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Exempt from filing fees pursuant to Government Code section 6103

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SAN MATEO – UNLIMITED JURISDICTION

INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA,

Applicant,

v.

CALIFORNIA INSURANCE COMPANY, a California corporation,

Respondents.

Case No. 19-CIV-06531

DECLARATION OF GIOVANNI A. MUZZARELLI

Date: March 4, 2021
Time: 2:00 p.m.
Dept.: 28, Hon. George A. Miram

DECLARATION OF GIOVANNI A. MUZZARELLI

I, Giovanni A. Muzzarelli, declare:

1. I am a Senior Casualty Actuary for the California Department of Insurance. I have been asked to give this Declaration in connection with the Conservator's Application for Approval of Rehabilitation Plan. I am familiar with the matters addressed in this Declaration and, if called as a witness, could and would competently so testify.

2. My educational background includes a Bachelor of Science degree granted in 1990 from the University of California San Diego with a double major in Systems & Control Engineering and Quantitative Economics & Decision Sciences. In addition, in 1994 I received a Masters in Management with a concentration in Finance from the Kellogg School of Business at Northwestern University.

3. My professional certifications include the following:

   a. FCAS – Fellowship in the Casualty Actuarial Society.

   b. MAAA - Member of the American Academy of Actuaries

   c. CERA – Chartered Enterprise Risk Analyst

   d. CPCU – Chartered Property Casualty Underwriter

   e. ARe – Associate in Reinsurance

4. My work experience includes over 25 years in various actuarial roles in both industry and regulatory capacities. While at Fireman's Fund Insurance Company, I was the senior actuarial analyst from 1994 to 1996, responsible for commercial groups and captives, reflecting many commercial lines of business including workers compensation. From 1996 to 1998 I was the manager of the middle-market workers compensation actuarial pricing unit, which focused on guaranteed cost policies. From 1998 to 2002 I managed the reserving function across all personal and commercial lines of business, including workers compensation. From 2002 to 2010, I led the capital management team which included the development of pricing benchmarks for all lines of personal and commercial

business, the management of internal and external (rating agency and solvency) capital models, reinsurance support, investment committee support, and various risk management activities.

5. While at the California Department of Insurance (CDI) since 2010, I have been involved with the financial review of a broad portfolio of property casualty insurance companies including a number focused on workers compensation. From the start of my time at CDI, I have served as a CDI representative to the Actuarial Committee of the Workers Compensation Insurance Rating Bureau of California (WCIRB), including leading public rate hearings where the WCIRB presents to the Commissioner its annual and semi-annual rate filing for the upcoming policy period, and coauthoring the actuarial section of the CDI decision regarding the rate filing.

6. The purpose of this Declaration is to provide technical information and my actuarial opinions on certain aspects of Schedule 2.6 of the Rehabilitation Plan proposed by the Conservator and certain other information regarding the California workers' compensation market and California Insurance Company (CIC). I am familiar with Schedule 2.6 and participated in its drafting.

7. In the course of my duties, I have had occasion to review aspects of the operations of CIC and related affiliates. I am familiar with the Guaranteed Cost policy marketed by CIC and the associated Reinsurance Participation Agreement (RPA) marketed by its affiliate Applied Underwriters Captive Reinsurance Assurance Co. (AUCRA). References in this Declaration to the Guaranteed-Cost policy and the RPA are to the form in which they were marketed prior to 2017.

8. I participated in the periodic regularly scheduled financial solvency review of CIC and affiliates in 2014 and 2018, which reviewed the financial condition of CIC and its affiliates as of December 31, 2013 and December 31, 2017, respectively. In 2016 and 2017, I participated in the negotiations with AUCRA resulting in the 2017 revisions to the RPA. As part of that negotiation, I reviewed CIC rate filings supporting the guaranteed cost plan for California workers compensation underlying the RPA.

I. WORKERS' COMPENSATION INSURANCE

9. Workers' compensation insurance is a line of property-casualty insurance. Workers compensation policies are issued by an admitted insurer to an employer (the policyholder) and cover the employer's employees who are injured in the course and scope of their employment.

10. As part of its core mission, the WCIRB develops industry advisory pure premium rates on an annual basis, and, in the event of significant changes in the California workers compensation environment, on a semi-annual basis. In order to develop the advisory pure premium rates, the WCIRB collects industry-wide loss and premium data by classification, with WCIRB staff performing extensive validation and analysis which is then presented and reviewed by the Actuarial Committee. The Actuarial Committee is comprised of a number of senior actuaries of insurers which write significant volume of workers compensation business in California, as well as an actuary representing the public members of the WCIRB Governing Committee (a more senior committee which includes senior management of insurers as well as several members representing various aspects of the public interest, such as labor, and who are appointed by the Insurance Commissioner). The Actuarial Committee decides on a proposed rate filing recommendation, which is then presented to the Board of Governors which ultimately makes the official filing recommendation. Senior WCIRB management presents the rate filing in a public hearing chaired by the Insurance Commissioner, after which the Commissioner releases his decision regarding the rate filing, reflecting input from CDI staff as appropriate.

11. The most common and most straightforward premium plan for workers compensation is the guaranteed cost plan. In such a plan, a premium is developed on a prospective basis without adjustment for loss experience during the policy period. A rate per $100 of payroll by classification is agreed upon at the inception of the policy period, and the premium equals the rate multiplied by the expected exposure ($100 of payroll by employee classification) during the policy period. At the conclusion of the policy period, a payroll audit will determine the actual payroll during the policy period and an adjustment to premium will be made. Thus a guaranteed cost plan has a premium that is

fixed at the inception of the policy, adjusted only to reflect the actual versus expected payroll by classification earned by employees during the policy period.

12. In contrast to a guaranteed cost plan where the premium is fixed but for changes in payroll, a retrospective rating plan allows the policyholder to share in the financial risk and reward with regard to their insurance coverage. In such a plan, policyholders benefit from better than expected loss experience during the policy period, subject to a minimum premium, and are limited to the impact of worse than expected loss experience via a maximum premium amount (both minimum and maximum premiums are adjusted for changes in payroll by classification similar to a guaranteed cost plan). One can think of the retrospective plan as being overlaid on top of an underlying guaranteed cost plan, balanced such that the expected value of the retrospective premium across all potential loss amounts equals the guaranteed cost plan premium. As is the case for guaranteed cost plans, retrospective plan policy periods are generally for one year.

II. ACTUARIAL AND ACCOUNTING CONCEPTS AND TERMINOLOGY

13. Before addressing the specifics of Schedule 2.6, it may be helpful for me to explain certain technical concepts and terms that relate to the provisions of Schedule 2.6.

14. As mentioned above, a workers' compensation policy covers injuries to a policyholder's employees which occur during the course and scope of their employment. When an injury occurs, notice is given to the insurer and a claim file is established to record appropriate information relevant to the incident. Based on the initial information, an estimate for future payments associated with the claim is established. This estimate is called a case reserve. As medical and other services are provided and/or indemnity payments (foregone salary up to a limit if the injury results in time away from work) are made, the case reserve is reduced downward. If new information becomes available suggesting that additional or fewer payments will need to be made in the future beyond that already reflected in the remaining case reserve, the case reserve is adjusted as indicated.

15. The case reserves and payments described in the preceding paragraph relate to specific, individual claims. In the aggregate (across all policies in an insurer's portfolio written in a given

policy year), the sum of payments plus remaining case reserves tends to increase over time. This increase reflects the increase in cost and complexity of claims which remain open over time, above and beyond what is already reflected in case reserves. This expectation of increasing costs over time is reflected by a provision called incurred but not reported losses (IBNR). ("Losses" refers to the amounts paid out for indemnity payments to policy beneficiaries and for medical and other services related to the claim.) The relative amount of IBNR depends on a number of factors including but not limited to the structure of indemnity benefits in a given state, the provisions for medical care in the workers' compensation system in a given state, and the level of legal representation in the workers compensation system in a given state, as well as the claim characteristics of various job classifications (e.g., claims from roofers have a different composition than those from office workers).

16. The provision for IBNR is typically calculated via a loss development factor which represents the expected amount of IBNR relative to the sum of loss payments and case reserves, for a given group of claims. For example, if the amount of IBNR for a given set of claims is estimated to be 5% of the sum of loss payments plus case reserves, the loss development factor would be 1.05.

17. Another relevant aspect of retrospective rating plans is the closing-out of the plan. While workers compensation policies have an expiration date, the insurer is responsible for handling and paying claims associated with injuries that occur during the policy period regardless of when the costs are paid. A worker may require additional medical care for an injury that occurred and was reported years ago, and an injury that occurred during the term of the policy may be reported after the end of the term. While the probabilities of such events decline over time and eventually become very small, they still must be actuarially reflected in reserves. The actuary will set the reserves based on past claim payments and current reserves. Since the employer's total premiums in a loss-sensitive program depend on the total losses, both employer and insurer have an interest in settling on a final loss figure and total premium liability so they can close the books on the program. At some point after the end of the insured period, typically once there have been no new claims for a reasonable period,

the insurer and employer will negotiate a final figure for losses, calculate the resulting premium, and "close out" the program.

18. I have also been asked to explain the meaning of "unearned premium reserves." The unearned premium reserve is an amount set aside in the accounts of an insurer that represents the amount of premium applicable to the unexpired portion of a policy. It is a reserve to assure the return of unearned premiums in the event of policy cancellation. It comes about as the natural result of collecting premiums in advance for insurance to extend over a stated period into the future. In the aggregate, it is the estimated amount which an insurance company would be obliged to tender to its policyholders as returned premiums for the unexpired terms, if every policy in force were cancelled.

19. In general, the value of an insurance policy to the insurer, or of a portfolio of policies, can be broken out to that portion of the policy which has been earned as of a given valuation date and that portion of the policy which has not yet been earned. Assuming appropriate case reserves and IBNR have been established, the value of the earned portion of the policy has already been reflected in the accounts of the insurer as of the valuation date and equals the earned portion of the policy premium less incurred expenses and less the sum of claims payments, case reserves, and IBNR associated with the earned portion of the policy. The investment income expected to be generated by the assets supporting unpaid losses and expenses over the life of the liabilities would also need to be considered. The value of the unearned portion of the policy would be estimated in a similar fashion, and would equal future revenue (unearned portion of the policy premium) less expected expenses and losses associated with the unearned portion of the policy. As the unearned portion of the policy occurs in the future, there obviously have been no claims payments or case reserves established and thus the full amount of expected losses is an estimate. The expected investment income generated by the assets supporting unpaid losses and expenses over the life of the liabilities would need to be considered.

III. THE RPA

20. The RPA was a separate contract, between the Policyholder and a CIC Affiliate, AUCRA, that the Policyholder was required to purchase, in effect a compulsory side agreement. The RPA had not been filed with the California Department of Insurance (CDI), which the Commissioner found in the *Shasta Linen* case made it and charges under it illegal.

21. By its terms the RPA replaced the fixed charge of the Guaranteed-Cost Policy with a varying premium similar in effect to that of a retrospective rating plan. As described in an earlier paragraph, under a retrospective rating plan, policyholders benefit from better than expected loss experience during the policy period, subject to a minimum premium, and are limited to the impact of worse than expected loss experience via a maximum premium amount. The impact of imposing a minimum and a maximum premium is reflected via an insurance charge, which essentially functions as a fixed cost across all loss scenarios. One important aspect of a standard retrospective plan is that in the zone between the minimum and maximum premiums, a change in case incurred losses is reflected by a dollar-for-dollar change in the calculated retrospective premium.

22. Similar to a standard retrospective rating plan, application of the RPA results in a lower premium if losses are lower, subject to a minimum, and a higher premium if losses are higher, subject to a maximum. Unlike a standard retrospective rating plan, a change in case incurred loss results in varying relative changes in premium depending on the amount of loss (within the zone between minimum and maximum premiums). For losses close to zero, an increase in case incurred loss results in an increase in premium of well over a dollar, while at higher losses, a change in case incurred losses results in an increase in premium of lower than one dollar (in other words, while the slope of the graph of premium versus loss is constant for a standard retro plan between the minimum and maximum premiums, the slope changes under the RPA). For that reason, the RPA is called a "non-linear plan," since the line plotting premium versus losses is not a straight line but rather has different slopes as it moves from left to right (low to high losses).

23. One implication of the non-linearity of the RPA plan is that the insurance charge is not a fixed amount as it is for a standard retrospective rating plan. Rather, the insurance charge provision varies across loss scenarios such that the expected value of the insurance charge provision across all loss scenarios is the same as that for a standard retrospective plan. One consequence of this feature of the RPA is that the insurance charge provision at a given loss scenario is complicated to compute and presents a challenge for the insurer to explicitly explain to the policyholder the basis for its periodic retrospective premium calculations.

24. A second key difference between a standard retro plan and the RPA is that the RPA generally covers three policy years, versus the single year of a standard retro plan. One consequence is that the probability of low losses is much less for a three-year period than it is for a single year period, with clear implications for the potential of a policyholder to have a premium near the minimum under the RPA.

25. The combination of a steep slope (of the RPA premium graph versus losses) for losses near zero and the low probability of small losses over a three-year period allows for the policyholder to have unrealistic expectations regarding the likelihood of low RPA premium scenarios as well as the overall expected RPA premium across all loss scenarios. One of the revisions to the RPA negotiated between CDI and AUCRA in 2017 related to improved disclosures in the materials provided by CIC/AUCRA to potential clients to lessen this chance for misunderstanding

26. A third key difference between the RPA and a standard retrospective plan is the use of a reinsurer (in this case AUCRA) and a captive cell structure to facilitate the application of the RPA terms with the policyholder. The use of an affiliated reinsurer allows for the imposition of collateral requirements in conjunction with the RPA premium calculations. Collateral refers to cash deposits required from the policyholder and held by the reinsurer to ensure future payment of potential losses within the captive cell. This requirement is established in the RPA and necessarily involves factors relating to expected loss levels and the use of loss development factors to develop a provision for IBNR. Several issues complicate the application of collateral requirements in the RPA. The first is

that the factors used to develop the IBNR provision change substantially depending on whether the policyholder remains a participant in the RPA or whether the policyholder chooses to leave the program. The second issue is that the RPA allows the reinsurer to hold onto the collateral for up to seven years beyond the expiration of the three-year term of the RPA, with limited ability of the policyholder to argue its case in the event of disagreement over such factors which might drive collateral requirements such as case reserves and the IBNR provision. The collateral requirements become especially problematic when the policyholder desires to cancel its policy and discovers that there can be a very large increase in the required collateral as a result (collateral call). A second revision to the RPA negotiated between CDI and AUCRA in 2017 related to improved disclosures in the materials provided by CIC/AUCRA to potential clients to highlight the potential impact of additional collateral requirements if the policyholder decides to cancel or simply non-renew.

27. A further issue with the RPA has to do with its underlying Guaranteed Cost plan filed by CIC. To develop rates, an insurer generally references the WCIRB filed and approved pure premium rates (the term for expected losses and loss adjustment expenses) by classification, and then applies a loss cost multiplier to reflect two factors. The first factor is the company's expenses such as commissions and overhead, with an offset to reflect expected investment income. The second factor relates to the relative pricing needed for the insurer's book of business relative to the industry level pure premium rates developed by the WCIRB – this factor is called the uniform cost multiplier (UCM). For example, if an insurer's target market is preferred business (i.e., a segment having below-average losses), and if its loss experience provides supporting evidence, the insurer could file for a UCM less than 1.0. Conversely, if an insurer's book of business was on the other end of the required-price spectrum (above-average losses), it could file for a UCM larger than 1.0.

28. One would expect that in a competitive market like California workers compensation, an insurer would tend to be at a pricing disadvantage if it reflected UCM greater than necessary. In its guaranteed cost rate filings, CIC reflected a UCM well above 1.0, which it supported in its filings with loss trends that were much higher than observed in industry data. While the resulting high guaranteed

cost rates would seemingly put CIC at a competitive disadvantage, the high growth of CIC premium volume between 2010 and 2017 suggests otherwise. In the RPA negotiations in 2017, CDI noted its concern that the complexity of the RPA product coupled with the disclosure issues noted could result in clients not fully understanding the true expected value of the RPA premium. A third revision of the RPA negotiated between CDI and CIC/AUCRA in 2017 related to the lowering of the UCM in subsequent guaranteed rate filings underlying the RPA.

29. Another concern that was raised by various Policyholders against CIC/AUCRA is the potential for claims related to employee injuries to be settled for more than they should have been according to industry practice, and/or the setting of case reserves at amounts higher than they should have been. Due to the structure of the RPA where premiums rise faster than losses for low loss scenarios, there is the potential incentive for CIC/AUCRA to overpay claims or overstate case reserves. In addition to the policyholder potentially having to pay a higher RPA premium, there is also the potential for collateral requirements to be even more burdensome in the event the policyholder chooses to cancel its policy.

IV. OVERVIEW OF SCHEDULE 2.6

30. Schedule 2.6, which is incorporated by Section 2.6 of the Rehabilitation Plan, provides a procedure for claims by and against CIC and its affiliates from Policyholders concerning their policies and RPAs to be fairly resolved.

31. I understand that the Conservator has designed this procedure to reflect what he has determined to be the legal right of a party who was required to sign an illegal contract, either to affirm the contract or to reject the contract, with, in the latter case, the party being required to pay the other party the reasonable value of the goods or services it received. The Conservator has therefore proposed that Policyholders with Pending Litigation and Subsequent Litigation, as defined, should be permitted to choose from three different methods, denominated Option 1, Option 2, and Option 3, to calculate their rights and liabilities in the RPA litigation. In general, the three options can be characterized as follows:

a. Option 1, explained in Article III of Schedule 2.6, gives the Policyholder the right to affirm the original policy, disregard the illegal RPA, and be charged under the CIC Guaranteed-Cost Policy without the RPA. Option 1 is not a retrospective plan, and its pricing is not loss-sensitive.

b. Option 2, explained in Article IV of Schedule 2.6, gives the Policyholder the right to reject the CIC Guaranteed-Cost Policy and RPA and instead substitute, as a measure of the value of the coverage the Policyholder received, a loss-sensitive policy that was commercially available at the time it purchased the CIC policy. Option 2 is a retrospective plan, and its pricing is loss-sensitive.

c. Option 3, explained in Article V of Schedule 2.6, gives the Policyholder the right to affirm and accept its coverage under the Guaranteed-Cost Policy and the RPA. Option 3 is the retrospective, loss-sensitive coverage the Policyholder originally purchased.

32. In simplest terms, Schedule 2.6 calculates, under each option, how much the Policyholder paid to CIC and its Affiliates for the coverage, regardless of whether each payment was characterized as "premium" (the word typically used for the amount paid under an insurance policy), "collateral" (the term used in the RPA), or some other term. It then calculates how much the Policyholder would have been obligated to pay for the coverage under each option. The difference between the two (payments made minus payments due) is called the Restitution Amount under each option. If the Restitution Amount is positive (more paid than amounts due), CIC must refund the Restitution Amount to the Policyholder with interest. If the Restitution Amount is negative (amounts due are greater than the amounts paid), the Policyholder is obliged to pay CIC the Restitution Amount, also with interest.

33. Below I describe how these calculations are made. In general, the amounts paid under each option are relatively straightforward. Under Option 1, the Guaranteed-Cost Policy, the amount owed is relatively straightforward as well. But under Options 2 and 3, the loss-sensitive plans, the

amount owed depends in large part on the losses incurred under the policy, which, as discussed further below, can be quite complex.

34. In a retrospective rating plan, policyholders' premiums depend in significant part on ultimate losses under the policy. Since the full extent and cost of insured injuries may not manifest themselves until years after the policy term, for which the insurer at the time of the injury is still liable, it is necessary to estimate the ultimate losses in order to close the program and determine the policyholder's total liability.

V. COVERAGE OF SCHEDULE 2.6

35. Schedule 2.6 is available to resolve two categories of litigation: Pending Litigation and Subsequent Litigation.

36. "Pending Litigation" is defined as a Proceeding pending on the date the Court's Conservation Order issued, November 4, 2019 (the Conservation Date). "Proceeding" is defined as a matter pending before a court, before an arbitrator, or before the Commissioner in an administrative proceeding, in which CIC or its affiliate is a party against a Claimant (somebody with a claim contrary to CIC's or its affiliate) arising out of a workers' compensation policy or an RPA.

37. "Subsequent Litigation" consists of two categories.

a. The first category is a Proceeding not pending on the date the conservation commenced but has or will be brought thereafter by CIC or its Affiliate. These will be cases where CIC or the Affiliate claims that it is owed money by the Policyholder. CIC must identify these matters in which CIC or the Affiliate claims, or will claim, the right to bring litigation under the RPA. CIC and the Affiliate are barred from subsequent litigation that has not been identified.

b. The second category is for claims in which the Claimant asserts that it is owed money by CIC or an Affiliate arising out of the RPA, which claim was not time-barred as of the Conservation Date, and which the Claimant intends to bring against CIC or its Affiliate. Policyholders will receive

notice of the proposed Rehabilitation Plan and will be required to assert their rights to bring Subsequent Litigation by filing a Notice of Claim with the Conservator within 60 days of the notice. No Policyholder may assert a claim against CIC or an Affiliate arising out of the RPA unless it has filed a timely Notice of Claim.

VI. THE THREE OPTIONS

38. Here is how the Restitution Amount is calculated under the three options.

A. Option 1: The Guaranteed Cost Policy (Article III)

39. As stated in Article III, the Restitution Amount equals total payments made by the Policyholder less the CIC Guaranteed-Cost Premium, using audited payroll and rates by classification as set forth in the policy. I note that "CIC Guaranteed-Cost Premium" is listed as definition number 3 in Article I Definitions of Schedule 2.6 and that "Total Payments" is listed as definition number 33 in Article I Definitions.

B. Option 2: A Commercially Available Retrospective Rating Plan: the Cal-Retro Plan (Article IV)

40. The Cal-Retro Plan is representative of a standard retrospective plan which the employer could have purchased in the market. As stated in Article IV, the Restitution Amount equals total payments made by the Policyholder less the Retrospective Premium calculated under the Cal-Retro Plan.

41. As touched on in an earlier paragraph, a standard retrospective plan premium has a fixed provision for insurer operating expenses and an insurance charge determined at policy inception, which reflects the net cost of having a minimum and maximum premium. The insurer's actual losses during the policy period are added to the fixed provisions for insurer expenses and the insurance charge, which equals the Retrospective Premium subject to the minimum and maximum.

42. In order to calculate the fixed charges, recall that the starting point for a retrospective plan is the underlying guaranteed cost plan, over which the parameters of the retrospective plan are overlaid. In developing a proxy for the available market price of the

underlying guaranteed cost plan, we need to develop an estimated premium for the Policyholder's California operations (called the California Standard Premium) as well as for states other than California (Non-California Standard Premium). For the California operations, we multiply payroll in California by classification by the relevant published WCIRB pure premium rates, adjusted for the Policyholder's experience modification factor, and further multiplied by the factor of 1.15 to reflect an average insurer's expenses coupled with the level of competitive market pricing. The 1.15 factor was developed based on a review of historical industry-wide charged rate data versus filed pure premium data published by the WCIRB. For states other than California, we multiply payroll in the other states by the insurer's authorized rates by classification by state and adjusted for the experience modification factor.

43. The fixed insurance expense equals the sum of the California Standard Premium and the Non-California Standard Premium, multiplied by an estimate of industry-average operating expense ratios based on review of data published by the WCIRB. The fixed Insurance Charge is based on the relevant data published by the WCIRB in its filed Retrospective Rating Plan and Tables, multiplied by the sum of the California Standard Premium and the Non-California Standard Premium.

44. In addition to a Policyholder's paid losses and case reserves, a provision for IBNR needs to be made when adding actual losses to the fixed expenses in developing the close-out retrospective premium. A reasonable provision for IBNR for the typical CIC Policyholder can be developed based on historical loss data reflected in CIC's published annual statements. The process described in this section of Schedule 2.6 develops a set of loss development factors which can be used to develop the IBNR provision for Policyholders with a range of policy expiration dates. Given that the IBNR provision relates to future loss payments, it is appropriate to make an adjustment for the time value of money, reflecting an expected interest rate and a loss payout pattern.

C. Option 3: The RPA (Article V)

45. As stated in Article V, the Restitution Amount equals the total payments made by the Policyholder less the final cost as prescribed in the "Scenario Worksheet" for Cumulative 3-Year Program Amounts on the Claimant's "Workers' Compensation Program Summary & Scenarios". The "Scenario Worksheet" was provided to the potential Policyholder by AUCRA as part of the RPA presentation and displays the RPA final premium due relative to a number of loss scenarios ranging from zero to very large (well above that resulting in the maximum premium).

46. As mentioned earlier, the calculations of the RPA are quite complicated in its development of the varying insurance charge across loss scenarios, and the most straightforward approach to determining the RPA final premium is simply to interpolate between the two premiums associated with the loss scenarios which bound the actual ultimate loss as calculated in option 2 (i.e. loss payments plus case reserves plus IBNR provision for the policy period). As is the case with a guaranteed cost plan, an adjustment needs to be made to reflect any difference between actual payroll and estimated payroll at policy inception, which is done by multiplying the actual ultimate loss by the ratio of the actual loss pick containment amount (LPCA), which reflects actual payroll, and the expected LPCA, which reflects estimated payroll at policy inception. Changes to the term of the policy for other than a 36-month term would be reflected similarly.

VII. THE INDEPENDENT CONSULTANT

47. Schedule 2.6 calls for the Conservator to appoint an Independent Consultant to carry out certain functions in the implementation. The Independent Consultant must be a person or firm with expertise in actuarial science and financial management of a workers' compensation retrospective rating program, is required to be independent of CIC and its affiliates and of any Claimants and their counsel. The Independent Consultant should have available expertise on claims handling and reserving.

48. The process begins with the Independent Consultant translating the terms by which Schedule 2.6 describes the three options into templates (i.e., spreadsheets) that prescribe how

Options 1, 2, and 3 will be calculated. Those spreadsheets will specify the required data from CIC's records and the formulas by which the data are combined to produce the Reimbursement Amount for each option. The templates are made public, and anybody may offer comments on whether they correctly reflect the terms of Schedule 2.6. The Independent Consultant then finalizes the templates and makes them public.

49. CIC then submits a data file to the Independent Consultant containing the data elements specified by the templates. Incurred loss data are to be as of June 30, 2020. Simultaneous with CIC's submission of the data, it must provide a copy to the Claimant and its counsel, who may dispute any of the data. CIC is given an opportunity to respond to the dispute, and the Independent Consultant may obtain additional data from CIC. The Independent Consultant resolves the dispute, and that determination is final.

VIII. SETTLEMENT OFFERS, RESOLVING DISPUTES OVER INCURRED LOSSES, AND REVISED SETTLEMENT OFFERS

50. Once the data files are finalized, the Independent Consultant uses the templates to calculate for each Claimant the Option 1 Restitution Amount, the Option 2 Restitution Amount, and the Option 3 Restitution Amount. The Restitution Amounts include compound interest at the rate of 2.7 percent, which is the approximate annual yield of CIC's investments from 2010 through 2019. If the Restitution Amount is positive (the Policyholder gets a refund), CIC must pay the amount with interest. If the Restitution Amount is negative (the Policyholder owes CIC money), the amount must be paid to CIC with interest calculated at the same 2.7-percent interest rate.

51. From these calculations, the Independent Consultant prepares and submits to the Conservator a written Settlement Offer, offering, on behalf of CIC, to settle the Claimant's Pending Litigation or Subsequent Litigation under either the Option 1 Restitution Amount, the Option 2 Restitution Amount, or the Option 3 Restitution Amount. The Conservator promptly transmits the Settlement Offer to the Claimant.

52. The Claimant may choose one of the three options and settle the underlying litigation, or it may reject all three and opt out of the Schedule 2.6 process, in which case the Claimant is free to pursue the Pending Litigation or Subsequent Litigation outside of the conservation. However, there is another alternative available at this point for Claimants to seek adjustment of the Settlement Offers, as follows.

53. As described above, at this point the Restitution Amounts have been calculated solely on the basis of the data on CIC's books. However, over the past several years, the Commissioner has received complaints from CIC Policyholders that questioned CIC's recorded numbers for incurred losses. Those complaints have alleged that CIC overpaid claims and over-reserved case reserves and IBNR. The Conservator has therefore provided a mechanism, the Review of Incurred Losses in Article VII, for a Claimant to obtain review of both claim payments and reserves. To the extent that any changes are made regarding claims payments or case reserves as a result of this review, the IBNR provision and the restitution amount as calculated in Articles IV and V shall be adjusted accordingly.

IX. THE FINAL ELECTION AND THE OPPORTUNITY TO OPT OUT

54. At this point, the Claimant has 30 days to elect from the Settlement Offer (reflecting any adjustment of incurred losses).

X. CONCLUSION

55. In my opinion, the provisions of Schedule 2.6 represent a reasonable way to resolve the Pending and Subsequent Litigation over the RPA. The calculations it prescribes are actuarially sound.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at Novato, California on October 19, 2020.

Giovanni A. Muzzarelli