

Employers Holdings, Inc.
Form 10-K
February 25, 2010

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

S ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2009

OR

£ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _ to _

**Commission file number 001-33245
EMPLOYERS HOLDINGS, INC.**

(Exact name of registrant as specified in its charter)

NEVADA

(State or other jurisdiction of incorporation or organization)

04-3850065

(IRS Employer Identification No.)

10375 Professional Circle, Reno, Nevada 89521

(Address of principal executive offices and zip code)

(888) 682-6671

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

| | |
|--|---|
| Title of each class | Name of each exchange on which registered |
| Common Stock, \$0.01 par value per share | New York Stock Exchange |

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.
Yes No

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Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes No

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

*Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files) Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a small reporting company. See definitions of large accelerated filer, accelerated filer, non-accelerated filer, and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer Accelerated filer Non-accelerated filer Smaller reporting company

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2009 was \$620,534,946.

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes No

| | |
|--|-------------------------------|
| Class | February 19, 2010 |
| Common Stock, \$0.01 par value per share | 42,588,446 shares outstanding |

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Definitive Proxy Statement relating to the 2010 Annual Meeting of Stockholders are incorporated by reference in Items 10, 11, 12, 13 and 14 of Part III of this report.

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FORWARD-LOOKING STATEMENTS

This report contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and 21E of the Securities Exchange Act of 1934. You should not place undue reliance on these statements. These forward-looking statements include those related to our expected financial position, business, financing plans, litigation, future premiums, revenues, earnings, pricing, investments, business relationships, expected losses, loss reserves, acquisitions, competition and rate increases with respect to our business and the insurance industry in general. These forward-looking statements reflect our views with respect to future events and financial performance. The words believe, expect, plan, intend, project, estimate, may, should, will, continue, potential, anticipate and similar expressions identify forward-looking statements. Although we believe that these expectations reflected in such forward-looking statements are reasonable, we can give no assurance that the expectations will prove to be correct. Actual results may differ from those expected due to risks and uncertainties, including those discussed in Risk Factors in Item 1A of this report and the following:

impact of the
unprecedented
volatility and
uncertainty in
the financial
markets;

adequacy and
accuracy of our
pricing
methodologies;

our dependence
on a
concentrated
geographic
market and on
the workers
compensation
market;

developments in
the frequency or
severity of
claims and loss
activity that our
underwriting,
reserving or
investment
practices do not
anticipate based
on historical
experience or
industry data;

downgrade of
our rating or
changes in rating
agency policies
or practices;

negative
developments in
the workers
compensation
insurance
market;

increased
competition on
the basis of
coverage
availability,
claims
management,
safety services,
payment terms,
premium rates,
policy terms,
types of
insurance
offered, overall
financial
strength,
financial ratings
and reputation;

changes in the
availability, cost
or quality of
reinsurance and
failure of our
reinsurers to pay
claims timely or
at all;

changes in
regulations or
laws applicable
to us, our
policyholders or
the agencies that
sell our
insurance;

changes in legal theories of liability under our insurance policies;

effects of acts of war, terrorism or natural or man-made catastrophes;

non-receipt of expected payments;

performance of the financial markets and their effects on investment income and the fair values of investments;

failure of our information technology or communications systems;

adverse state and federal judicial decisions;

litigation and government proceedings;

loss of the services of any of our executive officers or other key personnel;

cyclical nature of the insurance industry;

changes in demand for our

products;

our status as an
insurance
holding
company with no
direct
operations;

the effects of
acquisitions that
we may
undertake; and

changes in
general
economic
conditions,
including
interest rates,
inflation and
other factors.

The foregoing factors should not be construed as exhaustive and should be read in conjunction with the other cautionary statements that are included in this report.

These forward-looking statements are subject to certain risks and uncertainties that could cause actual results to differ materially from historical or anticipated results, depending on a number of factors. These risks and uncertainties include, but are not limited to, those listed under the heading "Risk Factors" in Item 1A of this report. All subsequent written and oral forward-looking statements attributable to us or individuals acting on our behalf are expressly qualified in their entirety by these cautionary statements. We caution you not to place undue reliance on these forward-looking statements, which speak only as of the date of this report. We undertake no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise, except as required by law. Before making an investment decision, you should carefully consider all of the factors identified in this report that could cause actual results to differ.

NOTE REGARDING RELIANCE ON STATEMENTS IN OUR CONTRACTS

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and:

were not
intended to
be treated
as
categorical
statements
of fact, but
rather as a
way of
allocating
the risk to
one of the
parties if
those
statements
prove to be
inaccurate;

may have
been
qualified in
such
agreement
by
disclosures
that were
made to the
other party
in
connection
with the

negotiation
of the
applicable
agreement;

may apply
contract
standards
of
materiality
that are
different
from
materiality
under the
applicable
securities
laws; and

were made
only as of
the date of
the
applicable
agreement
or such
other date
or dates as
may be
specified in
the
agreement.

The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this report not misleading.

PART I

Item 1. Business

Overview

Employers Holdings, Inc. (EHI) is a Nevada holding company and is the successor to EIG Mutual Holding Company (EIG), which was incorporated in Nevada in 2005. EHI's principal executive offices are located at 10375 Professional Circle, in Reno, Nevada. Our insurance subsidiaries are domiciled in California, Florida and Nevada. Unless otherwise indicated, all references to we, us, our, the Company or similar terms refer to EHI together with its subsidiaries.

We are a specialty provider of workers' compensation insurance focused on select small businesses engaged in low to medium hazard industries. We employ a disciplined, conservative underwriting approach designed to individually select specific types of businesses, predominantly those in the four lowest of the seven workers' compensation insurance industry-defined hazard groups, that we believe will have fewer and less costly claims relative to other businesses in the same hazard groups. Workers' compensation is a statutory system under which an employer generally is required to provide coverage for its employees' medical, disability, vocational rehabilitation and death benefit costs for work-related injuries or illnesses. We distribute our products almost exclusively through independent agents and brokers and through our strategic partnerships and alliances. We operate as a single reportable segment and conduct operations in 30 states, with approximately 50% of our business in California.

In January 2009, we began implementation of a strategic restructuring plan to achieve the corporate and operational objectives of the acquisition and integration of AmCOMP Incorporated (AmCOMP), and in response to then current economic conditions. The restructuring plan included net staff reductions of approximately 150 employees, or 14% of our total workforce, and consolidation of corporate functions into our Reno, Nevada headquarters. The restructuring, which consisted of office consolidations, rebranding and staff reductions, was largely completed in the first half of 2009. The remainder of our integration plan, including consolidation of our claims and underwriting systems, was completed in January 2010.

In June 2009, Standard & Poor's added the Company to the S&P SmallCap 600 Index, which we believe is one of the leading small-capitalization market indices in the United States.

Our insurance subsidiaries have each been assigned an A.M. Best Company (A.M. Best) rating of A- (Excellent), the fourth highest of sixteen possible ratings, with a stable financial outlook. This A.M. Best rating is a financial strength rating designed to reflect our ability to meet our obligations to policyholders. This rating does not reflect our ability to meet non-insurance obligations and is not a recommendation to purchase or discontinue any policy or contract issued by us or to buy, hold or sell our securities.

We had net premiums written of \$368.3 million and \$308.3 million, total revenues of \$495.9 million and \$396.8 million and net income of \$83.0 million and \$101.8 million for the years ended December 31, 2009 and 2008, respectively. Our combined ratio on a statutory basis was 99.0% for the year ended December 31, 2009 (elsewhere in this report, unless otherwise stated, the term combined ratio refers to a calculation based on U.S. generally accepted accounting principles (GAAP)). For the purpose of calculating our combined ratio on a statutory basis, the results of operations of AmCOMP are included for the 12 months ended December 31, 2008. Our combined ratio on a statutory basis for the five years ended December 31, 2008 was 84.9%. This ratio was lower than the industry composite combined ratio calculated by A.M. Best for individual companies for which more than 50% of their business is in workers' compensation. The industry combined ratio on a statutory basis for these companies was 105.9% during the same five-year period. Companies with lower combined ratios than their peers generally experience greater profitability. We had total assets of \$3.7 billion at December 31, 2009.

Our corporate structure is as follows:

The states of domicile of our four insurance subsidiaries are as follows:

| | <u>State of Domicile</u> |
|---|--------------------------|
| Employers Insurance Company of Nevada (EICN) | Nevada |
| Employers Compensation Insurance Company (ECIC) | California |
| Employers Preferred Insurance Company (EPIC) | Florida |
| Employers Assurance Company (EAC) | Florida |

History

On January 1, 2000, our Nevada insurance subsidiary, EICN, assumed all the assets, liabilities and operations of the Nevada State Industrial Insurance System (the Fund), including in-force policies and historical liabilities associated with the Fund for losses prior to January 1, 2000, pursuant to legislation enacted in the 1999 Nevada legislature. In connection with that assumption, our Nevada insurance subsidiary assumed the Fund's rights and obligations under a retroactive 100% quota share reinsurance agreement (referred to as the LPT Agreement), which the Fund had entered into with third party reinsurers. The LPT Agreement substantially reduced the exposure to losses for pre-July 1995 Nevada insured risks. The Fund, which was an agency of the State of Nevada, had over 80 years of workers compensation experience in Nevada. Subsequently, through July 2002, we operated exclusively in Nevada.

We formed a wholly-owned stock corporation incorporated in California, ECIC, and on July 1, 2002 we acquired the renewal rights to a book of workers' compensation insurance business, and certain other tangible and intangible assets from Fremont Compensation Insurance Group and its affiliates, or collectively, Fremont. The book of business we acquired from Fremont was primarily comprised of accounts in California and, to a lesser extent, in Colorado, Idaho, Montana and Utah. As a result of this transaction, we were able to establish our important relationships and distribution agreements with ADP, Inc. (ADP) and Anthem Blue Cross, an operating subsidiary of Wellpoint, Inc. (Wellpoint).

In 2003, EICN and ECIC, as well as our wholly-owned subsidiaries Employers Occupational Health, Inc. (EOH), and Elite Insurance Services, Inc. (Elite), began to operate under the Employers Insurance Group trade name. On April 1, 2005, we reorganized into a mutual insurance holding company, EIG Mutual Holding Company, wholly-owned by the policyholders of EICN.

Effective February 5, 2007, we completed an initial public offering (IPO), which occurred in conjunction with our conversion from a mutual insurance holding company owned by our policyholder members to a Nevada stock corporation owned by our public stockholders, and changed our name to Employers Holdings, Inc. and all of the membership interests in EIG were extinguished. In exchange, eligible members of EIG received shares of our common stock or cash.

On October 31, 2008, we acquired 100% of the outstanding common stock of AmCOMP (the Acquisition). The Acquisition included two insurance subsidiaries and three other subsidiaries: EIG Services, Inc. (formerly Pinnacle Administrative Company), Pinnacle Benefits, Inc. and AmSERV, Inc. The newly acquired insurance subsidiaries, EPIC and EAC, are mono-line workers' compensation

insurance companies focused on small businesses engaged in low to medium hazard industries, primarily in Southeastern and Midwestern states.

Our Strategies

We plan to continue pursuing profitable growth and favorable return on equity through the following strategies:

Maintain Focused Operations

We focus on providing workers' compensation insurance to select small businesses engaged in low to medium industry-defined hazard groups. We believe this focus provides us with a unique competitive advantage because we are able to gain in-depth customer and market knowledge and expertise. We execute our business strategy through regional managers and their local teams who have a deep understanding of the business climate and our targeted policyholders in the states in which we operate. Our focus on small businesses also enables us to provide specialized attention to our customers' unique needs, which we believe leads to higher satisfaction and policy retention.

Maintain Focus on Underwriting Profitability

We intend to maintain focus on disciplined underwriting and continue to pursue profitable growth opportunities across market cycles. We carefully monitor market trends to assess new business opportunities that we expect will meet our pricing and risk standards.

We employ a disciplined, conservative and highly automated underwriting approach designed to individually select specific types of businesses that we believe will have fewer and less costly claims relative to other businesses in the same industry-defined hazard group. Within each industry-defined hazard group, our underwriters use their local market expertise and disciplined underwriting to assess employers and risks on an individual basis and to select those types of employers and risks that allow us to generate attractive returns. We believe that as a result of our disciplined underwriting standards, we are able to price our policies competitively and profitably.

Continue to Grow in Our Existing Markets

We plan to continue to seek profitable growth in our existing markets by addressing the workers' compensation insurance needs of small businesses, which we believe represent a large and profitable market segment. We intend to expand our presence in our existing markets, including significant new markets serviced by our acquired insurance subsidiaries, EPIC and EAC, by seeking to expand our relationships with agents and by entering into additional strategic partnerships and alliances. We believe that the A.M. Best A- (Excellent) financial strength rating issued to EPIC and EAC, which were not previously rated, will also create additional growth opportunities.

In the states in which we operate, the workers' compensation market for small businesses is not highly concentrated, with a significant portion of premiums being written by numerous insurance companies with small individual market shares. We believe that our focus on workers' compensation insurance, our disciplined underwriting and risk selection, and our loss control and claims management expertise for small businesses position us to profitably increase market share in our existing markets.

Capitalize on Strategic Partnerships and Alliances to Reach Target Markets

We intend to continue to leverage our partnerships and alliances, taking into account the adequacy of premium rates, market dynamics, the labor market, political and economic conditions and the regulatory environment. Our strategic partnerships with ADP and Wellpoint have allowed us to access new customers and to write attractive business in an efficient manner. We are actively pursuing additional strategic partnership and alliance opportunities.

Capitalize on the Flexibility of Our Corporate Structure

As a publicly traded company, we have access to capital and equity markets. We believe this gives us financial and strategic flexibility to consider acquisitions, joint ventures and other strategic transactions, as well as new product offerings that make strategic sense for our business while achieving our goal of profitable growth.

Maintain Capital Strength

We believe that our financial strength is an important factor for independent agents, brokers and customers selecting our products. We intend to manage our capital prudently relative to our overall risk exposure, establishing adequate loss reserves to protect against future adverse developments while seeking to grow profits and long-term stockholder value. We will continue to fund the growth of our business and invest in infrastructure and may return capital to stockholders in order to achieve an optimal level of overall leverage to support our underwriting activities and to maintain our financial strength and ratings over the long-term.

As a result of the volatility in the financial markets and the tightening of the credit markets, we have taken steps to improve our liquidity, including increasing levels of cash and cash equivalents. We believe that opportunities to further expand our insurance operations and to invest at attractive returns will be available to us in the future. We believe that increasing liquidity and preserving available cash now will allow us greater flexibility in reacting to changes in the investment markets in the future.

Leverage Infrastructure, Technology and Systems

We believe we have an efficient, cost-effective and scalable infrastructure that complements our geographic reach and business model. We have developed a highly automated underwriting system, which allows for the electronic submission and review of insurance applications that employs our underwriting standards and guidelines. We believe our policy administration system reduces transaction costs and provides for more efficient and timely processing of applications for small policies that meet our standards. We believe this saves our independent agents and brokers considerable time in processing customer applications and maintains our competitiveness in our target markets. In January 2009, we implemented a new claims system that is designed to improve efficiency and enhance our ability to support claims processing. We will continue to invest in technology and systems across our business to maximize efficiency and create increased capacity that will allow us to lower our expense ratios while growing premiums. In January 2010, EPIC and EAC were successfully converted to both our policy administration and claims administration systems.

Industry

The principal concept underlying workers' compensation is that an employee injured in the course of his or her employment has only the legal remedies available under workers' compensation laws and does not have any other recourse against his or her employer. Generally, workers are covered for injuries that occur within the course and scope of their employment. An employer's obligation to pay workers' compensation benefits does not depend on any negligence or wrongdoing on the part of the employer and exists even for injuries that result from the negligence or wrongdoings of another person, including the employee. The level of benefits varies by state, the nature and severity of the injury or disease and the wages of the injured worker.

Workers' compensation insurance policies generally provide that the insurance company will pay all benefits that the insured employer may become obligated to pay under applicable workers' compensation laws. Each state has a statutory, regulatory and adjudicatory system that sets the amount of wage replacement to be paid, determines the level of medical care required to be provided, establishes the degree of permanent impairment and specifies the options in selecting healthcare providers. These state laws generally require two types of benefits for injured employees: (a) medical benefits, which include expenses related to diagnosis and treatment of an injury and/or

disease, as well as any required rehabilitation and (b) indemnity payments, which consist of temporary wage replacement, permanent disability payments and death benefits to surviving family members. To fulfill

these mandated financial obligations, virtually all businesses are required to purchase workers' compensation insurance or, if permitted by state law or approved by the U.S. Department of Labor, to self-insure, thereby retaining all risk. The businesses may purchase workers' compensation coverage from a private insurance company such as our insurance subsidiaries, a state-sanctioned assigned risk pool, a state agency, or a self-insurance fund (an entity that allows businesses to obtain workers' compensation coverage on a pooled basis, typically subjecting each employer to joint and several liability for the entire fund).

Workers' compensation was the fourth largest property and casualty insurance line in the U.S. in 2008, on a net written premium basis, according to A.M. Best. A.M. Best reported direct premiums written in 2008 (the most recent data available) for the workers' compensation industry (excluding governmental writers) were approximately \$39.0 billion, or 7.9% of the estimated \$492.9 billion in direct premiums written for the property and casualty insurance industry as a whole. According to A.M. Best, we were the fourteenth largest writer of non-governmental workers' compensation insurance in the United States in 2008.

Excluding governmental writers, premium volume in the workers' compensation industry was down 10.7% in 2008 compared to 2007, while the entire property and casualty industry experienced an 8.7% increase in direct premiums written for the same time period, according to A.M. Best.

The workers' compensation insurance industry classifies risks into seven industry-defined hazard groups, as defined by the National Council on Compensation Insurance (NCCI), based on severity of claims with businesses in the first or lowest group having the lowest claims costs. Businesses in the four lowest industry-defined hazard groups include restaurants, stores, educational institutions, physician offices, dentist offices, clothing manufacturers, machine shops, automobile and automobile service or repair centers and drivers.

Competition and Market Conditions

In 2009, the workers' compensation sector continued to see average medical and indemnity claims costs rise as claim frequency declined. We believe the current environment is characterized by decreased operating margins caused primarily by a combination of decreasing premiums due to continued downward rate pressure and declining payrolls and increased price competition. In 2009 and going forward into 2010, we continue to have concerns related to increased volatility and uncertainty in the financial markets and the current economic conditions, including the high rate of unemployment. We believe that overall market conditions, while challenging, still allow for profitable operations.

Our competitors include, but are not limited to, other specialty workers' compensation carriers, state agencies, multi-line insurance companies, professional employer organizations, third-party administrators, self-insurance funds and state insurance pools. Many of our existing and potential competitors are significantly larger and possess considerably greater financial and other resources than we do. Consequently, they can offer a broader range of products, provide their services nationwide, and/or capitalize on lower expenses to offer more competitive pricing. Our three primary competitors in California are the California State Compensation Insurance Fund, Berkshire Hathaway Insurance Group, and Republic Indemnity Company of America.

Competition in the workers' compensation insurance industry is based on many factors, including:

- pricing (either through premium rates or participating dividends);

level of
service;

insurance
ratings;

capitalization
levels;

quality of
care
management
services;

loss cost
management;

effective loss
prevention;
and

the ability to
reduce claims
expense.

Our A.M. Best rating of A- (Excellent), allows us to compete effectively for our target customers, select small businesses engaged in low to medium hazard industries. In addition, we believe our competitive advantages include our strong reputation in the markets in which we operate, excellent claims service, experienced and professional independent agents and brokers, and our strategic partnerships and alliances. We also strive to maintain the quality of our care management services, and to provide consultation services to clients to educate them on loss prevention and loss reduction strategies. We also compete on price, based on our actuarial analysis of current and anticipated loss cost trends, as appropriate.

California Market

California is the largest workers' compensation insurance market in the United States. In 2008, California accounted for an estimated \$7.6 billion in direct premiums written according to the 2009 Best's State/Line Report for property casualty lines of business, or approximately 16.5% of the U.S. workers' compensation market. Our direct premiums written in California were \$222.4 million in 2008. This made us the ninth largest non-governmental writer of workers' compensation in the state, as reported by A.M. Best.

California is a very competitive market. Although we continue to see an increase in new business submittals, the economic conditions in the state, including the high rate of unemployment, have contributed to a lower average policy size.

In 2003 and 2004, California enacted three key pieces of workers' compensation legislation that reformed medical determinations of injuries or illness, established medical fee schedules, allowed for the use of medical provider panels, modified benefit levels, changed the proof needed to file claims, and reformed many additional areas of the workers' compensation benefits and delivery system. Workers' compensation insurers in California responded to these reforms, which have reduced claim costs, by reducing their rates through 2008.

In October 2008, the Workers' Compensation Insurance Rating Bureau (WCIRB) recommended a 16.0% increase in the claims cost benchmark, representing advisory pure premium rates. The California Commissioner of Insurance (California Commissioner) responded with the approval of a 5.0% average increase in the claims cost benchmark on new and renewal policies beginning January 1, 2009.

Based upon our actuarial analysis of current and anticipated loss cost trends, we filed for an average 10.0% rate increase in California for new and renewal policies incepting on or after February 1, 2009.

In April 2009, the WCIRB submitted a revised recommendation to increase the claims cost benchmark 23.7% effective July 1, 2009. This recommendation was based upon two principal components: the WCIRB's evaluation of December 31, 2008 loss experience produced an indicated increase in the claims cost benchmark of 16.9%, indicating increased medical costs and an increase of 5.8% directly attributable to additional costs arising from Workers' Compensation Appeals Board decisions. On July 8, 2009, the California Commissioner rejected the recommendation of the WCIRB and left the claims cost benchmark unchanged.

We increased our rates in California by an average of 10.5% for all new and renewal policies incepting on or after August 15, 2009.

In August 2009, the WCIRB recommended a 22.8% increase in the claims cost benchmark effective January 1, 2010. This recommendation was based upon the WCIRB's evaluation of March 31, 2009 loss experience, which produced an indicated increase in the claims cost benchmark of 16.0%, again reflecting increased medical costs. The recommendation also indicated an increase of 5.8% directly attributable to additional costs arising from several Workers' Compensation Appeals Board decisions. On November 9, 2009, the California Commissioner again rejected the WCIRB recommendation and left the claims cost benchmark unchanged.

On March 15, 2010, we will increase our rates in California 3.0% on new and renewal policies.

Other Significant Markets

Florida Market. Florida is an administered pricing state. In administered pricing states, insurance rates are set by the state insurance regulators and are adjusted periodically. Rate competition generally is not permitted and consequently, policy dividend programs, which reflect an insured's risk profile, are an important competitive factor.

Effective in October 2003, workers' compensation reform legislation was enacted in Florida in an effort to reverse a trend of increasing costs in the state. These reforms have reduced claim costs and resulted in subsequent rate decreases, including an 18.6% average rate decrease for new and renewal policies incepting on or after January 1, 2009. The NCCI cited a significant drop in claims frequency and a reduction in the cost of claims as reasons for this most recent rate reduction.

On February 10, 2009, the Florida Insurance Commissioner (Florida Commissioner) approved a 6.4% increase in workers' compensation rates for new and renewal business incepting on or after April 1, 2009. This rate increase was in response to an October 2008 Florida Supreme Court decision that materially impacted the statutory caps on attorney fees that were part of the 2003 reforms. In June 2009, the Florida Commissioner approved a 6.0% decrease in workers' compensation rates effective July 1, 2009, for new and renewal policies and the unexpired portions of in-force policies with inception dates from April 1, 2009 through June 30, 2009. This rate decrease was due to the impact of Florida House Bill 903, which restored the statutory caps on attorney fees.

In August 2009, NCCI recommended a 6.8% overall average rate decrease in Florida for new and renewal policies incepting on or after January 1, 2010. According to the NCCI, this decrease was the result of significant reductions in claims frequency, although the NCCI noted that the pace of improvement has moderated. The Florida Commissioner approved this rate decrease, making a 63.2% cumulative rate decrease since the reforms of 2003.

Wisconsin Market. Wisconsin is also an administered pricing state. In July 2008, the Wisconsin Commissioner of Insurance (Wisconsin Commissioner) approved a 2.9% overall rate increase on new and renewal policies incepting on or after October 1, 2008. On May 14, 2009, the Wisconsin Compensation Rating Bureau recommended an overall rate increase of 0.4% for new and renewal policies incepting on or after October 1, 2009. On July 29, 2009, the Wisconsin Commissioner approved the recommended increase.

Nevada Market. As a result of increased competition, as well as decreasing claim costs, we have reduced our premium rates by 21.4% from 2003 through 2009. Beginning in 2007 and continuing through 2009, we saw competition from the self-insured market and a significant decline in payrolls.

We filed for an average 7.8% rate decrease for new and renewal policies incepting on or after March 1, 2009. Additionally, on March 1, 2010, we will decrease rates in Nevada 7.6% on new and renewal policies.

Illinois Market. In 2008, the Illinois Commissioner of Insurance (Illinois Commissioner) approved 3.5% and 2.5% average rate increases on new and renewal policies incepting on or after January 1, 2009 and April 1, 2009, respectively. EAC, our primary insurance subsidiary doing business in Illinois, increased average rates 2.8% and 2.5% on new and renewal policies incepting on or after January 1, 2009 and April 1, 2009, respectively.

In September 2009, the NCCI recommended no change to the overall premium level and an overall loss cost level decrease of 0.1% for industrial classes to become effective on January 1, 2010, for new and renewal policies. On November 10, 2009, the Illinois Commissioner approved the recommended rates. EAC decreased rates 0.1% for new and renewal policies in Illinois incepting on or after January 1, 2010.

Customers

Our target customers are select small businesses engaged in low to medium hazard industries. Our historical loss experience has been more favorable for lower industry-defined hazard groups than for higher hazard groups. Further, we believe it is generally more costly to service and manage the risks associated with higher hazard groups. By targeting businesses in low to medium hazard groups, we

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believe that we improve our ability to generate profitable underwriting results. As of December 31, 2009, 83.2% of our in-force premiums were generated by insureds in the four lowest industry-defined hazard groups (A-D). Within each hazard group, our underwriters use their local market expertise and disciplined underwriting to select specific types of businesses and risks that allow us to generate attractive returns. We underwrite these businesses based on individual risk characteristics, as opposed to following an occupational class-based underwriting approach. For example, while we insure many physician offices, our underwriting guidelines generally exclude offices that we believe have a higher risk profile, such as psychiatrist offices and drug treatment centers.

The following table sets forth our in-force premiums by type of insured for our top ten types of insureds and as a percentage of our total in-force premiums as of December 31, 2009:

| Employer Classifications | Hazard Group Level | In-force Premiums | Percentage of Total |
|--|--------------------|-------------------|---------------------|
| (in thousands, except percentages) | | | |
| Restaurants | A | \$ 38,171 | 9.9 % |
| Physician and physician office clerical | C | 29,994 | 7.8 |
| Automobile service or repair center and drivers | D | 25,260 | 6.6 |
| Store: Wholesale not otherwise classified | B | 16,599 | 4.3 |
| College: Professional employees and clerical | B | 9,957 | 2.6 |
| Store: Retail not otherwise classified | B | 8,758 | 2.3 |
| Machine shops not otherwise classified | D | 6,768 | 1.8 |
| Clerical office employees not otherwise classified | C | 6,552 | 1.7 |
| Hotel: All other employees and salespersons, drivers | B | 6,535 | 1.6 |
| Stores: Groceries and provisions retail | C | 6,254 | 1.6 |
| Total | | \$ 154,848 | 40.2 % |

The following table sets forth our in-force premiums by hazard group and as a percentage of our total in-force premiums as of December 31:

| Hazard Group | 2009 | Percentage of 2009 Total | 2008 | Percentage of 2008 Total | 2007 | Percentage of 2007 Total |
|------------------------------------|-----------|--------------------------|-----------|--------------------------|-----------|--------------------------|
| (in thousands, except percentages) | | | | | | |
| A | \$ 45,683 | 11.9 % | \$ 46,838 | 10.1 % | \$ 33,905 | 10.4 % |
| B | 82,086 | 21.3 | 94,080 | 20.2 | 77,871 | 23.8 |
| C | 137,973 | 35.8 | 157,481 | 33.8 | 118,215 | 36.1 |
| D | 54,582 | 14.2 | 63,206 | 13.6 | 42,345 | 12.9 |
| E | 43,036 | 11.2 | 61,936 | 13.3 | 31,890 | 9.8 |
| F | 20,131 | 5.2 | 39,410 | 8.5 | 21,440 | 6.6 |
| G | 1,534 | 0.4 | 2,657 | 0.5 | 1,346 | 0.4 |

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| | | | | | | | | | |
|-------|----|---------|---------|----|---------|---------|----|---------|---------|
| Total | \$ | 385,025 | 100.0 % | \$ | 465,608 | 100.0 % | \$ | 327,012 | 100.0 % |
|-------|----|---------|---------|----|---------|---------|----|---------|---------|

In 2009, our insureds had average annual premiums of approximately \$8,700. We are not dependent on any single employer and the loss of any single employer would not have a material adverse effect on our business.

We currently write business in 30 states and are licensed to write business in six additional states and the District of Colombia.

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The following table sets forth our in-force premiums by state and as a percentage of total in-force premiums as of December 31:

| State | 2009 | Percentage of 2009 Total | 2008 | Percentage of 2008 Total | 2007 | Percentage of 2007 Total |
|------------------------------------|------------|--------------------------|------------|--------------------------|------------|--------------------------|
| (in thousands, except percentages) | | | | | | |
| California | \$ 180,474 | 46.9 % | \$ 203,694 | 43.8 % | \$ 230,424 | 70.5 % |
| Florida | 27,964 | 7.3 | 46,248 | 9.9 | 510 | 0.2 |
| Wisconsin | 24,125 | 6.3 | 29,040 | 6.2 | | |
| Nevada | 24,050 | 6.2 | 38,971 | 8.4 | 59,598 | 18.2 |
| Illinois | 19,389 | 5.0 | 17,885 | 3.8 | 2,045 | 0.6 |
| Texas | 15,761 | 4.1 | 21,418 | 4.6 | 1,458 | 0.5 |
| Georgia | 12,744 | 3.3 | 12,826 | 2.8 | | |
| Indiana | 10,873 | 2.8 | 13,950 | 3.0 | | |
| Tennessee | 10,765 | 2.8 | 14,502 | 3.1 | | |
| Kentucky | 9,685 | 2.5 | 10,431 | 2.2 | | |
| Virginia | 7,805 | 2.0 | 7,760 | 1.7 | | |
| South Carolina | 5,530 | 1.4 | 7,698 | 1.7 | | |
| Idaho | 5,428 | 1.4 | 6,053 | 1.3 | 6,347 | 1.9 |
| Colorado | 5,073 | 1.3 | 8,073 | 1.7 | 11,839 | 3.6 |
| Montana | 4,947 | 1.3 | 3,882 | 0.8 | 4,600 | 1.4 |
| North Carolina | 4,418 | 1.1 | 5,346 | 1.1 | | |
| Other | 15,994 | 4.3 | 17,831 | 3.9 | 10,191 | 3.1 |
| Total | \$ 385,025 | 100.0 % | \$ 465,608 | 100.0 % | \$ 327,012 | 100.0 % |

The following table sets forth the number of in-force policies by state and as a percentage of total in-force policies as of December 31:

| State | 2009 | Percentage of 2009 Total | 2008 | Percentage of 2008 Total | 2007 | Percentage of 2007 Total |
|------------|--------|--------------------------|--------|--------------------------|--------|--------------------------|
| California | 27,812 | 63.0 % | 27,942 | 61.3 % | 24,997 | 74.2 % |
| Nevada | 4,119 | 9.3 | 5,221 | 11.4 | 6,145 | 18.2 |
| Florida | 2,630 | 6.0 | 3,115 | 6.8 | 79 | 0.2 |
| Texas | 1,592 | 3.6 | 1,747 | 3.8 | 151 | 0.5 |
| Wisconsin | 922 | 2.1 | 892 | 2.0 | | |
| Illinois | 801 | 1.8 | 689 | 1.5 | 96 | 0.3 |

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| | | | | | | |
|----------------|--------|---------|--------|---------|--------|---------|
| Colorado | 713 | 1.6 | 823 | 1.8 | 980 | 2.9 |
| Indiana | 687 | 1.6 | 804 | 1.8 | | |
| Tennessee | 593 | 1.3 | 639 | 1.4 | | |
| Georgia | 539 | 1.2 | 435 | 1.0 | | |
| Virginia | 454 | 1.0 | 363 | 0.8 | | |
| Idaho | 449 | 1.0 | 422 | 0.9 | 362 | 1.1 |
| South Carolina | 433 | 1.0 | 407 | 0.9 | | |
| Other | 2,410 | 5.5 | 2,100 | 4.6 | 889 | 2.6 |
| Total | 44,154 | 100.0 % | 45,599 | 100.0 % | 33,699 | 100.0 % |

At December 31, 2009, we experienced a year-over-year decrease of 3.2% in the total number of in-force policies, with the decrease occurring primarily in Nevada and Florida. Nevada policy count decreased 1,102, or 21.1%, while Florida policy count decreased 485, or 15.6% as a result of the continuing effects of adverse economic conditions. However, we experienced policy count growth in other states in which we operate, particularly in the Midwest and Southeast, which partially offset the declines in Nevada and Florida.

Premium revenues in 2009 reflect additional premiums from the Acquisition, cumulative rate increases of 21.6% in California, the net 2009 rate decrease in Florida of 18.6%, rate reductions in several other states, as well as the impacts of competitive pressures and lower payrolls due to the

economic contraction. We believe our policy count in the majority of our states will continue to grow, particularly in the Midwest and Southeast where we believe our A- (Excellent) A.M. Best rating is resulting in an increase in new business submissions. We emphasize disciplined pricing objectives and underwriting guidelines and we believe we are well positioned to continue to grow profitably. However, we cannot be certain how these trends will ultimately impact our consolidated financial position and results of operations.

Marketing and Distribution

We market and sell our workers' compensation insurance products through independent local, regional and national agents and brokers, and through our strategic partnerships and alliances, including our principal partners ADP and Wellpoint. Policies underwritten directly or through our independent agents and brokers generated \$312.7 million and \$386.7 million, or 81.2% and 83.1%, of our in-force premiums as of December 31, 2009 and 2008, respectively.

Independent Insurance Agents and Brokers

We establish and maintain strong, long-term relationships with independent agents and brokers who actively market our products and services. We emphasize personal interaction, offering responsive service and competitive commissions and maintaining a focus on workers' compensation insurance. Our sales representatives and field underwriters work closely with independent agents and brokers to market and underwrite our business, regularly visiting their offices and participating in presentations to customers. This results in enhanced understanding of the businesses and risks we underwrite and the needs of prospective customers.

We believe that the decision by independent agents and brokers to place business with an insurer depends in part upon superior services offered by the insurer to the agents and brokers and policyholders, as well as the insurer's expertise and dedication to a particular line of business. Accordingly, we continually seek to enhance the ease of doing business with us and to provide superior service. For example, our automated underwriting system enables agents and brokers to directly input data into the system and in some instances the system prices the risk and binds the coverage without human intervention. We do not delegate underwriting authority to agents or brokers that sell our insurance. We pay commissions on premiums written that we believe are competitive with other workers' compensation insurers. Additionally, we believe that we deliver prompt, efficient and professional support services.

As of December 31, 2009, we marketed and sold our insurance products through approximately 3,800 independent insurance agents and brokers in approximately 1,600 appointed agencies. Those agents and brokers produced \$309.5 million, \$381.9 million and \$235.6 million, or 80.4%, 82.0%, and 72.1% of our in-force premiums as of December 31, 2009, 2008 and 2007, respectively.

No single agency or brokerage accounted for more than 0.7%, 1.2% and 2.0% of our in-force premiums as of December 31, 2009, 2008 and 2007, respectively.

Strategic Partnerships and Alliances

To expand our distribution, we have developed important strategic relationships with companies that have established sales forces and common markets. Since 2002, we have jointly marketed our workers' compensation insurance products with ADP's payroll services primarily to small businesses in ten states and with Wellpoint's group health insurance plans in California. Additionally, we have entered into additional strategic partnerships with E-chx, Inc. (E-chx) and Granite Professional Insurance Brokerage, Inc. (Granite), Intego Insurance Services, LLC (Intego) and Small Business Payroll Services Group of Wells Fargo Bank, National Association (Wells Fargo). We are actively pursuing opportunities for other strategic partnerships and alliances.

Policies underwritten through our strategic partnerships and alliances generated \$72.3 million, \$78.9 million and \$84.4 million, or 18.8%, 16.9% and 25.8% of our in-force premiums as of December 31, 2009, 2008 and 2007,

respectively. The decrease in 2008, as compared to 2007, as a percentage of total in-force premiums was primarily attributable to increased total premium related to the Acquisition,

partially offset by overall premium declines attributable to our strategic partnerships and alliances, which continued in 2009. We do not delegate underwriting authority to our strategic distribution partners.

Wellpoint. The Wellpoint Integrated MedcompSM joint marketing program includes two agreements, a small group health insurance plan (for businesses with 1 to 50 employees) and a large group health insurance plan (for businesses with 51 to 250 employees). These two group health insurance plans are offered with our standard workers compensation insurance policy. This exclusive relationship allows us to distribute an integrated group health/workers compensation product in California through Wellpoint's life and health agents. The primary benefit to the employer is a single bill for their group health and workers' compensation insurance coverage and a discount on workers' compensation premiums. We believe that, in general, when businesses purchase this combination of coverage, their employees make fewer workers' compensation claims because those employees are insured for non-work related illnesses or injuries and thus are less likely to seek treatment for a non-work related illness or injury through their employers' workers' compensation insurance policy. We believe another key benefit to this program is the increased satisfaction from employees who are able to use the same medical network for occupational and non-occupational illness and injury. As the largest group health carrier in California, Wellpoint has negotiated favorable rates with its medical providers and associated facilities, which we benefit from through reduced claims costs. We pay Wellpoint fees that are a percentage of premiums paid for services provided under the Integrated MediComp program.

The small group and large group agreements automatically renew for one-year periods unless terminated by either party with at least 60 days notice prior to the expiration of the current term. These agreements have automatically renewed through January 1, 2011 and July 1, 2010, respectively.

ADP. ADP is a payroll services company which provides services to small and medium-sized businesses, and is the largest payroll service provider in the United States. As part of its services, ADP sells our workers' compensation insurance product along with its payroll and accounting services through ADP's insurance agency and field sales staff primarily to small businesses in ten states (Arizona, California, Colorado, Florida, Idaho, Illinois, Nevada, Oregon, Texas, and Utah). The majority of business written is through ADP's small business unit, which has accounts of 1 to 50 employees. We pay ADP fees that are a percentage of premiums paid for services provided through the ADP program.

ADP utilizes innovative methods to market workers' compensation insurance including the Pay-by-Pay[®] (PBP) program. An advantage of ADP's PBP program is that the policyholder is not required to pay a deposit at the inception of the policy. Rather, the workers' compensation premium is deducted each time ADP processes the policyholders' payrolls along with their appropriate federal, state, and local taxes. These characteristics of the PBP program enable us to competitively price the workers' compensation insurance written as a part of that program.

Although we do not have an exclusive relationship with ADP, we believe we are a key strategic partner of ADP for our selected markets and classes of business. Our agreement with ADP may be terminated without cause upon 120 days notice.

E-chx and Granite. We entered into a joint sales, services and program administration agreement with E-chx and Granite in November 2006, pursuant to which E-chx, a payroll solutions company providing payroll outsourcing solutions for small businesses, markets our workers' compensation insurance product with its payroll services. The program is only available in California. Although we do not have an exclusive relationship with E-chx, we are its only strategic partner in California. E-chx may terminate the agreement without cause upon 90 days written notice. E-chx offers products and services in all 50 states. We pay E-chx fees that are a percentage of premiums paid for services provided through the program.

E-chx offers an E-PAYSM program. An advantage of this program is that the policyholder is not required to pay a deposit at the inception of the policy. Rather, the workers' compensation premium is deducted each time E-chx processes the policyholders' payrolls along with their appropriate federal, state, and local taxes. These characteristics of the E-Pay program enable us to competitively price the workers' compensation insurance written as a part of that

program.

Additionally, as part of our distribution relationship, Granite markets our products through other payroll providers.

Intego. In 2007, we entered into a Partner Program and Agency Agreement with Intego, a full service insurance brokerage that works with approved, independent payroll service companies to identify potential business leads. Pursuant to this non-exclusive agreement, Intego markets our workers' compensation insurance product in Texas, Florida and Illinois to business customers of the independent payroll service companies with a billing that is integrated with their payroll products. Intego may terminate this agreement without cause upon 90 days written notice.

Wells Fargo. In 2008, we entered into a strategic relationship with the Small Business Payroll Services Group of Wells Fargo. This non-exclusive relationship allows the Small Business Payroll Services Group to offer our workers' compensation products as part of ExpressPay[®] and other payroll services in most of the western states in which we do business. ExpressPay is sold through Wells Fargo banking operations by bankers who are trained to identify and cross-sell the ExpressPay product.

Direct Business

We write a small amount of business that comes to us directly without using an agent or broker or one of our strategic distribution relationships. This direct business is a legacy of our assumption of the assets and liabilities of the Fund. Although we do not market any direct business, we intend to maintain this book of business because it is very well known by our underwriters and is profitable. At December 31, 2009, 2008 and 2007, approximately \$3.2 million, \$4.8 million and \$7.0 million, respectively, of our in-force premiums were from direct business.

Underwriting and Products

Disciplined Underwriting

We target select small businesses engaged in low to medium hazard industries. We employ a disciplined underwriting approach designed to individually select specific types of businesses, predominantly those in the four lowest of the seven workers' compensation insurance industry-defined hazard groups, that we believe will have fewer and less costly claims relative to other businesses in the same hazard groups.

Our underwriting guidelines are designed to minimize underwriting of classes and subclasses of business which have historically demonstrated claims severity that do not meet our target risk profiles. We price our policies based on the specific risks associated with each potential insured rather than solely on the industry class in which a potential insured is classified. As of December 31, 2009, policyholders in the four lowest industry-defined hazard groups generated approximately 83.2% of our in-force premiums. This is consistent with our strategy of targeting insureds in low to medium hazard businesses. Our statutory losses and loss adjustment expenses (LAE) ratio, a measure which relates inversely to our underwriting profitability, was 57.5% and 51.4% in 2009 and 2008, respectively, 15.6 and 21.7 percentage points below the 2008 statutory industry composite losses and LAE ratio calculated by A.M. Best for U.S. insurance companies having more than 50% of their premiums generated by workers' compensation insurance products. Our statutory losses and LAE ratio was at least ten percentage points below the A.M. Best composite losses and LAE ratio for the industry for each of the five years ended December 31, 2008. Our disciplined underwriting approach is a critical element of our culture and has allowed us to offer competitive prices, diversify our risks and achieve profitable growth.

We provide workers' compensation insurance coverage to several homogeneous groups of business such as physicians, dentists, restaurants, artisan contractors and retail stores. We review the premium, payroll, and loss history trends of each group annually and develop a schedule rating modification that is applied to all policyholders that meet the qualification standards for a given group. Qualification standards vary between groups and may include factors such as management experience, loss experience, and nature of operations conducted by the insured and/or other exposures specific to the class of business. Additionally, an insured's experience modification is applied in the determination of

its premium.

Our underwriting strategy involves continuing our disciplined underwriting approach in pursuing profitable growth opportunities. We carefully monitor market trends to assess new business opportunities, only pursuing opportunities that we expect to meet our pricing and risk standards. We seek to underwrite our portfolio of low to medium hazard risks with a view toward maintaining long-term underwriting profitability across market cycles.

We execute our underwriting processes through automated systems and seasoned underwriters with specific knowledge of local markets. Within these systems, we have developed underwriting templates for specific, targeted classes of business that produce faster quotations when all underwriting criteria are met by a specific risk. These underwriting guidelines consider many factors such as type of business, nature of operations, risk exposures and other employer-specific conditions, and are designed to minimize underwriting of certain classes and subclasses of business such as chemical manufacturing, high-rise construction and long-haul trucking, which have historically demonstrated claims severity that do not meet our target risk profiles.

While our underwriting systems are automated, we do not delegate underwriting authority to agents or brokers that sell our insurance or to any other third party. To create efficiency and standardization, we implemented an underwriting and policy administration system. As a result, two of our legacy underwriting systems have been discontinued and one remaining legacy system will be phased out beginning in early 2010. Our field underwriters continue to work closely with independent agents, brokers and our strategic distribution partners to market and underwrite our business, regularly visiting their offices and participating in presentations to customers.

The average length of experience of our current underwriters exceeds ten years. Our underwriting guidelines are defined centrally by our Corporate Underwriting Department and our Chief Underwriting Officer, who is responsible for supervision of the underwriting conducted at all of the business units, has the authority to permit a business unit to underwrite particular risks that fall outside the classes of business specified in our underwriting guidelines on a case-by-case basis.

Loss Control

Our loss control professionals provide consultation to policyholders to assist them in preventing losses and containing costs once claims occur. They also assist our underwriting personnel in evaluating potential and current policyholders and are an important part of our loss control strategy.

Premium Audit

We conduct premium audits on our policyholders annually upon the expiration of each policy. The purpose of these audits is to comply with applicable state and reporting bureau requirements and to verify that policyholders have accurately reported their payroll and employee job classifications. In addition to annual audits, we selectively perform interim audits on certain classes of business if unusual claims are filed or concerns are raised regarding projected annual payrolls, which could result in substantial variances at final audit.

Principal Products and Pricing

Our workers' compensation insurance product is written primarily on a guaranteed cost basis, meaning the premium for a policyholder is set in advance and varies based only upon changes in the policyholder's class and payroll. Class and specific risk credits are formulated to fit the needs of targeted classes and employer groups. Premiums are based on the particular class of business and our estimates of expected losses, LAE and other expenses related to the policies we underwrite. Generally, premiums for workers' compensation insurance policies are a function of:

the amount of
the insured

employer's
payroll;

the applicable
premium rate,
which varies
with the
nature of the
employees
duties and the
business of
the insured;

the insured's
industry
classification;
and

factors
reflecting the
insured
employer's
historical loss
experience.

In addition, our pricing decisions take into account the workers' compensation insurance regulatory requirements of each state in which we conduct operations, because such requirements address the rates that industry participants in that state may or should charge for policies.

We write business in administered pricing and loss cost states. In administered pricing states, insurance rates are set by the state insurance regulators and are adjusted periodically. Rate competition generally is not permitted in these states and, consequently, policy dividend programs, which reflect an insured's risk profile, are an important competitive factor. Florida, Wisconsin and Idaho are administered pricing states, while the other states in which we operate are loss cost states. In loss cost states, we have more flexibility to offer premium rates that reflect the risk we are taking based on each employer's profile.

We offer dividend plans to eligible policyholders, primarily in Florida and Wisconsin, under which a portion of the premium paid by a policyholder may be returned in the form of a dividend. Eligibility for these programs varies based upon the nature of the policyholder's operations, value of premium generated, loss experience and existing controls intended to minimize workers' compensation claims and costs. Payment of policy dividends specified in the dividend plans cannot be guaranteed.

In loss cost states, the state first approves a set of loss costs that provide for expected loss and, in most cases, LAE payments, which are prepared by an insurance rating bureau (for example, the WCIRB in California and the NCCI in Nevada). An insurer then selects a factor, known as a loss cost multiplier, to apply to loss costs to determine its rates. In these states, regulators permit pricing flexibility primarily through: (a) the selection of the loss cost multiplier; and (b) schedule rating modifications that allow an insurer to adjust premiums upwards or downwards for specific risk characteristics of the policyholder such as:

type of work
conducted at
the premises
or work
environment;

on-site
medical
facilities;

level of
employee
safety;

use of safety
equipment;
and

policyholder
management
practices.

In all of the loss cost states in which we currently operate, we use both variables (a) and (b) above to calculate a policy premium that we believe will cover the claim payments, losses and LAE, and company overhead and result in a reasonable profit for us.

Claims and Medical Case Management

The role of our claims department is to actively investigate, evaluate and pay claims efficiently, and to aid injured workers in returning to work in accordance with applicable laws and regulations. We have implemented rigorous claims guidelines, reporting and control procedures in our claims units and have claims operations throughout the markets we serve. We also provide medical case management services for all claims that we determine will benefit from such involvement.

Our claims department also provides claims management services for those claims incurred by the Fund and assumed by our Nevada insurance subsidiary in connection with the LPT Agreement with a date of injury prior to July 1, 1995. We receive a management fee from the third party reinsurers equal to 7% of the loss payments on these claims.

In Nevada, we have created our own medical provider network, and we make every appropriate effort to direct injured workers into this network. In the other states in which we do business, we utilize networks affiliated with Wellpoint and Coventry Health Care, Inc. In addition to our medical networks, we work closely with local vendors, including attorneys, medical professionals and investigators, to bring local expertise to our reported claims. We pay special attention to reducing costs in each region and have established discounting arrangements with the aforementioned service providers. We use preferred provider organizations, bill review services and utilization management to closely monitor medical costs and to verify that providers charge no more than the applicable fee schedule, or in some cases what is usual and customary.

We actively pursue subrogation and recovery in an effort to mitigate claims costs. Subrogation rights are based upon state and federal laws, as well as the insurance policy issued to the insured. Our subrogation efforts are handled through a dedicated subrogation unit.

Losses and Loss Adjustment Expenses Reserves

We are directly liable for losses and LAE under the terms of insurance policies our insurance subsidiaries underwrite. Significant periods of time can elapse between the occurrence of an insured loss, the reporting of the loss to us and our payment of that loss. Loss reserves are reflected on our balance sheets under the line item caption unpaid losses and loss adjustment expenses. As of December 31, 2009, our reserves for unpaid losses and LAE, net of reinsurance, were \$1.4 billion. The process of estimating reserves involves a considerable degree of judgment by management and, as of any given date, is inherently uncertain. For a detailed description of our reserves, the judgments, key assumptions and actuarial methodologies that we use to estimate our reserves and the role of our consulting actuary, see Item 7 Management's Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Policies Reserves for Losses and Loss Adjustment Expenses.

The following table provides a reconciliation of the beginning and ending loss reserves on a GAAP basis:

| | 2009 | December 31, 2008 | 2007 |
|--|--------------|------------------------------|--------------|
| | | (in thousands) | |
| Unpaid losses and LAE, gross of reinsurance, at beginning of period | \$ 2,506,478 | \$ 2,269,710 | \$ 2,307,755 |
| Less reinsurance recoverable, excluding bad debt allowance, on unpaid losses and LAE | 1,076,350 | 1,052,641 | 1,098,103 |
| Net unpaid losses and LAE at beginning of period | 1,430,128 | 1,217,069 | 1,209,652 |
| Losses and LAE, net of reinsurance, acquired in business combination | | 247,006 | |
| Losses and LAE, net of reinsurance, incurred in: | | | |
| Current year | 283,827 | 226,643 | 221,347 |
| Prior years | (51,359) | (71,707) | (60,011) |
| Total net losses and LAE incurred during the period | 232,468 | 154,936 | 161,336 |
| Deduct payments for losses and LAE, net of reinsurance, related to: | | | |
| Current year | 74,944 | 53,397 | 44,790 |
| Prior years | 214,499 | 135,486 | 109,129 |
| Total net payments for losses and LAE during the period | 289,443 | 188,883 | 153,919 |
| | 1,373,153 | 1,430,128 | 1,217,069 |

| | | | |
|---|--------------|--------------|--------------|
| Ending unpaid losses and LAE, net of reinsurance | | | |
| Reinsurance recoverable, excluding bad debt allowance, on unpaid losses and LAE | 1,052,505 | 1,076,350 | 1,052,641 |
| Unpaid losses and LAE, gross of reinsurance, at the end of period | \$ 2,425,658 | \$ 2,506,478 | \$ 2,269,710 |

Our estimates of incurred losses and LAE attributable to insured events of prior years have decreased for past accident years because actual losses and LAE paid and current projections of unpaid losses and LAE were less than we originally anticipated. We refer to such decreases as favorable developments. The reductions in reserves were \$51.4 million, \$71.7 million and \$60.0 million for the years ended December 31, 2009, 2008 and 2007, respectively. Estimates of net incurred losses and LAE are established by management utilizing actuarial indications based upon our historical and industry experience regarding claim emergence and claim payment patterns, and regarding claim cost trends, adjusted for future anticipated changes in claims-related and economic trends, as well as regulatory and legislative changes, to establish our best estimate of the losses and LAE reserves. The decrease in the prior year reserves was primarily the result of actual paid losses being less than expected, and revised assumptions used in the projection of future losses and LAE payments based on more current

information about the impact of certain changes, such as legislative changes, which was not available at the time the reserves were originally established. While we have had favorable developments over the past three years, the magnitude of these developments illustrates the inherent uncertainty in our liability for losses and LAE, and we believe that favorable or unfavorable developments of similar magnitude, or greater, could occur in the future. For a detailed description of the major sources of recent favorable developments, see Item 7 Management's Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Policies Reserves for Losses and Loss Adjustment Expenses and Note 11 in the Notes to our Consolidated Financial Statements.

Our reserves for unpaid losses and loss adjustment expenses (gross and net), as well as our case and incurred but not reported or IBNR reserves were as follows:

| | 2009 | December 31, 2008 | 2007 |
|---|--------------|----------------------|--------------|
| | | (in thousands) | |
| Case reserves | \$ 915,378 | \$ 886,789 | \$ 740,133 |
| IBNR | 1,198,019 | 1,293,313 | 1,235,124 |
| LAE | 312,261 | 326,376 | 294,453 |
| Gross unpaid losses and LAE | 2,425,658 | 2,506,478 | 2,269,710 |
| Reinsurance recoverables on unpaid losses and LAE, gross | 1,052,505 | 1,076,350 | 1,052,641 |
| Net unpaid losses and LAE | \$ 1,373,153 | \$ 1,430,128 | \$ 1,217,069 |

Loss Development

The following tables show changes in the historical loss reserves, on a gross basis and net of reinsurance, as of each of the ten years ended December 31, 2009, for EICN and ECIC and as of each of the years ended December 31, 2009 and 2008, for EPIC and EAC. These tables are presented on a GAAP basis. The paid and reserve data in the following tables is presented on a calendar year basis.

The top line of each table shows the net reserves and the gross reserves for unpaid losses and LAE recorded at each year-end. Such amount represents an estimate of unpaid losses and LAE occurring in that year as well as future payments on claims occurring in prior years. The upper portion of these tables (net and gross cumulative amounts paid, respectively) present the cumulative amounts paid during subsequent years on those losses for which reserves were carried as of each specific year. The lower portions (net reserves re-estimated) show the re-estimated amounts of the previously recorded reserves based on experience as of the end of each succeeding year. The re-estimated amounts change as more information becomes known about the actual losses for which the initial reserve was carried. An adjustment to the carrying value of unpaid losses for a prior year will also be reflected in the adjustments for each subsequent year. For example, an adjustment made in the 2000 year will be reflected in the re-estimated ultimate net loss for each of the years thereafter. The gross cumulative redundancy, or deficiency, line represents the cumulative change in estimates since the initial reserve was established. It is equal to the difference between the initial reserve and the latest re-estimated reserve amount. A redundancy means that the original estimate was higher than the current estimate. A deficiency means that the current estimate is higher than the original estimate.

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| | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|------------|------------|------------|------------|----------------|
| | | | | | (in thousands) |
| Net reserves for losses and LAE | | | | | |
| Originally estimated | \$ 936,000 | \$ 887,000 | \$ 908,326 | \$ 962,457 | \$ 1,089,814 |
| Net cumulative amounts paid as of: | | | | | |
| One year later | 108,748 | 81,022 | 80,946 | 91,130 | 96,661 |
| Two years later | 161,721 | 120,616 | 130,386 | 150,391 | 161,252 |
| Three years later | 191,453 | 149,701 | 165,678 | 193,766 | 207,868 |
| Four years later | 215,015 | 173,204 | 194,400 | 226,127 | 247,217 |
| Five years later | 235,613 | 194,980 | 218,453 | 255,851 | 285,388 |
| Six years later | 255,772 | 215,507 | 242,143 | 288,039 | |
| Seven years later | 275,750 | 235,653 | 269,341 | | |
| Eight years later | 294,760 | 260,036 | | | |
| Nine years later | 318,262 | | | | |
| Net reserves re-estimated as of: | | | | | |
| One year later | 896,748 | 875,522 | 847,917 | 924,878 | 1,011,759 |
| Two years later | 885,221 | 781,142 | 805,058 | 886,711 | 975,765 |
| Three years later | 800,959 | 742,272 | 779,373 | 884,426 | 954,660 |
| Four years later | 766,204 | 719,912 | 788,262 | 877,151 | 927,382 |
| Five years later | 743,997 | 730,112 | 788,481 | 858,617 | 900,588 |
| Six years later | 754,447 | 730,456 | 776,329 | 839,430 | |
| Seven years later | 754,462 | 720,155 | 763,988 | | |
| Eight years later | 745,665 | 712,717 | | | |
| Nine years later | 744,085 | | | | |
| Net cumulative redundancy: | 191,915 | 174,283 | 144,338 | 123,027 | 189,226 |
| Gross reserves December 31 | 2,326,000 | 2,226,000 | 2,212,368 | 2,193,439 | 2,284,542 |
| Reinsurance recoverable, gross | 1,390,000 | 1,339,000 | 1,304,042 | 1,230,982 | 1,194,728 |
| Net reserves December 31 | 936,000 | 887,000 | 908,326 | 962,457 | 1,089,814 |
| Gross re-estimated reserves | 2,071,274 | 1,990,116 | 2,000,610 | 2,030,945 | 2,050,937 |

| | | | | | |
|--|------------|------------|------------|------------|------------|
| Re-estimated reinsurance recoverables | 1,327,189 | 1,277,399 | 1,236,622 | 1,191,515 | 1,150,349 |
| Net re-estimated reserves | 744,085 | 712,717 | 763,988 | 839,430 | 900,588 |
| Gross reserves for losses and LAE | | | | | |
| Originally estimated | 2,326,000 | 2,226,000 | 2,212,368 | 2,193,439 | 2,284,542 |
| Gross cumulative amounts paid as of: | | | | | |
| One year later | 160,978 | 128,066 | 128,462 | 137,968 | 142,632 |
| Two years later | 260,995 | 215,176 | 224,740 | 243,203 | 252,379 |
| Three years later | 338,243 | 291,099 | 306,006 | 331,731 | 342,748 |
| Four years later | 408,643 | 360,535 | 379,881 | 407,845 | 424,811 |
| Five years later | 475,174 | 427,307 | 447,687 | 480,283 | 504,918 |
| Six years later | 540,329 | 490,296 | 514,091 | 554,408 | |
| Seven years later | 602,371 | 553,103 | 583,226 | | |
| Eight years later | 664,042 | 619,373 | | | |
| Nine years later | 729,432 | | | | |
| Gross reserves re-estimated as of: | | | | | |
| One year later | 2,280,978 | 2,211,566 | 2,121,867 | 2,148,829 | 2,178,514 |
| Two years later | 2,266,495 | 2,089,850 | 2,072,205 | 2,088,437 | 2,138,648 |
| Three years later | 2,157,647 | 2,049,340 | 2,024,790 | 2,084,764 | 2,110,481 |
| Four years later | 2,121,397 | 2,000,560 | 2,032,553 | 2,072,428 | 2,078,223 |
| Five years later | 2,072,866 | 2,009,608 | 2,028,211 | 2,050,124 | 2,050,937 |
| Six years later | 2,082,409 | 2,009,480 | 2,012,943 | 2,030,945 | |
| Seven years later | 2,082,287 | 1,997,550 | 2,000,610 | | |
| Eight years later | 2,072,850 | 1,990,116 | | | |
| Nine years later | 2,071,274 | | | | |
| Gross cumulative redundancy: | \$ 254,726 | \$ 235,884 | \$ 211,756 | \$ 162,494 | \$ 233,605 |

Reinsurance

Reinsurance is a transaction between insurance companies in which an original insurer, or ceding company, remits a portion of its premiums to a reinsurer, or assuming company, as payment for the reinsurer assuming a portion of the risk. Reinsurance agreements may be proportional in nature, under which the assuming company shares proportionally in the premiums and losses of the ceding company. This arrangement is known as quota share reinsurance.

Reinsurance agreements may also be structured so that the assuming company indemnifies the ceding company against all or a specified portion of losses on underlying insurance policies in excess of a specified amount, which is called an attachment level or retention in return for a premium, usually determined as a percentage of the ceding company's primary insurance premiums. This arrangement is known as excess of loss reinsurance. Excess of loss reinsurance may be written in layers, in which a reinsurer or group of reinsurers accepts a band of coverage up to a specified amount. Any liability exceeding the coverage limits of the reinsurance program is retained by the ceding company. The ceding company also bears the credit risk of a reinsurer's insolvency. In accordance with general industry practices, we purchase excess of loss reinsurance to protect against the impact of large individual, irregularly-occurring losses, and aggregate catastrophic losses from natural perils and terrorism, which would otherwise cause sudden and unpredictable changes in net income and the capital of our insurance subsidiaries.

Reinsurance is used principally:

- to reduce net liability on individual risks;

- to provide protection for catastrophic losses; and

- to stabilize underwriting results and preserve working capital.

Excess of Loss Reinsurance

Our current reinsurance program applies to all covered losses occurring between 12:01 a.m. July 1, 2009 and 12:01 a.m. July 1, 2010. The reinsurance program consists of two agreements, one excess of loss agreement and one catastrophic loss agreement, entered into between our insurance subsidiaries and current and future affiliates of EHI and the subscribing reinsurers. We have the ability to extend the term of the agreement to continue to apply to policies which are in-force at the expiration of the treaty generally for a period of 12 months. We may cancel the agreement at any time if any subscribing reinsurer ceases its underwriting operations; becomes insolvent; is placed in conservation, rehabilitation, liquidation; or has a receiver appointed or if any reinsurer is unable to maintain a rating by A.M. Best and/or Standard and Poor's of at least A- throughout the term of the agreement. Covered losses which occur prior to expiration or cancellation of the agreement continue to be obligations of the subscribing reinsurers, subject to the other conditions in the agreement. The subscribing reinsurers may terminate the agreement only for our breach of the obligations of the agreement. We are responsible for the losses if the subscribing reinsurer cannot or refuses to pay.

For the program year beginning July 1, 2009, we have purchased reinsurance up to \$200 million. We are solely responsible for any losses we suffer above \$200 million except those covered by the Terrorism Insurance Program Reauthorization Act of 2007. Our loss retention for the program year beginning July 1, 2009 is \$5 million. This means we have reinsurance for covered losses we suffer between \$5 million and \$200 million, subject to an aggregate loss cession limitation in the first layer (\$5 million in excess of \$5 million) of \$20 million. Additionally, in the second through fifth layers of our reinsurance program, our ultimate net loss shall not exceed \$10 million for any one life, and we are permitted one reinstatement for each layer upon the payment of additional premium. We believe that our retention is appropriate for our current level of capitalization.

The agreements include certain exclusions for which our subscribing reinsurers are not liable for losses, including but not limited to losses arising from the following: reinsurance assumed by us under obligatory reinsurance agreements; financial guarantee and insolvency; certain nuclear risks; liability as a member, subscriber or reinsurer of any pool, syndicate or association, but not assigned risk plans; liability arising from participation or membership in any insolvency fund; loss or damage caused by war or civil unrest other than terrorism; certain workers' compensation business covering persons employed in Minnesota; any loss or damage caused by any act of terrorism involving biological, chemical, nuclear or radioactive pollution or contamination. We have underwriting guidelines which generally require that

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insured risks fall within the coverage provided in the reinsurance program. Any risks written outside the reinsurance program require the review and approval of our Chief Underwriting Officer and/or Chief Operating Officer.

The agreements provide that we or any subscribing reinsurer may request commutation of any outstanding claim or claims 10 years after the effective date of termination or expiration of the agreements and provide a mechanism for the parties to achieve valuation for commutation. We may require a special commutation of the percentage share of any loss in the reinsurance program of any subscribing reinsurer that is in runoff.

There were no significant changes between years from our reinsurance program commencing July 1, 2008 to the reinsurance program commencing July 1, 2009.

Our practice is to select reinsurers with an A.M. Best rating of A- or better at agreement inception as indicated in the table below, which provides information about our reinsurers and their participation in our reinsurance program:

| Reinsurer | A.M. Best Rating | \$5m excess of \$5m | \$10m excess of \$10m | \$30mn excess of \$20m | \$50m excess of \$50m | \$100m excess of \$100m |
|---|------------------|---------------------|-----------------------|------------------------|-----------------------|-------------------------|
| Arch Reinsurance Company | A | % | % | 5.00 % | 5.00 % | 5.00 % |
| Aspen Reinsurance Bermuda | A | | 5.00 | 5.00 | 5.00 | 2.00 |
| Aspen Insurance UK Limited | A | 7.40 | 8.40 | 10.00 | 10.00 | 10.00 |
| Axis Specialty Limited | A | | | | | 7.50 |
| Catlin US/OBO Syndicate 2003 | A | 44.50 | 17.00 | 18.00 | | |
| Endurance Specialty Insurance Ltd | A | | 5.00 | 5.00 | 7.00 | 7.25 |
| Everest Reinsurance Bermuda | A + | | | 4.00 | 5.00 | 5.00 |
| Hannover Re (Bermuda) Ltd | A | | | | 1.25 | 5.00 |
| Hannover Rueckversicherung-AG | A | 25.00 | 15.00 | 15.00 | | |
| Lloyds Syndicate #0435 FDY ⁽¹⁾ | A | | 5.00 | | 2.50 | |
| Lloyds Syndicate #0570 ATR ⁽¹⁾ | A | | 3.25 | 3.25 | 2.50 | |
| Lloyds Syndicate #0623 AFB ⁽¹⁾ | A | | 4.25 | | 2.50 | |
| Lloyds Syndicate #0727 SAM ⁽¹⁾ | A | | 2.00 | | | 2.00 |
| Lloyds Syndicate #0780 ADV ⁽¹⁾ | A | 2.00 | | | | 2.00 |
| Lloyds Syndicate #1084 CSL ⁽¹⁾ | A | | | | | 3.00 |

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| | | | | | | |
|--|-----|----------|----------|----------|----------|----------|
| Lloyds Syndicate #1400 DRE Imagine ⁽¹⁾ | A | | 1.30 | | 1.00 | 1.00 |
| Lloyds Syndicate #1955 Barbican ⁽¹⁾ | A | 2.50 | 2.50 | 4.50 | 4.00 | 1.00 |
| Lloyds Syndicate #2001 AMLIN ⁽¹⁾ | A | | | | 3.00 | 3.00 |
| Lloyds Syndicate #2003 SJC ⁽¹⁾ | A | | | 5.85 | 7.50 | |
| Lloyds Syndicate #2987 BRT ⁽¹⁾ | A | 6.20 | 4.50 | 6.40 | 10.50 | 6.00 |
| Lloyds Syndicate #566 STN ⁽¹⁾ | A | 5.00 | | | 7.50 | 3.00 |
| Lloyds Syndicate #4472 LIB ⁽¹⁾ | A | 7.40 | | | 5.00 | 4.50 |
| Munich Reinsurance America, Inc | A + | | | 8.00 | 10.00 | 11.00 |
| Odyssey America Reinsurance Corporation | A | | 5.00 | 5.00 | | |
| Renaissance Re | A + | | | | | 0.50 |
| Safety National | A | | | | 4.25 | 3.25 |
| Tokio Millenium Re | A + | | 21.80 | 5.00 | 6.50 | 18.00 |
| | | 100.00 % | 100.00 % | 100.00 % | 100.00 % | 100.00 % |

(1) The overall rating of Lloyds from a security standpoint is called the market or floor rating. The existence of this market rating reflects the chain of security

and, in particular, the role of the Lloyd's Central Fund which ensures that each syndicate is backed by capital consistent with a financial strength rating of at least that of the Lloyd's market. These syndicates are rated under the overall rating of Lloyd's. Some syndicates have their own separate rating which is higher than the floor rating.

LPT Agreement

On July 1, 1999, the Nevada legislature enacted Senate Bill 37 (SB37). The provisions of SB37 specifically stated that the Fund could take retroactive credit as an asset or a reduction of liability,

amounts ceded to (reinsured with) assuming insurers with security based on discounted reserves for losses related to periods beginning before July 1, 1995, at a rate not to exceed 6%.

As a result of SB37, the Fund entered into the LPT Agreement, a retroactive 100% quota share reinsurance agreement, in a loss portfolio transfer transaction with third party reinsurers (the LPT Agreement). The LPT Agreement commenced on June 30, 1999 and will remain in effect until all claims for loss and outstanding loss under the covered policies have closed, the agreement is commuted, or terminated, upon the mutual agreement of the parties, or the reinsurer's aggregate maximum limit of liability is exhausted, whichever occurs earlier. The LPT Agreement does not provide for any additional termination terms. The LPT Agreement substantially reduced the Fund's exposure to losses for pre-July 1, 1995 Nevada insured risks. On January 1, 2000, our Nevada insurance subsidiary assumed all of the assets, liabilities and operations of the Fund, including the Fund's rights and obligations associated with the LPT Agreement.

Under the LPT Agreement, the Fund initially ceded \$1.525 billion in liabilities for the incurred but unpaid losses and LAE related to claims incurred prior to July 1, 1995, for consideration of \$775 million in cash. The LPT Agreement, which ceded to the reinsurers substantially all of the Fund's outstanding losses as of June 30, 1999 for claims with original dates of injury prior to July 1, 1995, provides coverage for losses up to \$2 billion, excluding losses for burial and transportation expenses. As of December 31, 2009 and 2008, the estimated remaining liabilities subject to the LPT Agreement were approximately \$888.4 million, and \$929.6 million, respectively. Losses and LAE paid with respect to the LPT Agreement totaled approximately \$489.0 million and \$447.9 million through December 31, 2009 and 2008, respectively.

The reinsurers agreed to assume responsibilities for the claims at the benefit levels which existed in June 1999. The LPT Agreement required the reinsurers to each place assets supporting the payment of claims by them in individual trusts that require that collateral be held at a specified level. The level must not be less than the outstanding reserve for losses and a loss expense allowance equal to 7% of estimated paid losses discounted at a rate of 6%. If the assets held in trust fall below this threshold, we may require the reinsurers to contribute additional assets to maintain the required minimum level of collateral. The value of these assets as of December 31, 2009 and 2008 was \$883.6 million and \$998.4 million, respectively. One of the reinsurers has collateralized its obligations under the LPT Agreement by placing the stock of a publicly held corporation, with a value of \$635.2 million at December 31, 2009, in a trust to secure the reinsurer's losses of \$488.6 million. Other reinsurers have placed treasury and fixed income securities in trusts to collateralize their losses.

The current reinsurers party to the LPT Agreement include ACE Bermuda Insurance Limited, XL Mid Ocean Reinsurance Company Ltd. and National Indemnity Company (NICO). The contract provides that during the term of the agreement all reinsurers need to maintain a rating of no less than A- as determined by A.M. Best.

We account for the LPT Agreement as retroactive reinsurance. Upon entry into the LPT Agreement, an initial deferred reinsurance gain was recorded as a liability on our consolidated balance sheet. This gain is amortized using the recovery method, whereby the amortization is determined by the proportion of actual reinsurance recoveries to total estimated recoveries, and the amortization is reflected in losses and LAE.

We are also entitled to receive a contingent commission under the LPT Agreement. The contingent commission is estimated based on both actual paid results to date and projections of expected paid losses under the LPT Agreement. Increases and decreases in the estimated contingent commission are reflected in our commission expense in the period that the estimate is revised.

Recoverability of Reinsurance

Reinsurance makes the assuming reinsurer liable to the ceding company, or original insurer, to the extent of the reinsurance. It does not, however, discharge the ceding company from its primary liability to its policyholders in the

event the reinsurer is unable to meet its obligations under such reinsurance. Therefore, we are subject to credit risk with respect to the obligations of our reinsurers. We regularly perform internal reviews of the financial strength of our reinsurers. However, if a reinsurer is unable to meet any of its obligations to our insurance subsidiaries under the reinsurance agreements, our

insurance subsidiaries would be responsible for the payment of all claims and claims expenses that we have ceded to such reinsurer. We do not believe that our insurance subsidiaries are currently exposed to any material credit risk. In addition to selecting financially strong reinsurers, we continue to monitor and evaluate our reinsurers to minimize our exposure to credit risks or losses from reinsurer insolvencies. At December 31, 2009, \$883.6 million was in a trust account for reinsurance related to the LPT Agreement and an additional \$7.6 million, not related to the LPT Agreement, was collateralized by cash or letter of credit.

The availability, amount and cost of reinsurance are subject to market conditions and to our experience with insured losses. There can be no assurance that our reinsurance agreements can be renewed or replaced prior to expiration upon terms as satisfactory as those currently in effect. If we were unable to renew or replace our reinsurance agreements:

our net liability on individual risks would increase;

we would have greater exposure to catastrophic losses;

our underwriting results would be subject to greater variability; and

our underwriting capacity would be reduced.

Certain information regarding our ceded reinsurance recoverables as of December 31, 2009 is provided in the following table:

| Reinsurer | Rating ⁽¹⁾ | Total Paid | Total Unpaid Losses and LAE, net | Total |
|---|-----------------------|------------|----------------------------------|-----------|
| | | | (in thousands) | |
| ACE Bermuda Insurance Limited | A + | \$ 1,056 | \$ 88,843 | \$ 89,899 |
| Ace Property & Casualty Insurance Company | A + | | 1,282 | 1,282 |

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| | | | | |
|---|---------|-----------|--------------|--------------|
| American Healthcare Indemnity Co | B + | | 3,340 | 3,340 |
| Aspen Insurance UK Limited | A | 57 | 9,269 | 9,326 |
| Continental Casualty Company | A | 1,016 | 33,505 | 34,521 |
| Everest Reinsurance Company | A + | 197 | 5,418 | 5,615 |
| Finial Re | A - | | 4,391 | 4,391 |
| Hannover Rueckversicherung-AG | A | 11 | 12,245 | 12,256 |
| Max Bermuda, Ltd | A - | 89 | 5,869 | 5,958 |
| Munich Reinsurance America, Inc | A + | 484 | 14,335 | 14,819 |
| National Indemnity Company | A ++ | 5,821 | 488,637 | 494,458 |
| National Union Fire Insurance Company of Pittsburgh | A | 47 | 2,336 | 2,383 |
| Odyssey America Reinsurance Corp | A | | 1,141 | 1,141 |
| Paris Re S.A | A | 45 | 2,414 | 2,459 |
| ReliaStar Life Insurance Company | A | 87 | 3,001 | 3,088 |
| RSUI Indemnity Company | A | | 2,045 | 2,045 |
| St. Paul Fire & Marine Insurance Company | A + | 15 | 5,103 | 5,118 |
| Swiss Reinsurance America Company | A | 199 | 15,853 | 16,052 |
| Tokio Millenium Re Ltd | A ++ | 157 | 5,961 | 6,118 |
| Westport Insurance Company | A | 13 | 1,901 | 1,914 |
| XL Reinsurance Limited | A | 3,704 | 310,951 | 314,655 |
| Lloyds Syndicates | A | 754 | 27,064 | 27,818 |
| All Other | Various | (79) | 7,601 | 7,522 |
| Total | | \$ 13,673 | \$ 1,052,505 | \$ 1,066,178 |

(1) A.M. Best's highest financial strength ratings for insurance companies are A++ and A+ (superior) and A and A- (excellent).

We review the aging of our reinsurance recoverables on a quarterly basis. At December 31, 2009, 6.3% of our reinsurance recoverables on paid losses were 90 days overdue.

Inter-Company Reinsurance Pooling Agreement

Our insurance subsidiaries are parties to an inter-company pooling agreement. Under this agreement, the results of underwriting operations of each company are transferred to and combined with those of the others and the combined results are then reapportioned. The allocations under the pooling agreement are as follows:

EICN 53%

ECIC 27%

EPIC 10%

EAC 10%

The pooling percentages are set forth in the inter-company pooling agreement and do not change between periods. These pooling percentages were established October 1, 2008, the effective date of the agreement. The allocation percentages were, in part, based upon the relative amount of unconsolidated company statutory surplus of the respective companies at the time of the agreement.

Our insurance subsidiaries rely on the capacity of the entire pool rather than just on their own capital and surplus. Transactions under the pooling agreement are eliminated on consolidation and have no impact on our consolidated GAAP financial statements.

Investments

We derive investment income from our invested assets. We invest our insurance subsidiaries' total statutory surplus and funds to support our loss reserves and our unearned premiums. As of December 31, 2009, the total amortized cost of our investment portfolio was \$1.90 billion and the fair market value of the portfolio was \$2.03 billion.

Our investment guidelines have been adjusted to meet our consolidated business strategy. The revised guidelines incorporate lower fixed income duration parameters, a reduction in our equity target, a lower target weight for the tax-exempt municipal fixed income sector and revised benchmark compositions. Our overall investment philosophy is to maximize total investment returns within the constraints of prudent portfolio management. The asset allocation is reevaluated by the Finance Committee of the Board of Directors on a quarterly basis. We employ Conning Asset Management (Conning) as our independent investment manager. Conning follows our written investment guidelines based upon strategies approved by our Board of Directors. In addition to the construction and management of the portfolio, we utilize the investment advisory services of Conning. These services include investment accounting and company modeling using Dynamic Financial Analysis (DFA). The DFA tool is utilized in developing a tailored set of portfolio targets and objectives, which in turn, is used in constructing an optimal portfolio.

We employ an investment strategy that emphasizes asset quality and considers the durations of fixed maturity securities against anticipated claim payments and expenditures or other liabilities. The amounts and types of our investments are governed by statutes and regulations in the states in which our insurance subsidiaries are domiciled. Our investment portfolio is structured so that investments mature periodically over time in reasonable relation to current expectations of future claim payments. Currently, we make claim payments from positive cash flow from operations and use excess cash to invest in operations, invest in marketable securities, return capital to our stockholders and fund our growth strategy.

At December 31, 2009, our investment portfolio, which is classified as available-for-sale, was made up almost entirely of investment grade fixed maturity securities whose fair values may fluctuate due to interest rate changes. We strive to limit interest rate risk by managing the duration of our fixed maturity securities. As of December 31, 2009, our

investments (excluding cash and cash equivalents) had a duration of 5.02. To minimize interest rate risk, our portfolio is weighted toward short-term and intermediate-term bonds; however, our investment strategy balances consideration of duration, yield and credit risk. We strive to limit credit risk by investing in a fixed maturity securities portfolio that is heavily weighted toward short-term to intermediate-term investment grade securities rated A or better. Our investment guidelines require that the minimum weighted average quality of our fixed maturity securities portfolio shall be AA. As of December 31, 2009, our fixed maturity securities

portfolio had an average quality of AA+, with approximately 77.5% of the market value rated AA or better.

We carry our securities on our consolidated balance sheet at fair value. Accordingly, changes in market prices of the equity securities we hold in our combined investment portfolio result in increases or decreases in our total assets. In order to minimize our exposure to equity price risk, we invest primarily in equity securities of mid-to-large capitalization issuers and seek to diversify our equity holdings across several industry sectors. Our objective during the past few years has been to reduce equity exposure as a percentage of our total portfolio by increasing our fixed maturity securities. Our investment strategy allows a maximum exposure of 20% of our total combined investment portfolio in equity securities, with our current target at 3.0% of the total portfolio. At December 31, 2009, the equity allocation of our investment portfolio was 3.4%.

Given the economic uncertainty and continued market volatility, we believe our asset allocation best meets our strategy to preserve capital for policyholders, provide sufficient income to support insurance operations, and to effectively grow book value over a long-term investment horizon.

We regularly monitor our portfolio to preserve principal values whenever possible. All securities in an unrealized loss position are reviewed to determine whether the impairment is other-than-temporary. Factors considered in determining whether a decline is considered to be other-than-temporary include length of time and the extent to which fair value has been below cost, the financial condition and near-term prospects of the issuer, our intent on not selling the securities, and that it is not more likely than not that we will be required to sell the securities until their fair value recovers above cost, or to maturity.

The following table shows the fair value, the percentage of the fair value to total invested assets and the tax equivalent yield based on the fair value of each category of invested assets as of December 31, 2009:

| Category | Fair Value | Percentage of Total | Yield |
|---|------------------------------------|------------------------|-------|
| | (in thousands, except percentages) | | |
| U.S. Treasuries | \$ 146,464 | 7.2 % | 3.7 % |
| U.S. Agencies | 124,969 | 6.2 | 4.3 |
| States and municipalities | 1,028,277 | 50.7 | 5.8 |
| Corporate securities | 337,610 | 16.6 | 6.2 |
| Residential mortgaged-backed securities | 279,963 | 13.8 | 5.7 |
| Commercial mortgaged-back securities | 29,774 | 1.5 | 5.2 |
| Asset-backed securities | 13,235 | 0.6 | 5.3 |
| Equity securities | 69,268 | 3.4 | 4.3 |
| Total investments | \$ 2,029,560 | 100.0 % | |

Weighted average yield

5.6

For securities that are redeemable at the option of the issuer and have a fair value that is greater than par value, the maturity used for the table below is the earliest redemption date. For securities that are redeemable at the option of the issuer and have a fair value that is less than par value, the maturity used for the table below is the final maturity date. For mortgage-backed securities, mortgage prepayment assumptions are utilized to project the expected principal redemptions for each security, and the maturity used in the table below is the average life based on those projected redemptions at December 31, 2009:

| Remaining Time to Maturity | Fair Value | Percentage of Total Fair Value |
|-----------------------------------|------------------------------------|---|
| | (in thousands, except percentages) | |
| Less than one year | \$ 139,036 | 7.1 % |
| One to five years | 908,419 | 46.3 |
| Five to ten years | 627,600 | 32.0 |
| More than ten years | 285,237 | 14.6 |
| Total | \$ 1,960,292 | 100.0 % |

Information Technology

Core Systems

Policy Administration. Our primary underwriting and policy administration system went into production in July 2006. This includes the base systems for underwriting evaluation, quoting, rating, policy issuance, policy servicing and endorsements and has been customized to support specific company requirements. In January 2010, we completed the integration of our acquired subsidiaries, EPIC and EAC, as they were converted to our underwriting platform and their legacy system was discontinued.

Claims Administration. In January 2009, we replaced the claims administration system previously used by EICN and ECIC and completed the conversion of EPIC and EAC to this system in January 2010. This claims administration system provides enhanced productivity through more efficient processing, improved management reporting and supports business rules that drive more effective claims handling.

Business Continuity/Disaster Recovery

We maintain business continuity and disaster recovery plans for our critical business functions, including the restoration of information technology infrastructure and applications. We have two data centers that act as production facilities and as disaster recovery sites for each other. In addition, we utilize an offsite data storage facility.

Regulation

Holding Company Regulation

Nearly all states have enacted legislation that regulates insurance holding company systems. Each insurance company in a holding company system is required to register with the insurance regulator of its state of domicile and furnish information concerning the operations of companies within the holding company system that may materially affect the operations, management or financial condition of the insurers within the system. Under these laws, the respective state insurance departments may examine us at any time, require disclosure of material transactions and require prior notice of, or approval for, certain transactions. All transactions within a holding company system affecting an insurer must have fair and reasonable terms and are subject to other standards and requirements established by law and regulation.

Pursuant to applicable insurance holding company laws, EICN is required to register with the Nevada Division of Insurance (Nevada DOI), ECIC is required to register with the California Department of Insurance (California DOI), and EPIC and EAC are required to register with the Florida Office of Insurance Regulation (Florida OIR). All transactions within a holding company system affecting an insurer must have fair and reasonable terms, charges or fees for services performed must be reasonable, and the insurer's total statutory surplus following any transaction must be both reasonable in relation to its outstanding liabilities and adequate for its needs. Notice to state insurance regulators is required prior to the consummation of certain affiliated and other transactions involving our insurance subsidiaries and such transactions may be disapproved by the state insurance regulators.

Change of Control

Under Nevada insurance law and our amended and restated articles of incorporation that became effective on February 5, 2007, for a period of five years following February 5, 2007, no person may acquire or offer to acquire beneficial ownership of five percent or more of any class of our voting securities without prior approval by the Nevada Commissioner of Insurance (Nevada Commissioner) of an application for acquisition. Under Nevada insurance law, the Nevada Commissioner may not approve an application for such acquisition unless the Commissioner finds that: (a) the acquisition will not frustrate the plan of conversion as approved by our members and the Commissioner; (b) the Board of Directors of EICN has approved the acquisition or extraordinary circumstances not contemplated in the plan

of conversion have arisen which would warrant approval of the acquisition; and (c) the acquisition is consistent with the purpose of relevant Nevada insurance statutes to permit conversions on terms and conditions that are fair and equitable to the members eligible to receive consideration. Accordingly, as a practical matter, any person seeking to acquire us within five years after February 5,

2007 may only do so with the approval of our Board of Directors. In December 2007, the Nevada Commissioner approved our application to waive any beneficial ownership over 5% if the excess was caused by the 2007 stock repurchase program.

In addition, the insurance laws of California, Florida and Nevada generally require that any person seeking to acquire control of a domestic insurance company must obtain the prior approval of the insurance commissioner. Insurance laws in many states in which we are licensed contain provisions that require pre-notification to the insurance commissioner of a change in control of a non-domestic insurance company licensed in those states. Control is generally presumed to exist through the direct or indirect ownership of ten percent or more of the voting securities of a domestic insurance company or of any entity that controls a domestic insurance company. Generally, other states insurance laws require prior notification to the insurance department of those states of a change of control of a non-domiciliary insurance company licensed to transact insurance in that state. Because we have insurance subsidiaries domiciled in California, Florida and Nevada, any future transaction that would constitute a change in control of us would generally require the party seeking to acquire control to obtain the prior approval of the California, Florida and Nevada Commissioners, and may require pre-notification of the change of control.

State Insurance Regulation

Insurance companies are subject to regulation and supervision by the insurance regulator in the state in which they are domiciled and, to a lesser extent, other states in which they conduct business. As an insurance holding company, we, as well as our insurance subsidiaries, are subject to regulation by the states in which our insurance subsidiaries are domiciled or transact business. These state agencies have broad regulatory, supervisory and administrative powers, including among other things, the power to grant and revoke licenses to transact business, license agencies, set the standards of solvency to be met and maintained, determine the nature of, and limitations on, investments and dividends, approve policy forms and rates in some states, periodically examine financial statements, determine the form and content of required financial statements, and periodically examine market conduct.

Detailed annual and quarterly financial statements, prepared in accordance with statutory accounting practices, and other reports are required to be filed with the insurance regulator in each of the states in which we are licensed to transact business. The California DOI, Florida OIR, and Nevada DOI periodically examine the statutory financial statements of their respective domiciliary insurance companies. In 2009, California and Nevada completed exams for ECIC and EICN, respectively. There were no material findings.

In Florida, workers compensation insurance companies are subject to statutes related to excessive profits. Florida excessive profits are calculated based upon a statutory formula that is applied over rolling three year periods. Workers compensation insurers are required to file annual excessive profit forms and to return any Florida excessive profits to policyholders in the form of a cash refund or credit toward the future purchase of insurance.

In addition, many states have laws and regulations that limit an insurer's ability to withdraw from a particular market. For example, states may limit an insurer's ability to cancel or not renew policies. Furthermore, certain states prohibit an insurer from withdrawing one or more lines of business from the state, except pursuant to a plan that is approved by the state insurance regulator. The state insurance regulator may disapprove a plan that may lead to market disruption. Laws and regulations that limit cancellation and non-renewal and that subject program withdrawals to prior approval requirements may restrict our ability to exit unprofitable markets.

Changes in individual state regulation of workers compensation may create a greater or lesser demand for some or all of our products and services, or require us to develop new or modified services in order to meet the needs of the marketplace and to compete effectively in that marketplace. In addition, many states limit the maximum amount of dividends and other payments that may be paid in any year by insurance companies to their stockholders and affiliates. This may limit the amount of distributions that may be made by our insurance subsidiaries.

Premium Rate Restrictions

Among other matters, state laws regulate not only the amounts and types of workers' compensation benefits that must be paid to injured workers, but in some instances the premium rates that may be charged by us to insure businesses for those liabilities. For example, in some states, including Florida, Wisconsin and Idaho, workers' compensation insurance rates are set by the state insurance regulators and are adjusted periodically. This style of rate regulation is referred to as administered pricing. Idaho also allows insurance companies to file rates that deviate upwards or downwards from the benchmark rates set by the insurance regulators.

In the vast majority of states, workers' compensation insurers have flexibility to offer rates that reflect the risk assumed by the insurer based on each employer's profile. These states are referred to as loss cost states. The majority of the states in which we currently operate, including California are loss cost states. In loss cost states, the state first approves a set of loss costs that provide for expected loss and, in most cases, LAE payments, which are prepared by an insurance rating bureau (for example, the WCIRB in California). An insurer then selects a factor, known as a loss cost multiplier, to apply to loss costs to determine its rates. In these states, regulators permit pricing flexibility primarily through: (a) the selection of the loss cost multiplier; and (b) schedule rating modifications that allow an insurer to adjust premiums upwards or downwards for specific risk characteristics of the policyholder such as:

type of work
conducted at
the premises
or work
environment;

on-site
medical
facilities;

level of
employee
safety;

use of safety
equipment;
and

policyholder
management
practices.

Financial, Dividend and Investment Restrictions

State laws require insurance companies to maintain minimum levels of surplus and place limits on the amount of premiums a company may write based on the amount of that company's surplus. These limitations may restrict the rate at which our insurance operations can grow.

State laws also require insurance companies to establish reserves for payments of policyholder liabilities and impose restrictions on the kinds of assets in which insurance companies may invest. These restrictions may require us to invest in assets more conservatively than we would if we were not subject to state law restrictions and may prevent us from obtaining as high a return on our assets as we might otherwise be able to realize absent the restrictions.

The ability of EHI to pay dividends on our common stock and to pay other expenses will be dependent to a significant extent upon the ability of our Nevada domiciled insurance company, EICN, and our Florida domiciled insurance company, EPIC, to pay dividends to their immediate holding company, Employers Group, Inc. (EGI) and, in turn, the ability of EGI to pay dividends to EHI.

Nevada law limits the payment of cash dividends by EICN to EGI by providing that payments cannot be made except from available and accumulated surplus otherwise unrestricted (unassigned) and derived from realized net operating profits and realized and unrealized capital gains. A stock dividend may be paid out of any available surplus. A cash or stock dividend otherwise prohibited by these restrictions, such as a dividend from special assigned surplus, may only be declared and distributed upon the prior approval of the Nevada Commissioner and is considered extraordinary. Special surplus for EICN is assigned surplus funds relating to statutory accounting for retroactive reinsurance and is not available for dividends without prior approval from the Nevada Commissioner.

EICN must give the Nevada Commissioner prior notice of any extraordinary dividends or distributions that it proposes to pay to EGI, even when such a dividend or distribution is to be paid out of available and otherwise unrestricted (unassigned) surplus. EICN may not pay such an extraordinary dividend or make an extraordinary distribution until the Nevada Commissioner either approves or does not disapprove the payment within 30 days after receiving notice of its declaration. An extraordinary dividend or distribution is defined by statute to include any dividend or distribution of cash or property whose fair market value, together with that of other dividends or distributions made within the preceding 12 months, exceeds the greater of: (a) 10% of EICN's statutory surplus as regards

policyholders at the next preceding December 31; or (b) EICN's statutory net income, not including realized capital gains, for the 12-month period ending at the next preceding December 31.

As of December 31, 2009 and 2008, EICN had positive unassigned surplus of \$301.1 million and \$205.9 million, respectively. On May 15, 2008, EICN requested and received approval from the Nevada Commissioner to increase a previously approved \$200.0 million extraordinary dividend to \$275.0 million subject to maintaining the risk-based capital (RBC) total adjusted capital of EICN above a specified level on the date of payment after giving effect to such payment. On August 18, 2008, EICN requested and received approval from the Nevada Commissioner to increase the extraordinary dividend from \$275.0 million to a total of \$355.0 million subject to the same terms and conditions. The additional extraordinary dividend provided capital management flexibility. As of December 31, 2008, the \$355.0 million in extraordinary dividends had been paid to EHI.

The maximum ordinary dividend that could have been paid in 2009 by our insurance subsidiaries to EHI was \$17.7 million. On July 31, 2009, a dividend of \$17.7 million was paid by EPIC to EGI, its immediate holding company, and subsequently from EGI to EHI.

As the direct owner of ECIC, EICN will be the direct recipient of any dividends paid by ECIC. The ability of ECIC to pay dividends to EICN is limited by California law, which provides that absent prior approval of the California Commissioner, dividends can only be declared from earned surplus. Earned surplus as defined by California law excludes amounts: (a) derived from the net appreciation in the value of assets not yet realized; or (b) derived from an exchange of assets, unless the assets received are currently realizable in cash. In addition, California law provides that the appropriate insurance regulatory authorities in the State of California must approve (or, within a 30-day notice period, not disapprove) any dividend that, together with all other such dividends paid during the preceding 12 months, exceeds the greater of: (a) 10% of ECIC's statutory surplus as regards policyholders at the preceding December 31; or (b) 100% of the net income for the preceding year.

The ability of ECIC to pay dividends was further limited by restrictions imposed by the California DOI in its approval of our October 1, 2008, reinsurance pooling agreement. Under that approval: (a) ECIC must initiate discussions of its business plan with the California DOI if its premium to policyholder surplus ratio exceeds 1.5 to 1; (b) ECIC will not exceed a ratio of premium to policyholder surplus of 2 to 1 without approval of the California DOI; (c) if at any time ECIC's policyholder surplus decreases to 80% or less than the September 30, 2008 balance, ECIC shall cease issuing new policies in California but may continue to renew existing policies until it has (i) received a capital infusion to bring its surplus position to the same level as that as of September 30, 2008 and (ii) submitted a new business plan to the California DOI; (d) ECIC will maintain a RBC level of at least 350%; (e) should ECIC fail to comply with any commitments listed herein, ECIC will consent to any request by the California DOI to cease issuing new policies in California, but may continue to renew existing policies until such time that as ECIC is able to achieve full compliance with each commitment; and (f) the obligations listed shall only terminate with the written consent of the California DOI.

Under Florida law, without regulatory approval, an insurance company may not pay dividends or make other distributions of cash or property to its stockholders within a 12-month period with a total fair market value exceeding the larger of 10% of surplus as of the preceding December 31st or 100% of its prior year's net income, not including realized capital gains, or net investment income plus a three-year carry forward. As the direct owner of EAC, EPIC will be the recipient of any dividends paid by EAC. The ability of EAC to pay dividends to EPIC is, limited by Florida law. As of December 31, 2009 and 2008, EPIC had positive unassigned surplus of \$46.8 million and \$69.0 million, respectively.

Guaranty Fund Assessments

In all of the states where our insurance subsidiaries are licensed to transact business, there is a requirement that property and casualty insurers doing business within each such state participate as member insurers in a guaranty

association, which is organized to pay contractual benefits owed pursuant to insurance policies issued by insolvent or failed insurers. These associations levy assessments, up to prescribed limits, on all member insurers in a particular state on the basis of the proportionate share of the premium written by member insurers.

In California, unpaid workers' compensation liabilities from insolvent insurers are the responsibility of the California Insurance Guarantee Association (CIGA). We pass CIGA assessments on to our

policyholders, via a surcharge based upon the estimated annual premium at the policy's inception. We have received, and expect to continue to receive, these guaranty fund assessments, which are paid to CIGA based on the premiums written. As of December 31, 2009, we recorded an asset of \$7.1 million for assessments paid to CIGA that includes prepaid policy surcharges still to be collected in the future from policyholders. We also write workers' compensation insurance in other states with similar obligations as those in California. In these states, we are directly responsible for payment of the assessment. We recorded an estimate of \$4.5 million and \$4.6 million for our expected liability for guaranty fund assessments at December 31, 2009 and 2008, respectively. The guaranty fund assessments are expected to be paid within two years of recognition.

Property and casualty insurance company insolvencies or failures may result in additional guaranty fund assessments to our insurance subsidiaries at some future date. At this time we are unable to determine the impact such assessments may have on our financial position or results of operations. We have established liabilities for guaranty fund assessments with respect to insurers that are currently subject to insolvency proceedings.

Pooling Arrangements

As a condition to conduct business in some states, including California, insurance companies are required to participate in mandatory workers' compensation shared market mechanisms, or pooling arrangements, which provide workers' compensation insurance coverage to private businesses that are otherwise unable to obtain coverage due, for example, to their prior loss experiences.

Closed Block

As required by Nevada law, we established a closed block as of February 5, 2007, for the preservation of the reasonable dividend expectations of eligible members and other policyholders. Certain policies entitle the holder to receive distributions from the surplus of EICN in accordance with the terms of a dividend plan or program with respect to such policy. The closed block was created for the benefit of: (a) all policies issued by EICN that were in-force as of February 5, 2007, and that were participating pursuant to a dividend plan or program of EICN and (b) all policies that were no longer in force as of February 5, 2007, but that were participating pursuant to a dividend plan or program of EICN, that had an inception date that was not earlier than 24 months prior to and not later than February 5, 2007, and for which a participating policy dividend had not been calculated, declared and paid by EICN as of February 5, 2007. The requirements for the closed block ended on February 5, 2009 and the remaining funds of approximately \$1.2 million reverted to EICN.

The National Association of Insurance Commissioners (NAIC)

NAIC is a group formed by state insurance regulators to discuss issues and formulate policy with respect to regulation, reporting and accounting of and by U.S. insurance companies. Although the NAIC has no legislative authority and insurance companies are at all times subject to the laws of their respective domiciliary states and, to a lesser extent, other states in which they conduct business, the NAIC is influential in determining the form in which such laws are enacted. Model Insurance Laws, Regulations and Guidelines (Model Laws) have been promulgated by the NAIC as a minimum standard by which state regulatory systems and regulations are measured. Adoption of state laws that provide for substantially similar regulations to those described in the Model Laws is a requirement for accreditation of state insurance regulatory agencies by the NAIC.

The Insurance Regulatory Information System (IRIS), is a system established by the NAIC to provide state regulators with an integrated approach to monitor the financial condition of insurers for the purposes of detecting financial distress and preventing insolvency. IRIS identifies 13 key financial ratios based on year-end data with each ratio identified with a usual range of result. These ratios assist state insurance departments in executing their statutory mandate to oversee the financial condition of insurance companies. None of our insurance subsidiaries are currently subject to any action by any state regulator with respect to IRIS ratios.

The NAIC has adopted a risk-based capital (RBC) formula to be applied to all insurance companies. RBC is a method of measuring the amount of capital appropriate for an insurance company to support its overall business operations in light of its size and risk profile. RBC standards are used by

state insurance regulators to determine appropriate regulatory actions relating to insurers that show signs of weak or deteriorating conditions.

The RBC Model Act provides for four different levels of regulatory attention depending on the ratio of the Company's total adjusted capital, defined as the total of its statutory capital and surplus to its RBC.

The Company Action Level is triggered if a company's total adjusted capital is less than 200% but greater than or equal to 150% of its RBC. At the Company Action Level, a company must submit a comprehensive plan to the state insurance regulator that discusses proposed corrective actions to improve its capital position. A company whose total adjusted capital is between 250% and 200% of its RBC is subject to a trend test. A trend test calculates the greater of any decrease in the margin (i.e., the amount in dollars by which a company's adjusted capital exceeds its RBC) between

the current year and the prior year and between the current year and the average of the past three years, and assumes that the decrease could occur again in the coming year.

The Regulatory Action Level is triggered if a company's total adjusted capital is less than 150% but greater than or equal to 100% of its RBC. At the Regulatory Action Level, the state insurance regulator will perform a special examination of the Company and issue an order specifying corrective actions that must be followed.

The Authorized Control Level is triggered if a company's total adjusted capital is less than 100% but greater than or equal to 70% of its RBC, at

which level the state insurance regulator may take any action it deems necessary, including placing the Company under regulatory control.

The Mandatory Control Level is triggered if a company's total adjusted capital is less than 70% of its RBC, at which level the state insurance regulator is mandated to place the Company under its control.

At December 31, 2009, each of our insurance subsidiaries had total adjusted capital in excess of amounts requiring company or regulatory action at any prescribed RBC action level.

Statutory Accounting and Solvency Regulations

State regulation of insurance company financial transactions and financial condition are based on statutory accounting principles (SAP). SAP differs in a number of ways from GAAP, which governs the financial reporting of most other businesses. In general, SAP financial statements are more conservative than GAAP financial statements, reflecting lower asset balances, higher liability balances and lower equity.

State insurance regulators closely monitor the financial condition of insurance companies reflected in SAP financial statements and can impose significant financial and operating restrictions on an insurance company that becomes financially impaired under SAP guidelines. State insurance regulators generally have the power to impose restrictions or conditions on the activities of a financially impaired insurance company, including: the transfer or disposition of assets; the withdrawal of funds from bank accounts; payment of dividends or other distributions; the extension of credit or the advancement of loans; and investments of funds, including business acquisitions or combinations.

Privacy Regulations

In 1999, the United States Congress enacted the Gramm-Leach-Bliley Act, which, among other things, protects consumers from the unauthorized dissemination of certain personal non-public financial information. Subsequently, a majority of states adopted additional regulations to address privacy issues. These laws and regulations apply to all

financial institutions, including insurance and finance companies, and require us to maintain appropriate procedures for managing and protecting certain personal information of our customers and to fully disclose our privacy practices to our customers. A NAIC initiative that impacted the insurance industry in 2001 was the adoption in 2000 of the Privacy of Consumer Financial and Health Information Model Regulation, which assisted states in promulgating regulations to comply with the Gramm-Leach-Bliley Act. In 2002, to further facilitate the implementation of the Gramm-Leach-Bliley Act, the NAIC adopted the Standards for Safeguarding Customer Information Model Regulation. Our insurance subsidiaries have established policies and procedures to comply with the Gramm-Leach-Bliley-related state privacy requirements.

Federal Legislative Changes

In response to the tightening of supply or unavailability of insurance and reinsurance following the September 11, 2001 terrorist attacks, the Terrorism Risk Insurance Act of 2002 (the 2002 Act) was enacted in November 2002. The principal purpose of the 2002 Act was to create a role for the Federal government in the provision of insurance for losses sustained in connection with foreign terrorism. Prior to the Act, insurance (except for workers' compensation insurance) and reinsurance for losses arising out of acts of terrorism were largely unavailable from private insurance and reinsurance companies.

In December 2007, the Terrorism Risk Act was extended by the Terrorism Risk Insurance Program Reauthorization Act of 2007 (TRIPRA). While the underlying structure of the 2002 Act was left intact, the 2007 extension included some adjustments. The workers' compensation laws of the various states generally do not permit the exclusion of coverage for losses arising from terrorism or nuclear, biological and chemical attacks. In addition, we are not able to limit our losses arising from any one catastrophe or any one claimant. Our reinsurance policies exclude coverage for losses arising out of nuclear, biological, chemical or radiological attacks. Under TRIPRA, federal protection is currently provided to the insurance industry for events, including acts of foreign and domestic terrorism, that result in an industry loss of at least \$100 million in 2007 through 2014. In the event of a qualifying industry loss (which must occur out of an act of terrorism certified as such by the Secretary of the Treasury), each insurance company is responsible for a deductible of 20% of direct earned premiums in the previous year, with the federal government responsible to reimburse each company for 85% of the insurer's loss in excess of the insurer's proportionate share of the \$100 billion industry aggregate limit in any one year. Accordingly, events may not be covered by, or may result in losses exceeding the capacity of our reinsurance protection and any protection offered by the TRIPRA or any subsequent legislation.

We do not believe that the risk of loss to our insurance subsidiaries from acts of terrorism is significant. Small businesses constitute a large portion of our policies, and we do not intend to write large concentrations of business in any particular market location. However, the impact of any future terrorist acts is unpredictable, and the ultimate impact on our insurance subsidiaries, if any, of losses from any future terrorist acts will depend upon their nature, extent, location and timing.

The current economic conditions have also raised the possibility of future legislative and regulatory actions, in addition to the enactment of the Emergency Economic Stabilization Act of 2008 (EESA), which could further impact our business. We cannot predict whether or when such actions may occur, or what effect, if any, such actions could have on our business, results of operations and financial condition.

Employees

In January 2009, we initiated a strategic restructuring plan that included staff reductions of approximately 150 employees, or 14% of our total workforce. These reductions began in January and were largely completed by mid-year 2009. Affected employees were eligible for severance benefits and outplacement support.

As of December 31, 2009, we had 941 full-time employees, six of whom were executive officers and six part-time employees. None of our employees are covered by a collective bargaining agreement. We believe our relations with our employees are excellent.

Website Information

Our corporate website is located at www.employers.com. Our annual report on Form 10-K, current reports on Form 8-K and amendments to those reports that we file or furnish pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 are available through our website, free of charge, as soon as reasonably practicable after they are electronically filed or furnished to the Securities and Exchange Commission (SEC). Our website also provides

access to reports filed by our Directors, executive officers and certain significant shareholders pursuant to Section 16 of the Securities Exchange Act of 1934. In addition, our Corporate Governance Guidelines, Code of Business Conduct and Ethics, our Code of Ethics for Senior Financial Officers and charters for the standing committees of our Board of Directors are available on our website. The information on our website is not incorporated by reference into this report. The Company will provide, free of charge, a copy of the documents upon request to Investor Relations, 10375 Professional Circle, Reno, Nevada 89521-4802. In addition, the

SEC maintains a website, www.sec.gov, that contains reports, proxy and information statements and other information that we file electronically with the SEC.

Executive Officers of the Registrant

The following provides information regarding our senior executive officers and key employees as of February 19, 2010. No family relationships exist among our executive officers.

| Name | Age⁽¹⁾ | Position |
|------------------|--------------------------|--|
| Douglas D. Dirks | 51 | President and Chief Executive Officer of Employers Holdings, Inc. |
| William E. Yocke | 59 | Executive Vice President and Chief Financial Officer of Employers Holdings, Inc. |
| Martin J. Welch | 54 | President and Chief Operating Officer, EICN, ECIC, EPIC and EAC |
| Lenard T. Ormsby | 57 | Executive Vice President, Chief Legal Officer, General Counsel and Corporate Secretary of Employers Holdings, Inc. |
| Ann W. Nelson | 48 | Executive Vice President, Corporate and Public Affairs, of Employers Holdings, Inc. |
| John P. Nelson | 47 | Executive Vice President and Chief Administrative Officer of Employers Holdings, Inc. |

(1) At
December
31, 2009.

Executive Officers

Douglas D. Dirks. Mr. Dirks has served as President and Chief Executive Officer of Employers Holdings, Inc., EGI and their predecessors since their creation in April 2005. He has served as Chief Executive Officer of EICN and ECIC since January 2006 and Chief Executive Officer of EPIC, EAC, EIG Services, Inc., Pinnacle Benefits, Inc. and AmSERV, Inc. since November 2008. He served as President and Chief Executive Officer of EICN from January 2000 until January 2006, and served as President and Chief Executive Officer of ECIC from May 2002 until January 2006. Mr. Dirks has served as President and Chief Executive Officer of EOH and Elite since 2002. He has been Director of Employers Holdings, Inc., EGI and their predecessors since April 2005; a Director of EICN since December 1999; EOH since 2000; EIS since August 1999; ECIC since May 2002; and a Director of EPIC, EAC, EIG Services, Inc. and AmSERV, Inc. since November 2008. Mr. Dirks was the Chief Executive Officer of the Fund from 1995 to 1999 and its Chief Financial Officer from 1993 to 1995. Prior to joining the Fund, he served in senior insurance regulatory positions and as an advisor to the Nevada Governor's Office. He presently serves on the Board of Directors of the Nevada Insurance Guaranty Association and the Nevada Insurance Education Foundation.

William E. Yocke. Mr. Yocke has served as Executive Vice President and Chief Financial Officer of Employers Holdings, Inc. since February 2007. He has served as Executive Vice President and Chief Financial Officer for EICN and ECIC from June 2005 to February 2007. He has been Treasurer of EPIC, EAC, and the Treasurer and Chief Financial Officer for EIG Services, Inc., Pinnacle Benefits, Inc. and AmSERV, Inc. since October 31, 2008. He has also been Treasurer of Employers Holdings, Inc., EGI and their predecessors and EICN, ECIC, EOH and EIS since 2005. Mr. Yocke is a Director of EPIC, EAC, EIG services, Inc. and Pinnacle Benefits, Inc. since October 31, 2008. Mr. Yocke has been a Director of ECIC since November 2005 and EICN since April 2007. Prior to joining the Company, Mr. Yocke was Senior Vice President for the Willis Group, a London-based risk management and

insurance intermediary, from 2004 to 2005. Previously, he served as Chief Financial Officer for AVRA Insurance Company from 2002 to 2004, Director of Deloitte & Touche West Region Actuarial and Risk Management Consulting from 1996 to 2002, and Director of West Region Risk Management Consulting for Ernst & Young LLP from 1987 to 1996.

Martin J. Welch. Mr. Welch has served as a Director of Employers Holdings, Inc., EGI, and their predecessors, and EICN and ECIC since March 2006. Since October 2008, Mr. Welch has served as a Director of EPIC, EAC, EIG Services, Inc. and Pinnacle Benefits, Inc. He has also served as President and Chief Operating Officer of EICN and ECIC since January 2006 and was Senior Vice President and

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Chief Underwriting Officer of EICN and ECIC from September 2004 to January 2006. Since October 2008, Mr. Welch has served as President and Chief Operating Officer of EPIC and EAC. He is President of EIG Services, Inc., Pinnacle Benefits, Inc. and AmSERV, Inc. Prior to joining the Company, he served as Senior Vice President, National Broker Division, for Wausau Insurance Companies from January 2003 to February 2004. Mr. Welch has more than 25 years of experience in workers' compensation and commercial property and casualty insurance.

Lenard T. Ormsby. Mr. Ormsby has served as Executive Vice President, General Counsel, Chief Legal Officer and Secretary of Employers Holdings, Inc. since February 2007. He was appointed Corporate Secretary to EIG in April 2005, General Counsel in October 2006 and Chief Legal Officer in November 2006. He previously served as Executive Vice President and General Counsel of EICN and ECIC from June 2002 to November 2006. He has served as Secretary or Assistant Secretary of EICN, ECIC, EOH and EIS since 2002, EGI since April 2005, and as Assistant Secretary of EPIC, EAC, Pinnacle Benefits, Inc., EIG Services, Inc. and AmSERV (and their predecessors) since November 2008. Mr. Ormsby has been a Director of ECIC since June 2004, EICN since April 2007, and EPIC, EAC, Pinnacle Benefits, Inc., EIG Services, Inc. and AmSERV (and their predecessors) since November 2008. He was Chief Operating Officer of the Fund and EICN from 1999 to June 2002 and General Counsel of the Fund from 1995 to 1999. Before joining the Fund, Mr. Ormsby was a partner in the Nevada law firm of McDonald, Carano, Wilson, McCune, Bergin, Frankovich & Hicks.

Ann W. Nelson. Mrs. Nelson has served as Executive Vice President, Corporate and Public Affairs, of Employers Holdings, Inc. since February 2007. She has served as Executive Vice President, Corporate and Public Affairs, of EICN and ECIC since January 2006. Ms. Nelson served EICN as Associate General Counsel from January through December 1999, as General Counsel from December 1999 through July 2002, Executive Vice President of Government Affairs from July 2002 through July 2004, and Executive Vice President of Strategy and Corporate Affairs from July 2004 through December 2005. Ms. Nelson's governmental experience includes service as Legal Counsel to Nevada Governor Bob Miller from 1994 to 1999, and as a Deputy District Attorney in the Civil Division of the Washoe County District Attorney's Office in Reno, Nevada from 1993 through 1994.

John P. Nelson. Mr. Nelson has been Executive Vice President and Chief Administrative Officer of Employers Holdings, Inc. since June 2008. He has been Senior Vice President and Chief Administrative Officer of Employers Holdings, Inc. since February 2007 and Senior Vice President and Chief Administrative Officer of EICN and ECIC since July 2004. Prior to joining the Company, he was Vice President, Human Resources & Administration for Fielding Graduate University in Santa Barbara, California from October 1993 to June 2004. Mr. Nelson has 25 years of experience in the field of Human Resources.

Key Employees

| Name | Position |
|---------------------|---|
| Paul I. Ayoub | Senior Vice President and Chief Information Officer |
| Stephen V. Festa | Senior Vice President and Chief Claims Officer |
| Jeff J. Gans | Senior Vice President and Chief Underwriting Officer |
| T. Hale Johnston | Senior Vice President and Regional Manager of the Pacific Region |
| Cynthia M. Morrison | Senior Vice President, Corporate Controller and Chief Accountant |
| M. Frank Pinson III | Senior Vice President and Regional Manager of the Midwest Region |
| David M. Quezada | Senior Vice President and General Manager of Strategic Partnerships and Alliances |
| Timothy J. Spear | Senior Vice President and Regional Manager of the Southeast Region |
| George Tway | Senior Vice President and Regional Manager of the Western Region |

Item 1A. Risk Factors

Investing in our common stock involves risks. In evaluating our company, you should carefully consider the risks described below, together with all the information included in this annual report. The risks facing our company include, but are not limited to, those described below. The occurrence of one or more of these events could significantly and adversely affect our business, prospects, financial condition, results of operations, cash flows and stock price and you could lose all or part of your investment.

Risks Related to Our Business

Difficult conditions in the economy and capital markets may adversely affect our profitability, financial condition and results of operations.

Our results of operations are materially affected by conditions in the economy and capital markets. The financial markets in the U.S. experienced severe volatility, uncertainty and disruption from the second half of 2007 through 2009. Concerns over the availability and cost of credit, the mortgage market, a declining real estate market, increased unemployment, volatile energy and commodity prices and geopolitical issues, among other factors, have contributed to increased volatility and diminished expectations for the economy and have caused a severe economic slowdown.

Factors such as consumer spending, business investment, government spending, the volatility and strength of the capital markets, and inflation all affect the business and economic environment and, indirectly, the profitability of our business. Further unfavorable economic developments, particularly as a result of increases in unemployment and the failure of small businesses, could adversely affect our earnings if our customers reduce payroll, choose not to renew their insurance with us or go out of business entirely. Challenging economic conditions also may impair the ability of our customers to pay premiums as they come due. These circumstances could have a material adverse effect on our business, financial condition and results of operations.

In addition, the fixed-income markets are experiencing a period of volatility, uncertainty and disruption, which has negatively impacted market liquidity conditions and increased the risk that issuers of fixed maturity securities will default on principal and interest payments. Initially, the effects were focused on the subprime segment of the mortgage-backed securities market. However, this volatility expanded to: (a) a broad range of mortgage and asset-backed and other fixed income securities, including those rated investment grade; (b) the U.S. and international credit and interbank money markets generally; and (c) a wide range of financial institutions and markets, asset classes, and sectors. As a result, the market for fixed income securities has experienced decreased liquidity, increased price volatility, credit downgrade events, and increased probability of default.

We have a substantial investment portfolio, comprised principally of fixed maturity securities. Government monetary policy can significantly and adversely affect the value of our investment portfolio, our profitability, and financial condition by: (a) significantly reducing the value of the fixed maturity securities we hold in our investment portfolio, creating net realized capital losses as other-than-temporary impairments (OTTI) occur, resulting in reductions to net income or net unrealized capital losses that could reduce our stockholders' equity; (b) reducing interest rates on high quality short-term investment securities, thereby materially reducing our net investment income; and (c) making valuation of certain investment securities difficult, potentially leading to significant period-to-period changes in our estimates of fair values, which could result in significant period-to-period volatility in our net income and stockholders' equity.

These factors and the continuing market disruption could significantly and adversely affect the value of our investment portfolio, our profitability and financial condition.

Our liability for losses and LAE is based on estimates and may be inadequate to cover our actual losses and expenses.

We must establish and maintain reserves for our estimated losses and LAE. We establish loss reserves in our financial statements that represent an estimate of amounts needed to pay and administer claims with respect to insured claims that have occurred, including claims that have occurred but have

not yet been reported to us. Loss reserves are estimates of the ultimate cost of individual claims based on actuarial estimation techniques, are inherently uncertain, and do not represent an exact measure of liability.

Several factors contribute to the uncertainty in establishing estimated losses, including the length of time to settle long-term, severe cases, claim cost inflation (deflation) trends and uncertainties in the long-term outcome of the 2003 and 2004 legislative reforms in California and the 2003 legislative reforms in Florida. Judgment is required in applying actuarial techniques to determine the relevance of historical payment and claim settlement patterns under current facts and circumstances. In certain states, we have a relatively short operating history and must rely on a combination of industry experience and our specific experience to establish our best estimate of losses and LAE reserves. The interpretation of historical data can be impacted by external forces, principally legislative changes, medical cost inflation, economic fluctuations and legal trends. We review our loss reserves each quarter. We may adjust our reserves based on the results of these reviews and these adjustments could be significant. Any changes in these estimates are reflected in our results of operations during the period in which they are made.

Loss reserves are estimates at a given point in time of our ultimate liability for cost of claims and of the cost of managing those claims, and are inherently uncertain. It is likely that the ultimate liability will differ from our estimates, perhaps significantly. Such estimates are not precise in that, among other things, they are based on predictions of future claim emergence and payment patterns and estimates of future trends in claim frequency and claim cost. These estimates assume that the claim emergence and payment patterns, claim inflation and claim frequency trend assumptions implicitly built into estimates will continue into the future. Unexpected changes in claim cost inflation can occur through changes in general inflationary trends, changes in medical technology and procedures, changes in wage levels and general economic conditions and changes in legal theories of compensability of injured workers and their dependents. Furthermore, future costs can be influenced by changes in the workers' compensation statutory benefit structure and in benefit administration and delivery. It often becomes necessary to refine and adjust the estimates of liability on a claim either upward or downward. Even after such adjustments, ultimate liability may exceed or be less than the revised estimates.

Workers' compensation benefits are often paid over a long period of time. In addition, there are no policy limits on our liability for workers' compensation claims as there are for other forms of insurance. Therefore, estimating reserves for workers' compensation claims may be more uncertain than estimating reserves for other lines of insurance with shorter or more definite periods between occurrence of the claim and final determination of the ultimate loss and with policy limits on liability for claim amounts. Accordingly, our reserves may prove to be inadequate to cover our actual losses.

Our estimates of incurred losses and LAE attributable to insured events of prior years have decreased for past accident years because actual losses and LAE paid and current projections of unpaid losses and LAE were less than we originally anticipated. We refer to such decreases as favorable developments. The reductions in reserves were \$51.4 million, \$71.7 million, \$60.0 million, for the years ended December 31, 2009, 2008, 2007, respectively. Estimates of net incurred losses and LAE are established by management utilizing actuarial indications based upon our historical and industry experience regarding claim emergence and claim payment patterns, and regarding medical cost inflation and claim cost trends, adjusted for future anticipated changes in claims-related and economic trends, as well as regulatory and legislative changes, to establish our best estimate of the losses and LAE reserves. The decrease in the prior year reserves was primarily the result of actual paid losses being less than expected, and revised assumptions used in projection of future losses and LAE payments based on more current information about the impact of certain changes, such as legislative changes, which was not available at the time the reserves were originally established. While we have had favorable developments over the past five years, the magnitude of these developments illustrates the inherent uncertainty in our liability for losses and LAE, and we believe that favorable or unfavorable developments of similar magnitude could occur in the future.

State insurance regulations in states where we operate have caused and may continue to cause downward pressure on the premiums we charge.

Our pricing decisions need to take into account the workers' compensation insurance regulatory regime of each state in which we operate, such as regimes that address the rates that industry participants in that state may or should charge for policies. As of December 31, 2009, 46.9% of our in-force premiums were generated in California. Accordingly, we are particularly affected by regulation in California.

The passage of any form of rate regulation in California could impair our ability to operate profitably in California, and any such impairment could have a material adverse effect on our financial condition and results of operations. Prior to 2009, California went through a cycle of substantial rate decreases. Between 2002 and 2004, three key pieces of workers' compensation regulation reform were enacted that reformed medical determinations of injuries or illness, established medical fee schedules, allowed for the use of medical provider panels, modified benefit levels, changed the proof needed to file claims, and reformed many additional areas of the workers' compensation benefits and delivery system. Workers' compensation insurers in California responded to these reforms by reducing their rates.

Although the California Commissioner does not set premium rates, he does adopt and publish a claims cost benchmark that represents advisory rates that would cover expected losses but do not contain an element to cover operating expenses or profit.

In administered pricing states, insurance rates are set by the state insurance regulators and are adjusted periodically. Rate competition is generally not permitted in these states. Of the states in which we currently operate, Florida, Wisconsin and Idaho have implemented such regulations. Additionally, we are exposed to the risk that other states in which we operate will adopt administered pricing regulations.

Due to the existence of rate regulation, and the possibility of adverse changes in such regulations, we cannot assure you that our premium rates will ultimately be adequate to cover the claim payments, losses and LAE and company overhead or, in the case of states without administered pricing, that our competitors will not set their premium rates at lower rates. In such event, we may be unable to compete effectively and our business, financial condition and results of operations could be materially adversely affected.

If we fail to price our insurance policies appropriately, our business competitiveness, financial condition or results of operations could be materially adversely affected.

Premiums are based on the particular class of business and our estimates of expected losses and LAE and other expenses related to the policies we underwrite. We analyze many factors when pricing a policy, including the policyholder's prior loss history and industry classification. Inaccurate information regarding a policyholder's past claims experience puts us at risk for mispricing our policies. For example, when initiating coverage on a policyholder, we must rely on the information provided by the policyholder or the policyholder's previous insurer(s) to properly estimate future claims expense. If the claims information is not accurately stated, we may under price our policies by using claims estimates that are too low. In order to set premium rates accurately, we must utilize an appropriate pricing model which correctly assesses risks based on their individual characteristics and takes into account actual and projected industry characteristics. As a result, our business, financial condition and results of operations could be materially adversely affected.

Our concentration in California ties our performance to the business, economic, demographic and regulatory conditions in this state. Any deterioration in the conditions in this state could materially adversely affect our financial condition and results of operations.

Our business has a concentration in California, where we generated 46.9% of our in-force premiums for as of December 31, 2009. Accordingly, unfavorable business, economic, demographic, competitive or regulatory conditions

in California could negatively impact our business.

California has been greatly impacted by the overall economic downturn, tightening of the credit markets and the resulting impacts on the residential real estate markets. The economic condition of the state has resulted in high unemployment and decreased payrolls. In addition, many California businesses are dependent on tourism revenues, which are, in turn, dependent on a robust economy. The

downturn in the national economy and the economy of California, or any other event that causes deterioration in tourism, could adversely impact small businesses such as restaurants that we have targeted as customers. The departure or insolvency of a significant number of small businesses could also have a material adverse effect on our financial condition or results of operations.

We may be exposed to greater risks than those faced by insurance companies whose business is less concentrated. For example, our average premium per policy in California as of December 31, 2009 has declined by approximately 11.0% since the same time in 2008, principally as a result of declining payroll. There may be further deterioration of the economic conditions in California that could materially adversely affect our financial condition and results of operations.

The fact that we write only a single line of insurance may leave us at a competitive disadvantage, and subjects our financial condition and results of operations to the cyclical nature of the workers' compensation insurance market.

We face a competitive disadvantage due to the fact that we only offer a single line of insurance. Some of our competitors have additional competitive leverage because of the wide array of insurance products that they offer. For example, a business may find it more efficient or less expensive to purchase multiple lines of commercial insurance coverage from a single carrier. Because we do not offer a range of insurance products and sell only workers' compensation insurance, we may lose potential customers to larger competitors who do offer a selection of insurance products.

The property and casualty insurance industry is cyclical in nature, and is characterized by periods of so-called "soft" market conditions in which premium rates are stable or falling, insurance is readily available and insurers' profits decline, and by periods of so-called "hard" market conditions, in which rates rise, insurance may be more difficult to find and insurers' profits increase. According to the Insurance Information Institute, since 1970, the property and casualty insurance industry experienced hard market conditions from 1975 to 1978, 1984 to 1987 and 2001 to 2004. Although the financial performance of an individual insurance company is dependent on its own specific business characteristics, the profitability of most workers' compensation insurance companies generally tends to follow this cyclical market pattern. Because we only offer workers' compensation insurance, our financial condition and operations are subject to this cyclical pattern, and we have no ability to change emphasis to another line of insurance. For example, during a period when there is excess underwriting capacity in the workers' compensation market and, therefore, lower profitability, we are unable to shift our focus to another line of insurance which is at a different stage of the insurance cycle and, thus, our financial condition and results of operations may be materially adversely affected. We believe the workers' compensation industry is currently experiencing increased price competition and excess underwriting capacity. This results in lower rate levels and smaller profit margins.

Because of cyclical in the workers' compensation market, due in large part to competition, capacity and general economic factors, we cannot predict the timing or duration of changes in the market cycle. We have experienced significant increased price competition in our target markets since 2003. This cyclical pattern has in the past and could in the future adversely affect our financial condition and results of operations.

If we do not maintain good relationships with independent insurance agents and brokers, they may sell our competitors' products rather than ours, and our revenues or profitability may decline.

We market and sell our insurance products primarily through independent, non-exclusive insurance agents and brokers. These agents and brokers are not obligated to promote our products and can and do sell our competitors' products. We must offer workers' compensation insurance products and services that meet the requirements of these agents and their customers. We must also provide competitive commissions to these agents and brokers. Our business model depends upon an extensive network of local and regional agents and brokers distributed throughout the states in which we do business. We need to maintain good relationships with the agents and brokers with which we contract to

sell our products. If we do not, these agents and brokers may sell our competitors' products instead of ours or may direct less desirable risks to us, and our revenues or profitability may decline. In addition, these agents and brokers may find it easier to promote the broader range of programs of some of our competitors than to promote our single-line workers' compensation insurance products. The loss of a number of our independent agents and brokers or the failure of these agents to successfully market our

products may reduce our revenues and our profitability if we are unable to replace them with agents and brokers that produce comparable premiums.

If our agreements with our principal strategic partners are terminated or we fail to maintain good relationships with them, our revenues may decline materially and our results of operations may be materially adversely affected. We are also subject to credit risk with respect to our strategic partners.

We have agreements with two principal strategic partners, ADP and Wellpoint, to market and service our insurance products through their sales forces and insurance agencies. As of December 31, 2009, we generated \$30.2 million of in-force premiums through ADP and \$40.4 million of in-force premiums through Wellpoint. The in-force premiums for ADP and Wellpoint were 7.8% and 10.5%, respectively, of total in-force premiums as of December 31, 2009. Our agreement with ADP is not exclusive, and ADP may terminate the agreement without cause upon 120 days notice. Although our distribution agreements with Wellpoint are exclusive, Wellpoint may terminate its agreements with us if the A.M. Best financial strength rating of ECIC were downgraded and we are not able to provide coverage through a carrier with an A.M. Best financial strength rating of B++ or better. Wellpoint may also terminate its agreements with us without cause upon 60 days notice. The termination of any of our principal strategic partnership agreements, our failure to maintain good relationships with our principal strategic partners or their failure to successfully market our products may materially reduce our revenues and have a material adverse effect on our results of operations if we are unable to replace the principal strategic partners with other distributors that produce comparable premiums. In addition, we are subject to the risk that our principal strategic partners may face financial difficulties, reputational issues or problems with respect to their own products and services, which may lead to decreased sales of our products and services. Moreover, if either of our principal strategic partners consolidates or aligns itself with another company or changes its products that are currently offered with our workers compensation insurance product, we may lose business or suffer decreased revenues.

We are also subject to credit risk with respect to ADP and Wellpoint, as they collect premiums that are due to us for the workers compensation products that are marketed together with their own products. ADP and Wellpoint are obligated on a monthly basis to pass on premiums that they collect on our behalf. Any failure to remit such premiums to us or to remit such amounts on a timely basis could have an adverse effect on our results of operations.

A downgrade in our financial strength rating could reduce the amount of business that we are able to write or result in the termination of certain of our agreements with our strategic partners.

Rating agencies rate insurance companies based on financial strength as an indication of an ability to pay claims. Our insurance subsidiaries are currently assigned a group letter rating of A- (Excellent) by A.M. Best, which is the rating agency that we believe has the most influence on our business. This rating is assigned to companies that, in the opinion of A.M. Best, have demonstrated an excellent overall performance when compared to industry standards. A.M. Best considers A- rated companies to have an excellent ability to meet their ongoing obligations to policyholders. This rating does not refer to our ability to meet non-insurance obligations and is not a recommendation to purchase or discontinue any policy or contract issued by us or to buy, hold or sell our securities.

The financial strength ratings of A.M. Best and other rating agencies are subject to periodic review using, among other things, proprietary capital adequacy models, and are subject to revision or withdrawal at any time. Insurance financial strength ratings are directed toward the concerns of policyholders and insurance agents and are not intended for the protection of investors or as a recommendation to buy, hold or sell securities. Our competitive position relative to other companies is determined in part by our financial strength rating. Any downgrade in the financial strength rating of our insurance subsidiaries could adversely affect our business through the loss of existing and potential policyholders and the loss of relationships with independent agents and brokers or strategic partners.

In view of the difficulties experienced recently by many financial institutions, including our competitors in the insurance industry, we believe that it is possible that external rating agencies, such as A.M. Best, may increase their

scrutiny of financial institutions, increase the frequency and scope of their reviews, request additional information from the companies that they rate, including additional information regarding the valuation of investment securities held, and may adjust upward the capital and other requirements employed in their models for maintenance of certain rating levels. We cannot

predict what actions rating agencies may take, or what actions we may take in response to the actions of rating agencies, which could materially adversely affect our business.

One of our strategic partners, Wellpoint, requires that we offer workers' compensation coverage through a carrier with a financial strength rating of B++ or better by A.M. Best. We currently offer this coverage through our subsidiary, ECIC. Our inability to offer such coverage could cause a reduction in the number of policies we write, would adversely impact our relationships with our strategic partners and could have a material adverse effect on our results of operations and our financial position. If ECIC's financial strength rating were downgraded, and we were not able to enter into an agreement to provide coverage through a carrier rated B++ or better by A.M. Best, Wellpoint could terminate its distribution agreements with us. We cannot assure you that we would be able to enter such an agreement if our rating was downgraded.

If we are unable to obtain reinsurance on favorable terms, our ability to write new policies and to renew existing policies could be adversely affected and our financial condition and results of operations could be materially adversely affected.

Like other insurers, we manage our risk by buying reinsurance. Reinsurance is an arrangement in which an insurance company, called the ceding company, transfers a portion of insurance risk under policies it has written to another insurance company, called the reinsurer, and pays the reinsurer a portion of the premiums relating to those policies. Conversely, the reinsurer receives or assumes risk from the ceding company. We currently purchase excess of loss reinsurance. We purchase reinsurance to cover larger individual losses and aggregate catastrophic losses from natural perils and acts of terrorism, excluding nuclear, biological, chemical and radiological events.

On July 1, 2009, we entered into a new reinsurance program that is effective through July 1, 2010. The reinsurance program consists of two agreements, one excess of loss agreement and one catastrophic loss agreement. The program provides coverage up to \$200.0 million per loss occurrence, subject to certain exclusions. Our loss retention for the program year beginning July 1, 2009 is \$5.0 million. The coverage is subject to an aggregate loss cession limitation in the first layer (\$5.0 million in excess of our \$5.0 million retention) of \$20.0 million. Additionally, in the second through fifth layers of our reinsurance program, our ultimate net loss shall not exceed \$10 million for any one life, and we are permitted one reinstatement for each layer upon the payment of additional premium. Covered losses which occur prior to expiration or cancellation of the reinsurance program continue to be obligations of the reinsurer and subject to the other conditions in the agreement. We are responsible for these losses if the reinsurer cannot or refuses to pay, see Item 1 Business Reinsurance.

Although reinsurance agreements generally bind the reinsurance companies during the treaty period at fixed pricing, market conditions beyond our control determine the availability and cost of the reinsurance protection for periods subsequent to the current treaty period. In certain circumstances, the price of reinsurance for risks already reinsured may also increase. The availability, amount and cost of reinsurance are all subject to market conditions and to our loss experience. We cannot be certain that our reinsurance agreements will be renewed or replaced prior to their expiration upon terms satisfactory to us. If we are unable to renew or replace our reinsurance agreements upon terms satisfactory to us, our net liability on individual risks would increase and we would have greater exposure to catastrophic losses. If this were to occur, our underwriting results would be subject to greater variability and our underwriting capacity would be reduced. As a result, these consequences could have a material adverse effect on our financial condition and results of operations. Any increase in the cost of reinsurance will, absent an increase in our loss retention, reduce our earnings. Accordingly, we may be forced to incur additional expense for reinsurance or may not be able to obtain reinsurance on acceptable terms, which could adversely affect our ability to write future business or result in the assumption of more risk with respect to those policies we issue.

We are subject to credit risk with respect to our reinsurers, and they may also refuse to pay or may delay payment of losses we cede to them.

Although we purchase reinsurance to manage our risk and exposure to losses, we continue to have direct obligations under the policies we write. We remain liable to our policyholders, even if we are unable to recover from our reinsurers what we believe we are entitled to receive under our reinsurance contracts. Reinsurers with whom we have contracted may default in their obligations as a result of

insolvency, lack of liquidity, operational failure or other reasons. Accordingly, we bear credit risk with respect to our reinsurers. Liquidity and the availability of capital continue to be restricted as a result of adverse credit market conditions and concerns about the economy. Reinsurers may not have enough liquidity to make timely payments. Disruptions, uncertainty or volatility in the financial markets may limit reinsurers' access to capital required to operate their businesses and in turn affect payments to us. The inability of any of our reinsurers to meet its financial obligations could materially and adversely affect our operations, as we remain primarily liable to our customers under the policies that we have insured. If this were to occur, our underwriting results would be subject to greater variability and our underwriting capacity would be reduced. As a result, these consequences could have a material adverse effect on our financial condition and results of operations.

Losses may not be recovered from our reinsurers until claims are paid, and in the case of long-term workers compensation cases, the creditworthiness of our reinsurers may change before we recover the amounts to which we are entitled. We obtained reinsurance covering the losses incurred prior to July 1, 1995, and we could be liable for all of those losses if the coverage provided by the LPT Agreement proves inadequate or we fail to collect from the reinsurer's party to such transaction. At December 31, 2009, we had \$1.1 billion of reinsurance recoverables for paid and unpaid losses and LAE of which only \$13.7 million is currently due to us. With the exception of certain losses assumed from the Fund these recoverables are unsecured. If we are unable to collect on our reinsurance recoverables, our financial condition and results of operations could be materially adversely affected.

Our assumption of the assets, liabilities and operations of the Fund covered all losses incurred by the Fund prior to January 1, 2000, pursuant to legislation passed in the 1999 Nevada legislature. We obtained reinsurance covering the losses incurred prior to July 1, 1995, and we could be liable for all of those losses if the coverage provided by the LPT Agreement proves inadequate or we fail to collect from the reinsurers party to such transaction.

On January 1, 2000, our Nevada insurance subsidiary assumed all of the assets, liabilities and operations of the Fund, including losses incurred by the Fund prior to such date. Our Nevada insurance subsidiary also assumed the Fund's rights and obligations associated with the LPT Agreement that the Fund entered into with third party reinsurers with respect to its losses incurred prior to July 1, 1995. The LPT Agreement was a retroactive 100% quota share reinsurance agreement under which the Fund initially ceded \$1.525 billion in liabilities for the incurred but unpaid losses and LAE related to claims incurred prior to July 1, 1995, for consideration of \$775 million in cash. The LPT Agreement provides coverage for losses up to \$2 billion, excluding losses for burial and transportation expenses. Accordingly, to the extent that the Fund's outstanding losses for claims with original dates of injury prior to July 1, 1995 exceed \$2 billion, they will not be covered by the LPT Agreement and we will be liable for those losses to that extent. Paid losses under the LPT Agreement totaled \$489.0 million through December 31, 2009. As of December 31, 2009, the estimated remaining liabilities subject to the LPT Agreement were approximately \$888.4 million.

The reinsurers under the LPT Agreement agreed to assume responsibilities for the claims at the benefit levels which existed in June 1999. Accordingly, if the Nevada legislature were to increase the benefits payable for the pre-July 1, 1995 claims, we would be responsible for the increased benefit costs to the extent of the legislative increase. Similarly, if the credit rating of any of the third party reinsurers that are party to the LPT Agreement were to fall below A- as determined by A.M. Best or to become insolvent, we would be responsible for replacing any such reinsurer or would be liable for the claims that otherwise would have been transferred to such reinsurer. For example, in 2002, the rating of one of the original reinsurers under the LPT Agreement, Gerling Global International Reinsurance Company Ltd. (Gerling) dropped below the mandatory A- A.M. Best rating to B+. Accordingly, we entered into an agreement to replace Gerling with National Indemnity Company (NICO) at a cost to us of \$32.8 million. We can give no assurance that circumstances requiring us to replace one or more of the current reinsurers under the LPT Agreement will not occur in the future, that we will be successful in replacing such reinsurer or reinsurers in such circumstances, or that the cost of such replacement or replacements will not have a material adverse effect on our results of operations or financial condition.

The LPT Agreement also required the reinsurers to each place assets supporting the payment of claims by them in individual trusts that require that collateral be held at a specified level. The

collateralization level must not be less than the outstanding reserve for losses and a loss expense allowance equal to 7% of estimated paid losses discounted at a rate of 6%. If the assets held in trust fall below this threshold, we can require the reinsurers to contribute additional assets to maintain the required minimum level. The value of these assets at December 31, 2009 was approximately \$883.6 million. If the value of the collateral in the trusts drops below the required minimum level and the reinsurers are unable to contribute additional assets, we could be responsible for substituting a new reinsurer or paying those claims without the benefit of reinsurance. One of the reinsurers has collateralized its obligations under the LPT Agreement by placing shares of stock of a publicly held corporation, with a value of \$635.2 million at December 31, 2009, in a trust to secure the reinsurer's obligation of \$488.6 million. The value of this collateral is subject to fluctuations in the market price of such stock. The other reinsurers have placed treasury and fixed maturity securities in trusts to collateralize their obligations.

For losses incurred by the Fund subsequent to June 30, 1995, we are liable for the entire loss, net of reinsurance purchased by the Fund. If the premiums collected by the Fund for policies written between July 1, 1995 and December 31, 1999 and the investment income earned on those premiums are inadequate to cover these losses, our reserves may prove inadequate and our results of operations and financial condition could be materially adversely affected.

Intense competition could adversely affect our ability to sell policies at rates we deem adequate.

The market for workers' compensation insurance products is highly competitive. Competition in our business is based on many factors, including premiums charged, services provided, financial ratings assigned by independent rating agencies, speed of claims payments, reputation, policyholder dividends, perceived financial strength and general experience. In some cases, our competitors offer lower priced products than we do. If our competitors offer more competitive premiums, dividends or payment plans, services or commissions to independent agents, brokers and other distributors, we could lose market share or have to reduce our premium rates, which could adversely affect our profitability. We compete with regional and national insurance companies, professional employer organizations, third-party administrators, self-insurance funds and state insurance funds. Our main competitors in each of the states in which we currently operate vary from state to state but are usually those companies that offer a full range of services in underwriting, loss control and claims. We compete on the basis of the services that we offer to our policyholders and on ease of doing business rather than solely on price.

Many of our competitors are significantly larger and possess greater financial, marketing and management resources than we do. Some of our competitors benefit financially by not being subject to federal income tax. Intense competitive pressure on prices can result from the actions of even a single large competitor. Competitors with more surplus than us have the potential to expand in our markets more quickly than we can. Additionally, greater financial resources permit an insurer to gain market share through more competitive pricing, even if that pricing results in reduced underwriting margins or an underwriting loss. Many of our competitors are multi-line carriers that can price the workers' compensation insurance that they offer at a loss in order to obtain other lines of business at a profit.

If we are unable to compete effectively, our business and financial condition could be materially adversely affected. In addition, new competition could cause the supply or demand for insurance to change, which could adversely affect our results of operations and financial condition.

If we are unable to realize our investment objectives, our financial condition and results of operations may be materially adversely affected.

Investment income is an important component of our revenue and net income. As of December 31, 2009, our investment portfolio, excluding cash and cash equivalents, had a fair value of \$2.03 billion. For the year ended December 31, 2009, we had \$90.5 million of net investment income. Our investment portfolio is managed by an independent asset manager that operates under investment guidelines approved by our Board of Directors. Although these guidelines stress diversification and capital preservation, our investments are subject to a variety of risks that are beyond our control, including risks related to general economic conditions, interest rate fluctuations and market

volatility. Interest rates are highly sensitive to many factors, including governmental monetary policies and domestic and international economic and political conditions. For example, general economic conditions may be adversely affected by U.S. involvement in hostilities with other countries and large-scale acts of

terrorism, or the threat of hostilities or terrorist acts. These and other factors affect the capital markets and, consequently, the value of our investment portfolio.

The outlook for our investment income is dependent on the future direction of interest rates, maturity schedules and cash flow from operations that is available for investment. The fair values of fixed maturity securities that are available-for-sale fluctuate with changes in interest rates and cause fluctuations in our stockholders' equity. Any significant decline in our investment income as a result of falling interest rates, deterioration in the credit of companies in which we have invested, decreased dividend payments or general market conditions could have an adverse effect on our net income and, as a result, on our stockholders' equity and policyholders' surplus.

Continued deterioration in the financial markets could lead to investment losses, which may adversely affect liquidity, our financial condition and results of operations.

We are exposed to significant financial risks related to the capital markets, including the risk of potential economic loss principally arising from adverse changes in the fair value of financial instruments. The major components of market risk affecting us are interest rate risk, credit spread risk, credit risk and equity price risk.

Interest rate risk. Our exposure to interest rate risk relates primarily to the market price, and cash flow variability associated with changes in interest rates. The fixed maturity security portion of our investment portfolio contains interest rate sensitive instruments that may be adversely affected by changes in interest rates resulting from governmental monetary policies, domestic and international economic and political conditions, and other factors beyond our control. A rise in interest rates would decrease the fair value of the investment portfolio, offset by our ability to earn higher rates of return on funds reinvested and new investments. Conversely, a decline in interest rates would increase the fair value of the investment portfolio, offset by lower rates of return on funds reinvested and new investments. We manage interest rate risk by instructing our investment manager to select fixed income investments consistent with our investment strategy. Our portfolio is weighted toward short-term and intermediate-term bonds; however, our investment strategy balances considerations of duration, yield and credit risk. We continually monitor the impact of interest rate risk on our liquidity obligations. Although we take measures to manage the economic risks of investing in a changing interest rate environment, we may not be able to mitigate the interest rate risk of our assets relative to our liabilities.

Credit spread risk. Our exposure to credit spreads primarily relates to market price and cash flow variability associated with changes in credit spreads, which we attempt to manage through issuer and industry diversification. A widening of credit spreads will decrease the fair value of our investment portfolio; if issuer credit spreads increase significantly or for an extended period of time, it would likely result in higher OTTI charges. Credit spread tightening will reduce net investment income associated with new purchases of fixed maturity securities. Continuing challenges include continued weakness in the real estate market, increased mortgage delinquencies, rating agency downgrades, deleveraging of financial institutions and hedge funds, and a serious dislocation in the interbank market.

Credit risk. We are subject to the risk that the issuers of fixed maturity securities we own may default on principal and interest payments they owe us. At December 31, 2009, the fixed maturity securities of \$2.0 billion in our investment portfolio represented 96.6% of our total invested assets. Of such total, 64.0% represented fixed maturity securities issued by municipalities, states and U.S. Government obligations.

The current economic downturn, acts of corporate malfeasance, widening risk spreads, budgetary deficits, or other events that adversely affect the issuers of these securities could cause the value of our fixed maturity securities portfolio and our net income to decline and the default rate of the fixed maturity securities in our investment portfolio to increase. A ratings downgrade affecting issuers of particular securities, or similar trends that could worsen the credit quality of issuers, such as the corporate issuers of securities in our investment portfolio, could also have a similar effect. Any event reducing the value of the fixed maturity securities we own on other than a temporary basis could have a material adverse effect on our business, financial condition and results of operations.

Equity price risk. Equity price risk is the risk that we may incur losses due to adverse changes in the market prices of the equity securities we hold in our investment portfolio. Any adverse change in

market prices of the equity securities decreases the fair value of our investment portfolio and affects our financial condition. In order to minimize equity price risk, we invest primarily in the equity securities of mid-to-large capitalization issuers and seek diversification across several industry sectors.

For more information regarding market, interest rate, or credit risk, see Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

The determination of the amount of impairments taken on our investments is highly subjective and could materially impact our financial condition and results of operations.

We regularly review our entire investment portfolio for declines in value. The determination of the amount of impairments taken on our investments is based on our periodic evaluation and assessment of our investments and known and inherent risks associated with the various asset classes. There can be no assurance that our management has accurately assessed the level of impairments in determining the OTTI reflected in our financial statements. Furthermore, additional impairments may need to be taken in the future. Historical trends may not be indicative of future impairments.

An investment in a fixed maturity or equity security is impaired if its fair value falls below its carrying value and the decline is considered to be other-than-temporary. Factors considered in determining whether a decline is other-than-temporary include, but are not limited to, the length of time and the extent to which fair value has been below cost, historical and projected company financial performance and financial condition, the dividend policy of the issuer, whether the decline is issuer or industry specific, the outlook for industry sectors, credit ratings, analyst reports, macro-economic changes and that it is not more likely than not that we will be required to sell the security before its expected recovery or maturity. Inherent in management's evaluation of the security are assumptions and estimates in evaluating the cause of the decline in the estimated fair value of the security and in assessing the prospects for near-term recovery.

The valuation of our investments include methodologies, estimations and assumptions that are subject to differing interpretations and could result in changes to investment valuations that may adversely affect our financial condition and results of operations.

Our estimate of fair value for our investments are based upon the inputs used in the valuation and give the highest priority to quoted prices in active markets and require that observable inputs be used in the valuations when available. In determining the level of the hierarchy in which the valuation is disclosed, the highest priority is given to unadjusted quoted prices in active markets and the lowest priority to unobservable inputs that reflect the Company's significant market assumptions. The three levels of the hierarchy are as follows:

Level
1 - unadjusted
quoted prices
for identical
assets or
liabilities in
active
markets that
we have the
ability to
access;

Level

2 quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; or valuations based on models where the significant inputs are observable (e.g., interest rates, yield curves, prepayment speeds, default rates, loss severities, etc.) or can be corroborated by observable market data; and

Level

3 valuations based on models where significant inputs are not observable and where the unobservable inputs reflect the Company's own assumptions about the assumptions

that market
participants
would use.

If quoted market prices and an estimate determined by using objectively verifiable information are unavailable, we produce an estimate of fair value based on internally developed valuation techniques. The use of internally developed valuation techniques may have a material effect on the estimated fair value amounts of our investments and our financial condition.

If we cannot obtain adequate or additional capital on favorable terms, including from writing new business and establishing premium rates and reserve levels sufficient to cover losses, we may not have sufficient funds to implement our future growth or operating plans and our business, financial condition or results of operations could be materially adversely affected.

Our ability to write new business successfully and to establish premium rates and reserves at levels sufficient to cover losses will generally determine our future capital requirements. If we have to raise additional capital, equity or debt, financing may not be available on terms that are favorable to us. In the case of equity financings, dilution to our stockholders could result. In any case, such securities may have rights, preferences and privileges that are senior to those of our shares of common stock. In the case of debt financings, we may be subject to covenants that restrict our ability to freely operate our business. If we cannot obtain adequate capital on favorable terms or at all, we may not have sufficient funds to implement our future growth or operating plans and our business, financial condition or results of operations could be materially adversely affected.

The capital and credit markets continue to experience extreme volatility and disruption that have negatively impacted market liquidity conditions. In some cases, the markets have produced downward pressure on stock prices and credit availability for certain issuers without regard to those issuers' underlying financial strength. Continuing disruptions, uncertainty or volatility in the financial markets may limit our access to capital required to operate our business, replace maturing debt obligations or access the capital necessary to grow our business. As a result, we may be forced to delay raising capital or be unable to raise capital on favorable terms, or at all, which could decrease our profitability, significantly reduce our financial flexibility and cause rating agencies to reevaluate our financial strength ratings.

We have outstanding indebtedness, which could impair our financial strength ratings and adversely affect our ability to react to changes in our business and fulfill our debt obligations.

Our indebtedness could have significant consequences, including:

- making it more difficult for us to satisfy our obligations;

- limiting our ability to borrow additional amounts to fund working capital, capital expenditures, debt service requirements, the execution of our business strategy, acquisitions

and other
purposes;

affecting the
way we
manage our
business due
to restrictive
covenants;

requiring us
to provide
collateral
which
restricts our
use of funds;

requiring us
to dedicate a
portion of our
cash flow
from
operations to
pay principal
and interest
on our debt,
which would
reduce the
funds
available to us
for other
purposes; and

making us
more
vulnerable to
adverse
changes in
general
economic and
industry
conditions,
and limiting
our flexibility
to plan for,
and react
quickly to,
changing
conditions.

We rely on our information technology and telecommunication systems, and the failure of these systems could materially and adversely affect our business.

Our business is highly dependent upon the successful and uninterrupted functioning of our information technology and telecommunications systems. We rely on these systems to process new and renewal business, provide customer service, administer and make payments on claims, facilitate collections, and, to automatically underwrite and administer the policies we write. Our main underwriting and policy administration system includes the base systems for underwriting evaluation, quoting, rating, policy issuance and servicing, and endorsements. This system, along with our other systems, enables us to perform actuarial and other modeling functions necessary for underwriting and rate development. The failure of any of our systems, including due to a natural catastrophe, or the termination of any third-party software licenses upon which any of these systems is based, could interrupt our operations or materially impact our ability to evaluate and write new business. As our information technology and telecommunications systems interface with and depend on third-party systems, we could experience service denials if demand for such services exceeds capacity or such third-party systems fail or experience interruptions. If sustained or repeated, a system failure or service denial could result in a deterioration of our ability to write and process new and renewal business, provide

customer service or compromise our ability to pay claims in a timely manner, which could have a material adverse effect on our business.

A breach of security with respect to our systems could also jeopardize the confidentiality of non-public data related to policyholders, claimants, vendors, or our employees, which could harm our reputation and expose us to possible liability. We rely on user authentication capabilities and use data encryption, but there can be no guarantee that advances in computer capabilities, new computer viruses, programming or human errors, or other events or developments would not result in a breach of our security measures, misappropriations of our proprietary information or an interruption of business operations.

Acts of terrorism and catastrophes could expose us to potentially substantial losses and, accordingly, could materially adversely impact our financial condition and results of operations.

Under our workers' compensation policies and applicable laws in the states in which we operate, we are required to provide workers' compensation benefits for losses arising from acts of terrorism. The impact of any terrorist act is unpredictable, and the ultimate impact on us would depend upon the nature, extent, location and timing of such an act. We would be particularly adversely affected by a terrorist act affecting any metropolitan area where our policyholders have a large concentration of workers.

Notwithstanding the protection provided by the reinsurance we have purchased and any protection provided by the 2002 Act, or its extension, the TRIPRA, the risk of severe losses to us from acts of terrorism has not been eliminated because our excess of loss reinsurance treaty program contains various sub-limits and exclusions limiting our reinsurers' obligation to cover losses caused by acts of terrorism. Our excess of loss reinsurance treaties do not protect against nuclear, biological, chemical or radiological events. If such an event were to impact one or more of the businesses we insure, we would be entirely responsible for any workers' compensation claims arising out of such event, subject to the terms of the 2002 Act, and the TRIPRA and could suffer substantial losses as a result.

Under the TRIPRA, federal protection is currently provided to the insurance industry for events, including acts of foreign and domestic terrorism, that result in an industry loss of at least \$100 million in 2009. In the event of qualifying industry loss (which must occur out of an act of terrorism certified as such by the Secretary of the Treasury), each insurance company is responsible for a deductible of 20% of direct earned premiums in the previous year, with the federal government responsible for reimbursing each company for 85% of the insurer's loss in excess of the insurer's loss, up to the insurer's proportionate share of the \$100 billion industry aggregate limit in any one year. Furthermore, the proposed federal budget plan for fiscal year 2011 includes provisions to scale back the protections provided under the TRIPRA by removing coverage for acts of domestic terrorism, increasing the deductible and allowing the program to expire in 2014. Accordingly, events may not be covered by, or may result in losses exceeding the capacity of, our reinsurance protection and any protection offered by the TRIPRA or any subsequent legislation. Thus, any acts of terrorism could expose us to potentially substantial losses and, accordingly, could materially adversely affect our financial condition and results of operations.

Our operations also expose us to claims arising out of catastrophes because we may be required to pay benefits to workers who are injured in the workplace as a result of a catastrophe. Catastrophes can be caused by various unpredictable events, either natural or man-made. Any catastrophe occurring in the states in which we operate could expose us to potentially substantial losses and, accordingly, could have a material adverse effect on our financial condition and results of operations.

The insurance business is subject to extensive regulation that limits the way we can operate our business and changes in regulation may reduce our profitability and/or limit our growth.

We are subject to extensive regulation by the insurance regulatory agencies in each state in which our insurance subsidiaries are licensed and most significantly by the insurance regulators in California, Florida and Nevada, the

states in which our insurance subsidiaries are domiciled. These state agencies have broad regulatory powers designed primarily to protect policyholders, not stockholders or other investors. Regulations vary from state to state, but typically address or include:

standards of
solvency,
including
risk-based
capital
measurements;

restrictions on the nature, quality and concentration of investments;

restrictions on the types of terms that we can include in the insurance policies we offer;

mandates that may affect wage replacement and medical care benefits paid under the workers compensation system;

requirements for the handling and reporting of claims;

procedures for adjusting claims, which can affect the cost of a claim;

restrictions on the way rates are developed and premiums are determined;

the manner in which agents may be appointed;

establishment
of liabilities
for unearned
premiums,
unpaid losses
and LAE and
other
purposes;

limitations on
our ability to
transact
business with
affiliates;

mergers,
acquisitions
and
divestitures
involving our
insurance
subsidiaries;

licensing
requirements
and approvals
that affect our
ability to do
business;

compliance
with all
applicable
medical
privacy laws;

potential
assessments
for the
settlement of
covered
claims under
insurance
policies issued
by impaired,
insolvent or
failed
insurance
companies or
other

assessments
imposed by
regulatory
agencies; and

the amount of
dividends that
our insurance
subsidiaries
may pay to
EGI and, in
turn, the
ability of EGI
to pay
dividends to
EHI.

Workers' compensation insurance is statutorily provided for in all of the states in which we do business. State laws and regulations provide for the form and content of policy coverage and the rights and benefits that are available to injured workers, their representatives and medical providers. Legislation and regulation also impact our ability to investigate fraud and other abuses of the workers' compensation systems where we operate. Our relationships with medical providers are also impacted by legislation and regulation, including penalties for the failure to make timely payments.

Regulatory authorities have broad discretion to deny or revoke licenses for various reasons, including the violation of regulations. We may be unable to maintain all required approvals or comply fully with the wide variety of applicable laws and regulations, which are continually undergoing revision and which may be interpreted differently among the jurisdictions in which we conduct business, or to comply with the then current interpretation of such laws and regulations. In some instances, where there is uncertainty as to applicability, we follow practices based on our interpretations of regulations or practices that we believe generally to be followed by the industry. These practices may turn out to be different from the interpretations of regulatory authorities. We are also subject to regulatory oversight of the timely payment of workers' compensation insurance benefits in all the states where we operate. Regulatory authorities may impose monetary fines and penalties if we fail to pay benefits to injured workers and fees to our medical providers in accordance with applicable laws and regulations.

The NAIC has developed a system to test the adequacy of statutory capital, known as RBC, which has been adopted by all of the states in which we operate. This system establishes the minimum amount of capital and surplus calculated in accordance with statutory accounting principles necessary for an insurance company to support its overall business operations. It identifies insurers that may be inadequately capitalized by looking at the inherent risks of each insurer's assets and liabilities and its mix of net premiums written. Insurers falling below a calculated threshold may be subject to varying degrees of regulatory action, including supervision, rehabilitation or liquidation. The need to maintain our risk-based capital levels may prevent us from expanding our business or meeting strategic goals in a timely manner. Failure to maintain our risk-based capital at the required levels could adversely affect the ability of our insurance subsidiaries to maintain regulatory authority to conduct our business.

The insurance industry is primarily regulated by individual states; while the federal government does not directly regulate the business of insurance, federal initiatives such as financial services regulation, privacy regulation and tort reform regulation may impact the insurance industry and our company. Proposals intended to control the cost and availability of healthcare services are being

debated in the U.S. Congress and state legislatures. Although we neither write health insurance nor assume any healthcare risk, rules affecting healthcare services may affect the workers' compensation insurance that we do write. Additionally, proposals intended to address global climate change concerns that could affect our business, or businesses that we insure, are being considered in the U.S. Congress and state legislatures. We cannot determine whether any of the above proposals may be adopted by the U.S. Congress or any state legislature or what effect, if any, such adoption would have on us.

The current economic conditions have also raised the possibility of future legislative and regulatory actions, in addition to the enactment of the Emergency Economic Stabilization Act of 2008 (EESA), which could further impact our business. Additionally, in view of recent events involving certain financial institutions, it is possible that the federal government will heighten its oversight of insurers, such as us, possibly through a federal system of insurance regulation, which the U.S. Congress has considered from time to time. The most recent proposal related to a federal system of insurance regulation, the National Insurance Consumer Protection Act (NICPA), was introduced into the U.S. Congress in April 2009. The NICPA would, among other things, create a federal agency with authority to organize, incorporate, operate, regulate and supervise national insurers, and would establish a systemic risk regulator for all insurance companies. The NICPA would require that certain insurance companies be regulated primarily by the federal government, with other insurers permitted to opt in favor of federal regulation. Additionally, a proposal currently being considered by the U.S. Congress would repeal the McCarran-Ferguson Act of 1945 (McCarran-Ferguson). According to the American Academy of Actuaries, any such repeal would limit the ability of an insurer to share data on which loss estimates, and ultimately premium rates, are based. The repeal of McCarran-Ferguson would have the effect of making the estimation of losses more uncertain, particularly for low-frequency, high-severity, long-tailed lines of business, such as workers' compensation. We cannot predict whether the proposals described above (or any other proposals) will be adopted, or what impact, if any, such proposals or, if enacted, such laws, could have on our business, financial condition or results of operations.

The extensive regulation of our business may affect the cost or demand for our products and may limit our ability to obtain rate increases or to take other actions that we might pursue to increase our profitability. In addition, we may be unable to maintain all required approvals or comply fully with the wide variety of applicable laws and regulations, which are subject to amendment. Further, changes in the level of regulation of the insurance industry or changes in laws or regulations or interpretations by regulatory authorities could impact our operations, require us to bear additional costs of compliance and impact our profitability.

We are a holding company with no direct operations. We depend on the ability of our subsidiaries to transfer funds to us to meet our obligations, and our insurance subsidiaries' ability to pay dividends to us is restricted by law.

EHI is a holding company that transacts substantially all of its business through operating subsidiaries. Its primary assets are the shares of stock of our insurance subsidiaries. The ability of EHI to meet obligations on outstanding debt, to pay stockholder dividends and to make other payments, depends on the surplus and earnings of our subsidiaries and their ability to pay dividends or to advance or repay funds, and upon the ability of our insurance subsidiaries, to pay dividends to EGI and, in turn, the ability of EGI to pay dividends to EHI.

Payments of dividends by our insurance subsidiaries are restricted by state insurance laws, including laws establishing minimum solvency and liquidity thresholds, and could be subject to contractual restrictions in the future, including those imposed by indebtedness we may incur in the future, see Item 1 Business Regulation Financial, Dividend and Investment Restrictions. As a result, we may not be able to receive dividends from these subsidiaries and we may not receive dividends in the amounts necessary to meet our obligations or to pay dividends on our common stock.

Our profitability may be adversely impacted by inflation, legislative actions and judicial decisions.

The effects of inflation, including medical cost inflation, causes claims costs to rise. Our reserve for losses and LAE includes assumptions about future payments for settlement of claims and claims handling expenses, such as medical

treatment and litigation costs. In addition, judicial decisions and legislative actions continue to broaden liability and policy definitions and to increase the severity of claims payments. To the extent inflation and these legislative actions and judicial decisions cause claims

costs to increase above reserves established for these claims, we will be required to increase our loss reserves with a corresponding reduction in our net income in the period in which the deficiency is identified.

Administrative proceedings or legal actions involving our insurance subsidiaries could have a material adverse effect on our business, financial condition or results of operations.

Our insurance subsidiaries are involved in various administrative proceedings and legal actions in the normal course of their insurance operations. Our subsidiaries have responded to the actions and intend to defend against these claims. These claims concern issues including eligibility for workers' compensation insurance coverage or benefits, the extent of injuries, wage determinations and disability ratings. Adverse decisions in multiple administrative proceedings or legal actions could require us to pay significant amounts in the aggregate or to change the manner in which we administer claims, which could have a material adverse effect on our financial condition and results of operations.

Our business is largely dependent on the efforts of our management because of its industry expertise, knowledge of our markets and relationships with the independent agents and brokers that sell our products. The loss of any members of our management team could disrupt our operations and have a material adverse effect on our ability to execute on our strategies.

Our success depends in substantial part upon our ability to attract and retain qualified executive officers, experienced underwriting personnel and other skilled employees who are knowledgeable about our business. The current success of our business is dependent in significant part on the efforts of Douglas D. Dirks, our President and Chief Executive Officer, Martin J. Welch, the President and Chief Operating Officer of our insurance subsidiaries, and William E. Yocke, our Executive Vice President and Chief Financial Officer. Many of our regional and local officers are also critical to our operations because of their industry expertise, knowledge of our markets and relationships with the independent agents and brokers who sell our products. We have entered into employment agreements with certain of our key executives. Currently, we do not maintain key man life insurance for our executives or senior management team. If we were to lose the services of members of our management team or key regional or local officers, we may be unable to find replacements satisfactory to us and our business. As a result, our operations may be disrupted and our financial performance may be materially adversely affected.

Assessments and other surcharges for guaranty funds, second injury funds and other mandatory pooling arrangements may reduce our profitability.

All states require insurance companies licensed to do business in their state to bear a portion of the unfunded obligations of insolvent insurance companies. These obligations are funded by assessments, which can be expected to continue in the future in the states in which we operate. Assessments are levied by guaranty associations within the state, up to prescribed limits, on all insurers doing business in that state on the basis of the proportionate share of the premiums written by insurers doing business in that state in the lines of business in which the impaired, insolvent or failed insurer is engaged. Maximum contributions required by law in any one state in which we currently offer insurance vary between 0.2% and 2.0% of premiums written. We recorded an estimate of \$4.5 million and \$4.6 million for our expected liability for guaranty fund assessments at December 31, 2009 and 2008, respectively. The assessments levied on us may increase as we increase our premiums written or if we write business in additional states. In some states, we receive a credit against our premium taxes for guaranty fund assessments. The effect of these assessments or changes in them could reduce our profitability in any given period or limit our ability to grow our business.

Most states have laws that provide for second injury funds that protect employers from higher insurance costs that can occur when a subsequent injury combines with a prior disability to result in substantially increased medical or disability costs than the subsequent injury alone would have produced. This protects an employer from loss or increased insurance cost because it hires or retains an employee who has a disability. Funding is provided pursuant to individual state statutes or regulations, and typically is made by assessments on insurance companies based on

premiums written, losses paid by the fund or losses paid by the insurance industry.

Further, as a condition to conducting business in some states, insurance companies are required to participate in mandatory worker's compensation shared market mechanisms, or pooling arrangements.

These arrangements provide workers' compensation insurance coverage to businesses that are otherwise unable to obtain coverage due, for example, to their prior loss experience. Although we price our product to account for the obligations that we may have under these pooling arrangements, we may not be successful in estimating our liability for these obligations. Accordingly, our prices may not fully account for our liabilities under pooling arrangements, which may cause a decrease in our profits. Further, insolvency of other insurance companies in these pooling arrangements would likely increase the liability of other members in the pool. The effect of these assessments and mandatory shared market mechanisms or changes in them could reduce our profitability or limit our ability to grow our business.

Risk Related to Our Common Stock

The price of our common stock may decrease, and you may lose all or part of your investment.

The trading price of our common stock may fluctuate as a result of a number of factors, many of which are beyond our control, including, among others:

the
performance of
the stock
market
generally and
the financial
industry and
insurance
companies
specifically;

quarterly
variations in
our results of
operations;

changes in
expectations as
to our future
results of
operations,
including
financial
estimates by
securities
analysts and
investors;

announcements
of claims
against us by
third parties;

departures of
key personnel;

changes in law
and regulation;

results of
operations that
vary from
those expected
by securities
analysts and
investors; and

future sales of
shares of our
common stock.

In addition, the stock market has experienced significant volatility that often has been unrelated or disproportionate to the operating performance of companies whose shares are traded. These market fluctuations could adversely affect the price of our common stock, regardless of our actual operating performance. As a result, the trading price of shares of our common stock may decrease and you may not be able to sell your shares at or above the price you paid to purchase them.

Insurance laws of Nevada, California, Florida and other applicable states, certain provisions of our charter documents and Nevada corporation law could prevent or delay a change of control and could also adversely affect the market price of our common stock.

Under Nevada insurance law and our amended and restated articles of incorporation that became effective upon completion of the conversion, for a period of five years following February 5, 2007 or, if earlier, until such date as we no longer directly or indirectly own a majority of the outstanding voting stock of EICN, no person may directly or indirectly acquire or offer to acquire in any manner beneficial ownership of 5% or more of any class of our voting securities without the prior approval of the Nevada Commissioner, see Item 1 Business Regulation Change of Control.

Additionally, we have insurance subsidiaries domiciled in California and Florida. The insurance laws of California and Florida require prior approval from the California DOI and the Florida OIR for any change of control of the subsidiary domiciled in their respective states. Insurance laws in many other states also contain provisions that require pre-notification to the insurance commissioners of a change in control of a non-domestic insurance company licensed in those states. In Florida, control is generally presumed to exist through the direct or indirect ownership of 5% or more of the voting securities of a domestic insurance company or of any entity that controls a domestic insurance company, while in California and Nevada, control is presumed to exist through the direct or indirect ownership of 10% or more of the voting securities of a domestic insurance company or of any entity that controls a domestic insurance company. Because we have insurance subsidiaries domiciled in California, Florida and Nevada any future transaction that would constitute a change in control of us would generally require the party acquiring control to obtain the prior approval of the California Commissioner, Florida

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Commissioner and the Nevada Commissioner and may require pre-notification in those states that have adopted pre-notification provisions upon a change of control. Obtaining these approvals may result in a material delay of, or deter, any such transaction. These laws may discourage potential acquisition proposals or tender offers, and may delay, deter or prevent a change of control, even if the acquisition proposal or tender offer is at a premium over the then current market price for our common stock and beneficial to our stockholders.

Provisions of our amended and restated articles of incorporation and amended and restated by-laws could discourage, delay or prevent a merger, acquisition or other change in control of us, even if our stockholders might consider such a change in control to be in their best interests. These provisions could also discourage proxy contests and make it more difficult for you and other stockholders to elect Directors and take other corporate actions. In particular, our amended and restated articles of incorporation and amended and restated by-laws include provisions:

dividing our
Board of
Directors into
three classes;

eliminating
the ability of
our
stockholders
to call special
meetings of
stockholders;

permitting
our Board of
Directors to
issue
preferred
stock in one
or more
series;

imposing
advance
notice
requirements
for
nominations
for election to
our Board of
Directors or
for proposing
matters that
can be acted
upon by
stockholders
at the
stockholder

meetings;

prohibiting
stockholder
action by
written
consent,
thereby
limiting
stockholder
action to that
taken at a
meeting of
our
stockholders;
and

providing our
Board of
Directors
with
exclusive
authority to
adopt or
amend our
by-laws.

These provisions may make it difficult for stockholders to replace directors and could have the effect of discouraging a future takeover attempt which is not approved by our Board of Directors, but which stockholders might consider favorable. Additionally, these provisions could limit the price that investors are willing to pay in the future for shares of our common stock.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our principal executive offices are located in leased premises in Reno, Nevada. In addition to serving as our corporate headquarters, it also serves as a branch office providing services in marketing, loss control and claims and underwriting related support. As of February 1, 2010, we leased 336,801 square feet of total office space in 14 states. Additionally, we own a 15,120 square foot building in Carson City, Nevada, which is used as a storage facility. Details of our significant locations are included in the following table:

| Location | Square Feet |
|---------------------------|--------------------|
| Corporate Offices: | |
| Reno, Nevada | 79,533 |
| Branch Offices: | |
| Glendale, California | 49,914 |
| Henderson, Nevada | 44,958 |
| North Palm Beach, Florida | 28,929 |
| San Francisco, California | 23,342 |
| Newbury Park, California | 15,724 |
| Other office space leases | 94,401 |

We believe that our existing office space is adequate for our current needs and we will continue to enter into new lease agreements to address future space requirements, as necessary.

Item 3. Legal Proceedings

From time to time, we are involved in pending and threatened litigation in the normal course of business in which claims for monetary damages are asserted. In the opinion of management, the ultimate liability, if any, arising from such pending or threatened litigation is not expected to have a material effect on our result of operations, liquidity or financial position.

Item 4. Submission of Matters to a Vote of Security Holders

During the quarter ended December 31, 2009, no matters were submitted to a vote of stockholders.

PART II**Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities****Market Information and Holders**

Our common stock has been listed on the New York Stock Exchange (NYSE) under the symbol EIG since our initial public offering on January 31, 2007. Prior to that time, there was no public market for our common stock.

The table below sets forth the reported high and low sales prices for our common stock for each quarterly period as reported by the NYSE during the last two fiscal years.

| 2008 | High | Low |
|----------------|-------------|------------|
| First quarter | \$ 18.69 | \$ 15.13 |
| Second quarter | 20.75 | 17.23 |
| Third quarter | 20.62 | 15.86 |
| Fourth quarter | 17.50 | 10.08 |

| 2009 | High | Low |
|----------------|-------------|------------|
| First quarter | \$ 16.08 | \$ 8.29 |
| Second quarter | 13.79 | 8.16 |
| Third quarter | 15.82 | 12.11 |
| Fourth quarter | 16.66 | 14.06 |

There were 1,887 holders of record as of February 19, 2010.

Limitations on Acquisitions of Common Stock

Under Nevada insurance law and our amended and restated articles of incorporation that became effective on completion of the conversion, for a period of five years following February 5, 2007 or, if earlier, until such date as Employers Holdings, Inc. no longer directly or indirectly owns a majority of the outstanding voting stock of EICN, no person may directly or indirectly acquire or offer to acquire in any manner beneficial ownership of five percent or more of any class of voting securities of Employers Holdings, Inc. without the prior approval by the Nevada Commissioner of an application for acquisition under Section 693A.500 of the Nevada Revised Statutes. Under Nevada insurance law, the Nevada Commissioner may not approve an application for such acquisition unless the Commissioner finds that: (a) the acquisition will not frustrate the plan of conversion as approved by our members and the Commissioner; (b) our Board of Directors has approved the acquisition or extraordinary circumstances not contemplated in the plan of conversion have arisen which would warrant approval of the acquisition; and (c) the acquisition is consistent with the purpose of relevant Nevada insurance statutes to permit conversions on terms and conditions that are fair and equitable to the members eligible to receive consideration. Accordingly, as a practical matter, any person seeking to acquire us within five years after February 5, 2007 may only do so with the approval of the Board of Directors of EICN. Furthermore, any person or entity who individually or together with an affiliate (as defined by applicable law) seeks to directly or indirectly acquire in any manner, at any time, beneficial ownership of 5% or more of any class of our voting securities will be subject to certain requirements, including the prior approval of the proposed acquisition by certain state insurance regulators, depending upon the circumstances involved. Any such acquisition without prior satisfaction of applicable regulatory requirements may be deemed void under state law.

Stockholder Dividends

Our Board of Directors authorized the payment of a quarterly dividend of \$0.06 per share of common stock to our stockholders of record beginning in the second quarter of 2007. Any

determination to pay additional or future dividends will be at the discretion of our Board of Directors and will be dependent upon:

the surplus
and earnings
of our
subsidiaries
and their
ability to pay
dividends
and/or other
statutorily
permissible
payments to
us, in
particular the
ability of
EICN and
EPIC to pay
dividends to
EGI and, in
turn, the
ability of EGI
to pay
dividends to
EHI;

our results of
operations
and cash
flows;

our financial
position and
capital
requirements;

general
business
conditions;

any legal, tax,
regulatory and
contractual
restrictions on
the payment
of dividends;
and

any other factors our Board of Directors deems relevant.

Following is a summary of dividends paid to stockholders by EHI:

| Dividends Declared | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
|---------------------------|----------------------|-----------------------|----------------------|-----------------------|
| 2008 | \$ 0.06 | \$ 0.06 | \$ 0.06 | \$ 0.06 |
| 2009 | \$ 0.06 | \$ 0.06 | \$ 0.06 | \$ 0.06 |

On February 24, 2010, the Board of Directors declared a \$0.06 dividend per share, payable March 24, 2010, to stockholders of record on March 10, 2010. There can be no assurance that we will declare and pay any additional or future dividends.

Issuer Purchases of Equity Securities

The following table summarizes the repurchase of our common stock for the year ended December 31, 2009:

| Period | Total Number of Shares Purchased | Average Price Paid Per Share⁽¹⁾ | Total Number of Shares Purchased as Part of Publicly Announced Program | Maximum Number (or Approximate Dollar Value) of Shares that May Yet be Purchased Under the Program⁽²⁾ (millions) |
|----------------------------------|---|---|---|---|
| January 1 - January 31, 2009 | | \$ | | \$ 85.8 |
| February 1 - February 28, 2009 | | | | 85.8 |
| March 17 - March 31, 2009 | 1,624,195 | 9.56 | 1,624,195 | 70.3 |
| April 1 - April 30, 2009 | 524,200 | 10.13 | 524,200 | 65.0 |
| May 1 - May 31, 2009 | 450,800 | 11.38 | 450,800 | 59.8 |
| June 1 - June 30, 2009 | 470,100 | 13.06 | 470,100 | 53.7 |
| July 1 - July 31, 2009 | 478,200 | 13.17 | 478,200 | 47.4 |
| August 1 - August 31, 2009 | 491,834 | 14.86 | 491,834 | 40.1 |
| September 1 - September 30, 2009 | 577,072 | 15.08 | 577,072 | 31.4 |
| October 1 - October 31, 2009 | 244,389 | 15.23 | 244,389 | 27.7 |
| November 1 - November 30, 2009 | 511,000 | 15.17 | 511,000 | 20.0 |
| December 1 - December 31, 2009 | 585,277 | 14.83 | 585,277 | 11.3 |
| Total 2009 Repurchases | 5,957,067 | 12.52 | | |

- (1) Includes fees and commissions paid on stock repurchases.
- (2) On February 21, 2008, the Board of Directors authorized a stock repurchase program of up to \$100 million of our common stock through June 30, 2009. On February 25, 2009, the Board of Directors extended this program through December 31, 2009. The shares were repurchased at prevailing market prices in open market transactions. From the inception of the program in 2008 to December 31, 2009, 6,743,862 shares were repurchased at

an average
cost of \$13.16
per share
including
commissions.

On November 4, 2009, the Board of Directors authorized a 2010 share repurchase program for up to \$50 million of the Company's common stock (2010 Program). The Company expects that shares may

be purchased at prevailing market prices from January 1, 2010 through December 31, 2010 through a variety of methods including open market or private transactions, in accordance with applicable laws and regulations. The timing and actual number of shares repurchased will depend on a variety of factors, including the share price, corporate and regulatory requirements and other market and economic conditions. Repurchases under the 2010 Program may be commenced or suspended from time to time without prior notice, and the program may be suspended or discontinued at any time.

Equity and Incentive Plan

The following table gives information about our common stock that may be issued upon the exercise of options, warrants and rights under all of the Company's existing equity compensation plans as of December 31, 2009. The Company does not have any plans not approved by the stockholders. The plan is discussed further in Note 17 in the Notes to our Consolidated Financial Statements which are included herein.

| Plan Category | (a) Number of securities to be issued upon exercise of outstanding options, warrants and rights | (b) Weighted-average exercised price of outstanding warrants and rights | (c) Number of securities remaining available for future issuance under compensation plans (excluding securities) reflected in column (a) |
|--|--|--|---|
| Equity compensation plans approved by stockholders | 2,074,120 | 16.30 | 1,531,418 |
| Equity compensation plans not approved by stockholders | | | |
| Total | 2,074,120 | 16.30 | 1,531,418 |

Performance Graph

The following graph compares the cumulative total return on \$100 invested in the common stock of EHI for the period commencing on January 31, 2007, and ending on December 31, 2009 with the cumulative total return on \$100 invested in each the Standard and Poor's 500 Index (S&P 500) and the Standard and Poor's 500 Property-Casualty Insurance Index (S&P PC). The closing market price for our common stock at December 31, 2009 was \$15.34.

Employers Holdings, Inc.

| | Cumulative Total Return | | |
|------------------------|---|------------------------|--|
| | Employers Holdings, Inc. | S&P 500 | S&P 500 P&C Insurance Index |
| 1/31/07 ⁽¹⁾ | 100.00 | 100.00 | 100.00 |
| 6/30/07 | 106.66 | 105.36 | 104.74 |
| 12/31/07 | 84.47 | 103.92 | 89.85 |
| 6/30/08 | 105.35 | 91.54 | 73.33 |
| 12/31/08 | 84.62 | 65.47 | 63.43 |
| 6/30/09 | 70.36 | 67.54 | 57.06 |
| 12/31/09 | 80.30 | 82.80 | 71.26 |

(1) Our common stock has been listed on the NYSE since our initial public offering on January 31, 2007.

Item 6. Selected Financial Data

The following selected historical consolidated financial data should be read in conjunction with Item 7 Management's Discussion and Analysis of Financial Condition and Results of Operations and the consolidated financial statements and related notes included elsewhere in this annual report on Form 10-K. The selected historical financial data as of December 31, 2009 and 2008 and for the years ended December 31, 2009, 2008 and 2007 have been derived from our audited consolidated financial statements and related notes thereto included elsewhere in this Form 10-K. The selected historical financial data as of December 31, 2007, 2006 and 2005 and for the year ended December 31, 2006 and 2005 have been derived from our audited consolidated financial statements and related notes thereto not included in this Form 10-K. These historical results are not necessarily indicative of results to be expected in any future period. These historical results are not necessarily indicative of results to be expected in any future period.

The selected historical financial data reflect the ongoing impact of the LPT Agreement, a retroactive 100% quota share reinsurance agreement that our Nevada insurance subsidiary assumed on January 1, 2000 in connection with our assumption of the assets, liabilities and operations of the Fund, pursuant to legislation passed in the 1999 Nevada legislature. Upon entry into the LPT Agreement, we recorded as a liability a deferred reinsurance gain which we amortize over the period during which underlying reinsured claims are paid. We record adjustments to the direct reserves subject to the LPT Agreement based on our periodic reevaluations of these reserves.

| | Years Ended December 31, | | | | |
|---|---|---------------------------|----------------|----------------|----------------|
| | 2009 | 2008⁽¹⁾ | 2007 | 2006 | 2005 |
| | (in thousands, except per share amounts and ratios) | | | | |
| Income Statement Data | | | | | |
| Revenues: | | | | | |
| Net premiums earned | \$ 404,247 | \$ 328,947 | \$ 346,884 | \$ 392,986 | \$ 438,250 |
| Net investment income | 90,484 | 78,062 | 78,623 | 68,187 | 54,416 |
| Realized gains (losses) on investments, net | 791 | (11,524) | 180 | 54,277 | (95) |
| Other income | 413 | 1,293 | 4,236 | 4,800 | 3,915 |
| Total revenues | 495,935 | 396,778 | 429,923 | 520,250 | 496,486 |
| Expenses: | | | | | |
| Losses and loss adjustment expense | 214,461 | 136,515 | 143,302 | 129,755 | 211,688 |
| Commission expense | 36,150 | 43,618 | 44,336 | 48,377 | 46,872 |
| Dividends to policyholders | 6,930 | 1,295 | (65) | 465 | 1,028 |
| Underwriting and other operating | 138,687 | 101,164 | 91,464 | 87,361 | 68,906 |

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expenses

| | | | | | |
|------------------|-------|-------|--|--|--|
| Interest expense | 7,409 | 2,135 | | | |
|------------------|-------|-------|--|--|--|

| | | | | | |
|---------------|---------|---------|---------|---------|---------|
| Total expense | 403,637 | 284,727 | 279,037 | 265,958 | 328,494 |
|---------------|---------|---------|---------|---------|---------|

| | | | | | |
|--------------------------------|--------|---------|---------|---------|---------|
| Net income before income taxes | 92,298 | 112,051 | 150,886 | 254,292 | 167,992 |
|--------------------------------|--------|---------|---------|---------|---------|

| | | | | | |
|--------------------|-------|--------|--------|--------|--------|
| Income tax expense | 9,277 | 10,266 | 30,603 | 82,722 | 30,394 |
|--------------------|-------|--------|--------|--------|--------|

| | | | | | |
|------------|-----------|------------|------------|------------|------------|
| Net income | \$ 83,021 | \$ 101,785 | \$ 120,283 | \$ 171,570 | \$ 137,598 |
|------------|-----------|------------|------------|------------|------------|

Earnings per common share⁽²⁾

| | | | | | |
|-------|---------|---------|---------|--|--|
| Basic | \$ 1.81 | \$ 2.07 | \$ 2.19 | | |
|-------|---------|---------|---------|--|--|

| | | | | | |
|---------|------|------|------|--|--|
| Diluted | 1.80 | 2.07 | 2.19 | | |
|---------|------|------|------|--|--|

Pro forma earnings per common share

| | | | | | |
|----------------------------------|--|--|---------|---------|---------|
| basic and diluted ⁽²⁾ | | | \$ 2.32 | \$ 3.43 | \$ 2.75 |
|----------------------------------|--|--|---------|---------|---------|

| | As of December 31, | | | | |
|---|--|---------------------|------------|------------|------------|
| | 2009 | 2008 ⁽¹⁾ | 2007 | 2006 | 2005 |
| | (in thousands, per share amounts and ratios) | | | | |
| Selected Operating Data | | | | | |
| Gross premiums written ⁽³⁾⁽⁴⁾ | \$ 379,949 | \$ 318,392 | \$ 351,847 | \$ 386,796 | \$ 451,444 |
| Net premiums written ⁽³⁾⁽⁵⁾ | 368,290 | 308,317 | 339,720 | 372,224 | 432,490 |
| Losses and LAE ratio ⁽⁶⁾ | 53.1 % | 41.5 % | 41.3 % | 33.0 % | 48.3 % |
| Commission expense ratio ⁽⁷⁾ | 8.9 | 13.3 | 12.8 | 12.3 | 10.7 |
| Dividends to policyholders ratio ⁽⁸⁾ | 1.7 | 0.4 | | 0.1 | 0.3 |
| Underwriting and other operating expense ratio ⁽⁹⁾ | 34.3 | 30.7 | 26.3 | 22.2 | 16.3 |
| Combined ratio ⁽¹⁰⁾ | 98.0 | 85.9 | 80.4 | 67.7 | 75.0 |
| Net income before impact of the deferred reinsurance gain LPT Agreement ⁽¹¹⁾⁽¹²⁾⁽¹³⁾ | \$ 65,014 | \$ 83,364 | \$ 102,249 | \$ 152,197 | \$ 93,844 |
| Earnings per common share before impact of LPT ⁽¹³⁾ | | | | | |
| Basic | \$ 1.42 | \$ 1.69 | | | |
| Diluted | 1.41 | 1.69 | | | |
| Pro forma earnings per common share basic and diluted before impact of LPT ⁽²⁾⁽¹³⁾ | | | \$ 1.98 | \$ 3.04 | \$ 1.80 |
| Dividends declared | 0.24 | 0.24 | 0.18 | | |

| | As of December 31, | | | | |
|---------------------------|-------------------------------|---------------------|------------|-----------|-----------|
| | 2009 | 2008 ⁽¹⁾ | 2007 | 2006 | 2005 |
| | (in thousands, except ratios) | | | | |
| Balance Sheet Data | | | | | |
| Cash and cash equivalents | \$ 191,572 | \$ 202,893 | \$ 149,703 | \$ 79,984 | \$ 61,083 |
| Total investments | 2,029,560 | 2,042,941 | 1,726,280 | 1,715,673 | 1,595,771 |

| | | | | | |
|--|------------|------------|------------|------------|------------|
| Reinsurance recoverable on paid and unpaid losses | 1,064,843 | 1,087,738 | 1,061,551 | 1,107,900 | 1,151,166 |
| Total assets | 3,676,653 | 3,825,098 | 3,264,309 | 3,266,840 | 3,188,777 |
| Unpaid losses and loss adjustment expense | 2,425,658 | 2,506,478 | 2,269,710 | 2,307,755 | 2,349,981 |
| Deferred reinsurance gain LPT Agreement ⁽¹¹⁾⁽¹²⁾ | 388,574 | 406,581 | 425,002 | 443,036 | 462,409 |
| Total liabilities | 3,178,254 | 3,380,370 | 2,884,856 | 2,963,063 | 3,044,170 |
| Total equity | 498,399 | 444,728 | 379,453 | 303,777 | 144,607 |
| Other Financial and Ratio Data | | | | | |
| Total equity including deferred reinsurance gain LPT Agreement ⁽¹¹⁾⁽¹²⁾⁽¹⁴⁾ | \$ 886,973 | \$ 851,309 | \$ 804,455 | \$ 746,813 | \$ 607,016 |

- (1) The income statement data for the year ended December 31, 2008, includes the operating results of AmCOMP from November 1, 2008 through December 31, 2008. The balance sheet data as of December 31, 2008, includes the assets and liabilities acquired from AmCOMP (see Note 4 in the Notes to our Consolidated Financial Statements which are included elsewhere in this report).
- (2) For 2007, the pro forma earnings per common share basic was calculated using the net income for the 12 months ended December 31, 2007, as presented on the accompanying

consolidated statements of income. The weighted average shares outstanding was calculated using those shares available to eligible members in the conversion, or 50,000,002 shares, for the period prior to the IPO, and the actual weighted shares outstanding for the period after the IPO. Earnings per common share diluted is based on the pro forma weighted shares outstanding basic adjusted by the number of additional common shares that would have been outstanding had potentially dilutive common shares been issued and reduced by the number of common shares that could have been purchased from the proceeds of the potentially dilutive shares. The Company's outstanding options have been excluded in computing the diluted earnings per share for the pro forma year ended December 31, 2007, because their inclusion would be anti-dilutive. Although there were 8,665 dilutive potential common shares at December 31, 2007, they did not impact the pro forma earnings per share number as shown. (See Note 21 in the Notes to our Consolidated Financial Statements which are included elsewhere in this report.)

For the years 2006 and prior, the pro forma earnings per common share basic and diluted is presented to depict the impact of our conversion described above, as prior to the conversion we did not have any outstanding common shares. The

pro forma earnings per common share basic and diluted was computed using only the shares of the our common stock issued to eligible members in the conversion (50,000,002), and does not include any shares issued to new investors in connection with the our initial public offering or the impact of the cash elections made by eligible members. We had no common stock equivalents outstanding for the periods presented prior to 2007 that would create a dilutive effect on pro forma earnings per share.

- (3) On September 1, 2009, we changed our method of recording ECIC written premiums to an annual method. As a result, the method of calculating

2008, 2007,
2006 and 2005
written
premiums has
been
conformed for
this change to
be comparable
to 2009 written
premiums. The
gross and net
premiums
written for all
periods
presented are
calculated
assuming the
written
premiums are
100% of the
estimated
annual
premium.
Historically,
written
premiums for
ECIC were
recorded using
a billed
method, where
premiums were
recorded at the
time policy
installments
were billed.

- (4) Gross
premiums
written is the
sum of both
direct
premiums
written and
assumed
premiums
written before
the effect of
ceded
reinsurance and
the
intercompany

pooling
agreement.
Direct
premiums
written are the
premiums on
all policies our
insurance
subsidiaries
have issued
during the year.
Assumed
premiums
written are
premiums that
our insurance
subsidiaries
have received
from any
authorized
state-mandated
pools and a
previous
fronting
facility. (See
Note 12 in the
Notes to our
Consolidated
Financial
Statements
which are
included
elsewhere in
this report.)

- (5) Net premiums
written is the
sum of direct
premiums
written and
assumed
premiums
written less
ceded
premiums
written. Ceded
premiums
written is the
portion of
direct
premiums

written that we cede to our reinsurers under our reinsurance contracts. (See Note 12 in the Notes to our Consolidated Financial Statements which are included elsewhere in this report.)

- (6) Losses and LAE ratio is the ratio (expressed as a percentage) of losses and LAE to net premiums earned.
- (7) Commission expense ratio is the ratio (expressed as a percentage) of commission expense to net premiums earned.
- (8) Dividends to policyholders ratio is the ratio (expressed as a percentage) of dividends to policyholders expense to net premium earned.
- (9) Underwriting and other operating expense ratio is

the ratio
(expressed as a
percentage) of
underwriting
and other
operating
expense to net
premiums
earned.

- (10) Combined ratio is the sum of the losses and LAE ratio, the commission expense ratio, dividends to policyholders ratio and the underwriting and other operating expense ratio. Because we only have one operating segment, holding company expenses are included in the combined ratio.
- (11) In connection with our January 1, 2000 assumption of the assets, liabilities and operations of the Fund, our Nevada insurance subsidiary assumed the Fund's rights and obligations associated with the LPT Agreement, a retroactive

100% quota share reinsurance agreement with third party reinsurers, which substantially reduced exposure to losses for pre-July 1, 1995 Nevada insured risks. Pursuant to the LPT Agreement, the Fund initially ceded \$1.525 billion in liabilities for incurred but unpaid losses and LAE, which represented substantially all of the Fund's outstanding losses as of June 30, 1999 for claims with original dates of injury prior to July 1, 1995.

- (12) Deferred reinsurance gain LPT Agreement reflects the unamortized gain from our LPT Agreement. Under GAAP, this gain is deferred and is being amortized using the

recovery method, whereby the amortization is determined by the proportion of actual reinsurance recoveries to total estimated recoveries, and the amortization is reflected in losses and LAE. We periodically reevaluate the remaining direct reserves subject to the LPT Agreement. Our reevaluation results in corresponding adjustments, if needed, to reserves, ceded reserves, reinsurance recoverables and the deferred reinsurance gain, with the net effect being an increase or decrease, as the case may be, to net income.

- (13) We define net income before impact of the deferred reinsurance gain LPT Agreement as net income

less: (a)
amortization of
deferred
reinsurance
gain LPT
Agreement and
(b) adjustments
to LPT
Agreement
ceded reserves.
For 2006 and
prior, we define
pro forma
earnings per
share basic and
diluted before
impact of the
LPT
Agreement as
net income
before impact
of the deferred
reinsurance
gain LPT
Agreement
divided by the
common shares
issued in our
conversion
(50,000,002).
These are not
measurements
of financial
performance
under GAAP,
but rather
reflects the
difference in
accounting
treatment
between
statutory and
GAAP, and
should not be
considered in
isolation or as
an alternative
to any other
measure of
performance
derived in

accordance
with GAAP.

We present net
income before
impact of the
deferred
reinsurance
gain LPT
Agreement
because we
believe that it is
an important
supplemental
measure of
operating
performance to
be used by
analysts,
investors and
other interested
parties in
evaluating us.

We present pro
forma earnings
per share basic
and
diluted before
impact of the
deferred
reinsurance
gain LPT
Agreement
because we
believe that it is
an important
supplemental
measure of
performance by
outstanding
common share
issued in our
conversion.

The LPT
Agreement was
a non-recurring
transaction
which does not
result in
ongoing cash

benefits and consequently we believe these presentations are useful in providing a meaningful understanding of our operating performance. In addition, we believe these non-GAAP measures, as we have defined them, are helpful to our management in identifying trends in our performance because the item excluded has limited significance in our current and ongoing operations. The table below shows the reconciliation of net income to net income before impact of the deferred reinsurance gain LPT Agreement for the periods presented:

| | Years Ended December 31, | | | | |
|------------|---------------------------------|-------------|-------------|-------------|-------------|
| | 2009 | 2008 | 2007 | 2006 | 2005 |
| | (in thousands) | | | | |
| Net income | \$ 83,021 | \$ 101,785 | \$ 120,283 | \$ 171,570 | \$ 137,598 |
| | 18,007 | 18,421 | 18,034 | 19,373 | 16,891 |

| | | | | | | |
|---|--|--|--|--|--|--------|
| Less impact of deferred reinsurance gain LPT Agreement Adjustment to LPT Agreement ceded reserves ^(a) | | | | | | 26,865 |
|---|--|--|--|--|--|--------|

| | | | | | |
|--|-----------|-----------|------------|------------|-----------|
| Net income before impact of the deferred reinsurance gain LPT Agreement | \$ 65,014 | \$ 83,364 | \$ 102,249 | \$ 152,197 | \$ 93,842 |
|--|-----------|-----------|------------|------------|-----------|

(a) Any adjustment to the estimated direct reserves ceded under the LPT Agreement is reflected in losses and LAE for the period during which the adjustment is determined, with a corresponding increase or decrease in net income in the

period. There is a corresponding change to the reinsurance recoverables on unpaid losses as well as the deferred reinsurance gain. A cumulative adjustment to the amortization of the deferred gain is also then recognized in earnings so that the deferred reinsurance gain reflects the balance that would have existed had the revised reserves been recognized at the inception of the LPT Agreement. (See Note 2 in the Notes to our Consolidated Financial Statements which are included elsewhere in this report.)

- (14) We define total equity including deferred reinsurance gain LPT Agreement as

total equity plus deferred reinsurance gain LPT Agreement. Total equity including deferred reinsurance gain LPT Agreement is not a measurement of financial position under GAAP and should not be considered in isolation or as an alternative to total equity or any other measure of financial health derived in accordance with GAAP.

We present total equity including deferred reinsurance gain LPT Agreement because we believe that it is an important supplemental measure of financial position to be used by analysts, investors and other interested parties in evaluating us. The LPT Agreement

was a non-recurring transaction and the treatment of the deferred gain does not result in ongoing cash benefits or charges to our current operations and consequently we believe this presentation is useful in providing a meaningful understanding of our financial position. The table below shows the reconciliation of total equity to total equity including deferred reinsurance gain LPT Agreement for the periods presented:

| | As of December 31, | | | | |
|--|---------------------------|-------------|-------------|-------------|-------------|
| | 2009 | 2008 | 2007 | 2006 | 2005 |
| | (in thousands) | | | | |
| Total equity | \$ 498,399 | \$ 444,728 | \$ 379,453 | \$ 303,777 | \$ 144,607 |
| Deferred reinsurance gain LPT Agreement | 388,574 | 406,581 | 425,002 | 443,036 | 462,409 |
| Total equity including deferred reinsurance gain LPT Agreement | \$ 886,973 | \$ 851,309 | \$ 804,455 | \$ 746,813 | \$ 607,016 |

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with the consolidated financial statements and the accompanying notes thereto included in Item 8 and Item 15 of this report. In addition to historical information, the following discussion contains forward-looking statements that are subject to risks and uncertainties and other factors described in Item 1A of this report. Our actual results in future periods may differ from those referred to herein due to a number of factors, including the risks described in the sections entitled Risk Factors and Forward-Looking Statements elsewhere in this report.

Overview

We are a specialty provider of workers' compensation insurance focused on select small businesses engaged in low to medium hazard industries. Workers' compensation is a statutory system under which an employer is required to pay for its employees' medical, disability and vocational rehabilitation and death benefit costs for work-related injuries or illnesses. Our business has historically targeted businesses located in several western states, primarily California and Nevada. During 2008, we were the ninth and fourteenth largest non-governmental writer of workers' compensation insurance in California and the United States, respectively, based on direct premiums written, as reported by A.M. Best. We operate as a single segment.

We believe we benefit by targeting small businesses, a market that is characterized by fewer competitors, more attractive pricing and strong persistency when compared to the U.S. workers' compensation insurance industry in general. As a result of our disciplined underwriting standards, we believe we are able to price our policies at levels which are competitive and profitable. Our approach to underwriting is therefore consistent with our strategy of not sacrificing profitability and stability for top-line revenue growth.

On October 31, 2008, we acquired 100% of the outstanding common stock of AmCOMP Incorporated (AmCOMP) for \$188.4 million (the Acquisition). As a result of the Acquisition, we are currently conducting business in 30 states from coast to coast, with a concentration in California. We are also licensed to write business in six additional states and the District of Columbia. We believe the Acquisition supports our strategic goals and achieving our vision of being the leader in the property and casualty insurance industry specializing in workers' compensation. Our results of operations for 2008 include the acquired operations of AmCOMP for the period November 1, 2008 through December 31, 2008.

As of December 31, 2009, we wrote 46.9% of our in-force premiums in California. We market and sell our workers' compensation insurance products through independent local and regional agents and brokers, and through our strategic distribution partners and alliances, including our principal strategic partners, ADP, Inc. (ADP) and Wellpoint, Inc. (Wellpoint). As of December 31, 2009, we wrote \$70.6 million, or 18.3%, of our in-force premiums through ADP and Wellpoint.

We commenced operations as a private domestic mutual insurance company on January 1, 2000 when our Nevada insurance subsidiary assumed the assets, liabilities and operations of the Nevada State Industrial Insurance System (the Fund). The Fund had over 80 years of workers' compensation experience in Nevada. In July 2002, we acquired the renewal rights to a book of workers' compensation insurance business, and certain other tangible and intangible assets, from Fremont Compensation Insurance Group and its affiliates (Fremont), primarily comprised of accounts in California and, to a lesser extent, in Idaho, Montana, Utah and Colorado. Because of the Fremont transaction, we were able to establish our important relationships and distribution agreements with ADP and Wellpoint. In February 2007, we completed an initial public offering and conversion from a mutual insurance holding company owned by our policyholder members to a Nevada stock corporation owned by our public stockholders.

In connection with our January 1, 2000 assumption of the assets, liabilities and operations of the Fund, our Nevada insurance subsidiary assumed the Fund's rights and obligations associated with the LPT Agreement, a retroactive

100% quota share reinsurance agreement with third party reinsurers, which substantially reduced exposure to losses for pre-July 1, 1995 Nevada insured risks. Pursuant to the LPT Agreement, the Fund initially ceded \$1.525 billion in liabilities for the incurred but unpaid

losses and LAE, which represented substantially all of the Fund's outstanding losses as of June 30, 1999 for claims with original dates of injury prior to July 1, 1995. Entry into the LPT Agreement resulted in a deferred reinsurance gain in accordance with U.S. generally accepted accounting principles (GAAP), and this deferred gain is being amortized using the recovery method, whereby the amortization is determined by the proportion of actual reinsurance recoveries to total estimated recoveries, and the amortization is reflected in losses and LAE. We periodically reevaluate the remaining direct reserves subject to the LPT Agreement. Our reevaluation results in corresponding adjustments, if needed, to reserves, ceded reserves, reinsurance recoverables and the deferred reinsurance gain, with the net effect being an increase or decrease, as the case may be, to net income. In addition, we receive a contingent commission under the LPT Agreement. Increases and decreases in the contingent commission are reflected in our commission expense, see Results of Operations.

The workers' compensation insurance market is highly competitive. Our strategy across market cycles is to maintain underwriting profitability, manage our expenses and focus on underserved markets within our targeted classes of businesses that we believe will provide greater opportunities for profitable returns.

Revenues

We derive our revenues primarily from the following:

Net Premiums Earned. Previously, we have used two accepted methodologies for recording written premiums. Three of our insurance subsidiaries, EPIC, EAC and EICN, have historically recorded written premiums using an annual method, where 100% of the estimated annual premium is recorded at the inception of the policy. ECIC has historically recorded written premiums using a billed method, where premiums were recorded at the time policy installments were billed. During the three months ended September 30, 2009, we conformed the method of recording written premiums for ECIC to an annual method in order to be consistent across the Company. Conforming the method had no impact on the consolidated statements of income, statements of stockholders' equity or net cash flows. The result of conforming the method impacted only premiums receivable and related unearned premium assets and liabilities. The change to written premiums has been applied to all periods presented and did not have a material effect on any periods presented.

Overall, net premiums earned increased 22.9% for the year ended December 31, 2009, compared to the same period in 2008, primarily attributable to the Acquisition. This increase was partially offset by decreases related to the impact of price competition, the economic conditions and our commitment to underwriting discipline.

The economic contraction has disproportionately impacted net earned premiums in both Nevada and Florida. Both states experienced double digit unemployment and a decline in tourism. Classes of small businesses that were particularly affected include contractors and restaurants. Declining payrolls due to unemployment and reduced work hours, closures of small businesses and our continued underwriting discipline all contributed to lower premiums in these states.

Overall, we expect to see continued downward pressure on premiums in 2010, which will be partially offset by policy count growth, including growth attributable to our A- (Excellent) A.M. Best rating being extended to EPIC and EAC and rate increases in California. It is uncertain how these trends will impact profitability. We believe that we are well positioned for an economic recovery due to our focus on small businesses, which have historically led economic recoveries.

California California, our largest market, represented 46.9% of our in-force premiums as of December 31, 2009. In California, we reduced our premium rates by 38.5% from January 1, 2006 through December 31, 2008. This compared with the recommendation of the California Commissioner of Insurance (California Commissioner) of a 45.0% rate decline since January 1, 2006.

In November 2007, the California Commissioner recommended that there be no overall change in the claims cost benchmark for policies written on or after January 1, 2008. In October 2008, the Workers Compensation Insurance Rating Bureau (WCIRB) recommended a 16.0% increase in the claims cost benchmark. The California Commissioner of Insurance (California Commissioner)

responded with the approval of a 5.0% average increase in the claims cost benchmark on new and renewal policies incepting on or after January 1, 2009.

Based upon our actuarial analysis of current and anticipated loss cost trends, we filed for an average 10.0% rate increase in California for new and renewal policies incepting on or after February 1, 2009.

In April 2009, the WCIRB submitted a revised recommendation to increase the claims cost benchmark 23.7% effective July 1, 2009. The recommendation was based upon an increase in medical costs and an increase of 5.8% directly attributable to additional costs arising from several Workers Compensation Appeals Board decisions. In July 2009, the California Commissioner rejected the recommendation of the WCIRB and left the claims cost benchmark unchanged.

We increased our rates by an average of 10.5% for all new and renewal policies incepting on or after August 15, 2009.

In August 2009, the WCIRB recommended a 22.8% increase in the claims cost benchmark effective January 1, 2010. This recommendation was based upon the same factors that supported the April 2009 recommendation. On November 9, 2009, the California Commissioner again rejected the WCIRB recommendation and left the claims cost benchmark unchanged.

Based upon our actuarial analysis of current and anticipated loss cost trends, we filed for a 3.0% increase for new and renewal policies incepting on or after March 15, 2010. The average rate we file does not necessarily indicate the rate we charge to individual policyholders because an insured's experience modification factor is subject to revision annually and our underwriters may increase or decrease rates based upon individual risk characteristics.

Florida Florida is an administered pricing state. In administered pricing states, insurance rates are set by the state Commissioner of Insurance who sets the rates that we are allowed to charge in those states.

In 2003, Florida enacted workers compensation reforms. The reforms have resulted in significant declines in claim frequency, an improvement in loss development and a reduction in the cost of claims. As a result, the Florida Commissioner of Insurance (Florida Commissioner) approved 18.6% and 18.4% rate decreases for new and renewal policies incepting on or after January 1, 2009 and 2008, respectively.

In February 2009, the Florida Commissioner approved a 6.4% increase in workers compensation rates for new and renewal policies incepting on or after April 1, 2009. This rate increase was in response to an October 2008 Florida Supreme Court decision that materially impacted the statutory caps on attorney fees that were part of the 2003 reforms. In June 2009, the Florida Commissioner approved a 6.0% decrease in workers compensation rates effective July 1, 2009, for new and renewal policies and the unexpired portions of outstanding policies with inception dates from April 1, 2009 through June 30, 2009. This rate decrease was due to the impact of Florida House Bill 903, which restored the statutory caps on attorney fees.

In August 2009, the National Council on Compensation Insurance (NCCI) recommended a 6.8% average rate decrease for new and renewal policies incepting on or after January 1, 2010. According to the NCCI, this recommendation was in response to significant reductions in claims frequency, although the NCCI noted that the pace of improvement has moderated. The Florida Commissioner approved this rate decrease, making the cumulative rate decrease 63.2% since the reforms of 2003. We cannot determine the full effect on our profitability at this time or if there will be continued downward pricing pressure in Florida.

Wisconsin Wisconsin is an administered pricing state. In July 2008, the Wisconsin Commissioner of Insurance (Wisconsin Commissioner) approved a 2.9% overall rate increase on new and renewal policies incepting on or after October 1, 2008. On May 14, 2009, the Wisconsin Compensation Rating Bureau recommended an average rate increase of 0.4% for new and renewal policies incepting on or after October 1, 2009. On July 29, 2009, the Wisconsin

Commissioner approved the recommended increase.

Nevada Nevada continues to face downward pricing pressures and the effects of the economic contraction. In 2009, both policy count and average policy size declined approximately 21% in Nevada.

These factors, along with the Acquisition, contributed to Nevada falling from our second to fourth largest producing state.

In February 2009, the Nevada Commissioner of Insurance (Nevada Commissioner) announced the approval of a filing submitted by the NCCI for an average loss cost decrease of 4.9% for new and renewal policies incepting on or after March 1, 2009. We filed for an average 7.8% rate decrease for new and renewal policies incepting on or after March 1, 2009.

In December 2009, the Nevada Commissioner announced the approval of a filing submitted by the NCCI for an average loss cost decrease of 7.6% for new and renewal policies incepting on or after March 1, 2010. We adopted the proposed rate decrease for new and renewal policies incepting on or after March 1, 2010. We cannot determine the full effect on our profitability at this time or if there will be continued downward pricing pressure in Nevada.

Illinois In 2008, the Illinois Commissioner of Insurance (Illinois Commissioner) approved 3.5% and 2.5% average rate increases on new and renewal policies incepting on or after January 1, 2009 and April 1, 2009, respectively. EAC, our primary insurance subsidiary doing business in Illinois, increased average rates 2.8% and 2.5% on new and renewal policies incepting on or after January 1, 2009 and April 1, 2009, respectively.

In September 2009, the NCCI recommended no change to the overall premium level, but a 0.1% decrease to the industrial classes of business effective January 1, 2010, for new and renewal policies. On November 10, 2009, the Illinois Commissioner approved the recommended rates. EAC decreased rates by 0.1% for new and renewal policies incepting on or after January 1, 2010.

Net Investment Income and Realized Gains (Losses) on Investments. We invest our statutory surplus and the funds supporting our insurance liabilities (including unearned premiums and unpaid losses and loss adjustment expenses (LAE)) in fixed maturity securities and equity securities. In addition, a portion of these funds is held in cash and cash equivalents to pay current claims. Net investment income includes interest and dividends earned on our invested assets and amortization of premiums and discounts on our fixed maturity securities less bank service charges, custodial and portfolio management fees. Realized gains and losses on our investments are reported separately from our net investment income. Realized gains (losses) on investments include the gain or loss on a security at the time of sale compared to its original cost (equity securities) or amortized cost (fixed maturity securities). Net unrealized gains or losses on our securities are reported separately within accumulated other comprehensive income on our consolidated balance sheet.

We monitor our portfolio to preserve principal values whenever possible. All securities in an unrealized loss position are reviewed to determine whether the impairment is other-than-temporary. When, in the opinion of management, an impairment is determined to be other-than-temporary, the security is written-down to its fair value and the amount written-down is recorded in earnings as a realized loss on investments in the period in which other-than-temporary determination is made.

Our investment guidelines have been modified to meet our consolidated business strategy. The revised guidelines incorporate lower fixed income duration parameters, a reduction in target equity balances, a lower target weight for the tax-exempt municipal fixed income sector and revised benchmark compositions. Our overall investment philosophy is to maximize total investment returns within the constraints of prudent portfolio risk management. We employ Conning Asset Manager (Conning) to act as our independent investment manager. Conning follows our written investment guidelines based upon strategies approved by our Board of Directors. The fixed maturity securities portion of our portfolio maintains a duration target of 5.00 and a maximum tax-exempt capacity of not more than 60% of the total fixed maturity portfolio. The equity portion of our portfolio has an authorized allocation range of 3-20%. Decreasing the equity allocation has the effect of decreasing surplus volatility (because under statutory accounting principles, equity securities are carried at fair value with the unrealized gains/losses charged directly to surplus in contrast to fixed income securities which are carried at amortized cost with no impact on surplus due to changes in fair

value). At year-end, our equity position was 3.4%, which is above our selected target of 3.0%. The decreasing equity allocation has helped to increase the tax-equivalent investment yield from 5.5% for the year ended December 31, 2008 to 5.6% for the year ended December 31, 2009. Our tax-exempt allocation is supported by our strong operating profitability and tax-paying status. As this process is dynamic in

nature and reviewed at a detailed level on a quarterly basis, there could be further changes in the duration and allocation of the portfolio.

Expenses

Our expenses consist of the following:

Losses and LAE. Losses and LAE represent our largest expense item and include claim payments made, estimates for future claim payments and changes in those estimates for current and prior periods and costs associated with investigating, defending and adjusting claims. The quality of our financial reporting depends in large part on accurately predicting our losses and LAE, which are inherently uncertain as they are estimates of the ultimate cost of individual claims based on actuarial estimation techniques. In some of our states we have a short operating history and must rely on a combination of industry experience and our specific experience to establish our best estimate of losses and LAE reserves. The interpretation of historical data can be impacted by external forces, principally regulatory changes, economic fluctuations and legal trends. In recent years, we experienced lower losses and LAE in California than we anticipated due to factors such as regulatory reform designed to reduce loss costs in that market and lower than expected inflation. However, there is uncertainty about whether recent paid loss trends in California will continue. The WCIRB's most recent evaluation of loss experience recognized increasing medical costs. We believe the joint marketing of our workers' compensation insurance with Wellpoint's health insurance products also assists in reducing losses since employees make fewer workers' compensation claims because they are insured for non-work related illnesses or injuries and thus are less likely to seek treatment for a non-work related illness or injury through their employers' workers' compensation insurance carrier.

We have established reserves for losses based on our current best estimate of loss costs, taking into consideration medical cost and incurred loss trends. As we continue to gain experience in our newer markets, we rely more on our own loss experience and place less reliance on industry experience.

Commission Expense. Commission expense includes direct commissions to our agents and brokers for the premiums that they produce for us. Also included in commission expense are incentive payments, other direct marketing costs and fees. Commission expense is net of contingent commission income related to the LPT Agreement. Commissions paid to our agents and brokers are deferred and amortized to commission expense in our consolidated statements of income as the premiums generating these commissions are earned. We pay commissions that we believe are competitive with other workers' compensation insurers.

We are entitled to receive a contingent profit commission under the LPT Agreement. The contingent profit is an amount based on the favorable difference between actual paid losses and loss expenses and expected paid losses and loss expenses under the LPT Agreement. (Loss expenses are deemed to be 7% of total losses paid and are paid to us as compensation for management of the LPT claims.) The reinsurers pay us 30% of any favorable difference in actual amounts paid compared to contractually expected amounts to be paid under the agreement. The calculation of the contingent profit commission, which is based on actual amounts paid versus expected amounts are determined every five years beginning June 30, 2004 for the first twenty-five years of the agreement. Conversely, we could be required to return any previously paid contingent profit commission, with interest in the event of unfavorable differences.

We estimate ultimate contingent profit commission through June 30, 2024 and record it as commission expense. Increases or decreases in the estimated contingent profit commission are reflected in commission expense in the period that the estimate is revised. For the year ended December 31, 2009, we decreased commission expenses by \$15.0 million as a result of an increase in contingent profit commissions and received \$10.3 million from the reinsurers. Estimated total losses and loss adjustment expenses covered by the LPT Agreement and to be paid through June 30, 2024 were reduced by approximately \$40 million from the previous estimate. Pursuant to the LPT Agreement, actual amounts paid for losses under the LPT Agreement for the period July 1, 1999 through June 30, 2009, were \$467.8 million as compared to contractually expected losses and loss expenses of approximately \$550

million.

Dividends to Policyholders. In administered pricing states such as Florida and Wisconsin, insurance rates are set by state insurance regulators. Rate competition generally is not permitted in these states

and, consequently, policyholder dividend programs are an important competitive factor. In Florida and Wisconsin, and to a much more limited extent in several of our other states, we offer dividend programs to eligible policyholders under which a portion of the premium paid by a policyholder may be returned in the form of a dividend. Eligibility for these programs varies based upon the nature of the policyholder's operations, expected premium paid, loss experience and existing controls intended to minimize workers' compensation claims and costs. An estimated provision for policyholders' dividends is accrued as the related premiums are earned. Such dividends do not become a fixed liability until declared by the respective Boards of Directors of our insurance subsidiaries.

Additionally, Florida statutes require the return of policyholders' premium pursuant to a formula based on underwriting results. Our ultimate obligation is dependent on our filings with the Florida Office of Insurance Regulation and on our prescribed loss reserves included in our annual statutory financial statements. We account for these payments as dividends to policyholders.

Underwriting and Other Operating Expenses. Underwriting and other operating expenses includes the costs to acquire and maintain an insurance policy (excluding commissions) consisting of premium taxes and certain other general expenses that vary with, and are primarily related to, producing new or renewal business. These acquisition costs are deferred and amortized to underwriting and other operating expense in the consolidated statements of income as the related premiums are earned. Other underwriting expenses consist of policyholder dividends, changes in estimates of future write-offs of premiums receivable, general administrative expenses such as salaries and benefits, rent, office supplies, depreciation and all other operating expenses not otherwise classified separately, fees and assessments of boards, bureaus and assessments of statistical agencies for policy service and administration items such as rating manuals, rating plans and experience data. Our underwriting and other operating expenses are a reflection of our operating efficiency in producing, underwriting and administering our business. Policy acquisition costs are variable based on premiums earned. However, underwriting and other costs are more fixed in nature and become a larger percentage of net premiums earned as premiums trend lower.

As a result of the restructuring plan, we incurred one-time pre-tax integration and restructuring charges, not including capitalized costs, of approximately \$5.7 million, including \$2.8 million of severance benefits for the year ended December 31, 2009. Additionally, we achieved pre-tax cost savings of approximately \$12.0 million in 2009; and expect to achieve pre-tax cost savings annually of \$20.0 million to \$22.0 million beginning in 2010.

Interest Expense. We incur interest expenses on acquired surplus notes and the Second Amended and Restated Secured Credit Facility (Amended Credit Facility). Interest expense is paid quarterly in arrears on the surplus notes. The expense for each interest payment on the surplus notes is based on the three-month LIBOR rate plus 405 to 425 basis points.

Interest expense is paid quarterly in arrears on the Amended Credit Facility. The interest expense is based on the 30-day LIBOR rate plus 125 basis points. Additionally, we have an interest rate swap agreement on the Amended Credit Facility. Interest paid on the Amended Credit Facility and the interest rate swap was \$5.8 million and \$1.2 million for the years ended December 31, 2009 and 2008, respectively.

Critical Accounting Policies

Management believes it is important to understand our accounting policies in order to understand our financial statements. Management considers some of these policies to be very important to the presentation of our financial results because they require us to make estimates and assumptions. These estimates and assumptions affect the reported amounts of our assets, liabilities, revenues and expenses and the related disclosures. Some of the estimates result from judgments that can be subjective and complex and, consequently, actual results in future periods might differ from these estimates.

Management believes that the most critical accounting policies relate to the reporting of reserves for losses and LAE, including losses that have occurred but have not been reported prior to the reporting date, amounts recoverable from reinsurers, recognition of premium revenue, deferred income taxes, the valuation of investments and goodwill and intangible asset impairment.

The following is a description of our critical accounting policies:

Reserves for Losses and Loss Adjustment Expenses

We are directly liable for losses and LAE under the terms of insurance policies our insurance subsidiaries underwrite. Significant periods of time can elapse between the occurrence of an insured loss, the reporting of the loss to the insurer and the insurer's payment of that loss. Our loss reserves are reflected in our consolidated balance sheets under the line item caption "unpaid losses and loss adjustment expenses." As of December 31, 2009, our reserves for unpaid losses and LAE, net of reinsurance, were \$1.4 billion.

Accounting for workers' compensation insurance requires us to estimate the liability for the expected ultimate cost of unpaid losses and LAE, referred to as loss reserves, as of a balance sheet date. Our estimate of loss reserves is intended to equal the difference between the expected ultimate losses and LAE of all claims that have occurred as of a balance sheet date and amounts already paid. Management establishes the loss reserve based on its own analysis of emerging claims experience and environmental conditions in our markets and review of the results of various actuarial projection methods and their underlying assumptions. Our aggregate carried reserve for unpaid losses and LAE is a point estimate, which is the sum of our reserves for each accident year in which we have exposure. This aggregate carried reserve calculated by us represents our best estimate of our outstanding unpaid losses and LAE.

Maintaining the adequacy of the loss reserve estimate is an inherent risk of the workers' compensation insurance business. As described below, workers' compensation claims may be paid over a long period of time. Therefore, estimating reserves for workers' compensation claims may involve more uncertainty than estimating reserves for other lines of insurance with shorter or more definite periods between occurrence of the claim and final determination of the claim amount. The amount by which estimated losses in the aggregate, measured subsequently by reference to payments and additional estimates, differ from those previously estimated for a specific time period is known as "reserve development." Reserve development is unfavorable when payments for losses are made for more than the levels at which they were reserved or when subsequent estimates indicate a basis for reserve increases on open claims. In this case, the previously estimated loss reserves are considered "deficient." Reserve development is favorable when estimates of ultimate losses indicate a decrease in established reserves. In this case, the previously estimated loss reserves are considered "redundant." Reserve development, whether due to an increase or decrease in the aggregate estimated losses, is reflected in operating results through an adjustment to incurred losses and LAE during the accounting period in which the development is recognized.

Although claims for which reserves are established may not be paid for several years or more, we do not discount loss reserves in our financial statements for the time value of money.

The three main components of our reserves for unpaid losses and LAE are case reserves, "incurred but not reported" or IBNR reserves, and LAE reserves.

Case reserves are estimates of future claim payments based upon periodic case-by-case evaluation and the judgment of our claims adjusting staff, as applied at the individual claim level. Our claims examiners determine these case reserves for reported claims on a claim-by-claim basis, based on the examiner's judgment and experience and on our case reserving practices. We update and monitor our case reserves frequently to appropriately reflect current information. Our case reserving practices account for the type of business or occupation of the injured worker, the circumstances surrounding the claim, the nature of the accident and of the resulting injury, the current medical condition and physical capabilities of the injured worker, the expected future course and cost of medical treatment and of the injured worker's disability, the existence of dependents of the injured worker, policy provisions, the statutory benefit provisions applicable to the claim, relevant case law in the state, and potentially other factors and considerations.

IBNR is an actuarial estimate of future claim payments beyond those considered in the case reserve estimates, relating to claims arising from accidents that occurred during a particular time period on or prior to the balance sheet date.

Thus, IBNR is the compilation of the estimated ultimate losses for each accident year less amounts that have been paid and case reserves. IBNR reserves, unlike case

reserves, do not apply to a specific claim, but rather apply to the entire body of claims arising from a specific time period. IBNR primarily provides for costs due to:

future
claim
payments
in excess
of case
reserves
on
recorded
open
claims;

additional
claim
payments
on closed
claims;
and

the cost of
claims
that have
not yet
been
reported
to us.

Most of our IBNR reserves relate to estimated future claim payments over and above our case reserves on recorded open claims. For workers compensation, most claims are reported to the employer and to the insurance company relatively quickly, and relatively small amounts are paid on claims that already have been closed (which we refer to as reopenings). Consequently, late reporting and reopening of claims are a less significant part of IBNR for our insurance subsidiaries.

LAE reserves are our estimate of the diagnostic, legal, administrative and other similar expenses that we will pay in the future to manage claims that have occurred on or before the balance sheet date. LAE reserves are established in the aggregate, rather than on a claim-by-claim basis.

A portion of our losses and LAE obligations are ceded to unaffiliated reinsurers. We establish our losses and LAE reserves both gross and net of ceded reinsurance. The determination of the amount of reinsurance that will be recoverable on our losses and LAE reserves includes both the reinsurance recoverable from our excess of loss reinsurance policies, as well as reinsurance recoverable under the terms of the LPT Agreement. Our reinsurance arrangements also include an intercompany pooling arrangement between EICN, ECIC, EPIC and EAC whereby each of the insurance subsidiaries cedes some of its premiums, losses, and LAE to the others, but this intercompany pooling arrangement does not affect our consolidated financial statements.

Our reserve for unpaid losses and loss adjustment expenses (gross and net), as well as the above-described main components of such reserves, were as follows:

| | 2009 | December 31, 2008 (in thousands) | 2007 |
|---|--------------|--|--------------|
| Case reserves | \$ 915,378 | \$ 886,789 | \$ 740,133 |
| IBNR | 1,198,019 | 1,293,313 | 1,235,124 |
| LAE | 312,261 | 326,376 | 294,453 |
| Gross unpaid losses and LAE | 2,425,658 | 2,506,478 | 2,269,710 |
| Reinsurance recoverables on unpaid losses and LAE, gross | 1,052,505 | 1,076,350 | 1,052,641 |
| Net unpaid losses and LAE | \$ 1,373,153 | \$ 1,430,128 | \$ 1,217,069 |

Workers' compensation is considered to be a long-tail line of insurance, meaning that there can be an extended elapsed period between when a claim occurs (when the worker is injured on the job) and the final payment and resolution of the claim. As discussed above, the long-tail for workers' compensation usually is not caused by a delay in the reporting of the claim. The vast majority of our workers' compensation claims are reported very promptly. The long-tail for workers' compensation is caused by the fact that benefits are often paid over a long period of time, and many of the benefit amounts are difficult to determine in advance of their payment. Our obligations with respect to an injured worker may include medical care and disability-related payments for the duration of the injured worker's disability, in accordance with state workers' compensation statutes, all of which payments are considered as part of a single workers' compensation claim and are our responsibility if we were providing coverage to the employer on the date of injury. For example, in addition to medical expenses, an injured worker may receive payments for lost income associated with total or partial disability, whether temporary or permanent (i.e., the disability is expected to continue until normal retirement age or death, whichever comes first). We may also be required to make payments, often over a period of many years, to surviving spouses and children of workers who are killed in the course and scope of their employment. The specific components of injured workers' benefits are defined by the laws in each state.

Based on historical insurance industry experience countrywide, as reported by A.M. Best, approximately ten percent of workers' compensation claim dollars are expected to be paid more than ten years after the claim occurred. While our payout pattern likely will differ from that of the industry,

industry experience illustrates the general duration of workers' compensation claims. The duration of the injured worker's disability, the course and cost of medical treatment, as well as the lifespan of dependents, are uncertain and are difficult to determine in advance. We endeavor to minimize this risk by closing claims promptly, to the extent feasible. In addition, there are no policy limits on our liability for workers' compensation claims as there are for other forms of insurance. We endeavor to mitigate this risk by purchasing reinsurance that will provide us with financial protection against the impact of very large claims and catastrophes.

Although we update and monitor our case reserves frequently as appropriate to reflect current information, it is very difficult to set precise case reserves for an individual claim due to the inherent uncertainty about the future duration of a specific injured worker's disability, the course and cost of medical care for that injured worker, and the other factors described above. Therefore, in addition to establishing case reserves on a claim-by-claim basis, we, like other workers compensation insurance companies, establish IBNR reserves based on analyses and projections of aggregate claims data. Evaluating data on an aggregate basis eliminates some of the uncertainty associated with an individual claim. However, considerable uncertainty remains as many claims can be affected simultaneously by changes in environmental conditions such as medical technology, medical costs and medical cost inflation, economic conditions, the legal and regulatory climate, and other factors. The cost of a group of workers' compensation claims is not known with certainty until every one of the claims is ultimately closed.

Unpaid LAE is also estimated and monitored. The amount that will be spent managing claims will depend on the duration of the claims, the course of the injured worker's disability and medical treatment, the nature and degree of any disputes relating to our obligations to the claimant, the administrative and legal environment in which issues are addressed and resolved, and the cost of the Company personnel and other resources that are used in the management of claims. Therefore, our LAE reserves also contribute to the overall uncertainty of our aggregate reserve for unpaid losses and LAE.

For the reasons described above, estimating reserves for workers' compensation claims may be more uncertain than estimating reserves for other lines of insurance with shorter or more definite periods between occurrence of the claim and final determination of the ultimate loss and with policy limits on the insurer's liability for claim amounts. Accordingly, our reserves may prove to be deficient or redundant relative to our actual losses and LAE.

Actuarial methodologies are used by workers' compensation insurance companies, including us, to analyze and estimate the aggregate amount of unpaid losses and LAE. As mentioned above, management considers the results of various actuarial projection methods and their underlying assumptions, among other factors, in establishing the reserves for unpaid losses and LAE.

Judgment is required in the actuarial estimation of unpaid losses and LAE. The judgments include the selection of methodologies to project the ultimate cost of claims; the selection of projection parameters based on historical company data, industry data, and other benchmarks; the identification and quantification of potential changes in parameters from historical levels to current and future levels due to changes in future claims development expectations caused by internal or external factors; and, the weighting of differing reserve indications that result from alternative methods and assumptions. The adequacy of our ultimate loss reserves, which are based on estimates, is inherently uncertain and represents a significant risk to our business, which we attempt to mitigate through our claims management process and by monitoring and reacting to statistics relating to the cost and duration of claims. However, no assurance can be given as to whether the ultimate liability will be more or less than our loss reserve estimates.

We retain an independent actuarial consulting firm (Consulting Actuary) to perform comprehensive studies of our losses and LAE liability on a semi-annual basis. The role of our Consulting Actuary is to conduct sufficient analyses to produce a range of reasonable estimates, as well as a point estimate, of our unpaid losses and LAE liability, and to present those results to our actuarial staff and to management.

For purposes of analyzing claim payment and emergence patterns and trends over time, we compile and aggregate our claims data by grouping the claims according to the year or quarter in which the

claim occurred (accident year or accident quarter), since each such group of claims is at a different stage of progression toward the ultimate resolution and payment of those claims. The claims data is aggregated and compiled separately for different types of claims and/or claimant benefits and/or for different states or groups of states in which we do business.

Both the Consulting Actuary and the internal actuarial staff select and apply a variety of generally accepted actuarial methods to our data. The methods vary in their responsiveness to different information, characteristics and dynamics in the data, and thus the results of the various methods assist the actuary in considering these characteristics and dynamics in the historical data. The methods employed for each segment of claims data, and the relative weight accorded to each method, vary depending on the nature of the claims segment and on the age of the claims

The primary methods utilized in recent evaluations are:

Paid Bornhuetter-Ferguson Method. A method assigning partial weight to initial expected losses for each accident year and partial weight to observed paid losses. The weights assigned to the initial expected losses decrease as the accident year matures.

Reported Bornhuetter-Ferguson Method. A method assigning partial weight to the initial expected losses and partial weight to observed reported loss dollars (paid losses plus case reserves). The weights assigned to the initial expected losses decrease as the accident year matures.

Paid Development Method. A method that uses actual historical, cumulative paid losses by accident year to develop estimated ultimate losses. The overall development is based on the assumption that each accident year will develop to estimated ultimate cost in a manner that is analogous to prior years, adjusted as deemed appropriate, for the expected effects of known changes in the workers' compensation environment, and, to the extent necessary, supplemented by analyses of the development of broader industry data.

Reported Development Method. A method that uses actual historical, cumulative reported loss dollars by accident year to develop estimated ultimate losses. The overall development is based on the assumption that each accident year will develop to estimated ultimate cost in a manner that is analogous to prior years, adjusted as deemed appropriate, for the expected effects of known changes in the workers' compensation environment, and, to the extent necessary, supplemented by analyses of the development of broader industry data.

Initial Expected Loss Method. This method is used as an input to the Bornhuetter-Ferguson methods. Initial expected losses for an accident year are based on one or more of: industry-benchmark losses per dollar of payroll for the mix of employment classes insured; prior evaluation dates' projections of ultimate losses for the accident year; by applying to premiums a set of initial expected loss ratios selected after analyzing the development projections for each accident year, loss trends, statutory benefit changes, rate change, and historical company loss ratios; and by applying to claim counts a set of expected claim severities selected after analyzing the claim severities implied by development method projections for other periods, loss trends, and statutory benefit changes.

Each of the methods listed above requires the selection and application of parameters and assumptions. The key parameters and assumptions are: the pattern with which our aggregate claims data will be paid or will emerge over time; claims cost inflation rates; the effects of legislative benefit changes and/or judicial changes; and trends in the frequency of claims, both overall and by severity of claim. Of these, we believe the most important are the pattern with which our aggregate claims data will be paid or emerge over time and claims cost inflation rates. Each of these key items is discussed in the following paragraphs.

All of the methods depend in part on the selection of an expected pattern with which the aggregate claims data will be paid or will emerge over time. We compile, to the extent available, long-term and short-term historical data for our insurance subsidiaries, organized in a manner which provides an indication of the historical patterns with which

claims have emerged and have been paid. To the extent that the historical data may not provide sufficient information about future patterns, whether due to environmental changes such as legislation or due to the small volume or short history of data for some segments of our business, benchmarks based on industry data, and forecasts made by industry rate bureaus regarding the effect of legislative benefit changes on such patterns, may be used to supplement,

adjust, or replace patterns based on our subsidiaries' historical data. Actuarial judgment is required in selecting the patterns to apply to each segment of data being analyzed, and our views regarding current and future claim patterns are among the factors that enter into our establishment of the losses and LAE reserves at each balance sheet date. When short-term averages or external rate bureau analyses indicate that the claims patterns are changing from historical company or industry patterns, that new or forecasted information typically is factored into the methodologies gradually, so that the projections will not overreact to what may turn out to be a temporary or unwarranted assumption about changes in patterns. When new claims emergence or payment patterns have appeared in the actual data repeatedly over multiple evaluations, or when the changes in patterns are explained by external events such as legislative benefit changes and/or judicial changes, those new patterns are given greater weight in the selection process. Because some claims are paid over many years, the selection of claim emergence and payment patterns involves judgmentally estimating the manner in which recently-occurring claims will develop many years or decades in the future, and it is likely that the actual development that will occur in the distant future could differ substantially from historical patterns or current projections. The current projections would differ if different claims development patterns were selected by the actuaries. The actual payout pattern for the aggregate claims associated with an accident year will not be known until decades later, when all the claims are closed.

The expected pattern with which the aggregate claims data will be paid or will emerge over time is expressed as a percentage of ultimate losses that remain to be paid at each evaluation date for each accident year or accident quarter. A lower estimate of the percentage of aggregate claims dollars remaining to be paid, when applied in the actuarial methods, produces a lower dollar estimate of the unpaid loss.

Several of the methods also involve adjusting historical data for inflation. For these methods, the inflation rates used in the analysis are judgmentally selected based on historical year-to-year movements in the cost of claims observed in the data of our insurance subsidiaries and in industry-wide data, as well as on broader inflation indices. The results of these methods would differ if different inflation rates were selected.

In projections using December 31, 2009 data, the methods that use explicit medical cost inflation assumptions included medical cost inflation assumptions ranging from 5.5% to 7.5%. The selection of medical cost inflation assumptions for use in the actuarial methodologies has been based on observed recent and longer-term historical medical cost inflation in our claims data and in the U.S. economy more generally. The rate of medical cost inflation as reflected in our historical medical payments per claim has averaged approximately 6.1% over the past five to ten years. The rate of medical cost inflation in the general U.S. economy, as measured by the consumer price index - medical care, has averaged approximately 4.1% over the past ten years.

For EICN, the analysis of unpaid loss is conducted on claims data prior to recognition of reinsurance. A separate projection is made of future reinsurance recoveries based on our reinsurance arrangements and an analysis of large claims experience, both for EICN and as reflected in industry-based benchmarks. The projections prior to recognition of reinsurance provide the basis for estimating gross-of-reinsurance unpaid losses, from which the projection of future reinsurance recoveries is subtracted to estimate net-of-reinsurance unpaid losses.

For ECIC, the analysis of unpaid loss is conducted on claims data net of reinsurance, and a separate projection is made of future reinsurance recoveries, which is added to the estimated net-of-reinsurance unpaid losses to estimate gross-of-reinsurance unpaid losses.

For EPIC and EAC, the analysis of unpaid losses is conducted for various retention levels corresponding to the reinsurance program structure, as well as on an unlimited retention basis as if there were no reinsurance. By applying factors that quantify the proportion of losses in each layer that are ceded to reinsurers, the analysis produces estimated net-of-reinsurance unpaid losses, as well as estimated gross-of-reinsurance unpaid losses.

Management along with internal actuarial staff and the Consulting Actuary separately analyze LAE and estimate unpaid LAE. This analysis relies primarily on examining the relationship between the aggregate amount that has been

spent on LAE historically, as compared with the volume of claims activity for the corresponding historical calendar periods. Based on these historical relationships,

estimates of the extent to which claim management resources are focused on the initial handling of claims and on the ongoing management of claims, and projections of the volume of claims activity in future calendar periods related to current and prior accident year claims, the Consulting Actuary selects a range of future LAE estimates that is a function of the projected future claim activity. The portion of unpaid LAE that will be recoverable from reinsurers is estimated based on the contractual reinsurance terms.

Based on the results of the analyses conducted, the stability of the historical data, and the characteristics of the various claims segments analyzed, the Consulting Actuary selects a range of estimated unpaid losses and LAE and a point estimate of unpaid losses and LAE, for presentation to internal actuarial staff and management. The selected range is intended to represent the range in which it is most likely that the ultimate losses will fall. This range is narrower than the range of indications produced by the individual methods applied because it is not likely, although it is possible, that the high or low result will emerge for every claim segment and accident year. The Consulting Actuary's point estimate of unpaid losses and LAE is based on a judgmental selection for each claim segment from within the range of results indicated by the different actuarial methods.

Management formally establishes loss reserves for financial statement purposes on a quarterly basis. In doing so, we make reference to the most current analyses of our Consulting Actuary, including a review of the assumptions and the results of the various actuarial methods used by the Consulting Actuary. Comprehensive studies are conducted as of June 30 and December 31 by both internal actuarial staff and the Consulting Actuary. On the alternate quarters, the preceding study results are updated for actual claim payment activity during the quarter.

Management determines the IBNR and LAE components of our loss reserves by establishing a point in the range of the Consulting Actuary's most recent analysis of unpaid losses and LAE. The selection of the point is based on management's own view of recent and future claim emergence patterns, payment patterns, and trend information obtained from internal actuarial staff pertaining to:

the markets in
which we are
operating,
including
economic,
business, and
political
conditions;

the
characteristics
of the business
we have
written in
recent
quarters;

recent and
pending
recoveries
from
reinsurance;

the number
and costs of
claims, and the
costs of
managing
claims; and

other similar
considerations
as we view
relevant.

The aggregate carried reserve calculated by management represents our best estimate of our outstanding unpaid losses and LAE. We believe that we should be conservative in our reserving practices due to the long-tail nature of workers compensation claims payouts, the susceptibility of those future payments to unpredictable external forces such as medical cost inflation and other economic conditions, and the actual variability of loss reserve adequacy that we have observed in the workers compensation insurance industry.

At December 31, 2009, management's best estimate of unpaid losses and LAE, net of reinsurance, was \$1.37 billion, which was \$1.0 million above the actuarial point estimate. In establishing its best estimate at December 31, 2009, management and internal actuarial staff reviewed and considered: (a) the Consulting Actuary assumptions, point estimate and range; (b) the inherent uncertainty of workers compensation unpaid losses and LAE liabilities; and (c) the particular uncertainties associated with: (i) the potential effects on the cost and payout pattern of claims following workers compensation system reforms enacted by the California and Florida legislatures in late 2003 and the regulatory implementation of those reforms, the effects of which will become clear over a number of years; (ii) the uncertain cost of administering claims (LAE) in the reformed California and Florida systems; (iii) the potential for legislative and/or judicial reversal of California and Florida reforms; (iv) the rapid growth in the volume of our business in California; and (v) the degree of movement observed in EICN's prior years' projections of losses and LAE in Nevada following premium and market share reductions. Management did not quantify a specific loss reserve increment for each of these sources of uncertainty, but rather established an overall provision for unpaid losses and LAE that, in management's opinion, represented a best estimate of unpaid losses and LAE at December 31, 2009 in light of the historical data, the actuarial assumptions, point estimate and range, current facts and circumstances, and the

sources of uncertainty identified by management. Management's best estimate of unpaid losses and LAE at December 31, 2009 fell within the actuarial range of estimates. The decrease in management's best estimate relative to the actuarial point estimate from December 31, 2008 to December 31, 2009 decreased losses and LAE expense incurred by \$15.4 million for the year ended December 31, 2009.

At December 31, 2008, management's best estimate of unpaid losses and LAE, net of reinsurance, was \$1.43 billion, which was \$16.5 million above the actuarial point estimate. In establishing its best estimate at December 31, 2008, management and internal actuarial staff reviewed and considered: (a) the consulting actuaries assumptions, point estimate and range; (b) the inherent uncertainty of workers' compensation unpaid losses and LAE liabilities; and (c) the particular uncertainties associated with: (i) the potential effects on the cost and payout pattern of claims following workers' compensation system reforms enacted by the California and Florida legislatures in late 2003 and the regulatory implementation of those reforms, the effects of which will become clear over a number of years; (ii) the uncertain cost of administering claims (LAE) in the reformed California and Florida systems; (iii) the potential for legislative and/or judicial reversal of California and Florida reforms; (iv) the rapid growth in the volume of our business in California; and (v) the degree of movement observed in EICN's prior years' projections of losses and LAE in Nevada following premium and market share reductions. Management did not quantify a specific loss reserve increment for each of these sources of uncertainty, but rather established an overall provision for unpaid losses and LAE that, in management's opinion, represented a best estimate of unpaid losses and LAE at December 31, 2008 in light of the historical data, the actuarial assumptions, point estimate and range, current facts and circumstances, and the sources of uncertainty identified by management. Management's best estimate of unpaid losses and LAE at December 31, 2008 fell within the actuarial range of estimates. The decrease in management's best estimate relative to the actuarial point estimate from December 31, 2007 to December 31, 2008 decreased losses and LAE expense incurred by \$72.3 million for the year ended December 31, 2008.

At December 31, 2007, management's best estimate of unpaid losses and LAE, net of reinsurance, was \$1.22 billion, which was \$88.8 million above the actuarial point estimate. In establishing its best estimate at December 31, 2007, management and internal actuarial staff reviewed and considered: (a) the consulting actuary's assumptions, point estimate and range; (b) the inherent uncertainty of workers' compensation unpaid losses and LAE liabilities; and (c) the particular uncertainties associated with: (i) the potential effects on the cost and payout pattern of claims following workers' compensation system reforms enacted by the California legislature in late 2003 and the regulatory implementation of those reforms, the effects of which will become clear over a number of years; (ii) the uncertain cost of administering claims (LAE) in the reformed California system; (iii) the potential for legislative and/or judicial reversal of California reforms; (iv) the rapid growth in the volume of our business in California; (v) the limited historical experience of ECIC to use as a base for projecting future loss development; and, (vi) the degree of movement observed in EICN's prior years' projections of losses and LAE in Nevada following premium and market share reductions. Management did not quantify a specific loss reserve increment for each of these sources of uncertainty, but rather established an overall provision for unpaid losses and LAE that, in management's opinion, represented a best estimate of unpaid losses and LAE at December 31, 2007 in light of the historical data, the actuarial assumptions, point estimate and range, current facts and circumstances, and the sources of uncertainty identified by management. Management's best estimate of unpaid losses and LAE at December 31, 2007 fell within the actuarial range of estimates. The increase in management's best estimate relative to the actuarial point estimate from December 31, 2006 to December 31, 2007 increased losses and LAE expense incurred by \$2.5 million for the year ended December 31, 2007.

The table below provides the actuarial range of estimated liabilities for net unpaid losses and LAE and our carried reserves at the dates shown:

| As of December 31, | | |
|---------------------------|-------------|-------------|
| 2009 | 2008 | 2007 |

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(in thousands)

| | | | |
|-----------------------------|--------------|--------------|--------------|
| Low end of actuarial range | \$ 1,234,222 | \$ 1,306,506 | \$ 1,034,632 |
| Carried reserves | 1,373,153 | 1,430,128 | 1,217,069 |
| High end of actuarial range | 1,523,983 | 1,586,777 | 1,290,274 |

75

Loss reserves are our estimates at a given point in time of our ultimate liability for the cost of claims and the cost of managing those claims, and are inherently uncertain. It is likely that the ultimate liability will differ from our estimates, perhaps significantly. Such estimates are not precise in that, among other things, they are based on predictions of future claim emergence and payment patterns and estimates of future trends in claim frequency and claim cost. These estimates assume that the claim emergence and payment patterns, claim inflation and claim frequency trend assumptions implicitly built into our selected loss reserve will continue into the future. Unexpected changes in claim cost inflation can occur through changes in general inflationary trends, changes in medical technology and procedures, changes in wage levels and general economic conditions and changes in legal theories of compensability of injured workers and their dependents. Furthermore, future costs can be influenced by changes in workers' compensation statutory benefit structure, and benefit administration and delivery.

In applying actuarial techniques, judgment is required to determine the relevance of historical claim emergence and payment patterns and other historical data, external industry benchmark data, information about current economic conditions such as inflation, and recent changes in environmental conditions such as legislation as well as company operational changes in selecting parameters for those techniques under current facts and circumstances. Judgment also is required in selecting from among the loss indications produced by the several actuarial techniques that are used. From evaluation to evaluation, it often is appropriate to adjust the various methods and parameters used in the projection of losses to reflect the expected or estimated effect of such factors. Even after such adjustments, ultimate liability may exceed or be less than the revised estimates.

Estimates of ultimate losses and LAE may change from one balance sheet date to the next when actual claim payment or individual case reserve estimates between those dates differ from the expected claim activity underlying the prior loss reserve estimate, and when actual LAE expenditures differ from expected expenditure levels underlying the prior LAE reserve estimate. As actual losses and LAE expenditures occur during a calendar period, they replace the portion of prior estimates of unpaid losses and LAE that relate to that period. In addition, the parameters used in the various methods and the relative weight accorded to the results of the different actuarial methods, all of which require judgment, may change as a result of observing that the actual pattern of expenditures differs from prior expectations, as well as based on new industry wide data and benchmarks derived from that data, when available. The parameters and weights used in estimating ultimate losses may also change when external conditions—such as the statutory benefit structures or the manner in which it is being interpreted and administered, or inflation—differ from expectations underlying the prior estimate of ultimate losses, and when the effects of factors related to internal operations differ from expectations underlying the prior estimate of ultimate losses.

Each of the actuarial methods used in the analysis and estimation of unpaid losses and LAE depend in part on the selection of an expected pattern with which the aggregate claims data will be paid or will emerge over time, and the assumption that this expected pattern will prevail into the future. We select relevant patterns as part of the periodic review and projection of unpaid losses and LAE. In selecting these patterns, we examine, to the extent available, long-term and short-term historical data for our insurance subsidiaries, benchmarks based on industry data and forecasts made by industry rate bureaus regarding the effect of legislative benefit changes on such patterns. Actuarial judgment is required in selecting the patterns to apply to each segment of data being analyzed.

Management judgment is required in selecting the amount of the loss reserve to record on our consolidated financial statements. Management reviews the various actuarial projections, the assumptions underlying those projections, the range of indications produced by the actuarial methods and the actual long-term and recent emergence and payment of claims. Management also considers the environmental conditions in which the insurance subsidiaries are doing business. In addition, management considers the degree of uncertainty associated with the estimates based on the degree of change that has occurred or is occurring in the environment and in operations.

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The following table provides a reconciliation of the beginning and ending loss reserves on a GAAP basis:

| | 2009 | December 31, 2008 | 2007 |
|--|--------------|------------------------------|--------------|
| | | (in thousands) | |
| Unpaid losses and LAE, gross of reinsurance, at beginning of period | \$ 2,506,478 | \$ 2,269,710 | \$ 2,307,755 |
| Less reinsurance recoverable, excluding bad debt allowance, on unpaid losses and LAE | 1,076,350 | 1,052,641 | 1,098,103 |
| Net unpaid losses and LAE at beginning of period | | | |