Pre-2005 PDRS</b>	<b>Difference</b>
<b>Summary</b>	<b>11.95%</b> <b>(11.75)</b>	<b>20.50%</b> <b>(20.62)</b>	<b>-41.7%</b> <b>(-43.0)</b>
<b>Consults</b>	<b>19.72%</b> <b>(20.44)</b>	<b>33.50%</b> <b>(33.83)</b>	<b>-41.1%</b> <b>(-39.6)</b>

<b>Average PD award (Sept. 2006 estimate in parentheses)</b>			
	<b>2005 PDRS</b>	<b>Pre-2005 PDRS</b>	<b>Difference</b>
<b>Summary</b>	<b>\$10,592</b> <b>(\$10,338)</b>	<b>\$22,508%</b> <b>(\$22,639)</b>	<b>-52.9%</b> <b>(-54.3)</b>
<b>Consults</b>	<b>\$20,840</b> <b>(\$21,680)</b>	<b>\$42,514</b> <b>(\$43,168)</b>	<b>-51.0%</b> <b>(-49.8)</b>



**Apportionment**

The extent of apportionment was evaluated for Summary rated claims. (Summary ratings are submitted to a judge to determine whether apportionment is appropriate. Consults are not submitted to a judge and apportionment is generally not considered by the DEU).


- 1,318 of 13,649 summary rated cases (9.7%) included apportionment.
- The average percent of the rating apportioned to other cases or causes was 40.4%, that is, on average, 59.6% was awarded in the current case when any apportionment was applied.
- The impact was to reduce the average rating on all cases by 4.9.
- Apportionment reduced the average PD award by 5.8%.

<b>Apportionment—Summary Ratings (Sept. 2006 in parentheses)</b>		
		<b>% of all</b>
<b>Number of ratings</b>	<b>13,649</b>	
<b>Number with apportionment</b>	<b>1,318</b>	<b>9.7%</b> <b>(9.9)</b>

<b>Apportionment—Summary Ratings</b>	
<b>Average % apportioned to non-industrial</b>	<b>40.4%</b> <b>(39.4)</b>
<b>Percent impact on rating</b>	<b>-4.9%</b> <b>(-5.0)</b>
<b>Percent impact on PD award</b>	<b>-5.8%</b> <b>(-6.1)</b>

Average ratings by impairment type:

	<u>Summary Ratings</u>		Average Rating	
	N	2005 PDRS	Pre-2005 PDRS	Difference
Wrist/Hand	1,772	7.0	12.7	-44.9%
Arm/Elbow/ Shoulder	3,554	10.5	17.6	-40.4%
Lower Extremity	3,035	8.5	18.5	-54.0%
Spine	4,596	15.6	26.8	-41.7%
Psych	170	27.7	26.9	+2.9%
Other	495	21.2	21.1	- 0.5%



	<u>Consult Ratings</u>		Average Rating	
	N	2005 PDRS	Pre-2005 PDRS	Difference
Wrist/Hand	1,174	10.3	22.6	-57.7%
Arm/Elbow/ Shoulder	3,824	15.4	28.9	- 46.6%
Lower Extremity	2,146	12.2	29.9	- 59.9%
Spine	7,864	22.4	38.0	- 41.0%
Psych	579	34.9	39.7	-12.1%
Other	917	35.2	34.2	+ 2.9%



## California Workers' Compensation Institute

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### **California Workers' Compensation Medical Payment Study: Medicare Reimbursement Models for Evaluation and Management Services**

**Prepared by  
John Ireland  
Brenda Ramirez  
Alex Swedlow  
January 24, 2007**

#### **Executive Summary**

In 2007, The California Division of Workers Compensation seeks to modify the Official Medical Fee Schedule which establishes health care reimbursement levels for most medical services within the workers' compensation system including Evaluation and Management office visits. At the request of the Administrative Director, CWCI estimated system-wide changes on 10 E&M office visit codes priced under 9 distinct California regional 2006 Medicare fee schedules. The authors used a database of approximately 1 million E&M codes with 2005 dates of service and compared the current OMFS reimbursement level with the 9 California Medicare fee schedules. Each medical encounter in the sample included the location of the injured worker which was used to create a 10<sup>th</sup> option, a weighted, regional-adjusted average reimbursement level for all 10 procedures in all 9 regions. The results show the 10 Medicare options would increase system-wide reimbursement levels for the 10 E&M codes between 16.4 and 46.1% or \$56 to \$157 million over 2005 OMFS amounts. A regional adjusted Medicare fee schedule would increase fees by 23% or \$79 million.

#### **Background**

The California Official Medical Fee Schedule (OMFS) for workers' compensation governs medical provider fees for the treatment of work injuries in the state. The Physician's portion of the OMFS uses the Current Procedural Terminology (CPT) and CPT-like codes to define and classify medical procedures into categories of services for purposes of identification, billing and reimbursement. To simplify the application of these codes, they are normally grouped into broad categories:

- Evaluation and Management (office, emergency room, and hospital visits, and consultations),
- Anesthesia,
- Surgery,
- Radiology,
- Pathology and Laboratory,
- Medicine,
- Physical Medicine,
- Manipulative Treatment, and
- Special Services.

Other services, such as pharmaceuticals, durable medical equipment, supplies, orthotics, prosthetics, ambulance services, as well as inpatient and outpatient facility fees are also part of the OMFS but do not fall under the Physician's portion of the OMFS. Workers' Compensation Insurance Rating Bureau figures show that in calendar year 2005, insured employers paid \$2.9 billion for treatments billed under the physicians' portion of the schedule and another \$.9 billion for other medical. The addition of medical fees paid by self-insured employers push the total medical dollars for 2005 towards the \$5 billion mark. Of the estimated \$5 billion, WCIRB estimated that \$1.9 billion in payments were for outpatient physician services.

Revisions to the fee schedule can result from biennial reviews mandated by California workers' compensation law. The state revised the physician fee schedule in 1994, 1996, and 1999. In 2004 under SB 228 maximum reasonable physician fees that exceeded Medicare's were reduced up to 5% and subsequently updated to conform to Medicare changes. Medicare payments are adjusted for geographical differences in resource costs. There are currently 89 geographically adjusted variations to the National Medicare fee schedule across the country; nine of them for California.

The Administrative Director of the Division of Workers' Compensation has proposed changes to maximum reasonable fees associated with 10 evaluation and management (E&M) office visit codes to make them comparable with Medicare rates. Medicare reimbursement rates in California vary across nine geographic regions within the state, however, so unless the Administrative Director were to adopt nine different fee schedules to apply to these E&M office visits, a single California Medicare equivalent must be determined.

This report models system-wide reimbursement effects from modifying the Official Medical Fee Schedule for the 10 E&M office visit fees to a variety of alternative Medicare pricing scenarios.

### **Study Goal, Data & Methods**

The goal of this study was to estimate the impact on California workers' compensation medical payments in 2005 had the OMFS reimbursements for evaluation and

management (E&M) office visits been set at 2006 Medicare rates. The OMFS has over 73 CPT codes within the Evaluation and Management section. The Division of Workers Compensation was interested in modifications to 10 specific office visit codes. Table 1 displays the ten primary CPT codes associated with E&M office visits for new and established patients.

**Table 1: 10 Primary Evaluation and Management Visit Codes**

CPT Code	E&M Office Code Description
99201	Office Visit/outpt E/M new pt, PF Hx & exam, SF MDM
99202	Office Visit /outpt E/M new pt, exp PF Hx & exam, SF MDM
99203	Office Visit/outpt E/M new pt, detailed Hx & exam, low MDM
99204	Office Visit/outpt E/M new pt, compr Hx & exam, mod MDM
99205	Office Visit/outpt E/M new pt, compr Hx & exam, high MDM
99211	Office Visit/outpt E/M estab pt that may not require phys
99212	Office/outpt E/M estab pt, PF Hx & exam, SF MDM
99213	Office Visit/outpt E/M estab pt, exp PF Hx & exam, low MDM
99214	Office Visit/outpt E/M estab pt, detailed Hx/exam, mod MDM
99215	Office Visit/outpt E/M estab pt, compreh Hx/exam, high MDM

The authors compiled a sample database of medical procedure codes with 2005 dates of service. The data was sampled from the Industry Claim Information System<sup>1</sup>, a proprietary database of claim and benefit payment information. Each procedure code was mapped to a fee schedule section. This encounter data also included the injured worker's zip code information which allowed the authors to model different Medicare regional fee schedules.

The volume associated with the 10 E&M codes represent the majority of all procedure codes in the E&M section of the OMFS. Table 2 displays the 10 visit codes as a percentage of all E&M activity in the 2005 data sample.

**Table 2: Total Volume, Billed and Payment Amounts for 10 Primary E&M Codes**

CPT Code	Volume	Billed Dollars	Paid Dollars
99201	3,016	\$331,815	\$118,538
99202	13,184	\$1,793,047	\$758,613
99203	59,086	\$7,422,498	\$4,458,254
99204	42,384	\$6,366,234	\$4,593,906
99205	13,713	\$2,630,996	\$1,978,149
99211	12,007	\$653,491	\$280,508
99212	55,726	\$4,491,634	\$1,981,603
99213	372,249	\$29,986,054	\$17,607,659

<sup>1</sup> The California Workers' Compensation Institute's Industry Claims Information System (ICIS) currently encompasses transaction-level data on more than 3.5 million California workers' compensation claims contributed by large and midsize national and regional insurers and self-insured employers for claims with dates of injury from 1993 to 2005.

CPT Code	Volume	Billed Dollars	Paid Dollars
99214	299,252	\$31,500,879	\$21,606,954
99215	90,111	\$13,758,628	\$9,979,362
Sub-total	960,728	98,935,275	63,363,545
All E&M Codes	1,201,442	\$154,315,288	\$94,203,218
<b>Pcnt of Total</b>	<b>80.0%</b>	<b>64.1%</b>	<b>67.3%</b>

The 10 codes represented 80% of all E&M services rendered in California workers' compensation and 2 out of 3 dollars paid for all codes in the E&M section.

In order to model the potential effect of the Medicare Fee Schedule on the entire California Workers Compensation System, the authors compiled additional system-wide medical payment data, summarized in Table 3.

**Table 3. Estimate of Total Payments for Evaluation and Management Services**

Total Physician Medical Payout (\$000s) – Insured 2005	\$1,900,000
Total Medical Payout (\$000s) - Industry 2005	\$2,375,000
Percent of Evaluation & Management Payments	21.4%
Estimated E&M Payout (2005)	\$ 508,250
Office Visit Code Revenue % of E&M Revenue	67.3%
<b>Estimated Office Visit Payment (\$000s) Industry 2005</b>	<b>\$342,052</b>

Total physician payments for the insured population of injured workers in calendar year 2005 were estimated using the WCIRB report of Losses and Expenses. The physician payment amount of \$1.9 billion was then adjusted by a factor of 1.25 to account for self-insured employer data not reported to the WCIRB resulting in a total estimated medical payout for physician services in 2005 of \$2.4 billion.<sup>2</sup>

Next, the proportion of the \$2.4 billion in physician payments related to evaluation and management services was estimated using the 2005 data sample from the ICIS database. Table 4 displays summary information about the study sample which encompasses 6 million outpatient services across 12 sections of the OMFS.

**Table 4. Sample Distribution of 2005 Date of Service Procedures, Billed and Paid Amounts by Fee Schedule Section**

Fee Schedule Section	Volume	Billed Dollars	Paid Dollars
Acupuncture	38,356	\$ 3,088,856	\$ 2,378,238
Anesthesiology	70,132	\$ 25,295,207	\$ 10,906,365
Chiropractic Manipulation	224,622	\$ 10,142,434	\$ 7,956,621

<sup>2</sup> Benefits, Coverage and Costs, 2004, National Academy of Social Insurance, Ishita Sengupta, Virginia Reno and John F Burton, Jr., July, 2006



Fee Schedule Section	Volume	Billed Dollars	Paid Dollars
Evaluation. & Mgmt.	1,201,442	\$ 154,315,288	\$ 94,203,218
Medical Treatment	223,538	\$ 38,402,351	\$ 25,755,776
Medical/Legal	89,742	\$ 67,743,044	\$ 64,521,419
Osteopathic Manipulation	1,859	\$ 135,863	\$ 81,221
Path/Laboratory	164,566	\$ 9,893,618	\$ 2,703,637
Physical Medicine	2,547,809	\$ 107,837,668	\$ 65,350,158
Radiology	382,243	\$ 107,487,482	\$ 43,879,429
Special Services	785,822	\$ 47,258,174	\$ 29,625,936
Surgery	238,765	\$ 253,325,525	\$ 92,483,520
<b>Grand Total</b>	<b>5,968,896</b>	<b>\$ 824,925,510</b>	<b>\$ 439,845,538</b>
<b>Percent of E&amp;M</b>	<b>20.1%</b>	<b>18.7%</b>	<b>21.4%</b>

This sample contains \$825 million in billed charges and \$440 million in payments rendered to injured workers in California in calendar year 2005. Each medical procedure was mapped to a specific section of the fee schedule through a crosswalk of CPT codes. The 1.2 million E&M codes represent 20.1% of all codes in the distribution. E&M billings totaled \$154 million, or 18.7% of all dollars billed for physician services with a total of \$94 million or 21.4% of all dollars paid.

The total amount that was paid for all the E&M services in the study sample was \$94.2 million. As displayed in Table 3, the total paid for the ten office visit E&M services were similarly calculated to be \$63.4 million, or 67.3% of all the E&M payments.

In the final step, the total payments to physicians for E&M services were assessed by multiplying the 21.4% of all charges accounted for by E&M services by the estimated \$2.4 billion paid to physicians to treat injured workers. That calculation shows that in 2005, California workers' compensation payments to physicians for E&M services totaled an estimated \$508 million. The Institute estimated that total payments for the 10 office visit E&M services in 2005 (the baseline) amounted to \$342 million, again using the 67.3 percent adjustment factor (Table 3) of the estimated total for all E&M services that year.

After deriving the system-wide baseline E&M office visit OMFS payments for 2005, a series of models were developed to estimate the change to the baseline payments if the workers' compensation office visits were reimbursed at Medicare levels<sup>3</sup>. The Institute derived the alternative scenarios from the nine different Medicare fee schedules specific to the nine Medicare regions in California, and then compared the estimated payments under each schedule. In addition, a tenth scenario was added using a weighted average of fees based on the geographic mix of services extracted from the ICIS database.

The Medicare geographic regions, based on specific counties in California, are:

<sup>3</sup> Information on Medicare regions and fee schedule amounts were accessed from [http://www.medicarenhic.com/cal\\_prov/fee\\_sched.shtml#2006](http://www.medicarenhic.com/cal_prov/fee_sched.shtml#2006)

1. Marin/Napa/Solano
2. San Francisco
3. San Mateo
4. Alameda/Contra Costa
5. Santa Clara
6. Ventura
7. Los Angeles
8. Orange
9. Rest of CA
10. Weighted Regional Adjusted Average

Using ICIS data, the authors compiled the number of office visits for services with dates of service during 2005 and assigned each office visit to a geographic region based on the zip code of the injured workers' home address and calculated the distribution of office visits, broken out by specific CPT code, across the nine geographic regions of the state (Table 5).

**Table 5: Percent of Office Visits by Type by Medicare Region**

CPT Code	Marin/Napa/Solano	San Francisco	San Mateo	Alameda/Contra Costa	Santa Clara	Ventura	LA	Orange	Rest of CA	TOTAL
99201	2.8%	2.3%	2.4%	6.1%	5.2%	2.6%	18.4%	4.9%	55.2%	100.0%
99202	4.6%	2.1%	1.8%	8.0%	4.6%	1.3%	14.0%	4.1%	59.6%	100.0%
99203	2.2%	1.1%	1.8%	5.7%	4.6%	3.0%	21.2%	5.0%	55.6%	100.0%
99204	1.5%	2.1%	1.4%	5.9%	2.5%	3.2%	21.8%	6.0%	55.6%	100.0%
99205	0.8%	1.6%	1.0%	4.4%	3.1%	3.8%	37.9%	7.9%	39.5%	100.0%
99211	1.4%	1.5%	1.4%	4.3%	4.4%	1.5%	22.7%	6.8%	56.0%	100.0%
99212	2.5%	1.6%	2.6%	5.9%	3.6%	1.3%	26.8%	4.2%	51.4%	100.0%
99213	2.8%	1.3%	1.8%	7.3%	4.2%	2.4%	18.0%	4.2%	57.9%	100.0%
99214	1.6%	1.8%	1.4%	8.2%	3.8%	3.4%	23.7%	7.1%	48.9%	100.0%
99215	0.8%	0.9%	0.7%	5.5%	3.8%	2.0%	36.7%	9.5%	40.1%	100.0%

The authors were surprised that more than half (52.3%) of all office visits were provided in the "Rest of California" region. To gain a better understanding of the geographic composition of this region, they analyzed the counties within the "Rest of California" region and compiled the following distribution of the office visits within the "Rest of California" category (Table 6).

**Table 6: Counties included in the "Rest of California" Region**

County	Office Visit Volume	Percent Of Total Office Visits
San Diego	95,900	7.17%
San Bernardino	66,222	4.95%
Riverside	61,738	4.62%



County	Office Visit Volume	Percent Of Total Office Visits
Sacramento	51,308	3.84%
Fresno	47,387	3.54%
Kern	33,253	2.49%
San Joaquin	31,419	2.35%
Stanislaus	30,390	2.27%
Sonoma	26,772	2.00%
Tulare	25,752	1.93%
Blanks	22,812	1.71%
Monterey	21,764	1.63%
Santa Barbara	19,641	1.47%
Merced	15,025	1.12%
Santa Cruz	14,135	1.06%
Shasta	11,479	0.86%
Butte	9,737	0.73%
San Luis Obispo	9,736	0.73%
Placer	9,014	0.67%
Imperial	8,757	0.66%
Humboldt	8,653	0.65%
Madera	8,194	0.61%
Yolo	7,681	0.57%
Mendocino	7,392	0.55%
Kings	7,267	0.54%
All Other Counties	47,362	3.54%
Total "Rest of CA"	698,790	52.27%

Several counties with significant population bases are included in the "Rest of California" Medicare region including San Diego (third largest), San Bernardino (fourth largest), Riverside (fifth largest) and Sacramento (eighth largest). (Source: California State Association of Counties). (There were also 22,812 office visits with no county locator in the ICIS database that were included in the tally for this region.)

The analysts applied the CPT code distribution from the 9 geographic regions (Exhibit One) to the corresponding Medicare fee schedules to develop a prorated Medicare fee schedule that would adjust for the mix of E&M services within each region. The prorated fee schedule became the basis for the tenth comparison scenario, the weighted average cost.

**Results**

The Institute compared the 10 OMFS4 for office visit CPT codes to the corresponding Medicare fees for each of the 9 California regions as well as the regional adjusted weighted average (Table 7). Table 8 displays the percentage difference between the OMFS and each of the Medicare schedules, including the weighted average of all regions (“Weighted Average”).

**Table 7. Comparison of OMFS and Medicare Reimbursement Levels for 10 E&M Codes**

CPT Code	OMFS	Marin	San Fran	San Mateo	Alameda	Santa Clara	Ventura	LA	Orange	Rest of CA	Weighted Average
99201	\$39.10	\$43.27	\$47.47	\$47.55	\$44.17	\$47.75	\$40.27	\$40.30	\$41.67	\$37.56	\$39.90
99202	\$57.80	\$75.87	\$82.78	\$82.98	\$77.43	\$83.37	\$70.99	\$71.13	\$73.30	\$66.50	\$70.19
99203	\$76.50	\$112.16	\$122.13	\$122.45	\$114.46	\$123.01	\$105.23	\$105.62	\$108.69	\$98.73	\$103.86
99204	\$109.65	\$157.58	\$171.02	\$171.55	\$160.78	\$172.38	\$148.32	\$148.96	\$152.97	\$139.52	\$146.12
99205	\$145.35	\$198.82	\$215.05	\$215.82	\$202.84	\$216.90	\$187.78	\$188.74	\$193.43	\$177.09	\$186.73
99211	\$23.80	\$26.72	\$29.88	\$29.86	\$27.30	\$29.97	\$24.33	\$24.15	\$25.29	\$22.33	\$23.81
99212	\$35.70	\$45.81	\$50.39	\$50.46	\$46.77	\$50.67	\$42.51	\$42.49	\$44.01	\$39.56	\$42.02
99213	\$47.60	\$62.06	\$68.00	\$68.14	\$63.35	\$68.46	\$57.78	\$57.75	\$59.66	\$53.94	\$56.93
99214	\$72.25	\$96.69	\$105.65	\$105.90	\$98.69	\$106.40	\$90.29	\$90.33	\$93.16	\$84.47	\$89.57
99215	\$110.50	\$138.43	\$150.27	\$150.75	\$141.26	\$151.52	\$130.19	\$130.55	\$134.08	\$122.45	\$129.41
<b>Weighted Average</b>	<b>\$66.07</b>	<b>\$87.81</b>	<b>\$95.85</b>	<b>\$96.08</b>	<b>\$89.62</b>	<b>\$96.54</b>	<b>\$82.11</b>	<b>\$82.21</b>	<b>\$84.72</b>	<b>\$76.88</b>	<b>\$81.24</b>

**Table 8. : Comparison of California’s Official Medical Fee Schedule for Office Visits to Regional Medicare Rates**

CPT Code	Marin	San Francisco	San Mateo	Alameda	Santa Clara	Ventura	Los Angeles	Orange	Rest of CA	Weighted Average
99201	10.7%	21.4%	21.6%	13.0%	22.1%	3.0%	3.1%	6.6%	-3.9%	2.1%
99202	31.3%	43.2%	43.6%	34.0%	44.2%	22.8%	23.1%	26.8%	15.1%	21.4%
99203	46.6%	59.6%	60.1%	49.6%	60.8%	37.6%	38.1%	42.1%	29.1%	35.8%
99204	43.7%	56.0%	56.5%	46.6%	57.2%	35.3%	35.9%	39.5%	27.2%	33.3%
99205	36.8%	48.0%	48.5%	39.6%	49.2%	29.2%	29.9%	33.1%	21.8%	28.5%
99211	12.3%	25.5%	25.5%	14.7%	25.9%	2.2%	1.5%	6.3%	-6.2%	0.0%
99212	28.3%	41.1%	41.3%	31.0%	41.9%	19.1%	19.0%	23.3%	10.8%	17.7%
99213	30.4%	42.9%	43.2%	33.1%	43.8%	21.4%	21.3%	25.3%	13.3%	19.6%
99214	33.8%	46.2%	46.6%	36.6%	47.3%	25.0%	25.0%	28.9%	16.9%	24.0%
99215	25.3%	36.0%	36.4%	27.8%	37.1%	17.8%	18.1%	21.3%	10.8%	17.1%
<b>Weighted Average</b>	<b>32.9%</b>	<b>45.1%</b>	<b>45.4%</b>	<b>35.7%</b>	<b>46.1%</b>	<b>24.3%</b>	<b>24.4%</b>	<b>28.2%</b>	<b>16.4%</b>	<b>23.0%</b>

<sup>4</sup> DWC OMFS reimbursement amounts were accessed at [http://www.dir.ca.gov/dwc/dwcproregs/OMFS\\_Regulations/OMFS\\_tableAMay.xls](http://www.dir.ca.gov/dwc/dwcproregs/OMFS_Regulations/OMFS_tableAMay.xls)

With the exception of two office visit codes with the “Rest of California” region, all of the Medicare fees for all regions are substantially greater than the corresponding OMFS fees. In general, the Medicare rates in Northern California are priced at a higher rate than those of Southern California or the “Rest of California.” Also, the differences among Medicare fee schedules are substantial. The average differences from OMFS to Medicare rates range from a high of 46.1% in Santa Clara to a low of 16.4% in the “Rest of California”.

To complete the estimate of system-wide changes on medical payments for the various Medicare fee schedules, the authors compared the OMFS baseline payments to the estimated office visit payments under each of the ten alternative payment schedules. The resulting adjustment factors (represented by the “Percentage Difference” column) and estimated medical payment impacts for the ten scenarios are represented in Table 9.

**Table 9: Potential Impact of Medicare Fees on Annual Medical Payments**

Fee Schedule	Percentage Difference	Estimated Annual Office Visit Payment	Increase in Est. Annual Office Visit Payments
2005 OMFS		\$342,052,250	
Marin/Napa/Solano	32.90%	\$454,587,440	\$112,535,190
San Francisco	45.10%	\$496,317,815	\$154,265,565
San Mateo	45.40%	\$497,343,972	\$155,291,722
Alameda/ Contra Costa	35.70%	\$464,164,903	\$122,112,653
Santa Clara	46.10%	\$499,738,337	\$157,686,087
Ventura	24.30%	\$425,170,947	\$83,118,697
Los Angeles	24.40%	\$425,512,999	\$83,460,749
Anaheim	28.20%	\$438,510,985	\$96,458,735
Rest of CA	16.40%	\$398,148,819	\$56,096,569
Medicare Weighted Avg	23.00%	\$420,724,268	\$78,672,018

The results show that all ten fee schedule options result in higher E&M reimbursements levels. The estimated system-wide increases range from \$56 million more per year if the “Rest of California” fee schedule were applied uniformly across the state to \$157 million more when the Santa Clara region fee schedule were applied statewide. The regional adjusted Medicare weighted average would add an estimated \$79 million in E&M payments. Ventura County has a similar overall increase of 24.3% or \$83 million over OMFS payments.

# The California Commission on Health and Safety and Workers' Compensation



## Impact of Physician-Dispensing of Repackaged Drugs on California Workers' Compensation, Employers Cost, and Workers' Access to Quality Care

A Study for the Commission on Health and Safety  
and Workers' Compensation

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**July 2006**

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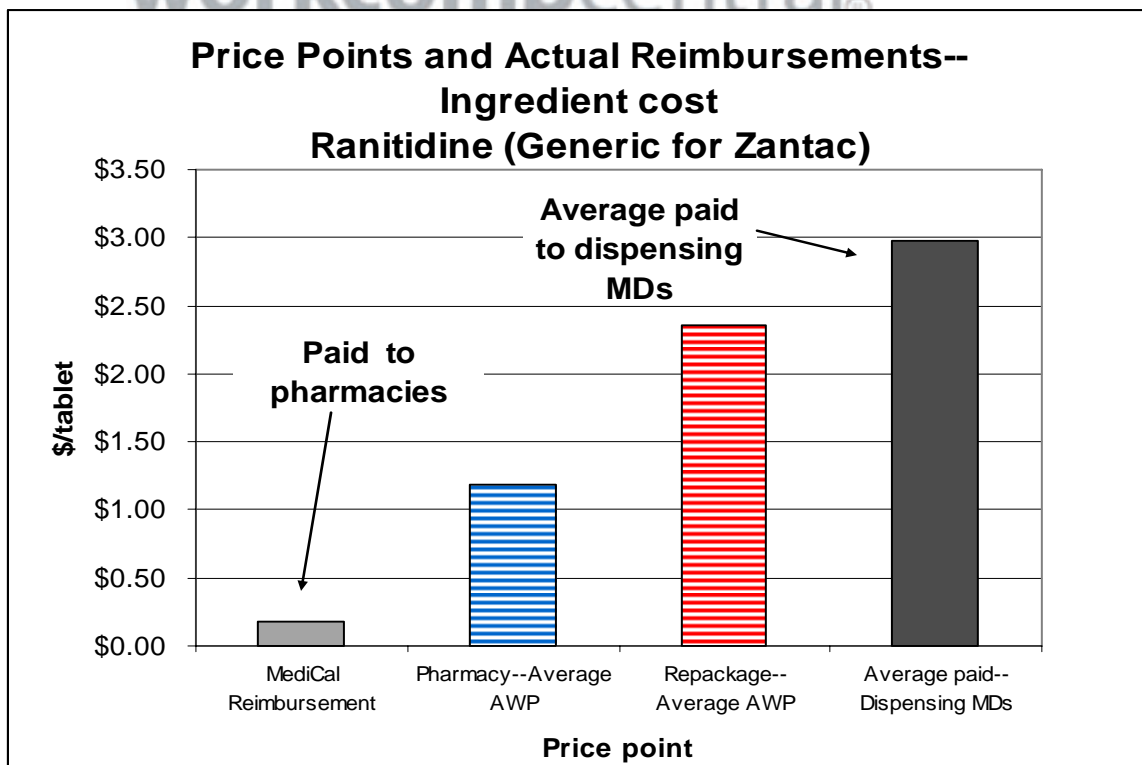
Christine Baker

**Executive Summary**

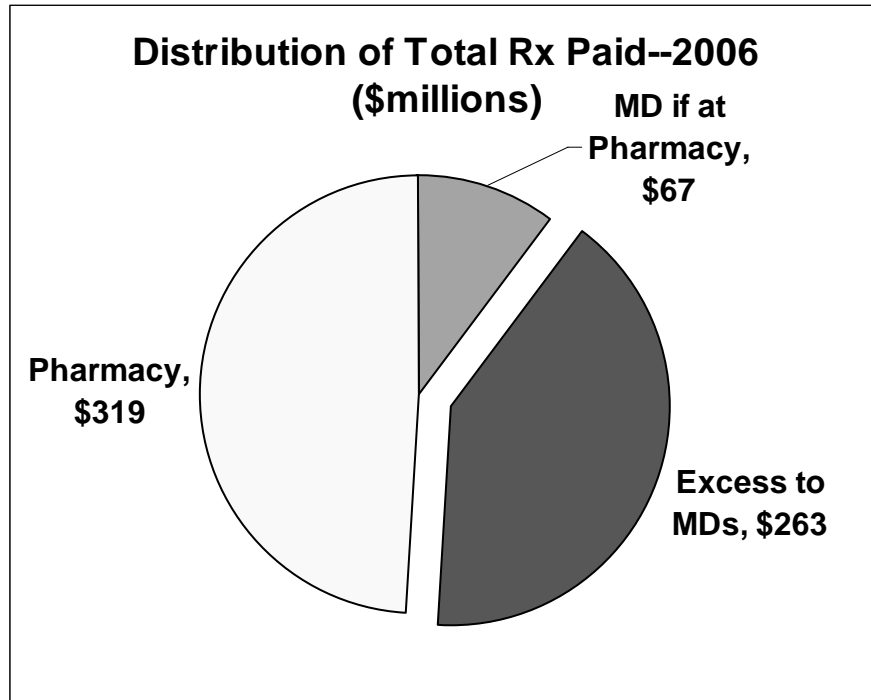
Physician-dispensed prescription drugs comprise a significant portion of all pharmaceutical prescriptions dispensed in California's workers' compensation system. Because of limits on the reach of statute and regulations adopted under Senate Bill (SB) 228, physician-dispensed pharmaceuticals are also much more expensive than the same drugs dispensed through a pharmacy. This report documents the extra costs placed on the workers' compensation system by physician-dispensed drugs. The report also reviews research on both the positive and negative impacts of physician dispensing, including the main arguments raised by proponents at Commission on Health and Safety and Workers' Compensation (CHSWC) meetings and at Division of Workers' Compensation (DWC) regulatory hearings.

Main findings on the direct cost of physician-dispensed drugs:

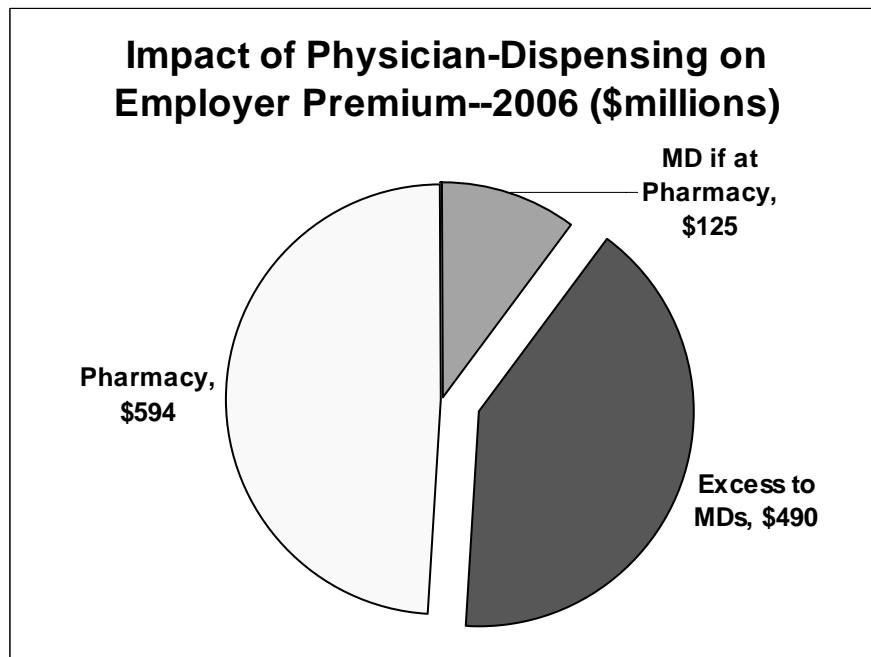
- Physician dispensing is much more common than most observers expected. 30.3% of prescriptions dispensed in the California workers' compensation system are dispensed by physicians directly from their offices.
- Approximately half (50.8%) of the total cost of pharmaceuticals in the workers' compensation system is paid to physicians for prescriptions dispensed from their offices.
- Because of the structure of the Official Medical Fee Schedule, physician-dispensed pharmaceuticals are much more costly than the same drugs dispensed by a pharmacy. On average, physician-dispensed drugs cost 490% of what is paid to pharmacies. In some cases, including the most commonly prescribed drug dispensed by physicians, the mark-up exceeds 1000%.
- The most common physician-dispensed drug, Ranitidine (generic Zantac) also has one of the highest mark-ups when physician dispensed. Physicians were reimbursed, on average for the ingredient cost at over 1700% (\$2.97/pill) what pharmacies were paid (\$0.18).



- We estimate that for calendar-year 2006, insurers and self-insured employers will pay \$649 million for prescription drugs. Of this paid amount, \$263 million will be paid to dispensing physicians in excess of what would have been paid for the same drugs if dispensed by a pharmacy.



- We estimate that insured employers will face premiums for the 2006 policy year which are \$490 million dollars higher than if all drugs were dispensed through pharmacies. This represents 2.2% of premium for the policy year.



Other findings on costs and benefits:

- The research literature on the subject of physician-dispensed drugs generally argues that physician dispensing leads to increased, possibly inappropriate, use of prescription drugs. The studies have usually been conducted outside the U.S., and the results cannot necessarily be generalized to the California workers' compensation system. However, research on physician practices with similar incentives, such as self-referral for lab tests or imaging, has consistently found that incentives inherent in self-referral lead to over-utilization.
- The data in this study were not designed to determine whether physician dispensing led to increased utilization or changes in the types of drugs prescribed. However, the study does find striking differences in the types of drugs dispensed by physicians and pharmacies. This research could be extended to allow a fuller analysis of how financial incentives may change prescribing practices.
- Research finds only weak evidence for better compliance with drug regimes when the physician dispenses directly to the patient. There is virtually no research demonstrating better health outcomes or more rapid recovery when physicians dispense.
- It is important to extend the research in this study to examine whether extensive use of physician dispensing does affect health outcomes, and if so, whether the effect is positive or negative.





## Report

**I. Introduction**

In 2000, the Commission on Health and Safety and Workers' Compensation (CHSWC) issued a report (Neuhauser, et. al., 2000) identifying potential savings in the area of prescription drugs. The Official Medical Fee Schedule (OMFS) in effect at the time of that study reimbursed dispensers of prescription drugs at a premium substantially above what was paid by MediCal (Medicaid), group-health providers, and many other workers' compensation jurisdictions.

In response, the Legislature enacted Senate Bill (SB) 228 (Alarcón) linking the pharmaceutical portion of the OMFS to the MediCal reimbursement formula. MediCal reimbursement levels are carefully monitored by the federal government, the largest single payor of medical treatment in the U.S. Consequently, Medicaid schedules determine the accepted level of reimbursement for the largest single payor.<sup>1</sup>

The MediCal schedule represented a substantial reduction from the pre-SB 228 schedule. Estimated savings were substantial. However, much of the anticipated savings have not been realized by employers because a substantial, and until now unidentified, portion of pharmaceutical costs were represented by physician-dispensed drugs which remained largely unaffected by the reforms.

The interpretation of the statute by the Division of Workers' Compensation (DWC) left considerable latitude for physician-dispensed drugs to be paid (at least as an upper limit) under the pre-SB 228 schedule. Previous research (Neuhauser, et al., 2000) had shown the pre-SB 228 schedule was overly generous. While the earlier schedule represents the maximum reasonable reimbursement rate, in practice, there has been little information on how employers/insurers were actually reimbursing dispensing physicians. In addition, there has been virtually no case law at the Workers' Compensation Appeals Board (WCAB) about what represents appropriate reimbursement for physician-dispensed prescriptions. As we will see below, some claims administrators have acted, in the absence of DWC regulatory direction, to pay "reasonable fees" that are less than the maximum reasonable fees of the pre-2004 fee schedule. Such reimbursements have been met with no apparent litigation in the lien arena.

This report examines how a major exception to linking of MediCal fees to workers' compensation fees, the dispensing of repackaged drugs directly by physicians, ~~limits~~ reduces the savings under SB 228. This loophole, in regulation by the Division of Workers' Compensation (DWC), continues to result in a significant fraction of prescriptions being paid at rates significantly higher, often several times higher, than prescriptions dispensed through pharmacies.<sup>2</sup>

Opportunities, both legislative and regulatory, have arisen to address this issue. That the issue had not been addressed more quickly resulted, in part, from a lack of information on the extent to which repackaged drugs, dispensed by doctors, are driving the pharmaceutical component of total workers' compensation medical costs. This void in information includes the types of drugs dispensed, the difference in price between drugs dispensed by physicians and those dispensed by pharmacies, and, finally, the total additional cost to employers and workers of the current pricing structure (Wynn,

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<sup>1</sup> In 2004, federal Medicaid programs paid \$38 billion of the \$188 billion paid for retail prescription drugs.

<sup>2</sup> The Division of Workers' Compensation has recently issued a notice of public hearing on proposed changes to regulations that address fees for drugs dispensed by physicians. These proposed regulations are included as Appendix 5. The authors have not yet had an opportunity to review the impact of the proposed regulations.



2005). Data on these issues are critical for crafting an appropriate legislative and/or regulatory solution that protects workers' access to care while controlling employers' costs.

A number of stakeholders, particularly physicians, occupational health clinics, and the suppliers of repackaged drugs have made claims for the superiority of physician dispensing over pharmacy dispensing. While high-quality research supporting these claims is virtually non-existent, these concerns should be weighed. We address the issues raised by proponents and opponents in Section 5 of this report. In Section 5 we also review the available literature on each argument and data from this study where relevant.

## 2.0 Description of Physician Dispensing

Pharmaceuticals prescribed and dispensed by physicians are often referred to as "repackaged" drugs because they are purchased by relabelers from manufacturers in large quantities (e.g., 1,000-10,000 tablets) relabeled, and repackaged into single prescriptions sizes (e.g., 15, 30, 60 tablets) appropriate for dispensing directly to patients.

For every combination of drug, labeler, and package size, an 11-digit National Drug Code (NDC) number is assigned. In addition, repackagers assign their own "average wholesale price" or AWP, a benchmark price frequently used by payors for reimbursement. The new AWP does not necessarily bear any resemblance to the original manufacturer's AWP.

California's professional code requires that physicians individually buy and maintain the drugs they dispense. (See Appendix 3 for the wording of the code.) Physician dispensing received a major boost in California with the introduction of computerized point-of-sale (POS) systems that are leased to physicians by repackagers and that automate the process of buying, dispensing, billing and maintaining inventory control for drugs dispensed from physician offices. POS systems allow even multi-physician groups to appropriately segregate repackaged drug inventories by physician and stay within the requirements of the codes.<sup>3</sup>

Some classes of drugs, while available from repackagers, are rarely or never dispensed by physicians because of additional controls imposed on these drugs by the Drug Enforcement Administration (DEA). DEA Class 2 drugs, those considered to have the most potential for abuse (e.g., morphine, amphetamines), are infrequently dispensed by physicians. In the data sample for this study, 99.5% of DEA Class 2 drugs were dispensed through pharmacies.

## 3.0 Description of pharmaceutical pricing

Pharmaceutical pricing is complex and poorly understood even by many regulatory agencies. Often this is because the terminology is arcane and sometimes misleading. Below is a brief explanation key drug pricing benchmarks. More detail is available in a prior CHSWC report.<sup>4</sup>

### 3.1 Average Wholesale Price (AWP)

AWP is probably the most widely quoted pricing benchmark, but the least meaningful. Every NDC number has an associated AWP. However, unlike what the name implies, the price has no relation to a

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<sup>3</sup> Physician dispensing was challenged by the retail pharmacy industry, but a California court case, 99 Cal. App. 4<sup>th</sup> 247, *Park Medical Pharmacy v. San Diego Orthopedic Associates Medical Group, Inc.*, upheld the legality of physicians dispensing from their offices without a pharmacy license. See Appendix 4.

<sup>4</sup> Additional detail is available in the prior report for CHSWC, at <http://www.dir.ca.gov/CHSWC/Pharmacy/pharmacover.html>

wholesale price, average or otherwise. It is simply a price point established by the manufacturer, wholesaler, or repackager. The AWP is often analogized to the “sticker price” on a new automobile because it is not a price that is actually paid by wholesale purchasers. However, this is a poor analogy in that the auto sticker price bears at least some relationship to the actual price. The AWP, on the other hand, is typically much higher than the actual amounts that are paid by pharmacies and other wholesale drug purchasers. Add a footnote: A 2002 study conducted by the Office of the Inspector General for the Department of Health and Human Services found a wide range of variation in the relationship between the AWP and estimated acquisition cost (EAC) that depended on the category of drug. Pharmacies purchased single source brand name drugs at an average cost of 82.8 percent of AWP compared to multiple source drugs with federal upper limits at 27.9% of AWP (Department of Health and Human Services, 2002).

Single-source, brand-priced drugs are newer pharmaceuticals, still under patent protection, and available from only one source (or occasionally more than one source under licensing arrangements). An example is Ambien, a non-narcotic, sleep aid, frequently prescribed in workers’ compensation. Other examples include the group of drugs know as Cox-II inhibitors, e.g., VIOXX, Celebrex, and Bextra. Cox-II inhibitors were prominent during the early period of the data for this study but were subsequently removed from the market because of severe side-effects (VIOXX), heavily restricted (Celebrex), or still generally available (Bextra). Single-source, brand-priced drugs are typically reimbursed by insurers (group health, Medicare/Medicaid, workers’ compensation) at a discount to the AWP. Currently, MediCal (California’s Medicaid program) discounts single-source, brand-priced drugs at 83% of AWP. In addition, MediCal negotiates significant rebates from the drug manufacturer for inclusion on the MediCal formulary. These rebates vary by drug, but overall average about 20-25% of MediCal total drug costs.<sup>5</sup>

No relationship exists between the AWP for single-source, brand-priced drugs and the AWP for multiple-source, generic drugs. Multiple-source, generic drugs represent, by far, the majority of dispensed drugs. However, because they are substantially less expensive, they represent a smaller portion of total expenditures. Typical of multiple-source, generic drugs are Ranitidine (generic for Zantac), Acetaminophen/Hydrocodone (Vicodin), and Naproxen (Naprosyn or Aleve [over-the-counter]). Each of these drugs is widely available in generic form and, as discussed below, the AWP is almost never related to the actual wholesale price or actual reimbursement rate.

### 3.2 Federal Upper Limit (FUL)

The Federal Upper Limit (FUL) is used for multiple-source, generic drugs with multiple manufacturing sources. Generally, any generic equivalent for a brand-priced drug for which the patent has expired and for which there are multiple manufacturing sources has a FUL price that applies to Federal Medicaid programs. There is sometimes a small window, maybe 6 months, between the expiration of the patent protection for a brand-priced drug and the establishment of a sufficient number of alternative manufacturing sources, during which a brand-priced drug with generic equivalents will still be priced relative to AWP. After the required number of manufacturers has entered the market, FUL pricing is definitive. FUL pricing establishes reimbursement at 150% of the lowest-cost generic equivalent available on the market, or, 150% of the AWP of the lowest-cost alternative available on the market anywhere in the U.S. The FUL often results in a Medicaid pricing limit that is a fraction of

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<sup>5</sup> Figures on total drug expenditures and total rebates were available on the California Department of Health Services (CDHS) website, but recent changes have left these data inaccessible. Challenges have been made that California underestimated potential rebates and has failed to collect all rebates to which the MediCal program was entitled.

the AWP for a particular manufacturer. How this price point relates to the average AWP for generic equivalents is discussed below.

Within MediCal, the Federal Upper Limit (FUL) is determinant of pricing for the majority of multiple-source, generic drugs.

### 3.3 Maximum Allowable Ingredient Cost (MAIC)

Maximum Allowable Ingredient Cost (MAIC) is an alternative pricing scheme, always lower than or equal to FUL. MAIC pricing is established independently by individual states for some drugs that within the state may be generally available at a price lower than the FUL. Often these lower prices are negotiated directly with manufacturers, possibly in lieu of or in addition to rebates to the state from the manufacturer.

### 3.4 California MediCal Pricing

SB 228 made the California MediCal program the basis for pricing pharmaceuticals in the state's workers' compensation system. The most common price for the California MediCal program is the FUL price, except where a separate MAIC price has been established in the absence of FUL or because the MAIC is a discount even to the FUL. MediCal also publishes a "no substitution" price which applies if the physician specifies that a specific drug be dispensed. The no-substitution price is currently AWP - 17%. For drugs without a FUL or MAIC price, typically brand-priced drugs without generic substitutes or for which fewer than three generic substitute prices are available, AWP - 17% is also the controlling price. In addition, the MediCal payment may not exceed the dispenser's (e.g., pharmacy's) customary retail price.

### 3.5 Pricing for Repackaged Drugs

MediCal excludes reimbursement for repackaged drugs. There is no price listed for these drugs or their National Drug Code (NDC) in the MediCal pharmaceutical fee schedule. In the absence of regulatory direction from the DWC, this has been interpreted as allowing reimbursement for these drugs to be controlled by the pre-SB 228 Official Medical Fee Schedule (OMFS) which set "maximum reasonable" reimbursement at 1.4\*AWP for generic drugs and 1.1\*AWP for brand-priced drugs (plus professional fee). Actual reimbursements made by some payors attempting to pay reasonable fees are less than the maximum amounts allowed pre-SB 228, but more than the amounts allowed for pharmacies.<sup>6</sup>

#### **Example of various prices---Ranitidine (generic for Zantac)**

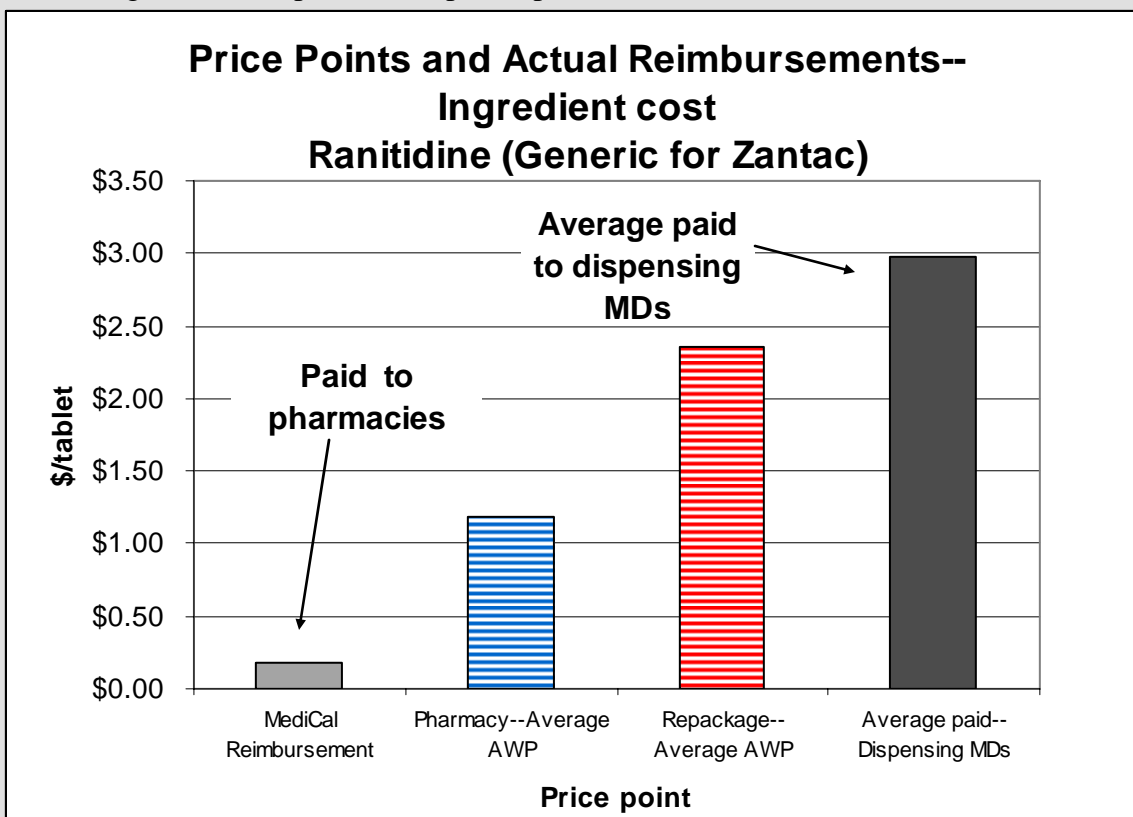
An example of how these various pricing approaches relate and how they can affect the price faced in workers' compensation by employers/insurers for any single drug may more clearly illustrate this issue. Ranitidine is the generic name for the drug Zantac that treats gastro-intestinal problems. The chart below indicates that:

- MediCal set reimbursement for Ranitidine 150 mg at \$0.18 per tablet.<sup>7</sup> This price was also the FUL price. This was what pharmacies were paid for each unit of the ingredient portion of reimbursement for a Ranitidine prescription (separate from the professional fee of \$7.25/prescription).

<sup>6</sup> While different payors appear to take different approaches to reimbursement of physician-dispensed drugs and a significant portion of reimbursements are at a reduction to the prior OMFS maximum reasonable fee, a quick survey of WCAB judges did not indicate that there was any significant lien activity or other legal challenges to reimbursement at less than the prior OMFS "maximum reasonable fee."

<sup>7</sup> MediCal price as of 7/05.

- The average AWP for Ranitidine dispensed by pharmacies was \$1.18 per tablet or about 6.5 times the actual reimbursement based on the FUL (\$0.18 per tablet).<sup>8</sup> That is, pharmacies were paid, on average, about AWP \* .15.
- Physician-dispensed Ranitidine had, on average, much higher AWP. The average AWP reported by drug repackagers was \$2.35 per tablet, or about twice the AWP for pharmacy-dispensed Ranitidine.
- Dispensing physicians were actually reimbursed, on average, \$2.97 per tablet. This was on average about 125% of average AWP and 1,750% of what pharmacies were reimbursed for the same ingredient component of a prescription.



There are several important points about this example. First, AWP for generic drugs often bear little resemblance to the actual acquisition cost of pharmacies. In the case of Ranitidine, pharmacies were willing to dispense and, presumably profit, receiving an average reimbursement of 15% of the “reported” average “wholesale” price. Second, FUL and MAIC, when available, are virtually always the controlling prices. If pharmacies had been reimbursed at AWP – 17%, the ingredient cost would have been 540% higher. Third, AWP for repackaged drugs are often (but not always) set even higher than the inflated AWP reported on pharmacy-dispensed drugs. Finally, because FUL and MAIC prices do not apply to repackaged drugs, the actual paid amounts, based on AWP, can be many times higher than if the same drugs were dispensed by a pharmacy where FUL or MAIC control.

#### 4.0 Impact of Physician Dispensing on California Workers’ Compensation Cost

Ranitidine is a particularly striking example of the impact of physician dispensing on employer cost. Estimating the impact of physician-dispensing across all drugs and total employer payments is more complex. Differences between physician-dispensing and pharmacy-dispensing costs depend upon a

<sup>8</sup> Average AWP as of 7/25/05 weighted to reflect the distribution of Ranitidine from different manufacturers as dispensed through pharmacies.

number of factors. We discuss below those factors and their impact. The following tables give examples that highlight the various issues.

Examples: Average Paid Amounts (Physician-Dispensed)						
Name	Units per script	Generic		Brand		Generic (Percent of scripts)
		Dispensing fee/unit	Ingredient paid/unit	Dispensing fee/unit	Ingredient paid/unit	
Ranitidine/Zantac 150mg	80.8	\$0.12	\$2.97	\$0.13	\$3.07	99.5%
Naproxen/Naprosyn 500mg	52.7	\$0.15	\$1.51	\$0.13	\$1.69	99.0%
Celebrex 200mg	26.1	n/a	n/a	\$0.15	\$3.93	0.0%
Ultram/Tramadol 50mg	80.3	\$0.11	\$0.93	\$0.10	\$0.90	83%
Vicodin 5/500	42.7	\$0.20	\$0.69	n/a	n/a	100%
Lidoderm 5% patch	n/a	n/a	n/a	n/a	n/a	n/a

Examples: Paid Amounts (Pharmacy-Dispensed)						
Name	Units per script	Generic		Brand		Generic (Percent of scripts)
		Dispensing fee/unit	Ingredient paid/unit	Dispensing fee/unit	Ingredient paid/unit	
Ranitidine/Zantac 150mg	68.1	\$0.11	\$0.11	\$0.17	\$2.19	99.0%
Naproxen/Naprosyn 500mg	47.0	\$0.18	\$0.15	\$0.20	\$1.57	99.0%
Celebrex 200mg	47.5	n/a	n/a	\$0.15	\$3.27	0.0%
Ultram/Tramadol 50mg	71.8	\$0.09	\$0.31	\$0.16	\$1.05	78.0%
Vicodin 5/500	46.3	\$0.16	\$0.08	\$0.22	\$0.67	97.0%
Lidoderm 5% patch		n/a	n/a	\$0.14	\$4.96	0.0%



#### 4.1 Professional fees

Payment for prescription drug dispensing is composed of two parts: (1) the per unit ingredient cost (discussed above); and (2) the professional or dispensing fee. The dispensing fee is a flat rate per prescription dispensed. The dispensing fee can be an important component of a prescription's cost, especially for generic drugs dispensed by pharmacies.

Dispensing fees do not vary much in absolute dollars. MediCal is at the upper end with a dispensing fee of \$7.50/prescription. The prior OMFS had dispensing fees of \$7.25 for generics and \$4.00 for brand-priced drugs. Prior research by the authors found \$2.00 to \$2.25 typical of group health and pharmacy benefit network dispensing fees. The cost of dispensing fees per unit of drug is then largely dependent on the average size of prescriptions. In addition, the average number of units dispensed does not vary substantially when dispensed by a physician or by a pharmacy. While individual drugs show variation in the units dispensed per script between pharmacy and physician dispensing, some higher and some lower, the average units per script across the top 20 drugs (by dollars for repack) is 52.8 units for physician dispensed and 54.0 units for pharmacy dispensed.

An additional point to note about dispensing fees is that they are a major component of pharmacy reimbursement for generic drugs. In the examples above, they range from about 1/3<sup>rd</sup> of the reimbursement for generic Vicodin to 3/4 of the reimbursement for Tramadol. For brand-priced drugs dispensed by pharmacies, the dispensing fee is only a small fraction of the total paid amount. Because of the higher ingredient cost of physician-dispensed generics, the professional fee is only a small fraction of reimbursements for repackaged drugs.

#### 4.2 Ingredient cost

Ingredient cost was discussed in detail in the example of Ranitidine. Here it is important to highlight that the spread between pharmacy reimbursement and physician reimbursement varies considerably depending on the drug and whether a brand or generic is dispensed. For example, in the table above, the spread between pharmacy-dispensed and physician-dispensed Tramadol is only about 120%, not the over 1,000% difference observed for Ranitidine.

The difference in ingredient cost for brand-priced drugs is much smaller still. Naprosen (Brand) is very similarly priced for pharmacy- and physician-dispensed and Ultram (Brand) is even slightly cheaper when physician-dispensed.

#### 4.3 Brand vs. generic

Except for physician-dispensed drugs, generic versions of a drug are always much less expensive if there are multiple manufacturers. Consequently, one factor in any equation of savings is the distribution between brand and generic in the dispensing venue. Physicians virtually always dispense generics, when available. Pharmacies are required to dispense generics, except when the physician specifies no substitution. Consequently, it is unlikely that shifting dispensing between physicians and pharmacists will change the overall distribution between brand-priced and generic equivalents.

For drugs, like Celebrex, where no generic equivalent was available at the time of the study, physicians are less likely to include these drugs in inventory, but when they do dispense these drugs, the cost is similar to pharmacy dispensing.

When a significant fraction of a particular drug with both brand and generic versions available is dispensed as the brand-priced type (e.g., Ultram), savings from shifting to pharmacy/MediCal pricing

will be smaller as a percent of expenditures on that particular drug. Ultram is one of the few brand-priced drugs with generic equivalents where we observed more than 1% of a physician-dispensed drug type being the single-source brand. Brand-priced drugs represent a somewhat larger portion of pharmacy prescriptions. This is most likely because dispensing physicians rarely stock the branded version, so when the patient needs a specific brand version, the prescriptions are almost always filled by a pharmacy.

#### 4.4 Less frequently dispensed or controlled drugs

Finally, some drugs are rarely or never dispensed by physicians. In the tables above, Lidoderm is not in the sample of physician-dispensed drugs because it was so infrequently physician dispensed. Physicians have been generally more reluctant to keep narcotics in inventory, and for some DEA classifications, they virtually never stock them. Physicians appear to be less likely to stock newer brand-priced drugs without generic substitutes (e.g., Ambien, Bextra), either because they do not yet prescribe them often enough, or possibly because the spread between AWP and what they are required to pay a repackager remains too narrow on these newer drugs. Also, there are a broad number of infrequently prescribed drugs that will not be economical for physicians to stock. For example (See Appendix 1), the top 20 drugs dispensed by physicians account for over 90% of the total dollars paid physicians. However, the top 20 pharmacy-dispensed drugs account for less than 50% of the dollars paid pharmacies. Over five times as many drugs (grouped by therapeutic equivalence, i.e., generic code sequence number) appeared in the sample of pharmacy-dispensed drugs as appeared in the sample of physician- dispensed drugs.

#### 4.5 Estimate of the percent impact on total workers' compensation pharmacy cost of physician-dispensed drugs

We were provided access to a large sample of workers' compensation pharmaceutical transactions from the Industry Claims Information System (ICIS) maintained by the California Workers' Compensation Institute (CWCI). Pharmacy transaction data included:

- Drug description
- NDC
- Units dispensed
- Billed amount
- Paid amount
- Service date

A dataset was obtained from First Data Bank (FDB) including NDC, pricing effective for all service dates, drug type (generic, brand), drugs in the same therapeutic class, and an identifier for repackaged drugs. MediCal pricing data was obtained from the state, including NDC, FUL price or MAIC price, and the "no substitution" price.

These three datasets provided the tools to estimate the additional cost to employers/insurers of physician-dispensed drugs.<sup>9</sup>

Table 4.5.1 compares the average reimbursement for physician-dispensed drugs and reimbursement for the same drug dispensed at a pharmacy. The drugs are ranked from top to bottom starting with the single drug (Ranitidine) responsible for the highest percentage of payments to dispensing physicians. The 23 drugs on the list account for over 90% of physician reimbursements for repackaged drugs.

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<sup>9</sup> Greater detail on the datasets and any sample exclusions is included in Appendix 2.

The first two columns give the names of the drugs and the broad therapeutic groups into which they fall. The most common therapeutic categories are antacids, non-steroidal anti-inflammatories (NSAID), muscle relaxants, and medications for pain. The third column gives the portion of each physician-dispensed drug that was dispensed as a generic. The final four columns compare the average reimbursement per unit for the generic and brand-priced drug, between physician-dispensed drugs and what MediCal reimbursed, on average, during the same period.





Table 4.5.1

Top Physician Dispensed Drugs		Percent of Repack = Generic	Current Physician Dispensed Cost/Unit		MediCal Pharmacy Dispensed Cost/Unit	
Description	Drug class		Generic	Brand	Generic	Brand
RANITIDINE 150MG TABLET	Antacid	99.5%	\$3.09	\$3.20	\$0.22	\$2.36
SOMA 350MG TABLET	muscle relaxant	100.0%	\$2.97		\$0.50	\$3.85
NAPROSYN 500MG TABLET	NSAID	99.0%	\$1.66	\$1.85	\$0.33	\$1.77
ULTRAM 50MG TABLET	analgesic	83.0%	\$1.04	\$1.00	\$0.40	\$1.21
VICODIN 5/500 TABLET	pain medication Class III	100.0%	\$0.88		\$0.24	\$0.89
DARVO CET-N 100 TABLET	pain medication Class IV	100.0%	\$0.86		\$0.31	\$1.22
VOLTAREN 75MG TABLET EC	NSAID	100.0%	\$1.66		\$0.73	\$2.15
MOTRIN 800MG TABLET	NSAID	99.5%	\$0.61	\$0.49	\$0.18	\$0.53
PIROXICAM 20MG CAPSULE	NSAID	100.0%	\$3.23		\$0.29	\$3.45
FLEXERIL 10MG TABLET	muscle relaxant	100.0%	\$1.39		\$0.45	\$1.51
NAPROSYN 375MG TABLET	NSAID	100.0%	\$1.29		\$0.30	\$1.63
VICODIN ES TABLET	pain medication Class III	100.0%	\$0.71		\$0.25	\$0.82
HYDROCODONE/APAP 10/650 TAB	pain medication Class III	100.0%	\$1.25		\$0.29	\$1.39
LODINE 500MG TABLET	NSAID	100.0%	\$1.72		\$0.85	\$1.67
CELEBREX 200MG CAPSULE	NSAID	0.0%		\$4.08		\$2.86
NORCO 10/325 TABLET	pain medication Class III	100.0%	\$0.87		\$0.77	\$1.09
LODINE 400MG TABLET	NSAID	100.0%	\$2.12		\$0.53	\$1.79
CEPHALEXIN 500MG CAPSULE	antibiotic	100.0%	\$3.02		\$0.58	\$3.32
TYLENOL W/CODEINE #3 TABLET	narcotic-analgesic	100.0%	\$0.76		\$0.37	\$0.69
AMBIEN 10MG TABLET	sedative/hypnotics	0.0%		\$5.37		\$3.22
DAYPRO 600MG CAPLET	NSAID	100.0%	\$2.18		\$0.12	\$0.21
VIOXX 25MG TABLET	Cox II inhibitor	0.0%		\$4.65		\$2.80
ZANAFLEX 4MG TABLET	muscle relaxant	100.0%	\$2.20		\$0.89	\$1.54

Table 4.5.2 extends this analysis by computing the average reduction in price if the physician-dispensed drugs had been dispensed at the MediCal rate in effect on the service date. This table is the crux of the analysis. Column 7, "Overall % reduction" gives the average reduction in reimbursement for each physician-dispensed drug if dispensed at a pharmacy. The estimate is weighted for the distribution between brand-priced and generic. For example, if physician-dispensed Ranitidine had been dispensed by a pharmacy, on average, the cost would have been reduced by 93%. Norco, (a combination of Hydrocodone and Acetaminophen) would have seen a smaller reduction of 11%.

The next column calculates the impact of a change to pharmacy pricing on the total cost of physician-dispensed drugs. Again, for Ranitidine, prescriptions for this drug represented 31.2% of reimbursements for physician-dispensed drugs (column 8). Combining the information in column 7 and column 8, one can calculate that impact on the total cost of physician-dispensed drugs if any individual drug had been priced at the pharmacy level. For example, because Ranitidine accounts for such a large portion of physician-dispensed drug costs (31.2%) and the reduction is so large (93%), the effect of moving just this one drug to pharmacy pricing would be to reduce the total reimbursement to physicians for dispensing drugs by almost 29%. Because Norco accounts for a smaller portion of reimbursements (0.8%) and the reduction is smaller (11%), the impact of physician reimbursements is only 0.1%.

We analyzed these data for the full range of drugs dispensed by physicians. The total impact of switching to MediCal (pharmacy) reimbursement for physician-dispensed drugs would be to reduce the total reimbursement to dispensing physicians by 79.6%, or, stated another way, if the same drugs had been dispensed through pharmacies, the total cost would have been one-fifth of what was actually reimbursed to physicians.

The logo for workcompcentral, featuring the text "workcompcentral" in a lowercase, sans-serif font. A stylized orange arrow points downwards from the top of the letter "o" in "work" towards the text.

Table 4.5.2

Top Physician-Dispensed Drugs  Description	Percent of Repack = Generic	Current Physician-Dispensed Cost/Unit		MediCal Pharmacy Dispensed Cost/Unit		Overall Pct Change	% of total Physician-dispensed reimbursements	% change in total cost of repack
		Generic	Brand	Generic	Brand			
RANITIDINE 150MG TABLET	99.5%	\$3.09	\$3.20	\$0.22	\$2.36	-93%	31.2%	-28.9%
SOMA 350MG TABLET	100.0%	\$2.97		\$0.50	\$3.85	-83%	25.6%	-21.3%
NAPROSYN 500MG TABLET	99.0%	\$1.66	\$1.85	\$0.33	\$1.77	-79%	8.6%	-6.8%
ULTRAM 50MG TABLET	83.0%	\$1.04	\$1.00	\$0.40	\$1.21	-48%	5.2%	-2.5%
VICODIN 5/500 TABLET	100.0%	\$0.88		\$0.24	\$0.89	-73%	2.9%	-2.1%
DARVOCET-N 100 TABLET	100.0%	\$0.86		\$0.31	\$1.22	-64%	2.8%	-1.8%
VOLTAREN 75MG TABLET EC	100.0%	\$1.66		\$0.73	\$2.15	-56%	2.1%	-1.2%
MOTRIN 800MG TABLET	99.5%	\$0.61	\$0.49	\$0.18	\$0.53	-70%	1.8%	-1.3%
PIROXICAM 20MG CAPSULE	100.0%	\$3.23		\$0.29	\$3.45	-91%	1.6%	-1.5%
FLEXERIL 10MG TABLET	100.0%	\$1.39		\$0.45	\$1.51	-68%	1.3%	-0.9%
NAPROSYN 375MG TABLET	100.0%	\$1.29		\$0.30	\$1.63	-77%	1.3%	-1.0%
VICODIN ES TABLET	100.0%	\$0.71		\$0.25	\$0.82	-65%	1.2%	-0.8%
HYDROCODONE/APAP 10/650 TAB	100.0%	\$1.25		\$0.29	\$1.39	-77%	1.1%	-0.8%
LODINE 500MG TABLET	100.0%	\$1.72		\$0.85	\$1.67	-51%	1.0%	-0.5%
CELEBREX 200MG CAPSULE	0.0%		\$4.08		\$2.86	-30%	0.8%	-0.2%
NORCO 10/325 TABLET	100.0%	\$0.87		\$0.77	\$1.09	-11%	0.8%	-0.1%
LODINE 400MG TABLET	100.0%	\$2.12		\$0.53	\$1.79	-75%	0.8%	-0.6%
CEPHALEXIN 500MG CAPSULE	100.0%	\$3.02		\$0.58	\$3.32	-81%	0.7%	-0.6%
TYLENOL W/CODEINE #3 TABLET	100.0%	\$0.76		\$0.37	\$0.69	-51%	0.7%	-0.4%
AMBIEN 10MG TABLET	0.0%		\$5.37		\$3.22	-40%	0.5%	-0.2%
DAYPRO 600MG CAPLET	100.0%	\$2.18		\$0.12	\$0.21	-95%	0.4%	-0.4%
VIOXX 25MG TABLET	0.0%		\$4.65		\$2.80	-40%	0.3%	-0.1%
ZANAFLEX 4MG TABLET	100.0%	\$2.20		\$0.89	\$1.54	-59%	0.2%	-0.1%

#### 4.6 Estimate of the total cost impact of physician-dispensed drugs

According to the latest Workers' Compensation Insurance Rating Bureau (WCIRB) of California report on "Workers Compensation Losses and Expenses," (2006), prescription-drug expenses for insured employers were \$436 million for calendar-year 2005. Insured employers account for approximately 72% of the total market in 2005. Consequently, we can estimate that total prescription reimbursements for all employers were approximately \$600 million. Using 8%, a conservative estimate of the average annual growth in prescription drug costs for all health care, we estimate that prescription-drug cost for the current calendar year (2006) will be \$471 million for insured employers and \$649 million for all employers.

From an insured-employer perspective, the most important estimate is incurred cost, as this determines how much employers actually pay: estimated incurred costs are the basis for premium setting. Because incurred costs represent what will be paid on the current policy-year claims often many years in the future, a rule of thumb used in previous CHSWC studies, is that incurred costs are two times current paid amounts.<sup>10</sup> In addition, insurer premiums are set at a multiple to direct costs (pure premium rates set by the WCIRB and Department of Insurance). The multiple is expected to cover administrative costs, taxes, commissions, and profits. While this number varies over time, another decent rule of thumb is that premiums are set at 1.3 times estimated direct costs. Based on these rules, one can estimate that the total incurred cost of prescription drugs on policy year 2006 claims will be \$942 million (2 x \$471 million) and the total cost to insured employers for prescription drugs, including administrative costs, will be approximately \$1,225 million for policies incepting in 2006.

For the study, we reviewed a very large sample of workers' compensation prescription-drug claims. Focusing on calendar-year 2004, after the new MediCal-linked fee schedule was adopted, we found that physician-dispensed drugs accounted for 30.3% of prescriptions written and 50.8% of all payments for prescription drugs. Consequently, estimated payments to physicians for dispensing prescription drugs during the 2006 calendar year will amount to \$330 million.

Because, on average, physician-dispensed drugs cost four times what the same drug costs when dispensed by a pharmacy, the total impact of physician-dispensed drugs on the paid and incurred costs for employers can be estimated as follows:

- Paid amounts (all employers) for 2006 will be \$263 million higher because of physician dispensing.
- Incurred amounts, for insurers, will be \$379 million higher than if all prescriptions were dispensed through pharmacies.
- Insured-employer premiums for policy-year 2006 will be \$490 million higher than if all prescriptions were dispensed through pharmacies.
- Premium paid by insured employers will be 2.2% higher for policy-year 2006 than if all prescriptions were dispensed through pharmacies.

## 5.0 Other Cost-benefit Issues

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<sup>10</sup> This is somewhat conservative for an area like pharmaceuticals where the annual growth rates are quite high and likely to over-estimate somewhat for benefit areas like permanent disability, where benefits are fixed as of the injury date.

A number of issues have been raised by proponents and opponents of physician dispensing:

- For physician dispensing:
  - Improved access to prescriptions for workers,
  - Better compliance with ideal drug regiment,
  - Improved health outcomes, because of better compliance,
  - Physicians better able to deliver time-critical, lifesaving therapies that would otherwise be delayed, and
  - Better patient information and hence safer drug therapy, particularly for non-English speaking workers.
  - Provides physicians with an additional source of income to supplement OMFS reimbursements
  
- Against physician dispensing:
  - Higher cost (discussed above),
  - Increased incentive for physicians to over-prescribe,
  - Increased incentive for physicians to prescribe “what’s on the shelf” rather than best drug available,
  - Limited patient information, and
  - Reduced safety checks.

Some of the above issues cannot be answered definitively with the data and research at hand. However, the important issues can be informed by the data prepared for this project and from additional information from a review of prior published research.

#### 5.1 Physician dispensing compensates for problems with access to pharmacy dispensing in workers’ compensation

In March 2000, Neuhauser et al. published a study on the accessibility of pharmacies to injured workers. At that time, some stakeholders speculated that fee-schedule changes in the reimbursement level of pharmaceuticals would lead to fewer pharmacies participating in the workers’ compensation system. This potential exodus of pharmacies, it was argued, would create an access problem for injured workers. For this report, researchers analyzed the proximity of 1.5 million injured workers against a database of pharmacies that were accepting workers’ compensation prescriptions. The results showed that at the time, California injured workers had to travel an average of 2.0 miles from their home to the closest pharmacy and had an average of 5 pharmacies within a 4-1/2 mile radius of their homes. It was noted that these estimates were conservative, as hospitals, clinics, physician offices and other facilities that also dispense drugs were not included in the analysis.

Given the adoption of the new fee schedule with its significant reduction in fee-schedule reimbursement levels from the prior fee schedule, the question of access has reemerged. Some of the same stakeholders who previously speculated that fee-schedule adjustments would compromise injured workers’ access to medications again have voiced concern over a potential reluctance of California’s pharmacies to continue to support the workers’ compensation system.

In order to revisit the access issue, the aforementioned access analysis has been updated with current data. The new analysis uses data on more than 1 million injured workers and a revised list of pharmacies that accepted workers’ compensation prescriptions in 2004. The results are displayed in the chart below, with comparative results summarized in Table 5.1.1.

**Chart 5.1.1. Access Standard Comparison between Injured Workers' and Pharmacies**

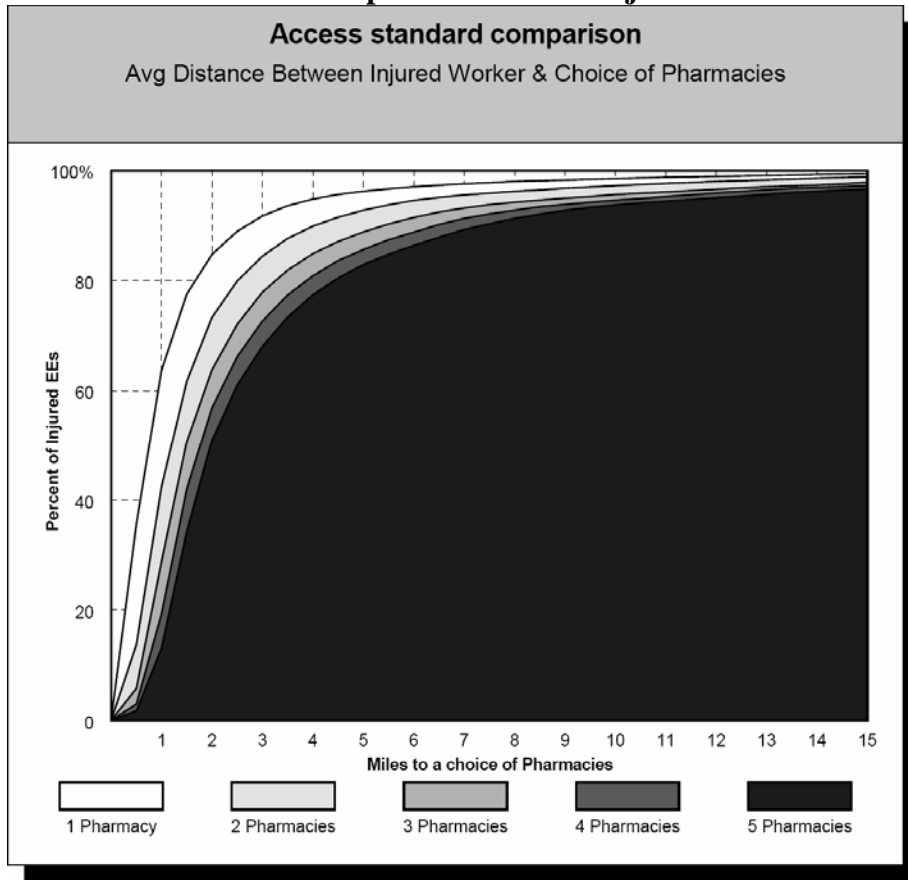


Chart 5.1.1 shows that more than 80 percent of California’s injured workers have a pharmacy that fills workers’ compensation prescriptions within 2 miles of their home. Almost 95 percent of injured workers have a pharmacy within 4 miles.

Table 5.1.1 compares the results of the prior 2000 analysis against 2004 revised and updated injured-worker and pharmacy-location data.

**Table 5.1.1. Average Distance between Injured Worker & Choice of Pharmacies**

Study Group	Average Distance Between Injured Worker & Choice of Workers' Comp Pharmacies				
	1	1 to 2	1 to 3	1 to 4	1 to 5
Original Study (Pre-2004 Fee Schedule)	2.0	2.7	3.4	3.9	4.5
Follow-up Study (under current 2004 Fee Schedule)	1.2	2.0	2.5	3.0	3.5
Percent Difference	-40.0%	-25.9%	-26.5%	-23.1%	-22.2%



The new data show that injured workers live within an average of 1.2 miles of a pharmacy that fills workers’ compensation prescriptions, a 40 percent reduction from the average of 2 miles noted in the 2000 study. Furthermore, the new study shows that on average, injured workers now have a choice of up to 5 pharmacies within 3.5 miles of their homes, compared to 4.5 miles in the 2000 study. This significant improvement in access is due in part to an increase in the number of pharmacies in California.

Other stakeholders have asserted that a change in reimbursement levels for repackaged drugs will result in physicians withdrawing from providing repackaged drugs, the result of which would cause another form of compromised access for injured workers. The authors also explored the association between physicians who dispense repackaged drugs and nearby pharmacies that routinely fill workers’ compensation prescriptions.

**Table 5.1.2. Access: Average Distance between Repackaged Drug Dispensing MD to Choice of Pharmacies<sup>11</sup>**

	Distance from Repackaged Drug Dispensing MD to Choice of Pharmacies (in miles)					
	1	1 to 2	1 to 3	1 to 4	1 to 5	Total
Median	0.5	0.9	1.1	1.3	1.5	<b>1.1</b>
Mean	0.8	1.2	1.6	1.9	2.2	<b>1.6</b>

Table 5.1.2 shows that on average, injured workers need travel less than one mile from their physician’s office to access a pharmacy to fill their workers’ compensation prescription. Injured workers would have a choice of 5 pharmacies within 2.2 miles from their repackaged drug- dispensing physician.

We conclude that there is no evidence that prior to the new pharmacy schedule, reimbursement rates compromised workers’ access to pharmacies willing to dispense drugs under workers’ compensation. There is also no evidence that workers’ access to pharmacies willing to fill workers’ compensation prescriptions was reduced subsequent to the new pharmacy schedule. Access is at least as good in the post-SB 228 environment, if not better.

5.2 Physician dispensing leads to better compliance with drug regimes and, consequently, better health outcomes.

A major thrust of arguments in favor of physician dispensing revolves around better patient care and, ultimately, better health outcomes. The contention is that if physicians dispense directly to patients, patients will be more likely to obtain the drugs and, consequently, more likely to follow the appropriate regime. In turn, this will lead to better health outcomes.

This argument certainly has some validity. It is undeniable that if the drug is dispensed by the physician, then patients are more likely (100% of the time) to obtain the prescribed drug than if they have to fill the prescription at a pharmacy. However, the impact on health outcomes is unclear. For

<sup>11</sup> Includes pharmacies that have filled at least one workers’ compensation prescription.

example, the most common physician-dispensed drug is Ranitidine, an antacid typically prescribed for important, but infrequent side-effects for medium to long-term treatment with NSAIDs for conditions such as arthritis or chronic pain. One can imagine that patients fill prescriptions for side effects whenever the discomfort from the side effects due to the primary medication exceeds the anticipated side effects from the secondary medication and the burden of filling the prescription. Since all medications carry the risk of negative side effects, it is appropriate to think that some threshold burden on filling the prescription is beneficial.

The literature here is mixed. Osterberg and Blaschke (2005) present an extensive review article on compliance issues, listing major barriers to compliance with the prescribed drug regime, but never identify dispensing by physicians as a positive or negative factor. This suggests that at least peer-review research is silent on the advantage/disadvantages of physician dispensing on compliance. Ginde, et al. (2003) selected patients because they were candidates for antibiotics and the appropriate regime was important and clearly defined. The authors found a lower percentage of patients obtained drugs when directed to a pharmacy (at no cost) vs. when the prescription was received directly from the hospital after visiting the emergency department. However, actual compliance with the regime, based on self-reports, was the same and return visits to the emergency department were similar. The Ginde study was the only study reviewed that even attempted to link provider dispensing with outcomes.

### 5.3 Incentive for physician to over-prescribe (or prescribe “what’s on the shelf”)

One of the most common and important concerns raised by opponents of physician dispensing is that physicians who profit on the dispensing side may respond to the incentive by prescribing more drugs or the same drugs more often than non-dispensing physicians. Assuming that physicians without a profit incentive prescribe appropriately, opponents would argue that any additional scripts represent over-prescribing.

Physician dispensing of pharmaceuticals can be seen as a special case of a fairly large body of research addressing “physician induced demand” in health-care economics. Pertinent to the issue here, this research has consistently found that when physicians have a financial interest in a particular auxiliary service, the incentive tends to drive increased utilization. That utilization is generally interpreted as excess treatment. However, while the literature consistently finds much higher utilization when the physician has a financial interest in the ancillary service, the literature is not as strong at demonstrating that the services represent over-utilization rather than a more appropriate level of utilization relative to non-referring physicians.

Incentives for physician referral to physician-owned laboratories for medical testing have been extensively evaluated. The research on physician-owned laboratories was sufficiently compelling that Congress enacted national legislation restricting physician financial interest in medical laboratories (Iglehart, J. K., 1990, 1991). This was probably the initial thrust of statutory and regulatory restrictions on physician “self-referral” in the face of convincing evidence of higher-utilization driven by financial incentives.

Physician “self-referral” to imaging at centers where the referring physician had a financial interest or when the imaging was done within the doctor’s office, was the subject of extensive research in the 1980s and early 1990s. Hilman, et al., 1990, 1992; Mitchell, J.M. and Scott, E., 1992; and Kouri, Parsons and Alpert, 2002, among others, found evidence of substantially increased utilization of



diagnostic imaging when physicians had a direct financial interest in the imaging process. Swedlow et al, (1992) made similar findings specific to workers' compensation.

Research on the impact of physician dispensing on pharmaceutical use and health outcomes is more limited, particularly in the U.S. Much of the research and commentary occurred during the 1980s and surrounded federal decisions regarding Medicare/Medicaid prescriptions drugs. Medicaid generally prohibits payment for repackaged drugs and otherwise limits payments to a schedule of payments based on reimbursements to pharmacies.

More recently, the issue has risen to prominence because of the dramatically increasing importance of pharmaceuticals as a portion of total health-care costs. But, not much has been written about the extent of physician dispensing or its impact. Abood (1989) was the only reference identified that estimated the extent of physician dispensing,  $1/10^{\text{th}}$  of 1% of scripts. In addition, much of the research and commentary are being generated outside the U.S. and/or in journals associated with pharmacy professional association, presenting a potential for bias. In particular, pharmacists have seen the increase in physician dispensing as a challenge to their income and have responded with aggressive efforts to emphasize the importance of the role of the pharmacist. Gilbert (1998) discusses much of the tension between pharmacists and dispensing doctors, using the perspective of South Africa. Axon (1993), in a pharmacy research journal, references a UK study, not identified, to say that dispensing doctors issued 12.9% more prescriptions than non-dispensing colleagues, at an additional 10.3% higher expenditure per patient. Nelson (1987) argues that physicians "might" dispense what is on the shelf, while Adritz and Rogan, pharmacy college professors, argue that benefits to patient of physician dispensing are over-estimated. Vivian et al. (2006) argue for a narrow legal interpretation of statutes regarding physician dispensing.<sup>12</sup>

On the other hand, physicians and medical associations actively protect their professional turf. Lober et al. (1988) proffer a non-empirically based, review article supporting physician dispensing. And certainly in the recent California debate both physicians and the distributors of repackaged drugs have marshaled several studies purporting to support the advantages of physician dispensing. Again, these studies are generally driven by the particular professional perspective of the author(s).

Independent research literature has generally found that physician dispensing leads to higher utilization of prescriptions drugs. In addition, some literature also finds the increased utilization is also associated with inappropriate or excess dispensing. Gilbert (1998) found dispensing-physicians averaged 2.38 scripts per patient while non-dispensers average 1.67. It is not clear whether the study controlled for differences in medical specialty, patients, etc. Trapp and Hansen (2002a, 2002b), in Zimbabwe, find dispensing doctors did not differ by rationality of drug prescribing which was poor for both dispensing and non-dispensing physicians. However, dispensing doctors prescribed sub-curative doses significantly more often and prescribed correct doses significantly less often. Park, et al. (2005) found that in Korea, after imposition of restrictions on physician dispensing, antibiotic prescribing declined substantially for patients with viral illnesses (inappropriate use of antibiotics) and only minimally for patients with bacterial illnesses (appropriate use of antibiotics). The dispensing restrictions also reduced the prescribing of non-antibiotic drugs. Nizami et al. (1996), doing a study in Pakistan, found dispensing doctors under-prescribe oral re-hydration salt (ORS), the cheapest, first-level response, and over prescribe of anti-diarrhea medications relative to doctors that do not dispense.

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<sup>12</sup> Reference the court case in CA.

Trap, B and E. Hansen, (2002), find dispensing physicians contributed to increasing health hazards, cost, and risk of developing bacterial resistance, by inappropriately prescribing antibiotics.

The data prepared for this study can not be used to address directly the question of whether physician dispensing changes a physician's prescribing practices. The prescriptions were not linked to individual claims or individual physicians. However, some dramatic differences between the distribution of drugs between dispensing and non-dispensing physicians suggest that their prescribing practices differ.

A review of the Tables in Appendix 1 shows substantial differences between the drugs most frequently dispensed by physicians and pharmacists. Some of these differences can be explained by other issues discussed in the Appendix, e.g., dispensing physicians are less likely to dispense low-margin, single-source, brand-name drugs, drugs on DEA restricted lists, and infrequently prescribed drugs. However, some of the differences are difficult to explain except as incentive-driven prescribing practices. For example, although 70% of scripts are pharmacy-dispensed, 9 out of 10 prescriptions for Ranitidine are physician-dispensed. Ranitidine, as noted early, has one of the highest mark-ups associated with repackaged drugs, 1,750% of pharmacy reimbursement for the same ingredient portion. About ¾ of scripts for Carisprodol/Soma (a commonly dispensed muscle relaxant) are dispensed by physicians. Again, Carisprodol is also associated with a very high mark-up when dispensed by physicians. These two drugs alone account for 57% of all dollars paid for drugs dispensed by physicians, but only 2.6% of amounts paid to pharmacies.

#### 5.4 Claim: Eliminating physician-dispensing would endanger patients by limiting access to time-critical, life-saving medications

This claim has been made several times in different forums by proponents of physician dispensing. However, nothing in the data reviewed supports this contention. A review of the top 50 repackaged drugs does not reveal the types of drugs that might be considered time-critical, life-saving prescriptions.

#### 5.5 Information and safety

Both proponents and opponents of physician dispensing claim the high ground on information and safety. There is no definitive literature on this issue and empirically, it would be complex to establish which venue is the safest for dispensing. However, it is difficult to understand, logically, why physician dispensing would result in better information being communicated to the patient than pharmacy dispensing, especially in an occupational-medicine setting. First, proponents argue that physicians will give better or more complete information than pharmacists. However, it is not clear why physicians would give different information depending on the source of dispensing. We expect that physicians will give full and complete information to their patients whether they dispense or not. On the other hand, pharmacy dispensing allows another opportunity to communicate appropriate information to patients that should only reinforce safer dispensing and consumption.

One concern raised about physician dispensing within occupational medicine is potential problems with drug interactions. Occupational physicians may not be completely or accurately informed about all medications the patient takes for non-occupational conditions. If the worker is using the same pharmacist for all medications, there is an additional check on potential drug interactions.

Finally, both proponents and opponents raise the issue of language barriers and potential safety problems. Here again, it is difficult to find logical support for physician dispensing leading to better information. It would seem that the treating physician (often selected by the employer, not the worker)

will be no more likely to speak the native language of a non-English speaking worker than the pharmacist (probably selected by the worker). Also, it would only seem to increase the chances of appropriate communication to have cautions communicated from both sources rather than either one alone.

## 6.0 Conclusions

Physician-dispensed prescription drugs comprise a significant portion of all pharmaceutical prescriptions dispensed in California's workers' compensation system. Because of limits on the reach of statute and regulations adopted under SB 228, physician-dispensed pharmaceuticals are also much more expensive than the same drugs dispensed through a pharmacy. This report documents the extra costs placed on the system by physician-dispensed drugs. The report also reviews research on both the positive and negative impacts of physician dispensing, including the main arguments raised by proponents at CHSWC meetings and at DWC regulatory hearings.

Main findings on the direct cost of physician-dispensed drugs:

- Physician dispensing is much more common than most observers expected. 30.3% of prescriptions dispensed in the California workers' compensation system are dispensed by physicians directly from their offices.
- Approximately half (50.8%) of the total cost of pharmaceuticals in the system is paid to physicians for prescriptions dispensed from their offices.
- Because of the structure of the OMFS, physician-dispensed pharmaceuticals are much more costly than the same drugs dispensed by a pharmacy. On average, physician-dispensed drugs cost 490% of what is paid to pharmacies. In some cases, including the most commonly prescribed drug dispensed by physicians, the mark-up exceeds 1000%.
- We estimate that for calendar-year 2006, insurers and self-insured employers will pay \$649 million for prescription drugs. Of this paid amount, \$263 million will be paid to dispensing physicians in excess of what would have been paid for the same drugs if dispensed by a pharmacy.
- It is estimated that insured employers will face premiums for the 2006 policy year that are \$490 million dollars higher than if all drugs were dispensed through pharmacies. This represents 2.2% of premium for the policy year.

Other findings on costs and benefits:

- The research literature on the subject of physician-dispensed drugs generally argues that physician dispensing leads to increased, possibly inappropriate, use of prescription drugs. The studies have usually been done outside the U.S., and the results cannot necessarily be generalized to the California workers' compensation. However, research on physician practices with similar incentives, such as self-referral for lab tests or imaging, has consistently found that incentives inherent in self-referral lead to over-utilization.
- The data in this study were not designed to determine whether physician dispensing led to increased utilization or changes in the types of drugs prescribed. However, the study does find striking differences in the types of drugs dispensed by physicians and pharmacies. This research could be extended to allow more thorough analysis of how financial incentives may change prescribing practices.
- Research finds only weak evidence for better compliance with drug regimes when the physician dispenses directly to the patient. There is virtually no research demonstrating better health outcomes or more rapid recovery when physicians dispense.

- It would be important to extend the research in this study to examine whether extensive use of physician dispensing does affect health outcomes, and if so, whether the effect is positive or negative.



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**Appendix 1: Tables showing top 50 drugs by total cost and number of scripts**

The following tables identify the top 50 drugs separately by the number of scripts written and total cost. The tables allow comparisons between the distribution of drugs prescribed and dispensed by physicians and those where the physician prescribes, but the drugs are dispensed by a pharmacy.

The tables need to be evaluated with some care. Physicians will not dispense the full range of drugs available. They will not find it convenient and/or profitable to maintain inventories of infrequently prescribed drugs. They may also find it unprofitable to maintain inventories of drugs that have low-profit margins, given that they dispense much less frequently than a pharmacy and each individual transaction may be more costly to inventory and dispense than with a high-volume pharmacy. Brand-name drugs without a generic equivalent is a class of drugs where the profit margin is lower than for drugs commonly dispensed as generics. Consequently, infrequently prescribed drugs, like specialized antibiotics and brand-name drugs without a generic equivalent, like Bextra, will be over-represented in pharmacy dispensing.

On the other hand, frequently prescribed drugs with broad application in occupational medicine are more appropriately compared between the two dispensing venues. In any case, the bias of any comparison is that a drug will be over-represented within pharmacy dispensing.

There are several and sometimes dozens of drugs within a therapeutic class. Drugs may have therapeutic advantages in particular cases, specific drug interactions with other medications the worker may be taking, or problematic side effects for any particular patient. Dispensing physicians cannot maintain as broad a selection of drugs as pharmacies, whose primary business is dispensing. Consequently, if physicians are not limiting their choice of the best drug to prescribe by what is "available on the shelf," they will shift to pharmacies, at least to some extent, the process of dispensing all but the most commonly prescribed drugs. Therefore, the drugs universally maintained in inventory will be somewhat over-represented in the distribution of physician-dispensed drugs. Drugs infrequently maintained in physician-dispensed inventories will be over-represented in pharmacy dispensing relative to physician dispensing, because dispensing physicians may prescribe those drugs, but have them filled at a pharmacy.

The tables are arranged in three sets of two tables. The first set of tables lists the top 50 drugs dispensed in workers' compensation, regardless of where they were dispensed, a physician's office or pharmacy. The second pair of tables gives the top 50 drugs among those dispensed from physician offices. The third set gives the top 50 drugs as dispensed by pharmacies. Within each of these three sets, the first table gives the top 50 drugs by total cost and the second table gives the top 50 by number of scripts dispensed.

**All Prescriptions: Top 50 Drugs (GCN Sequence Number) Paid Amounts  
(Repack & Pharmacy)**

GCN_S eqno	Percent of all \$	Description	Brand	Generic	Drug class
011673	16.3%	RANITIDINE 150MG TABLET	Zantac	Ranitidine	Antacid
004663	14.0%	SOMA 350MG TABLET	Soma	Carisoprodol	Muscle relaxant
008362	4.7%	NAPROSYN 500MG TABLET	Naprosyn	Naproxen	NSAID
041286	4.0%	CELEBREX 200MG CAPSULE	Celebrex	Celecoxib	NSAID
023139	3.1%	ULTRAM 50MG TABLET	Ultram	Tramadol	Analgesic
043256	2.7%	LIDODERM 5% PATCH			
004204	2.3%	VICODIN 5/500 TABLET	Vicodin	Hydrocodone	Pain medication Class III
030623	2.3%	NORCO 10/325 TABLET	Vicodin	Hydrocodone	Pain medication Class III
042635	2.3%	VIOXX 25MG TABLET	Vioxx		Cox II inhibitor
049798	1.9%	BEXTRA 20 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor
004273	1.8%	DARVOCET-N 100 TABLET	Darvocet-N	Acetam/propox.	Pain medication Class IV
019188	1.7%	AMBIEN 10MG TABLET	Ambien	Zolpidem	Sedative/hypnotics
021414	1.5%	NEURONTIN 300MG CAPSULE	Neurontin	Gabapentin	Anti-seizure
008350	1.2%	MOTRIN 800MG TABLET	Motrin	Ibuprofen	NSAID
008374	1.2%	VOLTAREN 75MG TABLET EC	Voltaren	Diclofenac	NSAID
004207	1.1%	VICODIN ES TABLET	Vicodin	Hydrocodone	Pain medication Class III
004681	1.0%	FLEXERIL 10MG TABLET	Flexeril	Cyclobenzaprine	Muscle relaxant
048456	1.0%	ULTRACET TABLET	Ultracet	Tramadol	Opiate
024506	0.9%	OXYCONTIN 40MG TABLET SA	Oxycontin	Oxycodone	Opiate
008371	0.8%	PIROXICAM 20MG CAPSULE	Feldene	Piroxicam	NSAID
041805	0.8%	NEURONTIN 600 MG TABLET	Neurontin	Gabapentin	Anti-seizure
049795	0.8%	BEXTRA 10 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor
051112	0.8%	SKELAXIN 800 MG TABLET	Skelaxin	Metaxalone	Muscle relaxant
008361	0.7%	NAPROSYN 375MG TABLET	Naprosyn	Naproxen	NSAID
025702	0.7%	OXYCONTIN 80MG TABLET SA	Oxycontin	Oxycodone	Opiate
009043	0.6%	CEPHALEXIN 500MG CAPSULE	Keflex	Cephalosporins	Antibiotic
016899	0.6%	HYDROCODONE/APAP 10/650	Vicodin	Hydrocodone	Pain



		TAB			medication Class III
030107	0.6%	PREVACID 30 MG CAPSULE DR	Prevacid	LansoprazoleSR	PPI/Anti-acid
004165	0.5%	TYLENOL W/CODEINE #3 TAB	Tylenolw/cod.	Acet. w/codeine	Narcotic-analgesic
020175	0.5%	LODINE 400MG TABLET	Lodine	Etodolac	NSAID
024505	0.5%	OXYCONTIN 20MG TABLET SA	Oxycontin	Oxycodone	Opiate
027368	0.5%	LODINE 500MG TABLET	Lodine	Etodolac	NSAID
015881	0.4%	DURAGESIC 50MCG/HR PATCH	Duragesic	Fentanyl topical	Narcotic analgesics
015883	0.4%	DURAGESIC 100MCG/HR PATCH	Duragesic	Fentanyl topical	Narcotic analgesics
029837	0.4%	TOPAMAX 25 MG TABLET	Topomax	Topiramate	Anti-convulsant
030274	0.4%	ZANAFLEX 4MG TABLET	Zanaflex	Tizanidine HCL	Muscle relaxant
033530	0.4%	PRILOSEC 20 MG CAPSULE DR	Prilosec	Omeprazole	Antacid
044758	0.4%	VIOXX 50 MG TABLET	Vioxx		Cox II inhibitor
004664	0.3%	SKELAXIN 400MG TABLET	Skelaxin	Metaxalone	Muscle relaxant
016574	0.3%	RELAFEN 500MG TABLET	Relafen	Nabumetone	NSAID
017204	0.3%	DAYPRO 600MG CAPLET	Daypro	Oxaprozin	NSAID
019187	0.3%	AMBIEN 5MG TABLET	Ambien	Zolpidem	Sedative/hypnotics
029156	0.3%	MOBIC 7.5 MG TABLET	Mobic	Meloxicam	NSAID
041285	0.3%	CELEBREX 100MG CAPSULE	Celebrex	Celecoxib	NSAID
041806	0.3%	NEURONTIN 800 MG TABLET	Neurontin	Gabapentin	Anti-seizure
046228	0.3%	ZOLOFT 50 MG TABLET	Zoloft	Sertraline	Anti-depressant
046229	0.3%	ZOLOFT 100 MG TABLET	Zoloft	Sertraline	Anti-depressant
046404	0.3%	EFFEXOR XR 75 MG CAPSULE SA	Effexor	Venlafaxine	Anti-depressant
047526	0.3%	NEXIUM 40 MG CAPSULE	Nexium	Esomeprazole magnesium	Antacid
050712	0.3%	LEXAPRO 10 MG TABLET	Lexapro	Escitalopram oxalate	Anti-depressant

79.4% Top 50 as percent of all paid amounts (pharmacy and repackaged)

**All Prescriptions: Top 50 Drugs (GCN Sequence Number) by Prescriptions  
(Repack & Pharmacy)**

GCN_S eqno	% of all scripts	Description	Brand	Generic	Drug class
004204	10.4%	VICODIN 5/500 TABLET	Vicodin	Hydrocodone	Pain medication Class III
004663	7.2%	SOMA 350MG TABLET	Soma	Carisoprodol	Muscle relaxant
011673	5.3%	RANITIDINE 150MG TABLET	Zantac	Ranitidine	Antacid
004273	4.2%	DARVOCET-N 100 TABLET	Darvocet-N	Acetam. & propox.	Pain medication Class IV
008362	4.2%	NAPROSYN 500MG TABLET	Naprosyn	Naproxen	NSAID
008350	4.1%	MOTRIN 800MG TABLET	Motrin	Ibuprofen	NSAID
004207	3.7%	VICODIN ES TABLET	Vicodin	Hydrocodone	Pain medication Class III
023139	3.4%	ULTRAM 50MG TABLET	Ultram	Tramadol	Analgesic
030623	3.4%	NORCO 10/325 TABLET	Vicodin	Hydrocodone	Pain medication Class III
041286	2.8%	CELEBREX 200MG CAPSULE	Celebrex	Celecoxib	NSAID
004681	2.5%	FLEXERIL 10MG TABLET	Flexeril	Cyclobenzaprine	Muscle relaxant
042635	2.0%	VIOXX 25MG TABLET	Vioxx		Cox II inhibitor
008349	1.7%	MOTRIN 600MG TABLET	Motrin	Ibuprofen	NSAID
004165	1.6%	TYLENOL W/CODEINE #3 TAB	Tylenol	Codeine	Pain reliever/fever reducer
009043	1.5%	CEPHALEXIN 500MG CAPSULE	Keflex	Cephalosporins	Antibiotic
019188	1.5%	AMBIEN 10MG TABLET	Ambien	Zolpidem	Sedative/hypn otics
049798	1.5%	BEXTRA 20 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor
048456	1.2%	ULTRACET TABLET	Ultracet	Tramadol	Opiate
021414	1.0%	NEURONTIN 300MG CAPSULE	Neurontin	Gabapentin	Anti-seizure
043256	1.0%	LIDODERM 5% PATCH			
008374	0.8%	VOLTAREN 75MG TABLET EC	Voltaren	Diclofenac	NSAID
016899	0.7%	HYDROCODONE/APAP 10/650 TAB	Vicodin	Hydrocodone	Pain medication Class III
051112	0.7%	SKELAXIN 800 MG TABLET	Skelaxin	Metaxalone	Muscle relaxant
004205	0.6%	HYDROCODONE/APAP 7.5/500 TAB	Vicodin	Hydrocodone	Pain medication Class III

008361	0.6%	NAPROSYN 375MG TABLET	Naprosyn	Naproxen	NSAID
008371	0.6%	PIROXICAM 20MG CAPSULE	Feldene	Piroxicam	NSAID
046046	0.6%	ELAVIL 25 MG TABLET	Elavil	Amitriptyline HCL 25 MG Tab	Anti-depressant
049795	0.6%	BEXTRA 10 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor
003768	0.5%	DIAZEPAM 5MG TABLET	Diastat	Diazepam	Seizure/muscle spasms
030274	0.5%	ZANAFLEX 4MG TABLET	Zanaflex	Tizanidine HCL	Muscle relaxant
003690	0.4%	TEMAZEPAM 30MG CAPSULE	Restoril	Temazepam	Sleep aid
003766	0.4%	DIAZEPAM 10MG TABLET	Diastat	Diazepam	Seizure/muscle spasms
004655	0.4%	METHOCARBAMOL 750MG TAB	Robaxin	Methocarbamol	Muscle relaxant
016574	0.4%	RELAFEN 500MG TABLET	Relafen	Nabumetone	NSAID
020175	0.4%	LODINE 400MG TABLET	Lodine	Etodolac	NSAID
026439	0.4%	HYDROCODONE/APAP 10/500 TAB	Vicodin	Hydrocodone	Pain medication Class III
046214	0.4%	FLUOXETINE 20 MG CAPSULE	Prozac	Fluoxetine HCL 20 MG Capsule	Anti-depressant
046241	0.4%	TRAZODONE 50 MG TABLET	Desyrel	Trazodone	Anti-depressant
003689	0.3%	TEMAZEPAM 15MG CAPSULE	Restoril	Temazepam	Sleep aid
003773	0.3%	ALPRAZOLAM 0.25MG TABLET	Xanax	Alprazolam	Anti-anxiety
003774	0.3%	ALPRAZOLAM 0.5MG TABLET	Xanax	Alprazolam	Anti-anxiety
019187	0.3%	AMBIEN 5MG TABLET	Ambien	Zolpidem	Sedative/hypnotics
021413	0.3%	NEURONTIN 100MG CAPSULE	Neurontin	Gabapentin	Anti-seizure
030107	0.3%	PREVACID 30 MG CAPSULE DR	Prevacid	Lansoprazole SR	PPI/anti-acid
041285	0.3%	CELEBREX 100MG CAPSULE	Celebrex	Celecoxib	NSAID
041805	0.3%	NEURONTIN 600 MG TABLET	Neurontin	Gabapentin	Anti-seizure
044758	0.3%	VIOXX 50 MG TABLET	Vioxx		Cox II inhibitor
047431	0.3%	HYDROCODONE-APAP 7.5/325 TB	Norco 7.5/325 Tablet	Anexsia 7.5/325 MG Tablet	
047478	0.3%	FLEXERIL 5 MG TABLET	Flexeril	Cyclobenzaprine	Muscle Relaxant
050712	0.3%	LEXAPRO 10 MG TABLET	Lexapro	Escitalopram oxalate	Anti-depressant

77.2% Top 50 as percent of all prescriptions (pharmacy and repackaged)

**Repackaged Drugs: Top 50 Drugs (GCN Sequence Number) by Paid \$**

GCN_S eqno	% of Repack Paid	Description	Brand	Generic	Drug class
011673	31.2%	RANITIDINE 150MG TABLET	Zantac	Ranitidine	Antacid
004663	25.6%	SOMA 350MG TABLET	Soma	Carisoprodol	Muscle relaxant
008362	8.6%	NAPROSYN 500MG TABLET	Naprosyn	Naproxen	NSAID
023139	5.2%	ULTRAM 50MG TABLET	Ultram	Tramadol	Analgesic
004204	2.9%	VICODIN 5/500 TABLET	Vicodin	Hydrocodone	Pain medication Class III
004273	2.8%	DARVOCET-N 100	Darvocet-N	Acetam & Propox.	Pain medication Class IV
008374	2.1%	VOLTAREN 75MG TABLET EC	Voltaren	Diclofenac	NSAID
008350	1.8%	MOTRIN 800MG TABLET	Motrin	Ibuprofen	NSAID
008371	1.6%	PIROXICAM 20MG CAPSULE	Feldene	Piroxicam	NSAID
004681	1.3%	FLEXERIL 10MG TABLET	Flexeril	Cyclobenzaprine	Muscle relaxant
008361	1.3%	NAPROSYN 375MG TABLET	Naprosyn	Naproxen	NSAID
004207	1.2%	VICODIN ES TABLET	Vicodin	Hydrocodone	Pain medication Class III
016899	1.1%	HYDROCODONE/APAP 10/650 TAB	Vicodin	Hydrocodone	Pain medication Class III
027368	1.0%	LODINE 500MG TABLET	Lodine	Etodolac	NSAID
020175	0.8%	LODINE 400MG TABLET	Lodine	Etodolac	NSAID
030623	0.8%	NORCO 10/325 TABLET	Vicodin	Hydrocodone	Pain medication Class III
041286	0.8%	CELEBREX 200MG CAPSULE	Celebrex	Celecoxib	NSAID
004165	0.7%	TYLENOL W/CODEINE #3 TABLET	Tylenol w/Codeine	Acetam.and Codeine	Pain reliever/fever reducer
009043	0.7%	CEPHALEXIN 500MG CAPSULE	Keflex	Cephalosporins	Antibiotic
019188	0.5%	AMBIEN 10MG TABLET	Ambien	Zolpidem	Sedative/hypnotics
008373	0.4%	VOLTAREN 50MG TABLET EC	Voltaren	Diclofenac	NSAID
015961	0.4%	LODINE 300MG CAPSULE	Lodine	Etodolac	NSAID

017204	0.4%	DAYPRO 600MG CAPLET	Daypro	Oxaprozin	NSAID
004660	0.3%	PARAFON FORTE DSC 500MG CPT	Parafon Forte	Chlorzoxazone	Muscle relaxant
011667	0.3%	CIMETIDINE 400MG TABLET	Tagamet	Cimetidine	Histamine receptor antagonists
016574	0.3%	RELAFEN 500MG TABLET	Relafen	Nabumetone	NSAID
042635	0.3%	VIOXX 25MG TABLET	Vioxx		Cox II Inhibitor
046046	0.3%	EFFEXOR XR 75 MG CAPSULE SA	Effexor	Venlafaxine	Anti-depressant
003690	0.2%	TEMAZEPAM 30MG CAPSULE	Restoril	Temazepam	Sleep aid
003694	0.2%	HALCION 0.25MG TABLET	Halcion	Triazolam	Sleep aid
004205	0.2%	HYDROCODONE/APAP 7.5/500 TB	Vicodin	Hydrocodone	Pain medication Class III
004655	0.2%	METHOCARBAMOL 750MG TABLET	Robaxin	Methocarbamol	Muscle relaxant
008349	0.2%	MOTRIN 600MG TABLET	Motrin	Ibuprofen	NSAID
030274	0.2%	ZANAFLEX 4MG TABLET	Zanaflex	Tizanidine HCL	Muscle relaxant
046214	0.2%	FLUOXETINE 20 MG CAPSULE	Prozac	Fluoxetine HCL 20 MG Capsule	Anti-depressant
046241	0.2%	TRAZODONE 50 MG TABLET	Desyrel	Trazodone	Anti-depressant
046242	0.2%	TRAZODONE 100 MG TABLET	Desyrel	Trazodone	Anti-depressant
003689	0.1%	TEMAZEPAM 15MG CAPSULE	Restoril	Temazepam	Sleep aid
003692	0.1%	FLURAZEPAM 30MG CAPSULE	Dalmane	Flurazepam	Sleep aid
003774	0.1%	ALPRAZOLAM 0.5MG TABLET	Xanax	Alprazolam	Anti-anxiety
004169	0.1%	TYLENOL W/CODEINE #4 TABLET	Tylenol w/Codeine	Acetam.and codeine	Pain reliever/fever reducer
008358	0.1%	ANAPROX DS 550MG TABLET	Aleve	Naproxen	NSAID
016575	0.1%	RELAFEN 750MG TABLET	Relafen	Nabumetone	NSAID
021414	0.1%	NEURONTIN 300MG CAPSULE	Neurontin	Gabapentin	Anti-seizure
030107	0.1%	PREVACID 30 MG CAPSULE DR	Prevacid	Lansoprazole SR	PPI/anti-acid
041285	0.1%	CELEBREX 100MG CAPSULE	Celebrex	Celecoxib	NSAID
046213	0.1%	FLUOXETINE HCL 10 MG CAPSULE	Prozac	Fluoxetine 10 MG Capsule	Anti-depressant
046229	0.1%	ZOLOFT 100 MG TABLET	Zoloft	Sertraline	Anti-depressant
046237	0.1%	WELLBUTRIN 100 MG TABLET	Wellbutrin	Bupropion HCL 100 MG Tablet	Anti-depressant

049798	0.1%	BEXTRA 20 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor
97.8%		Top 50 as percent of all repackaged paid amounts			



**Repackaged Drugs: Top 50 Drugs (GCN Sequence Number) by Number of Percent of Prescriptions**

GCN_S eqno	% of repack scripts	Description	Brand	Generic	Drug class
011673	15.7%	RANITIDINE 150MG TABLET	Zantac	Ranitidine	Antacid
004663	14.2%	SOMA 350MG TABLET	Soma	Carisoprodol	Muscle relaxant
008362	8.7%	NAPROSYN 500MG TABLET	Naprosyn	Naproxen	NSAID
004204	8.3%	VICODIN 5/500 TABLET	Vicodin	Hydrocodone	Pain medication Class III
023139	6.9%	ULTRAM 50MG TABLET	Ultram	Tramadol	Analgesic
008350	6.2%	MOTRIN 800MG TABLET	Motrin	Ibuprofen	NSAID
004273	6.1%	DARVOCET-N 100 TABLET	Darvocet-N	Acetam. & Propox.	Pain medication Class IV
004207	3.4%	VICODIN ES TABLET	Vicodin	Hydrocodone	Pain medication Class III
004681	2.5%	FLEXERIL 10MG TABLET	Flexeril	Cyclobenzaprine	Muscle relaxant
004165	2.0%	TYLENOL W/CODEINE #3 TABLET	Tylenol w/Codeine	Acetam. & Codeine	Pain reliever/fever reducer
008374	1.7%	VOLTAREN 75MG TABLET EC	Voltaren	Diclofenac	NSAID
008361	1.5%	NAPROSYN 375MG TABLET	Naprosyn	Naproxen	NSAID
008371	1.4%	PIROXICAM 20MG CAPSULE	Feldene	Piroxicam	NSAID
016899	1.3%	HYDROCODONE/APAP 10/650 TAB	Vicodin	Hydrocodone	Pain medication Class III
030623	1.3%	NORCO 10/325 TABLET	Vicodin	Hydrocodone	Pain medication Class III
009043	1.0%	CEPHALEXIN 500MG CAPSULE	Keflex	Cephalosporins	Antibiotic
020175	0.8%	LODINE 400MG TABLET	Lodine	Etodolac	NSAID
027368	0.8%	LODINE 500MG TABLET	Lodine	Etodolac	NSAID
041286	0.7%	CELEBREX 200MG CAPSULE	Celebrex	Celecoxib	NSAID
008373	0.5%	VOLTAREN 50MG TABLET EC	Voltaren	Diclofenac	NSAID
016574	0.4%	RELAFEN 500MG TABLET	Relafen	Nabumetone	NSAID
017204	0.4%	DAYPRO 600MG CAPLET	Daypro	Oxaprozin	NSAID
019188	0.4%	AMBIEN 10MG TABLET	Ambien	Zolpidem	Sedative/hypno



					tics
042635	0.3%	VIOXX 25MG TABLET	Vioxx		Cox II inhibitor
030274	0.2%	ZANAFLEX 4MG TABLET	Zanaflex	Tizanidine HCL	Muscle relaxant
041285	0.2%	CELEBREX 100MG CAPSULE	Celebrex	Celecoxib	NSAID
049798	0.2%	BEXTRA 20 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor
004664	0.1%	SKELAXIN 400MG TABLET	Skelaxin	Metaxalone	Muscle relaxant
021414	0.1%	NEURONTIN 300MG CAPSULE	Neurontin	Gabapentin	Anti-seizure
026439	0.1%	HYDROCODONE/APAP 10/500 TAB	Vicodin	Hydrocodone	Pain medication Class III
030107	0.1%	PREVACID 30 MG CAPSULE DR	Prevacid	Lansoprazole SR	PPI/anti-acid
048456	0.1%	ULTRACET TABLET	Ultracet	Tramadol	Opiate
050712	0.1%	LEXAPRO 10 MG TABLET	Lexapro	Escitalopram oxalate	Anti-depressant
051112	0.1%	SKELAXIN 800 MG TABLET	Skelaxin	Metaxalone	Muscle relaxent
019187	0.0%	AMBIEN 5MG TABLET	Ambien	Zolpidem	Sedative/hypnotics
024506	0.0%	OXYCONTIN 40MG TABLET SA	Oxycontin	Oxycodone	Opiate
025702	0.0%	OXYCONTIN 80MG TABLET SA	Oxycontin	Oxycodone	
027462	0.0%	PROTONIX 40 MG TABLET EC	Protonix	Pantoprazole	PPI/anti-acid
029156	0.0%	MOBIC 7.5 MG TABLET	Mobic	Meloxicam	NSAID
029837	0.0%	TOPAMAX 25 MG TABLET	Topomax	Topiramate	Anti-convulsant
033530	0.0%	PRILOSEC 20 MG CAPSULE DR	Prilosec	Omeprazole 20 MG CapsuleDR	Antacid
041805	0.0%	NEURONTIN 600 MG TABLET	Neurontin	Gabapentin	Anti-seizure
041806	0.0%	NEURONTIN 600 MG TABLET	Neurontin	Gabapentin	Anti-seizure
043256	0.0%	LIDODERM 5% PATCH			
044758	0.0%	VIOXX 50 MG TABLET	Vioxx		Cox II inhibitor
046228	0.0%	ZOLOFT 50 MG TABLET	Zoloft	Sertraline	Anti-depressant
046229	0.0%	ZOLOFT 100 MG TABLET	Zoloft	Sertraline	Anti-depressant
046404	0.0%	EFFEXOR XR 75 MG CAPSULE SA	Effexor	Venlafaxine	Anti-depressant
047526	0.0%	NEXIUM 40 MG CAPSULE	Nexium	Esomeprazole magnesium	Antacid
049795	0.0%	BEXTRA 10 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor

87.8% Top 50 as percent of all repackaged prescriptions



**Pharmacy: Top 50 Drugs (GCN Sequence Number) by Paid Amounts**

GCN_S eqno	% of Pharm \$	Description	Brand	Generic	Drug class
041286	7.4%	CELEBREX 200MG CAPSULE	Celebrex	Celecoxib	NSAID
043256	5.4%	LIDODERM 5% PATCH			
042635	4.4%	VIOXX 25MG TABLET	Vioxx		Cox II inhibitor
030623	3.9%	NORCO 10/325 TABLET	Vicodin	Hydrocodone	Pain medication Class III
049798	3.7%	BEXTRA 20 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor
021414	3.0%	NEURONTIN 300MG CAPSULE	Neurontin	Gabapentin	Anti-seizure
019188	2.9%	AMBIEN 10MG TABLET	Ambien	Zolpidem	Sedative/hypnotics
048456	1.9%	ULTRACET TABLET	Ultracet	Tramadol	Opiate
004204	1.8%	VICODIN 5/500 TABLET	Vicodin	Hydrocodone	Pain medication Class III
004663	1.8%	SOMA 350MG TABLET	Soma	Carisoprodol	Muscle relaxant
024506	1.8%	OXYCONTIN 40MG TABLET SA	Oxycontin	Oxycodone	Opiate
051112	1.7%	SKELAXIN 800 MG TABLET	Skelaxin	Metaxalone	Muscle relaxant
041805	1.6%	NEURONTIN 600 MG TABLET	Neurontin	Gabapentin	Anti-seizure
025702	1.5%	OXYCONTIN 80MG TABLET SA	Oxycontin	Oxycodone	
049795	1.5%	BEXTRA 10 MG TABLET	BEXTRA	Valdecoxib	Cox-II inhibitor
030107	1.1%	PREVACID 30 MG CAPSULE DR	Prevacid	Lansoprazole SR	PPI/anti-acid
024505	1.0%	OXYCONTIN 20MG TABLET SA	Oxycontin	Oxycodone	Opiate
004207	0.9%	VICODIN ES TABLET	Vicodin	Hydrocodone	Pain medication Class III
004273	0.8%	DARVOCET-N 100 TABLET	Darvocet-N	Acetam. & propox.	Pain medication Class IV
015881	0.8%	DURAGESIC 50MCG/HR PATCH	Duragesic	Fentanyl topical	Narcotic analgesics
015883	0.8%	DURAGESIC 100MCG/HR PATCH	Duragesic	Fentanyl topical	Narcotic analgesics
023139	0.8%	ULTRAM 50MG TABLET	Ultram	Tramadol	Analgesic
033530	0.8%	PRILOSEC 20 MG CAPSULE DR	PriLOSEC	Omeprazole 20 MG Capsule DR	Antacid
044758	0.8%	VIOXX 50 MG TABLET	Vioxx		Cox II inhibitor
004681	0.7%	FLEXERIL 10MG TABLET	Flexeril	Cyclobenzaprine	Muscle relaxant

029837	0.7%	TOPAMAX 25 MG TABLET	Topomax	Topiramate	Anti-convulsant
030274	0.7%	ZANAFLEX 4MG TABLET	Zanaflex	Tizanidine HCL	Muscle relaxant
041806	0.7%	NEURONTIN 800 MG TABLET	Neurontin	Gabapentin	Anti-seizure
046228	0.7%	ZOLOFT 50 MG TABLET	Zoloft	Sertraline	Anti-depressant
008350	0.6%	MOTRIN 800MG TABLET	Motrin	Ibuprofen	NSAID
019187	0.6%	AMBIEN 5MG TABLET	Ambien	Zolpidem	Sedative/hypnotics
029156	0.6%	MOBIC 7.5 MG TABLET	Mobic	Meloxicam	NSAID
046229	0.6%	ZOLOFT 100 MG TABLET	Zoloft	Sertraline	Anti-depressant
046404	0.6%	EFFEXOR XR 75 MG CAPSULE SA	Effexor	Venlafaxine	Anti-depressant
047526	0.6%	NEXIUM 40 MG CAPSULE	Nexium	Esomeprazole magnesium	Antacid
050712	0.6%	LEXAPRO 10 MG TABLET	Lexapro	Escitalopram oxalate	Anti-depressant
004664	0.5%	SKELAXIN 400MG TABLET	Skelaxin	Metaxalone	Muscle relaxant
008362	0.5%	NAPROSYN 500MG TABLET	Naprosyn	Naproxen	NSAID
009043	0.5%	CEPHALEXIN 500MG CAPSULE	Keflex	Cephalosporins	Antibiotic
013724	0.5%	DIFLUCAN 200MG TABLET	Diflucan	Fluconazole	Antifungal
015882	0.5%	DURAGESIC 75MCG/HR PATCH	Duragesic	Fentanyl topical	Narcotic analgesics
022479	0.5%	IMITREX 50MG TABLET	Imitrex	Sumatriptan	Migraine
027462	0.5%	PROTONIX 40 MG TABLET EC	Protonix	Pantoprazole	PPI/anti-acid
041285	0.5%	CELEBREX 100MG CAPSULE	Celebrex	Celecoxib	NSAID
046405	0.5%	EFFEXOR XR 150 MG CAPSULE SA	Effexor	Venlafaxine	Anti-depressant
047478	0.5%	FLEXERIL 5 MG TABLET	Flexeril	Cyclobenzaprine	Muscle relaxant
021415	0.4%	NEURONTIN 400MG CAPSULE	Neurontin	Gabapentin	Anti-seizure
026170	0.4%	TOPAMAX 100 MG TABLET	Topomax	Topiramate	Anti-convulsant
029157	0.4%	MOBIC 15 MG TABLET	Mobic	Meloxicam	NSAID
029928	0.4%	LEVAQUIN 500MG TABLET	Levaquin	Levofloxacin	Anti-bacterial

66.4% Top 50 as percent of all pharmacy paid amounts

Pharmacy: Top 50 Drugs (GCN Sequence Number) by Prescriptions Written

GCN_S eqno	% of Pharm scripts	Description	Brand	Generic	Drug class	Pct * 1999	rank 99 *
004204	11.3%	VICODIN 5/500 TABLET	Vicodin	Hydrocodone	Pain, Class III	10.2%	1
030623	4.3%	NORCO 10/325 TABLET	Vicodin	Hydrocodone	Pain, Class III	0.9%	20
004663	4.1%	SOMA 350MG TABLET	Soma	Carisoprodol	Muscle relaxant	4.9%	2
004207	3.9%	VICODIN ES TABLET	Vicodin	Hydrocodone	Pain, Class III	4.1%	4
041286	3.8%	CELEBREX 200MG CAPSULE	Celebrex	Celecoxib	NSAID	1.3%	12
004273	3.3%	DARVOCET-N 100 TABLET	DarvocetN	Acetam. & Propoxyp	Pain, Class IV	4.8%	3
008350	3.2%	MOTRIN 800MG TABLET	Motrin	Ibuprofen	NSAID	3.2%	6
042635	2.8%	VIOXX 25MG TABLET	Vioxx		Cox II inhibitor	0.3%	61
004681	2.4%	FLEXERIL 10MG TABLET	Flexeril	Cyclobenzaprine	Muscle relaxant	3.0%	7
008362	2.3%	NAPROSYN 500MG TABLET	Naprosyn	Naproxen	NSAID	1.9%	9
049798	2.1%	BEXTRA 20 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor	.	.
019188	2.0%	AMBIEN 10MG TABLET	Ambien	Zolpidem	Sleep aid	1.2%	13
023139	1.9%	ULTRAM 50MG TABLET	Ultram	Tramadol	Analgesic	4.0%	5
008349	1.8%	MOTRIN 600MG TABLET	Motrin	Ibuprofen	NSAID	1.8%	10
048456	1.7%	ULTRACET TABLET	Ultracet	Tramadol	Opiate	.	.
009043	1.6%	CEPHALEXIN 500MG CAPSULE	Keflex	Cephalosporins	Antibiotic	0.7%	25
043256	1.5%	LIDODERM 5% PATCH				.	.
004165	1.4%	TYLENOL W/CODEINE #3 TABLET	Tylenol/cod	Codeine	Narcotic-analgesic	2.4%	8
021414	1.4%	NEURONTIN 300MG CAPSULE	Neurontin	Gabapentin	Anti-seizure	1.1%	15
051112	0.9%	SKELAXIN 800 MG TABLET	Skelaxin	Metaxalone	Muscle relaxant	.	.
011673	0.8%	RANITIDINE 150MG TABLET	Zantac	Ranitidine	Antacid	0.5%	38
049795	0.8%	BEXTRA 10 MG TABLET	Bextra	Valdecoxib	Cox-II inhibitor	.	.
003768	0.6%	DIAZEPAM 5MG TABLET	Valium	Diazepam	Anti-anxiety	0.8%	23
004205	0.6%	HYDROCODONE/APAP 7.5/500 TB	Vicodin	Hydrocodone	Pain, Class III	1.2%	14
026439	0.6%	HYDROCODONE/APAP 10/500 TAB	Vicodin	Hydrocodone	Pain, Class III	0.7%	24
030274	0.6%	ZANAFLEX 4MG TABLET	Zanaflex	Tizanidine HCL	Muscle relaxant	0.2%	81
046046	0.6%	ELAVIL 25 MG TABLET	Elavil	Amitriptyline HCL 25 MG Tab	Anti-depressant	.	.
047478	0.5%	FLEXERIL 5 MG	Flexeril	Cyclobenzaprin	Muscle relaxant	.	.

		TABLET			e		
003766	0.4%	DIAZEPAM 10MG TABLET	Diastat	Diazepam	Anti-anxiety	0.7%	27
003774	0.4%	ALPRAZOLAM 0.5MG TABLET	Xanax	Alprazolam	Anti-anxiety	0.4%	39
008374	0.4%	VOLTAREN 75MG TABLET EC	Voltaren	Diclofenac	NSAID	0.6%	29
016574	0.4%	RELAFEN 500MG TABLET	Relafen	Nabumetone	NSAID	1.0%	16
016899	0.4%	HYDROCODONE/APAP 10/650 TAB	Vicodin	Hydrocodone	Pain, Class III	1.0%	17
019187	0.4%	AMBIEN 5MG TABLET	Ambien	Zolpidem	Sleep aid	0.3%	57
021413	0.4%	NEURONTIN 100MG CAPSULE	Neurontin	Gabapentin	Anti-seizure	0.3%	59
030107	0.4%	PREVACID 30 MG CAPSULE DR	Prevacid	Lansoprazole SR	PPI/anti-acid	.	.
041805	0.4%	NEURONTIN 600 MG TABLET	Neurontin	gabapentin	Anti-seizure	.	.
044758	0.4%	VIOXX 50 MG TABLET	Vioxx		Cox II inhibitor	.	.
046214	0.4%	FLUOXETINE 20 MG CAPSULE	Prozac	FLUOXETINE HCL 20 MG CAPSULE	Anti-depressant	.	.
046228	0.4%	ZOLOFT 50 MG TABLET	Zoloft	Sertraline	Anti-depressant	.	.
046241	0.4%	TRAZODONE 50 MG TABLET	Desyrel	Trazodone	Anti-depressant	.	.
047431	0.4%	HYDROCODONE- APAP 7.5/325 TB	Norco 7.5/325 Tablet	Anexsia 7.5/325 MG Tablet		.	.
050712	0.4%	LEXAPRO 10 MG TABLET	Lexapro	Escitalopram oxalate	Anti-depressant	.	.
003758	0.3%	ATIVAN 1MG TABLET	Ativan	Lorazepam	Relieve anxiety	0.4%	51
003773	0.3%	ALPRAZOLAM 0.25MG TABLET	Xanax	Alprazolam	Anti-anxiety	0.3%	66
004655	0.3%	METHOCARBAMOL 750MG TAB	Robaxin	Methocarbamol	Muscle relaxant	0.8%	22
004664	0.3%	SKELAXIN 400MG TABLET	Skelaxin	Metaxalone	Muscle relaxant	0.5%	35
029837	0.3%	TOPAMAX 25 MG TABLET	Topomax	Topiramate	Anti-convulsant	.	.
033530	0.3%	PRILOSEC 20 MG CAPSULE DR	Prilosec	Omeprazole 20 MG CapsuleDR	Antacid	.	.
041285	0.3%	CELEBREX 100MG CAPSULE	Celebrex	Celecoxib	NSAID	0.7%	28
70.9%		Top 50 as percent of all pharmacy prescriptions					

\* In the study done for CHSWC, published in 2000, the authors estimated the distribution of the top pharmacy-dispensed drugs. Those data, both percent and rank are presented here for comparison purposes. There was considerable change in the distribution of drugs just in the 5 years between data sets for these two studies.

**Appendix 2—Data Descriptions**ICIS Description

Data on pharmacy transaction in California Workers' compensation system including:

- Drug description
- NDC
- Units dispensed
- Billed amount
- Paid amount
- Service date

were compiled from the Industry Claim Information System (ICIS) maintained by the California Workers' Compensation Institute (CWCI).<sup>13</sup> Nine national or regional (west coast) workers' compensation insurers, representing over 75 percent of the total insurance premium written in the California workers' compensation system, as well as several large self-insured employers, submitted data for the ICIS database. The ICIS data used in this study were comprised of open and closed claims with pharmacy benefit payments between January 1, 2002, and June 30, 2004, with all payments made for service dates through June 30, 2004. These claims are representative of the broad range of policies (industry type and premium/payroll size) and claim characteristics (injury type, demographics) found in the overall population of California workers' compensation injuries or claims. This study used over 1.3 million prescriptions reflecting over \$84 million in payments.

A random sample of all submitted prescriptions was extracted from the CWCI/ICIS database for the years January 1, 2002 to June 31, 2004. The sample included 1,470,071 scripts paid by insurers during this period. The insurers sampled were approximately 70% of the insured market.

Of the sample, 10,141 records had missing National Drug Codes (NDCs). They were excluded because information could not be attached to identify the drug prescribed. Of the remaining 1,459,930 cases, 159,259 did not match a current NDC. Of these, 21,899 could be matched to a prior NDC (using the data element PNDC in the First Data Bank file). This left 1,322,570 records.

4,397 records were deleted because no units.

84,191 records were dropped because they were over-the-counter transactions. Over-the-counter paid amounts were 1.1% of the sample's paid amounts.

All prescriptions for one specific drug, Botox, were dropped because the unit values were often incorrect. There were only 31 records, one of which was a repackaged case. The price on the repackaged case was only marginally higher than the others.

This left a working file of 1,233,951.

Of these, 17,767 or 1.4% had paid amounts of \$0. These were eliminated as non-reimbursed.

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<sup>13</sup> ICIS is a proprietary database maintained by the California Workers' Compensation Institute (CWCI) that contains detailed information, including employer and employee characteristics, medical-service information, and benefit-cost and other administrative-cost information on over 2.5 million workplace injuries.

In addition, 2,177 cases that were listed as “durable medical equipment” were dropped.

Finally, one case with an erroneous amount paid value (AMTPD=9999.99) was dropped.

The final sample size was 1,214,000 prescriptions.

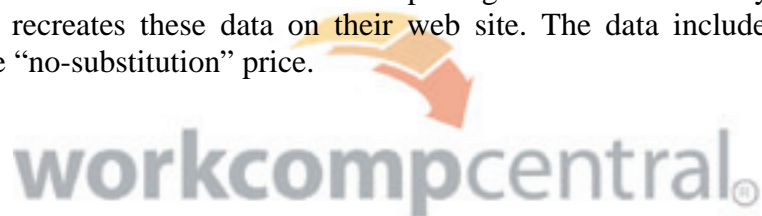
#### First Data Bank (FDB)

First Data Bank (FDB) is one of two primary sources for pricing information on the full range of prescriptions drugs, durable medical equipment, and over-the-counter products. FDB maintains data on every NDC and includes, among other, the following data:

- Drug description
- NDC
- GCN-Sequence Number (identifies therapeutically equivalent drugs)
- Brand/Generic indicator
- Repackage indicator
- Prices for all service dates and pricing regimes (FUL, AWP, etc.)

#### MediCal Pricing

MediCal makes available on the Internet the pricing standards for every drug (NDC) covered by MediCal. DWC recreates these data on their web site. The data include the FUL/MAIC price, if available and the “no-substitution” price.





**Appendix 3: BUSINESS AND PROFESSIONS CODE**  
**SECTION 4170-4175 [covering physician dispensing]**

4170. (a) No prescriber shall dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph

(4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, a manufacturer as defined in this chapter, or a pharmacist.

(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person, who holds a physician's and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, or a certificate to practice podiatry, and who is duly registered by the Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, or the Board of Osteopathic Examiners of this state.

4170.5. (a) Veterinarians in a veterinary teaching hospital operated by an accredited veterinary medical school may dispense and administer dangerous drugs and devices and controlled substances from a common stock.

(b) The veterinary teaching hospital shall designate a pharmacist to be responsible for ordering the drugs for the common stock and the designated

pharmacist-in-charge shall be professionally responsible to insure that inventories, security procedures, training, protocol development, recordkeeping, packaging, labeling, and dispensing occur in a manner that is consistent with the promotion and protection of the health and safety of the public.

(c) The veterinary teaching hospital's pharmacist-in-charge shall develop policies, procedures, and guidelines that recognize the unique relationship between the institution's pharmacists and veterinarians in the control, management, dispensation, and administration of drugs.

(d) The board may inspect a veterinary teaching hospital dispensing or administering drugs pursuant to this section.

4171. (a) Section 4170 shall not prohibit the furnishing of a limited quantity of samples by a prescriber, if the prescriber dispenses the samples to the patient in the package provided by the manufacturer, no charge is made to the patient therefor, and an appropriate record is entered in the patient's chart.

(b) Section 4170 shall not apply to clinics, as defined in subdivision (a) of Section 1204 or subdivision (b) or (c) of Section 1206 of the Health and Safety Code, to programs licensed pursuant to Sections 11876, 11877, and 11877.5 of the Health and Safety Code, or to a prescriber dispensing parenteral chemotherapeutic agents, biologicals, or delivery systems used in the treatment of cancer.

4172. A prescriber who dispenses drugs pursuant to Section 4170 shall store all drugs to be dispensed in an area that is secure. The Medical Board of California shall, by regulation, define the term "secure" for purposes of this section.

4173. This chapter does not prevent the dispensing of drugs or devices by registered nurses functioning pursuant to Section 2725.1.

4174. Notwithstanding any other provision of law, a pharmacist may dispense drugs or devices upon the drug order of a nurse practitioner functioning pursuant to Section 2836.1 or a certified nurse-midwife functioning pursuant to Section 2746.51, a drug order of a physician assistant functioning pursuant to Section 3502.1 or a naturopathic doctor functioning pursuant to Section 3640.5, or the order of a pharmacist acting under Section 4052.

4175. (a) The California State Board of Pharmacy shall promptly forward to the appropriate licensing entity, including the Medical Board of California, the Veterinary Medical Board, the Dental Board of California, the State Board of Optometry, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Bureau of Naturopathic Medicine, or the Physician Assistant Committee, all complaints received related to dangerous drugs or dangerous devices dispensed by a prescriber, certified nurse-midwife, nurse practitioner, naturopathic doctor, or physician assistant pursuant to Section 4170.

(b) All complaints involving serious bodily injury due to dangerous drugs or dangerous devices dispensed by prescribers, certified nurse-midwives, nurse practitioners, naturopathic doctors, or physician assistants pursuant to Section 4170 shall be handled by the Medical Board of California, the Dental Board of California, the State Board of Optometry, the Osteopathic Medical Board of California, the Bureau of Naturopathic Medicine, the Board of Registered Nursing, the Veterinary Medical Board, or the Physician Assistant Committee as a case of greatest potential harm to a patient.



Appendix 4: Court case supporting physician dispensing

*99 Cal. App. 4th 247, \*; 120 Cal. Rptr. 2d 858, \*\*;  
2002 Cal. App. LEXIS 4225, \*\*\*; 67 Cal. Comp. Cas 770*

PARK MEDICAL PHARMACY, Plaintiff and Appellant, v. SAN DIEGO ORTHOPEDIC ASSOCIATES  
MEDICAL GROUP, INC., Defendant and Respondent.

No. **D038051**.

COURT OF APPEAL OF CALIFORNIA, FOURTH APPELLATE DISTRICT, DIVISION ONE


99 Cal. App. 4th 247; 120 Cal. Rptr. 2d 858; 2002 Cal. App. LEXIS 4225; 67 Cal. Comp. Cas  
770; 2002 Cal. Daily Op. Service 5171; 2002 Daily Journal DAR 6542

June 11, 2002, Decided  
June 11, 2002, Filed

**PRIOR HISTORY:** [\*\*\*1] APPEAL from a judgment of the Superior Court of San Diego  
County. Super. Ct. No. GIC754386. S. Charles Wickersham, Judge.

**DISPOSITION:** The judgment is affirmed.

**CASE SUMMARY:**



**PROCEDURAL POSTURE:** Plaintiff pharmacy sued defendant medical group for dispensing  
drugs in violation of the Cal. Bus. & Prof. Code § 4170 and for unlawfully operating a retail  
pharmacy. The medical group moved the summary judgment, which was granted in favor of the  
medical group by the Superior Court of San Diego County (California). The pharmacy appealed.

**OVERVIEW:** The physicians of the medical group individually dispensed drugs on a for-profit  
basis to their worker's compensation patients after informing the patients that they could get a  
prescription that could be filled anywhere. The pharmacy also alleged that the medical group  
interfered with its business by diverting patients away from the pharmacy and included causes of  
action for violations of unfair business practices. The appellate court found that: (1) under the  
provisions of Cal. Bus. & Prof. Code § 4170 the medical group was entitled to dispense drugs on  
a for-profit basis to their patients as a part of their treatment, (2) maintaining a separate room  
to hold the drugs was not a "pharmacy" because the drugs were not for sale to the public, and  
(3) the legislative intent was to prohibit physicians from having a store where they sold drugs to  
the general public, and to limit physicians to dispensing drugs to their own patients for the  
condition for which the patient was seeking treatment.

**OUTCOME:** The judgment of the superior court was affirmed.

## Appendix 5

**Title 8, California Code of Regulations**  
**Chapter 4.5, Division of Workers' Compensation**  
**Subchapter 1 - Administrative Director – Administrative Rules**

**Article 5.3**

**Section 9789.40**

(a) The maximum reasonable fee for pharmaceuticals and pharmacy services rendered after January 1, 2004 is 100% of the fee reimbursement prescribed in the relevant Medi-Cal payment system, including the Medi-Cal professional fee for dispensing. Medi-Cal rates will be made available on the Division of Workers' Compensation's Internet Website ([http://www.dir.ca.gov/DWC/dwc\\_home\\_page.htm](http://www.dir.ca.gov/DWC/dwc_home_page.htm)) or upon request to the Administrative Director at:

DIVISION OF WORKERS' COMPENSATION  
(ATTENTION: OMFS - PHARMACY)  
P.O. BOX 420603  
SAN FRANCISCO, CA 94142.

(b) For a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003-determined in accordance with this subdivision, plus \$7.25 professional fee for dispensing or \$8.00 if the patient is in a skilled nursing facility or an intermediate care facility.

(1) If the National Drug Code for the drug product as dispensed is not in the Medi-Cal database, and the National Drug Code for the underlying drug product from the original labeler appears in the Medi-Cal database, then the maximum fee shall be the reimbursement allowed pursuant to section 14105.45 of the Welfare and Institutions Code using the National Drug Code for the underlying drug product from the original labeler as it appears in the Medi-Cal database, calculated on a per unit basis. The maximum fee shall include only a single professional fee for dispensing for each dispensing.

(2) If the National Drug Code for the drug product as dispensed is not in the Medi-Cal database and the National Drug Code for the underlying drug product from the original labeler is not in the Medi-Cal database, then the reimbursement shall be 83 percent of the average wholesale price of the lowest priced therapeutically equivalent drug, calculated on a per unit basis.

(c) For purposes of this section:

(1) “therapeutically equivalent drugs” means drugs that have been assigned the same Therapeutic Equivalent Code starting with the letter “A” in the Food and Drug Administration’s publication “Approved Drug Products with Therapeutic Equivalence Evaluations” (“Orange Book”). The Orange Book may be accessed through the Food and Drug Administration’s website: <http://www.fda.gov/cder/orange/default.htm>;

(2) “National Drug Code for the underlying drug product from the original labeler” means the National Drug Code of the drug product actually utilized by the repackager in producing the repackaged product.

(d) The changes made to this Section in 2006 shall be applicable to all pharmaceuticals dispensed or provided on or after December 1, 2006.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.



**Part B**  
**Plans Subject to Insurance Commissioner Approval**

The WCIRB is recommending:

1. Amendments to the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (Title 10, California Code of Regulations, Section 2318.6), to be effective July 1, 2007 and applied as of the first anniversary rate date of a risk on or after July 1, 2007 (Section A); and
2. Amendments to the *California Workers' Compensation Experience Rating Plan—1995* (Title 10, California Code of Regulations, Section 2353.1), to be effective July 1, 2007 and applied as of the first anniversary rating date of a risk on or after July 1, 2007 (Section B).



**Part B  
Section A  
Recommended Amendments to the *California Workers' Compensation Uniform Statistical Reporting Plan—1995*  
Title 10, California Code of Regulations, Section 2318.6  
Effective July 1, 2007**

It is recommended that the following amendments to the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP) be approved effective July 1, 2007 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after July 1, 2007.

Amend Part 1, *General Provisions*, Section I, *Introduction*, Rule 3, *Effective Date*, to show that the effective date of the amended USRP is 12:01 A.M., July 1, 2007.

PROPOSED

**Part 1 — General Provisions**

**Section I — Introduction**

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**3. Effective Date**

The provisions of this Plan are effective at 12:01 A.M., ~~January 1, 2007~~ July 1, 2007. When a change in this Plan is approved, a notice summarizing the change and its effective date, as specified by the Insurance Commissioner, will be published by the WCIRB.

This Plan and all amendments thereto, unless otherwise specifically provided, shall be applied as of the first anniversary rating date of the risk, as established by the WCIRB, which is on or after the effective date of the change but shall not otherwise be available to outstanding ratings.

\* \* \* \* \*

Amend Part 3, *Standard Classification System*, Section VI, *Administration of Classification System*, to address the audit requirements related to 2006 legislation (Assembly Bill No. 881), which requires each policy written for a C-39 licensed contractor to be audited and to clarify the applicability of the change in the physical audit threshold from \$16,000 to \$10,000 that was adopted effective January 1, 2007.

PROPOSED

**Part 3 – Standard Classification System**

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**Section VI – Administration of Classification System**

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**4. Audit of Payroll**

The audit and assignment of payroll shall be governed by the rules, classifications and pure premium rates contained herein, subject to the following specific requirements:

- a. The insurer shall make an actual audit of the employer’s records for the purpose of determining the payroll in accordance with the following:
  - (1) Each policy producing a final premium of \$10,000 or more shall be audited at least once a year. (See Part 4, Section II, *Definitions*, for the definition of “Final Premium.”)
  - (2) Each policy producing a final premium of less than ~~\$16,000~~ 10,000 shall be audited at sufficient intervals to ensure determination of proper payrolls. (See Part 4, Section II, *Definitions*, for the definition of “Final Premium.”) In each year when such a policy is not audited, a signed payroll statement shall be obtained from the employer. In the event that neither an audit nor a signed statement of payroll is obtained, the insurer shall comply with the rules for reporting unaudited exposure on unit statistical reports found in Part 4, Section III, Rule 22d, *Estimated Exposure Indicator*, and Section IV, Rule 4, *Exposure Amount*, of this Plan.
  - (3) Notwithstanding subsections (1) and (2), each policy insuring the holder of a C-39 license from the Contractors State License Board shall be audited at least once a year.

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Amend Part 4, *Unit Statistical Report Filing Requirements*, Section I, *General Instructions*, to clarify the timing of the unit statistical report filing requirements.

PROPOSED

**Part 4 – Unit Statistical Report Filing Requirements**

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**Section I – General Instructions**

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**7. Date of Filing**

Unit statistical report data shall be filed as follows:

**a. First Reports**

The first reporting of exposure, premium and loss information is due in the WCIRB no later than twenty (20) months after the ~~month of the~~ inception date of the policy.

**b. Second Reports**

The second reporting of losses is due in the WCIRB no later than thirty-two (32) months after the ~~month of the~~ inception date of the policy.

**c. Third Reports**

The third reporting of losses is due in the WCIRB no later than forty-four (44) months after the ~~month of the~~ inception date of the policy.

**d. Fourth Reports**

The fourth reporting of losses is due in the WCIRB no later than fifty-six (56) months after the ~~month of the~~ inception date of the policy.

**e. Fifth Reports**

The fifth reporting of losses is due in the WCIRB no later than sixty-eight (68) months after the ~~month of the~~ inception date of the policy.

**f. Sixth Reports**

The sixth reporting of losses is due in the WCIRB no later than eighty (80) months after the ~~month of the~~ inception date of the policy.

**g. Seventh Reports**

The seventh reporting of losses is due in the WCIRB no later than ninety-two (92) months after the ~~month of the~~ inception date of the policy.

**h. Eighth Reports**

The eighth reporting of losses is due in the WCIRB no later than one hundred four (104) months after the ~~month of the~~ inception date of the policy.

**i. Ninth Reports**

The ninth reporting of losses is due in the WCIRB no later than one hundred sixteen (116) months after the ~~month of the~~ inception date of the policy.

**j. Tenth Reports**

The tenth reporting of losses is due in the WCIRB no later than one hundred twenty-eight (128) months after the ~~month of the~~ inception date of the policy.

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Amend Part 4, *Unit Statistical Report Filing Requirements*, Section II, *Definitions*, to clarify the example pertaining to final premium to indicate that any surcharges for policyholder audits charged by the insurer pursuant to provisions in 2006 legislation (Assembly Bill No. 881) are to be included in reported final premium amounts.

PROPOSED

**Part 4 – Unit Statistical Report Filing Requirements**

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**Section II – Definitions**

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**11. Final Premium(s)**

Reported in the “Total Standard Premium” field on the unit statistical report, this is the total premium charged to the policyholder, EXCEPT that it does not include the following:

- a. Reinsurance assumed,
- b. Adjustment for reinsurance ceded,
- c. Retrospective rating adjustments,
- d. Policyholder dividends,
- e. Application of deductible credits,
- f. Premium charges arising from the Terrorism Risk Insurance Act of 2002, and
- g. Policy assessments, including California Insurance Guarantee Association (CIGA) assessments, California Workers’ Compensation Revolving Fund assessments, and California workers’ compensation fraud surcharges.

The following hypothetical examples illustrate how final premiums on two large policies are to be determined (assuming, for simplicity, that retrospective rating adjustments and policy-



holder dividends do not apply to these two policies, but a charge arising from the Terrorism Risk Insurance Act of 2002 does apply):

		Example One	Example Two
(1)	Subject Premium (Based on exposure and insurer's rates)	\$ 100,000	\$ 200,000
(2)	Experience Rating Credit	20,000	—
(3)	Experience Rating Debit	—	10,000
(4)	Deductible Credit	—	50,000
(5)	Other Credit Adjustments*	30,000	2,000
(6)	Other Debit Adjustments**	5,000	3,000
(7)	Charge for Terrorism Risk Insurance Act of 2002	500	1,500
(8)	Actual Premium Charged [ (1) + (3) + (6) + (7) ] - [ (2) + (4) + (5) ]	55,500	162,500
(9)	<b>Final Premium to be Reported</b> [ (1) + (3) + (6) ] - [ (2) + (5) ], or simply (8) + (4) - (7)	<b>\$ 55,000</b>	<b>\$ 211,000</b>

\* schedule rating credits, merit rating credits, premium discounts, Insolvent Insurer Rating Adjustment Factor credits, etc., if applicable.

\*\* schedule rating debits, surcharge for waiver of subrogation, surcharge for Coverage B increased limits, surcharge for policyholder audits authorized by Insurance Code Section 11665, Insolvent Insurer Rating Adjustment Factor debits, etc., if applicable.



**Part B  
Section B  
Recommended Amendments to the *California Workers' Compensation Experience Rating Plan—1995*  
Title 10, California Code of Regulations, Section 2353.1  
Effective July 1, 2007**

It is recommended that the following amendments to the *California Workers' Compensation Experience Rating Plan—1995* (ERP) be approved effective July 1, 2007 with respect to new and renewal policies as of the first anniversary rating date of a risk on or after July 1, 2007.

Amend Section I, *General Provisions*, Rule 2, *Effective Date*, to show that the effective date of the amended Experience Rating Plan is 12:01 A.M., July 1, 2007.

PROPOSED

**Section I — General Provisions**

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**2. Effective Date**

The rules and rating values of this Plan are effective at 12:01 A.M., ~~January 1, 2007~~ July 1, 2007. When a change in this Plan is approved, a notice summarizing the change and its effective date, as specified by the Insurance Commissioner, will be published by the WCIRB.

This Plan and all amendments thereto, unless otherwise specifically provided, shall be applied as of the first anniversary rating date of the risk, as established by the WCIRB, that is on or after the effective date of the change, but shall not otherwise be available to outstanding ratings. No policy may be cancelled or rewritten to avoid application of this provision.

\* \* \* \* \*

Amend Section III, *Eligibility and Experience Period*, Rule 1, *Eligibility Requirements for California Workers' Compensation Insurance*, to adjust the eligibility requirement from \$16,000 to \$14,192 to reflect the amendments in pure premium rates proposed in this filing.

PROPOSED

**Section III — Eligibility and Experience Period**

1. **Eligibility Requirements for California Workers' Compensation Insurance.** A risk shall qualify for experience rating of its California workers' compensation insurance premium under this Plan if not less than ~~\$16,000~~ \$14,192 is produced by applying pure premium rates to the total remuneration that would be used in the experience rating calculation for the risk.

Only completed policy periods shall be used in determining eligibility. Any risk eligible for experience rating shall be experience rated.

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Amend the expected loss rates shown in Table II, *Expected Loss Rates and Full Coverage D-Ratios*, to reflect the most current loss experience available.<sup>1</sup>

PROPOSED



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<sup>1</sup> The WCIRB is not proposing any changes to the "D-ratios" contained in Table 2.

**Table II**  
**Expected Loss Rates and Full Coverage D-Ratios (Proposed)**  
**Effective July 1, 2007**

Legend:

(A) See Page B:B-5 of this Expected Loss Rate Section

Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio
0005	2.53	0.24	2117	5.70	0.25	3082	4.35	0.21	3821	4.43	0.20	4558	2.50	0.19
0016	3.91	0.23	2121	3.02	0.23	3085	5.47	0.21	3828	3.04	0.21	4611	1.48	0.23
0034	3.31	0.24	2142	1.71	0.26	3099	2.62	0.23	3830	2.35	0.23	4623	3.41	0.20
0035	2.63	0.20	2150	3.94	0.20	3110	3.73	0.19	3831	1.36	0.21	4635	1.71	0.20
0036	4.27	0.24	2163	3.66	0.25	3131	2.23	0.21	3840	2.33	0.23	4665	3.95	0.22
0038	5.57	0.21	2211	6.10	0.22	3146	3.20	0.20	4000	2.20	0.20	4683	3.36	0.22
0040	1.97	0.23	2222	3.52	0.20	3152	1.98	0.21	4034	4.45	0.22	4691	2.08	0.20
0041	2.79	0.21	2362	4.41	0.20	3165	2.29	0.20	4036	1.28	0.23	4692	0.73	0.22
0042	3.04	0.21	2402	3.24	0.20	3169	3.35	0.22	4038	3.90	0.20	4717	3.71	0.21
0044	2.86	0.22	2413	4.40	0.20	3175	3.73	0.23	4041	3.27	0.21	4720	2.00	0.21
0045	2.69	0.24	2501	2.29	0.21	3178	1.90	0.20	4049	3.35	0.21	4740	0.97	0.23
0050	4.37	0.22	2570	3.93	0.23	3179	3.06	0.20	4111	1.42	0.22	4771	1.36	0.21
0079	2.05	0.21	2571	4.03	0.20	3180	3.41	0.21	4112	0.46	0.22	4828	1.90	0.20
0106	9.68	0.19	2576	3.70	0.21	3220	2.51	0.23	4114	3.34	0.22	4829	1.25	0.19
0171	4.42	0.21	2584	3.45	0.23	3241	3.22	0.22	4130	4.32	0.22	4831	2.74	0.20
0172	2.67	0.21	2585	4.42	0.24	3257	3.26	0.21	4150	1.83	0.21	4922	1.50	0.21
0251	2.23	0.25	2586	2.96	0.20	3300	5.42	0.22	4239	3.41	0.19	4983	3.34	0.21
0400	3.18	0.21	2589	2.96	0.20	3339	3.61	0.20	4240	3.64	0.22	5020	2.38	0.20
0401	3.47	0.24	2623	3.55	0.20	3365	5.08	0.19	4243	3.00	0.24	5027	4.64	0.19
1122	3.47	0.19	2660	2.32	0.24	3372	4.37	0.20	4244	2.93	0.19	5028	2.83	0.17
1123	7.66	0.22	2683	3.29	0.21	3383	1.45	0.21	4250	3.00	0.21	5040	4.59	0.19
1124	4.83	0.22	2688	3.28	0.22	3400	3.02	0.22	4251	2.35	0.21	5057	5.32	0.16
1320	1.58	0.19	2702	7.76	0.18	3401	3.25	0.22	4279	3.34	0.22	5059	10.54	0.17
1322	5.11	0.17	2710	5.46	0.23	3501	2.55	0.22	4283	2.86	0.20	5102	3.78	0.18
1330	5.03	0.21	2727	8.04	0.18	3507	4.06	0.21	4286	3.65	0.20	5107	2.57	0.20
1438	4.79	0.20	2731	4.60	0.21	3560	2.28	0.23	4295	3.39	0.19	5108	4.06	0.25
1452	2.10	0.20	2757	5.58	0.22	3568	1.45	0.21	4297	0.26	0.21	5128	0.85	0.21
1463	8.19	0.18	2759	3.99	0.25	3569	1.73	0.23	4299	2.41	0.21	5140	1.70	0.20
1624	3.47	0.20	2790	1.89	0.25	3570	3.06	0.20	4304	3.76	0.21	5146	2.88	0.20
1699	2.34	0.23	2797	4.74	0.23	3572	0.74	0.23	4312	2.90	0.24	5160	1.25	0.20
1701	5.31	0.19	2806	3.96	0.23	3573	1.11	0.24	4351	1.33	0.24	5183	3.27	0.20
1710	2.67	0.19	2812	3.37	0.22	3574	2.33	0.20	4354	1.19	0.21	5184	1.78	0.18
1741	3.03	0.20	2819	5.72	0.25	3577	0.80	0.21	4360	1.30	0.25	5185	3.76	0.20
1803	3.81	0.21	2840	4.67	0.21	3612	2.17	0.24	4361	1.68	0.23	5186	1.23	0.19
1925	5.21	0.20	2842	3.85	0.24	3620	4.47	0.19	4362	0.96	0.24	5187	1.65	0.20
2002	4.05	0.22	2852	4.46	0.21	3632	2.30	0.21	4410	3.94	0.21	5190	2.07	0.20
2003	3.61	0.21	2881	4.30	0.22	3634	2.21	0.22	4420	7.31	0.19	5191	1.21	0.20
2014	3.35	0.22	2883	5.35	0.20	3643	1.98	0.20	4432	1.42	0.23	5192	2.99	0.20
2030	3.95	0.26	2915	3.10	0.21	3647	3.17	0.21	4470	2.74	0.19	5195	2.86	0.18
2063	2.82	0.23	2923	3.22	0.23	3651	1.90	0.21	4478	3.34	0.22	5201	3.62	0.20
2081	5.75	0.24	3018	2.23	0.20	3681	0.75	0.22	4492	3.46	0.22	5205	2.19	0.18
2095	4.07	0.22	3022	2.76	0.22	3682	1.38	0.24	4494	3.08	0.20	5207	1.98	0.22
2102	2.67	0.26	3030	5.21	0.20	3683	1.57	0.24	4495	2.84	0.21	5212	2.93	0.20
2106	3.19	0.23	3039	6.47	0.21	3719	1.62	0.17	4496	2.56	0.21	5213	2.95	0.18
2107	3.03	0.27	3040	4.64	0.20	3724	2.53	0.19	4497	2.17	0.23	5214	3.17	0.17
2108	4.95	0.24	3060	4.12	0.21	3726	2.57	0.20	4498	3.05	0.20	5222	3.86	0.17
2109	3.93	0.24	3066	2.84	0.22	3805	0.97	0.21	4499	3.04	0.21	5225	4.50	0.16
2111	3.63	0.22	3070	0.50	0.24	3807	2.64	0.22	4511	0.78	0.22	5348	2.25	0.20
2113	5.46	0.22	3076	4.30	0.20	3808	1.78	0.26	4512	0.27	0.27	5403	7.53	0.19
2116	3.89	0.20	3081	4.58	0.22	3815	3.54	0.21	4557	1.72	0.21	5432	2.60	0.18

**Table II**  
**Expected Loss Rates and Full Coverage D-Ratios (Proposed)**  
**Effective July 1, 2007**  
 (Continued)

Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio
5436	2.52	0.22	6834	3.15	0.19	8031	3.35	0.24	8393	2.05	0.19	9011	2.44	0.20
5443	3.06	0.19	7133	1.84	0.21	8032	3.29	0.22	8397	2.70	0.21	9015	2.73	0.21
5446	4.41	0.18	7198	4.68	0.21	8039	3.07	0.24	8400	1.38	0.25	9016	2.59	0.26
5447	2.14	0.18	7207	5.57	0.21	8041	3.09	0.23	8500	5.10	0.21	9031	2.87	0.20
5467	4.59	0.23	7219	4.68	0.21	8042	1.90	0.23	8601	0.36	0.23	9033	3.45	0.22
5470	3.33	0.19	7232	4.21	0.18	8046	2.42	0.22	8631	8.20	0.18	9043	1.22	0.24
5473	5.57	0.17	7248	2.00	0.21	8057	2.76	0.22	8720	2.00	0.20	9048	2.83	0.28
5474	4.25	0.18	7272	5.68	0.17	8059	2.88	0.23	8729	0.79	0.21	9050	3.63	0.22
5479	3.41	0.19	7332	2.43	0.28	8060	1.61	0.20	8740	0.74	0.22	9053	1.20	0.24
5482	1.94	0.17	7360	5.34	0.21	8061	1.83	0.21	8741	0.07	0.22	9059	1.77	0.24
5484	7.07	0.18	7365	5.74	0.18	8062	0.80	0.22	8742	0.34	0.22	9060	2.12	0.22
5485	3.57	0.16	7382	4.75	0.21	8063	2.24	0.21	8743	0.12	0.23	9061	1.94	0.23
5506	3.32	0.18	7392	4.21	0.25	8064	2.33	0.22	8745	3.22	0.25	9066	2.12	0.22
5507	2.09	0.19	7403	3.43	0.26	8065	1.60	0.22	8748	0.57	0.21	9067	1.55	0.25
5538	4.66	0.21	7405	0.93	0.27	8066	0.89	0.22	8749	0.30	0.24	9069	2.35	0.25
5542	1.71	0.18	7409	4.67	0.18	8070	1.11	0.22	8755	0.53	0.21	9070	3.85	0.21
5552	12.82	0.17	7410	2.65	0.21	8071	0.81	0.28	8800	2.03	0.20	9079	1.78	0.25
5553	5.67	0.16	7421	1.84	0.22	8078	1.36	0.29	8801	0.59	0.24	9085	2.89	0.23
5606	0.75	0.20	7424	1.44	0.18	8102	1.41	0.22	8803	0.13	0.24	9092	1.49	0.23
5630	7.53	0.19	7428	2.62	0.22	8103	5.41	0.21	8804	1.63	0.23	9096	6.95	0.20
5631	2.60	0.18	7429	3.20	0.26	8106	3.92	0.22	8806	2.66	0.26	9097	2.35	0.22
5632	7.53	0.19	7500	2.39	0.23	8107	2.30	0.21	8807	0.63	0.22	9101	2.21	0.23
5633	2.60	0.18	7515	0.89	0.21	8110	1.14	0.21	8808	0.52	0.24	9151	0.58	0.23
5645	7.53	0.19	7520	2.39	0.24	8111	3.33	0.22	8810	0.30	0.23	9154	2.18	0.24
5650	4.40	0.19	7538	5.80	0.18	8113	5.21	0.25	8813	0.45	0.22	9155	0.97	0.28
5697	2.60	0.18	7539	0.96	0.21	8116	2.85	0.23	8818	0.63	0.22	9156	2.60	0.29
5951	0.57	0.24	7580	2.09	0.20	8117	3.48	0.23	8820	0.30	0.21	9180	1.90	0.27
6003	3.98	0.16	7600	2.23	0.23	8204	5.21	0.24	8821	0.89	0.19	9181	6.61	0.33
6011	3.48	0.17	7601	4.91	0.17	8209	4.40	0.19	8822	0.47	0.23	9182	1.45	0.27
6204	5.58	0.18	7605	1.71	0.21	8215	5.46	0.20	8823	2.21	0.25	9184	4.49	0.26
6206	1.99	0.20	7606	1.79	0.26	8227	3.42	0.20	8827	2.51	0.20	9185	10.30	0.24
6213	1.95	0.23	7607	0.21	0.23	8232	3.99	0.21	8829	2.54	0.22	9220	3.56	0.23
6216	2.89	0.20	7610	0.49	0.23	8264	4.93	0.21	8830	1.22	0.24	9402	2.49	0.18
6218	3.52	0.18	7706	2.88	0.24	8265	5.07	0.21	8831	1.32	0.29	9403	4.50	0.21
6220	1.44	0.18	7707	(A)		8267	3.49	0.20	8834	0.73	0.23	9410	1.06	0.23
6233	1.93	0.18	7720	2.45	0.22	8278	(A)		8838	0.79	0.26	9420	2.95	0.27
6235	5.04	0.18	7721	2.53	0.21	8286	4.47	0.23	8839	0.65	0.21	9422	2.71	0.24
6237	2.77	0.18	7722	(A)		8290	2.17	0.21	8840	0.34	0.23	9424	5.65	0.19
6251	3.63	0.20	7855	1.95	0.17	8291	2.88	0.22	8846	0.57	0.23	9426	4.91	0.19
6254	2.71	0.18	8001	2.45	0.22	8292	4.35	0.21	8847	3.95	0.23	9501	2.45	0.21
6258	2.50	0.18	8004	2.04	0.24	8293	10.30	0.19	8850	1.55	0.21	9507	2.15	0.21
6307	6.05	0.19	8006	2.48	0.25	8304	4.49	0.21	8851	3.20	0.20	9516	2.13	0.22
6308	2.48	0.17	8008	1.68	0.23	8324	2.17	0.20	8852	2.00	0.20	9519	3.23	0.21
6315	4.00	0.19	8013	0.83	0.21	8350	2.66	0.21	8859	0.10	0.26	9521	2.63	0.20
6316	2.10	0.18	8015	2.52	0.22	8387	2.51	0.20	8868	0.63	0.24	9522	2.70	0.21
6325	2.70	0.19	8017	1.86	0.24	8388	3.00	0.22	8875	0.98	0.22	9529	3.49	0.20
6361	2.92	0.21	8018	3.24	0.22	8389	2.77	0.21	9007	2.59	0.20	9549	4.27	0.21
6364	4.18	0.21	8019	0.94	0.23	8390	3.04	0.24	9008	4.67	0.20	9552	5.76	0.19
6400	4.19	0.21	8021	5.15	0.21	8391	1.74	0.22	9009	2.54	0.20	9586	1.59	0.21
6504	3.50	0.22	8028	2.99	0.22	8392	3.70	0.21	9010	3.34	0.20	9610	0.92	0.22

**Table II**  
**Expected Loss Rates and Full Coverage D-Ratios (Proposed)**  
**Effective July 1, 2007**  
 (Continued)

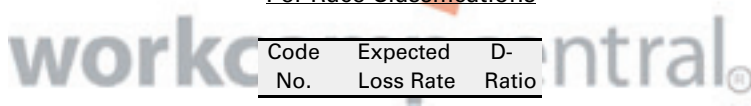
Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio	Code No.	Expected Loss Rate	D-Ratio
9620	2.09	0.20												

Per Capita Classifications

Code No.	Expected Loss Rate	D-Ratio
7707	196.29	0.21
7722	118.86	0.22

Per Race Classifications

Code No.	Expected Loss Rate	D-Ratio
8278	38.94	0.17



**Part B**  
**Section B**  
**Appendix A**  
**Computation of Experience Rating Plan Values**

The Experience Rating Plan values are updated on a regular basis to reflect the most current information available. The amendments to the Experience Rating Plan eligibility and expected loss rates proposed to be effective July 1, 2007 are discussed below.

**Eligibility**

To maintain approximately the same volume of experience rated employers, the WCIRB regularly updates the experience rating eligibility threshold. Based on the proposed 11.3% July 1, 2007 decrease in pure premium rates discussed in Part A, the eligibility threshold should be revised from \$16,000 to \$14,192.

**Expected Loss Rates**

Experience rating relies on two primary components: the actual loss experience of the specific employer to be experience rated, and an estimate of the losses that can be expected from all employers of similar size within the same classification. The "expected loss rate" for each classification represents the average losses per \$100 of payroll estimated to be incurred by employers in each classification during the three-year experience rating period. The 2007 expected loss rates are intended to approximate the average actual losses per \$100 of payroll that will be used in calculating 2007 experience modifications. Specifically, this includes estimates of the average losses per \$100 of payroll incurred against 2003 policies at third Unit Statistical Report (USR) level (losses valued at 42 months from policy inception), 2004 policies at second USR level (losses valued at 30 months from policy inception) and 2005 policies at first USR level (losses valued at 18 months from policy inception).

The expected loss rates adopted effective January 1, 2007 were calculated based on (a) the average losses per \$100 of payroll underlying the WCIRB's January 1, 2007 pure premium rate filing classification relativities<sup>1</sup> and (b) a correction factor intended to adjust the losses per \$100 of payroll from the classification relativity loss level to the average level of losses to be reflected in 2007 experience modification calculations.<sup>2</sup> The correction factor used to derive the January 1, 2007 expected loss rates proposed in August 2006 was based on the most current statistical information on policy year 2003, 2004 and 2005 losses per \$100 of payroll that was available at the time.

The WCIRB is now proposing expected loss rates to be effective July 1, 2007 based on updated policy year 2003, 2004 and 2005 losses per \$100 of payroll that is now available. In addition to this correction factor, the proposed expected loss rates effective July 1, 2007, which are included in the proposed Table II of the Experience Rating Plan, also reflect (a) the 2007 experience rating off-balance correction factor; (b) a factor to reflect the losses eliminated by the loss limitation of \$175,000 used in experience rating; and (c) a factor to reflect the estimated impact of revisions resulting from Senate Bill No. 1217 on the loss amounts used in the experience rating calculation.

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<sup>1</sup> See Part C, Section C of the WCIRB's amended January 1, 2007 pure premium rate filing submitted on September 14, 2006.

<sup>2</sup> See Part A, Section B, Appendix A of the WCIRB's January 1, 2007 pure premium rate filing submitted on August 16, 2006 for a discussion of the calculation of this statewide adjustment factor.

(These factors are unchanged from the analogous factors used to derive the proposed pure premium rates effective January 1, 2007.)

The composite factor used to calculate the proposed expected loss rates effective July 1, 2007 is computed in Exhibit 1. Exhibit 1, lines 1 through 3 show the calculation of the average classification relativity based on the total statewide payroll generated on 2002 and 2003 policies and the relativity for each classification. These relativities, which are discussed in detail in Part C, Section C of the WCIRB's amended January 1, 2007 pure premium rate filing, reflect the overall level of losses in the approved pure premium rates effective July 1, 2006. Exhibit 1, line 3 shows the statewide average 2007 classification relativity.

Line 4 shows the computation of the estimated average ratio of losses to \$100 of payroll for the time period and maturity level reflected in year 2007 modifications (policy year 2003 at the third USR level, policy year 2004 at the second USR level, and policy year 2005 at the first USR level). Currently, the statewide average ratio of losses to payroll at second USR level for policy year 2003 and first USR level for policy year 2004 is available. Also, a preliminary statewide 2005 ratio of losses to \$100 of payroll is also available. The WCIRB estimates the policy year 2003 average ratio of losses to \$100 of payroll at third USR level by applying an average development factor to the reported average policy year 2003 second USR level ratio of losses to \$100 of payroll. The development factor is primarily based on the actual development of the 2003 and 2004 accident years as discussed in Part A, Section B. The 2004 policy year ratio of losses to \$100 of payroll at second USR level was estimated in a similar fashion by applying an average development factor to the policy year 2004 first USR level ratio. Lastly, the estimated 2005 policy year ratio of losses to \$100 of payroll at first USR level was based on a preliminary summary of the policy year 2005 USRs that have been submitted to the WCIRB as of the date of this filing.<sup>3</sup>

Line 5 shows the factor needed to adjust the average classification relativity to the level of losses anticipated in the 2007 experience rating data. This factor is then adjusted by the selected experience rating off-balance (see Part C, Section B, Appendix E of the WCIRB's amended January 1, 2007 pure premium rate filing), the factor to reflect the individual loss limitation of \$175,000 in the experience rating calculation, and the factor to reflect the estimated average impact of revisions resulting from Senate Bill No. 1217. The resultant factor of 0.666<sup>4</sup> shown in Exhibit 1, line 9 is applied to the formula classification relativities included in Part C, Section C of the WCIRB's amended January 1, 2007 pure premium rate filing to generate the proposed expected loss rates effective July 1, 2007 included in the proposed Table II of the Experience Rating Plan.<sup>5</sup>

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<sup>3</sup> Through March 2007, most of the USRs on January 2005 through July 2005 policies have been submitted to the WCIRB.

<sup>4</sup> This compares to an adjustment factor of 0.714 used to compute the approved expected loss rates effective January 1, 2007.

<sup>5</sup> The "D-ratios" shown in the proposed Table II of the *California Workers' Compensation Experience Rating Plan—1995* effective July 1, 2007 reflect no change from the approved D-ratios effective January 1, 2007.



CALCULATION OF FACTOR TO ADJUST 2007 FORMULA CLASSIFICATION  
RELATIVITIES TO EXPECTED LOSS RATE LEVEL  
Effective July 1, 2007

1. Total payroll 2002 and 2003 (in 00s)						\$7,596,703,581
2. Total payroll 2002 and 2003 x formula classification relativities						\$13,563,462,154
3. Average formula classification relativity: (2) ÷ (1)						1.785
4. Expected classification relativity - experience rating data						
	Policy Year	Current Report Level	Ratio of Losses to Payroll	Development Factor	Projected Report Level	Expected Ratio of Losses to Payroll
	2003	2nd	1.661	1.083	3rd	1.798
	2004	1st	0.968	1.210	2nd	1.171
	2005	1st	0.801	1.000	1st	0.801
				Average		1.257
5. Factor to adjust formula classification relativities to level of experience rating data: (4) ÷ (3)						0.704
6. Selected Experience Rating Off-Balance						1.030
7. Factor to reflect loss limitation						0.923
8. Adjustment for Impact of Senate Bill No. 1217						0.995
9. Factor to adjust formula classification relativities to expected loss rate level: (5) x (6) x (7) x (8)						0.666

Notes:

Payroll dollars are in hundreds.

Lines (1) and (2) are from the WCIRB's Classification Relativity analysis included in the WCIRB's amended January 1, 2007 pure premium rate filing submitted on September 14, 2006.

The ratios of losses to payroll in line (4) are based on unit statistical data for policy years 2003, 2004 and preliminary data for 2005. The loss development factors are based on the WCIRB's most recent evaluation of accident year experience.

Line (6) is from the WCIRB's Experience Rating Off-Balance exhibit included in the WCIRB's amended January 1, 2007 pure premium rate filing submitted on September 14, 2006.

Line (7) reflects the individual loss limitation of \$175,000 per accident in the experience rating calculation. It is calculated based on the latest information on the distribution of claims by size.

Line (8) is calculated based on the average impact of Senate Bill No. 1217 rerates in prior years.