Exhibit 33
As Filed

DELAWARE COMPENSATION RATING BUREAU, INC.

Evaluation of Senate Bill 238 of 2012

The following narrative and table present the approach used in 2013 and 2014 in the DCRB's estimates of the potential effects of SB238 of 2012 on workers compensation costs in Delaware.

As presented in the accompanying materials, this legislation is expected to reduce medical losses in Delaware by approximately 0.42 percent.

Delaware Compensation Rating Bureau, Inc.

Evaluation of Effects of Senate Bill 238 on Workers Compensation Costs

The Delaware Compensation Rating Bureau, Inc. (DCRB) offers the following narrative and accompanying exhibits as an assessment of the effects of Senate Bill 238 on Delaware workers compensation benefit costs.

BACKGROUND:

Senate Bill 1 of 2007 provided for the establishment of a Health Care Payment System for workers compensation claims. The Health Care Payment System was to include "payment rates, instructions, guidelines, and payment guides and policies regarding application of the payment system".

"Payment rates" came to be embodied in a fee schedule originally promulgated by a contractor designated by statute using a statistical construct applied to charge data. Procedures for which the contractor had or was able to obtain sufficient information were assigned dollar amounts as maximum allowable payments in the fee schedule. Where insufficient information was available, the Health Care Payment system provided for reimbursement to non-hospital providers at a specified percentage of actual charges as of November 1, 2008 adjusted annually by percentage changes to the Consumer Price Index-Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics.

For hospitals, the Health Care Payment System provided for reimbursement at 85 percent of charges as of October 31, 2006 adjusted annually by percentage changes to the Consumer Price Index-Urban, U.S. City Average for Medical Care as published by the United States Bureau of Labor Statistics.

The reference dates of November 1, 2008 for non-hospital providers and October 31, 2006 for hospitals were sometimes referred to as "anchor dates". Over time, however, it became known that for a combination of practical and legal reasons the derivation of reimbursement metrics consistent with those anchor dates and the prescribed CPI indices was not, in fact, taking place. Senate Bill 238 was drafted for the apparent purpose of revisiting the determination of reimbursement amounts for certain (substantial) elements of hospital services and for Ambulatory Surgical Centers. The new legislation, among other things, seems to have been intended to make the indexing of reimbursements to CPI indices originally envisioned under Senate Bill 1 both legal and practicable.

SUMMARY OF SENATE BILL 238:

Senate Bill 238 became effective January 31, 2013. As of that date, hospital fees related to inpatient services, outpatient surgical services and emergency services became subject to reimbursement at 80 percent of each hospital's current actual charges, subject to an adjustment as determined by the Department of Labor. The adjustment compares the average blended rate change for all hospitals for the year prior to each October 31 to (what the DCRB expects would be the most recent change in) the Consumer Price Index-Urban, U.S. City Average for Medical Care as published by the United States Bureau of Labor Statistics. Each hospital's reimbursement rate as a percentage of current actual charges is then either increased or reduced as necessary to balance the combined blended rate change for all hospitals and the percentage reimbursement factor to the observed change in the selected CPI metric.

For Ambulatory Surgical Center fees, Senate Bill 238 established reimbursement at 85 percent of each ASC's actual charges subject to an adjustment as determined by the Department of Labor. The adjustment compares the rate change for each ASC for the year prior to each October 31 to (what the DCRB expects would be the most recent change in) the CPI – U, Medical as published by the United States Bureau of Labor Statistics. Each Ambulatory Surgical Center's reimbursement rate as a percentage of current actual charges is then either increased or reduced as necessary to balance the combined rate change and the percentage reimbursement factor to the observed change in the CPI – U, Medical.

DCRB's APPROACH TO EVALUATING SB238:

We utilized Medical Data Call information as a basis for our evaluation of this legislation. DCRB asked for access to information that was to have been provided to the Department of Labor and/or developed by a financial advisor retained by the Department of Labor under provisions of SB238, but confidentiality concerns, which DCRB understands and respects, arose with regard to our request.

Our methodology consisted of the following sequential steps:

1. Data available for the two-year period July 2010 through June 2012 was screened to identify services that were subject to SB238. This process involved using combinations of Place of Service codes, provider taxonomy codes and procedure code(s) associated with each Medical Data Call record to identify the following categories of services:

- Hospital Inpatient Services (Place of Service 21, “Hospital Inpatient”, in combination with either provider taxonomy 28xxx, “Hospital” or 27xxx, “Hospital Unit”)

- Hospital Outpatient Surgical Services (Place of Service 22, “Hospital Outpatient”, in combination with either provider taxonomy 28xxx, “Hospital” or 27xxx, “Hospital Unit”) and with procedure codes 10021 through 69990 from the Current Procedural Terminology (“CPT”) listing)

- Emergency Services (Place of Service 23, “Emergency Room” in combination with either provider taxonomy 28xxx, “Hospital” or 27xxx, “Hospital Unit”)

- Ambulatory Surgical Centers (Place of Service Code 24, “Ambulatory Surgical Center” in combination with provider taxonomy 261QA1903x, “Ambulatory Surgical Center”)

2. Records identified as having been adjusted under the terms of an applicable contract or agreement were removed from the data attributable to services subject to SB238, as contract provisions override fee schedule provisions under terms of Delaware’s Health Care Payment System.

3. DCRB reviewed distributions of charges and payments within each category of service subject to SB238, and found some records for which the payment amounts were greater than the charged amounts and other records where the paid amounts were zero. DCRB knows that some bills have been entered into the Medical Data Call database with payment amounts for the entire bill entered on a single charge line, which results in some records appearing to include overpayments and others appearing to have been completely rejected. DCRB decided that the best approach available under these circumstances was to derive paid-to-charged relationships for the records falling within the range above zero and not greater than 1.00 for each category of service, and then apply that ratio to the total charges for the category to derive “restated” paid amounts to fairly weight the impact of SB238 in our analysis.

4. SB238 savings factors were derived for each category of service, recognizing the reimbursement levels in effect immediately before and after the implementation of the law on January 31, 2013.

   For hospital inpatient and for hospital outpatient surgery, the pre-SB238 reimbursements were at 85 percent of charges and the post-SB238

reimbursement will be at 79.36 percent of charges. This change in reimbursement levels results in savings factors of 0.0664.
For emergency services the pre-SB238 reimbursement level was 100 percent of charges, while the post-SB238 reimbursement is at 79.36 percent of charges. This change in reimbursement levels results in a savings factor of 0.2064.

Ambulatory surgical centers' reimbursement levels are adjusted individually under SB238. The DCRB was not able to obtain detail about those adjustments, owing to concerns about confidentiality of information by provider. Absent that detail, DCRB has assumed that the ambulatory surgical centers collectively received the same proportional adjustment to prevailing reimbursement levels as hospitals. This approach results in a savings factor of 0.0080, since ambulatory surgical centers were adjusted from their prior reimbursement level of 85 percent of charges and were not reduce to 80 percent as were hospitals.

5. The savings factors derived as discussed above were applied to the restated payments subject to SB238 for each category of service, and the resulting savings were added across all categories of service to derive a subtotal across the service categories subject to SB238. That overall savings factor is 0.0741, or almost 7.5 percent.

6. The total savings in medical payments for service areas subject to SB238 was then compared to the Medical Data Call payments across all categories of service including contract and non-contract services. That comparison produces an overall savings factor of 0.42 percent.

The above-described analysis measures the impact of SB238 on expenditure levels as of January 31, 2013. Since 2008, DCRB rate filings have included measures of the savings anticipated due to Senate Bill 1.

Rate and loss cost levels that were approved effective December 1, 2011 and December 1, 2012 respectively were each at least somewhat lower than actuarially-derived indications provided during the review of those DCRB filings, and as a result the DCRB cannot directly assess the impact of SB238 on rate level at this time. However, some perspective about context for the above evaluation can be obtained by considering adjustments being carried forward in DCRB filings based on provisions of Senate Bill 1.

When measuring medical severity trends, the DCRB adjusts its available experience data to a pre-SB1 level and develops the rate of change in severity ratios based on a series of recent policy years. The measured severity trend rate is then applied up to September 1, 2008, the implementation date selected by

DCRB for cost-containment provisions of SB1. For time periods subsequent to September 1, 2008, the DCRB has reduced the measured medical severity trend rate by 1.8 points per year, with that reduction reflecting anticipated amelioration of medical cost trends resulting from the indexing of fees and charges originally envisioned under SB1.

SB238 responds to the fact that since Senate Bill 1 was implemented medical charges not subject to specific dollar fees in the Health Care Payment System have not been indexed from beginning "anchor points" based on specified CPI indices, but rather have been paid at selected percentages of current charges.

Accounting for the time between September 1, 2008 and January 31, 2013 (4 years and 5 months) at an annual rate differential of 1.8 percent, medical expenditures as of January 31, 2013 would be approximately 8.20 percent higher than the levels anticipated based on provisions of SB1 due to the trend reductions applied in DCRB filings on account of those provisions. In effect, the savings realized from January 31, 2013 expenditures as a result of SB238 are actually a fraction of a percent smaller than the estimated increases in expenditures subject to SB238 occurring since September 1, 2008 because the indexing provisions of SB1 for reimbursement calculated as percentages of charged amounts were not successfully accomplished prior to January 31, 2013.

Delaware Compensation Rating Bureau, Inc.
SB238 - Estimated Savings Relative to Current Charge and Payment Levels

		Selected Data **(a)**	Selected Data Subject to Contract	Selected Data Subject to SB238	Selected Data Restated Subj to SB238	SB238 Savings Factor **(b)**	Post SB238 Savings
Hospital - Inpatient	Charged	25,527,042	17,007,881	8,519,161	8,519,161		
	Paid	17,785,310	12,713,278	5,072,033	7,300,804	0.0664	484,773
	Paid/ Charged	69.7%	74.7%	59.5%	85.7%		
		-	-	-			
Hospital - Outpatient Surgery	Charged	2,876,205	1,989,038	887,167	887,167		
	Paid	2,211,004	1,538,079	672,925	747,737	0.0664	49,650
	Paid/ Charged	76.9%	77.3%	75.9%	84.3%		
		-	-	-			
Emergency Services	Charged	1,066,422	821,759	244,663	244,663		
	Paid	871,806	685,463	186,344	226,978	0.2064	46,848
	Paid/ Charged	81.8%	83.4%	76.2%	92.8%		
		-	-	-			
Ambulatory Surgical Centers	Charged	5,148,964	1,589,500	3,559,464	3,559,464		
	Paid	3,041,509	830,671	2,210,837	2,803,608	0.0080	22,429
	Paid/ Charged	59.1%	52.3%	62.1%	78.8%		
Subtotal	Charged	34,618,633	21,408,179	13,210,454	13,210,454		
	Paid	23,909,629	15,767,491	8,142,139	11,079,127	0.0741	603,700
	Paid/ Charged	69.1%	73.7%	61.6%	83.9%		
Total - All Transactions	Charged	209,962,398					
	Paid	143,041,644				**0.42%**	603,700
	Paid/ Charged	68.1%					

(a) Selection Criteria		CPT	POS	Taxonomy
Hospital - Inpatient			21	Taxonomy (Hospital(28xxxx), Hospital Unit(27xxxx))
Hospital - Outpatient Surgery	Surgery	10021-69990	22	Taxonomy (Hospital(28xxxx), Hospital Unit(27xxxx))
Emergency Services			23	Taxonomy (Hospital(28xxxx), Hospital Unit(27xxxx))
Ambulatory Surgical Centers			24	Taxonomy (Ambulatory Surgical Center (261QA1903X))
Total - All Transactions	All	All	All	All

(b) Savings Factors

1 - (0.7936/0.8500) = 0.0664
1 - (0.7936/0.8500) = 0.0664
1 - (0.7936/1.0000) = 0.2064
1 - (0.7936/0.8000) = 0.0080

Transaction Dates - July 1, 2010 to June 30, 2012

Delaware Compensation Rating Bureau, Inc.

Discussion of Senate Bill 238 Impact on Medical Trend

Subsequent to the enactment of Senate Bill 1 of 2007, it came to light that the regulation of provider charges for hospitals and ambulatory surgical centers intended under that legislation had not been accomplished by virtue of both legal and practical limitations. Providers could not separate workers compensation cases from other services and charge them different amounts than were applicable to other patients due to Medicare requirements. Further, neither providers nor payers were possessed of the extent of historical information that would have been required to index charges or reimbursements back to historical benchmarks envisioned under Senate Bill 1.

Senate Bill 238 of 2012 addressed these issues by changing the regulation of hospitals and ambulatory surgical centers from specifying allowable charges to providing a mechanism for adjusting reimbursements from prevailing charges at levels consistent with the original intent of Senate Bill 1. These changes became effective January 31, 2013.

The DCRB evaluated the impacts of hospital and ambulatory surgical center charges escaping the intended effects of Senate Bill 1, and found that the trend adjustment previously posited for enhanced control of inflationary changes would have been 1.5 percent instead of 1.8 percent from the implementation of Senate Bill 1 to the effective date of Senate Bill 238 of 2012.

The following exhibit shows the estimated adjustments to the medical trend rate before and after the implementation of Senate Bill 238.

Delaware Compensation Rating Bureau, Inc.
Estimated Adjustment to Medical Trend at 9/1/2008 (SB1) and 1/31/2013 (SB238)

	Not Subj to SB238 Contract	Selected Data Restated Subj to SB238 No Contract	Total	Remaining Payments Not Subj to SB238 Contract	Remaining Payments Not Subj to SB238 No Contract	Remaining Payments Not Subj to SB238 Total	Total - All Payments Contract	Total - All Payments No Contract	Total - All Payments Total
Hospital - Inpatient	12,713,278	7,300,804	20,014,082						
Hospital - Outpatient Surgery	1,538,079	747,737	2,285,816						
Emergency Services	685,463	226,978	912,441						
Ambulatory Surgical Centers	830,671	2,803,608	3,634,279						
Total - All Transactions	15,767,491	11,079,127	26,846,618	51,168,035	65,026,991	116,195,026	66,935,526	76,106,118	143,041,644
Percent of Payments	11.02%	7.75%	18.77%	35.77%	45.46%	81.23%	46.79%	53.21%	100.00%
Annual Adjustment to Medical Trend									
Effective 1/31/2013							0.0%	-3.4%	-1.8%
Effective 9/1/2008 to 1/31/2013	0.0%	0.0%		0.0%	-3.4%		0.0%	-2.9%	-1.5%