Employers Holdings, Inc.
Form 10-K
March 01, 2012

UNITED STATES SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-K

R ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2011

OR

o 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	04-3850065
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)

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 o No R

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 o No R

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 R No o

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 R No o

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. o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller 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 R Accelerated filer o Non-accelerated filer o Smaller reporting company o

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2011 was $634,835,041.

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

Class	February 23, 2012
Common Stock, $0.01 par value per share	32,596,685 shares outstanding

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Definitive Proxy Statement relating to the 2012 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

The Private Securities Litigation Reform Act of 1995 provides a safe harbor for forward-looking statements if accompanied by meaningful cautionary statements identifying important factors that could cause actual results to differ materially from those discussed. You should not place undue reliance on these statements, which speak only as of the date of this report. 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. Statements including words such as “expect,” “intend,” “plan,” “believe,” “estimate,” “may,” “anticipate,” “will” or similar statements of a future or forward-looking nature identify forward-looking statements. 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. All forward-looking statements address matters that involve 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 set forth in Item 1A. “Risk Factors” and the other documents that we have filed with the Securities and Exchange Commission.

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 may 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.

Notwithstanding the inclusion of the foregoing cautionary statements, Employers Holdings, Inc. acknowledges that 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

General

Employers Holdings, Inc. (EHI) is a Nevada holding company incorporated in Nevada in 2005. Unless otherwise indicated, all references to "we," "us," "our," the "Company" or similar terms refer to EHI together with its subsidiaries. We had 651 full-time employees at December 31, 2011 and our principal executive offices are located at 10375 Professional Circle in Reno, Nevada.

Our insurance subsidiaries have each been assigned an A.M. Best Company (A.M. Best) rating of "A-" (Excellent), with a "stable" financial outlook.

Our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, current reports on Form 8-K, amendments to those reports, and Proxy Statement for our Annual Meeting of Stockholders are available free of charge on our website at www.employers.com as soon as reasonably practicable after they are electronically filed with 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 stockholders pursuant to Section 16 of the Securities Exchange Act of 1934. In addition, our Corporate Governance Guidelines, Code of Business Conduct and Ethics, Code of Ethics for Senior Financial Officers, and charters for the standing committees of our Board of Directors are available on our website. Copies of these documents may also be obtained free of charge by written request to Investor Relations, 10375 Professional Circle, Reno, Nevada 89521-4802. The SEC also maintains a website at www.sec.gov that contains these materials and other information that we file electronically with the SEC.

Description of Business

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 lowest four 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 that generally requires an employer to provide coverage for its employees' medical, disability, vocational rehabilitation, and death benefit costs for work-related injuries or illnesses. We operate as a single reportable segment and conduct operations in 31 states and the District of Columbia, with more than one-half of our business in California. We had total assets of $3.5 billion, $3.5 billion, and $3.7 billion at December 31, 2011, 2010, and 2009, respectively. The following table highlights key results of our operations for the last three years.

For the Years Ended	Net Premiums Written	Total Revenue	Net Income	Statutory Combined Ratio[1]	
	(in thousands, except ratios)				
December 31, 2011	$410,038	$464,154	$48,313	112.1	%
December 31, 2010	313,098	415,604	62,799	109.8	
December 31, 2009	368,290	495,935	83,021	99.0	

(1) Our combined ratio on a statutory basis is a measure of underwriting profitability. Elsewhere in this report, unless otherwise stated, the term "combined ratio" refers to a calculation based on U.S. generally accepted accounting principles (GAAP).

Our statutory combined ratio for the five years ended December 31, 2010 was 91.3%, compared to the industry composite statutory combined ratio of 110.8% for the same five-year period (calculated by A.M. Best for individual companies that have more than 50% of their business in workers' compensation).

Our insurance subsidiaries are domiciled in the following states:

	State of Domicile
Employers Insurance Company of Nevada (EICN)	Nevada
Employers Compensation Insurance Company (ECIC)	California
Employers Preferred Insurance Company (EPIC)	Florida
Employers Assurance Company (EAC)	Florida

Products and Services

Workers' compensation provides insurance coverage for the statutorily prescribed benefits that employers are required to provide to their employees who may be injured or suffer illness in the course of employment. The level of benefits varies by state, the nature and severity of the injury or disease, and the wages of the injured worker. 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, including expenses related to the diagnosis and treatment of an injury, disease, or both, 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.

Disciplined Underwriting

Our strategy is to 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 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. Our disciplined underwriting approach is a critical element of our culture and has allowed us to offer competitive prices, diversify our risks, and out-perform the industry.

The following table compares our statutory losses and loss adjustment expenses (LAE) ratio, a measure which relates inversely to our underwriting profitability, to the statutory industry composite losses and LAE ratio reported by A.M. Best (calculated for U.S. insurance companies having more than 50% of their premiums generated by workers' compensation insurance products).

	Statutory Losses and LAE Ratio	
Year	EHI	A.M. Best
2006	37.9 %	77.1 %
2007	46.4	77.7
2008	51.4	78.6
2009	57.5	86.1
2010	66.2	87.4
2011	77.6	N/A[1]

(1) Statutory industry composite loss and LAE ratio data is not currently available for 2011.

We execute our underwriting processes through automated systems and experienced underwriters with specific knowledge of local markets. We have developed automated underwriting templates for specific classes of business that produce faster quotes when certain underwriting criteria are met. Our underwriting guidelines consider many factors, such as type of business, nature of operations and risk exposures, and are designed to minimize or prevent underwriting of certain undesirable classes of business.

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 underwriting discipline.

Premium Audit

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

Claims and Medical Case Management

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

Our claims department also provides claims management services for those claims incurred by the Nevada State Industrial Insurance System (the Fund) and assumed by EICN and subject to a 100% retroactive reinsurance agreement (the LPT Agreement) with dates of injury prior to July 1, 1995. Additional information regarding the LPT Agreement is set forth under “–Reinsurance–LPT Agreement.” We receive a management fee from the third party

reinsurers equal to 7% of the loss payments on these claims.

We maintain an exclusive medical provider network in Nevada and make every appropriate effort to direct injured workers into this network for medical treatments. We utilize networks affiliated with Anthem Blue Cross of California (Anthem) and Coventry Health Care, Inc. in other states. 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 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.

We actively pursue fraud and subrogation recoveries to mitigate claims costs. Subrogation rights are based upon state and federal

laws, as well as the insurance policies we issue. Our fraud and subrogation efforts are handled through dedicated units.

Information Technology

Core Operating Systems

We have an efficient, cost-effective and scalable infrastructure that complements our geographic reach and business model and have developed a highly automated underwriting system. This technology allows for the electronic submission, review, and quoting of insurance applications applying our underwriting standards and guidelines. This policy administration system reduces transaction costs and provides for more efficient and timely processing of applications for small policies that meet our underwriting standards. We believe this approach saves our independent agents and brokers considerable time in processing customer applications and maintains our competitiveness in our target markets. 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.

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 off-site data storage facility.

Customers and Workers' Compensation Premiums

The workers' compensation insurance industry classifies risks into seven 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.

We target 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 less costly to service and manage the risks associated with these lower hazard groups. Our underwriters use their local market expertise and disciplined underwriting to select specific types of businesses and risks within the classes of business we underwrite that allow us to generate loss ratios that are consistently better than the industry average.

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	2011	Percentage of 2011 Total	2010	Percentage of 2010 Total	2009	Percentage of 2009 Total
	(in thousands, except percentages)					
A	$70,398	17.9 %	$45,537	14.2 %	$45,683	11.9 %
B	95,783	24.3	74,435	23.2	82,086	21.3
C	145,282	36.9	120,656	37.6	137,973	35.8
D	58,534	14.9	47,906	14.9	54,582	14.2
E	19,094	4.8	24,592	7.7	43,036	11.2
F	4,682	1.2	7,531	2.3	20,131	5.2
G	148	<0.1	480	0.1	1,534	0.4
Total	$393,921	100.0 %	$321,137	100.0 %	$385,025	100.0 %

Our in-force premiums for our top ten types of insureds and as a percentage of our total in-force premiums as of December 31, 2011 were as follows:

Employer Classifications	In-force Premiums	Percentage of Total	
	(in thousands, except percentages)		
Restaurants	$65,644	16.7	%
Dentists, Optometrists, and Physicians	31,836	8.1	
Automobile Service or Repair Shops	26,983	6.8	
Wholesale Stores	19,725	5.0	
Hotels, Motels, and Clubs (Country, Golf, etc.)	18,220	4.6	
Schools – Colleges and Religious Organizations	12,811	3.2	
Gasoline Stations	12,519	3.2	
Real Estate Management	12,109	3.1	
Professional Services	9,582	2.4	
Groceries and Provisions	8,109	2.1	
Total	$217,538	55.2	%

We currently write business in 31 states and the District of Columbia. Our business is concentrated in California, which makes the results of our operations more dependent on the trends that are unique to that state and that from time-to-time may differ from national trends. State legislation, local competition, economic and employment trends, and workers' compensation medical costs trends can be material to our financial results.

As of December 31, 2011, our policyholders had average annual in-force premiums of $6,490. We are not dependent on any single policyholder and the loss of any single policyholder would not have a material adverse effect on our business.

Our total in-force premiums and number of policies in-force by state were as follows as of December 31:

State	2011		2010		2009	
	Premium In-force	Policies In-force	Premium In-force	Policies In-force	Premium In-force	Policies In-force
	(dollars in thousands)					
California	$221,910	36,867	$172,621	29,244	$180,474	27,812
Illinois	24,744	2,433	18,617	932	19,389	801
Georgia	16,393	2,050	10,772	757	12,744	539
Florida	15,226	2,399	15,071	1,963	27,964	2,630
Nevada	14,639	3,718	16,940	3,596	24,050	4,119
Other	101,009	13,226	87,116	8,069	120,404	8,253
Total	$393,921	60,693	$321,137	44,561	$385,025	44,154

The following trends affected our workers' compensation business from 2009 through 2011:

- Premium in-force increased 22.7% during 2011, primarily due to increasing policy count as we continued to execute our growth strategy;
- The decrease in premium in-force during 2010 reflected the impacts of the most recent recession, which particularly affected certain classes of small business, including contractors and restaurants, and declining payrolls due to reduced employment and work hours, closures of small businesses and our continued focus on profitable underwriting despite aggressive pricing in a highly competitive market; and
- The increase in total policies in-force reflects our efforts to continue to grow our business profitably across market cycles.

We cannot be certain how these trends will ultimately impact our consolidated financial position and results of operations.

Our premiums are generally a function of the applicable premium rate, the amount of the insured's payroll, and if applicable, a factor reflecting the insured's historical loss experience (experience modification factor). Premium rates vary by state according to the nature of the employees' duties and the business of the employer. The premium is

computed by applying the applicable premium rate to each class of the insured's payroll after it has been appropriately classified. Total policy premium is determined after applying an experience modification factor and a further adjustment, known as a schedule rating adjustment, which may be made in certain circumstances, to increase or decrease the policy premium. Schedule rating adjustments are made at the discretion of the underwriter based on individual risk characteristics of the insured and subject to maximum amounts as established in our premium rate filings.

Our premium rates are based upon actuarial analyses for each state in which we do business, except in “administered pricing” states, primarily Florida and Wisconsin, where premium rates are set by state insurance regulators.

In California, where over one-half of our premiums are earned, the Workers' Compensation Insurance Rating Bureau (WCIRB) recommends claims cost benchmarks to be used by companies in determining their premium rates. These benchmark rates are advisory only and cover expected loss costs, but do not contain elements to cover operating expenses or profit.

In April 2011, the WCIRB provided an informational filing highlighting the cost drivers that indicated a cumulative 39.8% increase in the claims cost benchmark since January 1, 2009 based on an analysis of December 31, 2010 loss experience. This included deterioration of more than 12 percentage points in the claims cost benchmark since the WCIRB's previous recommendation for a 27.7% increase based on an analysis of June 30, 2010 loss experience. The WCIRB indicated that this further deterioration was due to: (a) continued adverse loss development on the 2009 accident year; (b) high emerging costs on the 2010 accident year, primarily due to increased claims frequency; (c) less optimistic forecasts for statewide wage growth in California; and (d) increased LAE that is likely as a result of certain Workers' Compensation Appeals Board decisions.

In August 2011, the WCIRB modified its benchmark for pure premium rates. The benchmark is now based on the industry average filed pure premium rate, rather than the pure premium rate approved by the California Commissioner of Insurance. The WCIRB submitted its new proposed pure premium rate proposed to be effective January 1, 2012. The WCIRB noted that while 2012 projected costs continue to be below pre-reform highs and the new proposed pure premium rate is slightly less than the industry average filed rate, these new proposed rates reflect significant deterioration in projected losses and LAE and less optimistic economic forecasts, compared to last year.

We set our premium rates in California based upon actuarial analyses of current and anticipated loss trends with a goal of maintaining underwriting profitability. Due to increasing loss costs, primarily medical cost inflation, we increased our filed premium rates in California by a cumulative 33.3% since February 1, 2009.

The following table sets forth the percentage increases to our filed California rates effective for new and renewal policies incepting on or after the dates shown.

Effective Date	Premium Rate Change Filed in California	
February 1, 2009	10.0	%
August 15, 2009	10.5	
March 15, 2010	3.0	
March 15, 2011	2.5	
September 15, 2011	3.9	

Losses and LAE Reserves and Loss Development

We are directly liable for losses and LAE under the terms of insurance policies our insurance subsidiaries write. 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 consolidated balance sheets under the line item caption “unpaid losses and loss adjustment expenses.” Estimating reserves is a complex process that involves a considerable degree of judgment by management and, as of any given date, is inherently uncertain. Loss reserve estimates represent a significant risk to our business, which we attempt to mitigate by continually reviewing loss cost trends and by attempting to set our premium rates to adequately cover anticipated costs.

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 LAE” and Note 8 in the Notes to our Consolidated Financial Statements.

The following tables show changes in the historical loss reserves, on a gross basis and net of reinsurance, at December 31 for each of the 10 years prior to 2011 for EICN and ECIC, and for each of the years ended December 31, 2008 through December 31, 2010 for EPIC and EAC. This information is presented on a GAAP basis and the paid and reserve data is presented on a calendar year basis.

The top line of each table shows the net and 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 and gross reserves re-estimated, respectively) 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. 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.

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2
	(in thousands)										
Net reserves for losses and LAE											
Originally estimated	$887,000	$908,326	$962,457	$1,089,814	$1,208,481	$1,209,652	$1,217,069	$1,430,128	$1,373,153	$1,323,686	$
Net cumulative amounts paid as of:											
One year later	81,022	80,946	91,130	96,661	106,859	109,129	127,912	214,499	206,653	218,569	
Two years later	120,616	130,386	150,391	161,252	175,531	186,014	219,496	342,174	361,048		
Three years later	149,701	165,678	193,766	207,868	229,911	249,059	295,646	449,914			
Four years later	173,204	194,400	226,127	247,217	279,405	302,863	354,867				
Five years later	194,980	218,453	255,851	285,388	321,060	345,801					
Six years later	215,507	242,143	288,039	317,489	354,765						
Seven years later	235,653	269,341	315,180	344,968							
Eight years later	260,036	292,791	338,611								
Nine years later	280,809	313,506									
Ten years later	299,289										
Net reserves re-estimated as of:											
One year later	875,522	847,917	924,878	1,011,759	1,101,352	1,149,641	1,151,246	1,378,769	1,359,023	1,324,813	
Two years later	781,142	805,058	886,711	975,765	1,049,628	1,085,358	1,100,706	1,352,021	1,340,366		
Three years later	742,272	779,373	884,426	954,660	1,004,589	1,035,028	1,079,913	1,319,989			
Four years later	719,912	788,262	877,151	927,382	970,671	1,010,407	1,046,648				
Five years later	730,112	788,481	858,617	900,588	949,446	973,921					
Six years later	730,456	776,329	839,430	883,388	917,843						
Seven years later	720,155	763,988	826,608	855,070							
Eight years later	712,717	755,793	804,958								
	707,037	740,182									

Nine years later											
Ten years later	697,215										
Net cumulative redundancy (deficiency):	189,785	168,144	157,499	234,744	290,638	235,731	170,421	110,137	32,786	(1,127	)–
Gross reserves - December 31	2,226,000	2,212,368	2,193,439	2,284,542	2,349,981	2,307,755	2,269,710	2,506,478	2,425,658	2,279,729	2
Reinsurance recoverable, gross	1,339,000	1,304,042	1,230,982	1,194,728	1,141,500	1,098,103	1,052,641	1,076,350	1,052,505	956,043	9
Net reserves - December 31	887,000	908,326	962,457	1,089,814	1,208,481	1,209,652	1,217,069	1,430,128	1,373,153	1,323,686	1
Gross re-estimated reserves	1,969,508	1,970,936	1,990,684	2,001,243	2,027,729	2,050,177	2,094,050	2,386,424	2,370,646	2,299,653	2
Re-estimated reinsurance recoverables	1,272,292	1,230,754	1,185,726	1,146,173	1,109,886	1,076,257	1,047,402	1,066,435	1,030,280	974,840	9
Net re-estimated reserves	697,216	740,182	804,958	855,070	917,843	973,920	1,046,648	1,319,989	1,340,366	1,324,813	1
Gross reserves for losses and LAE											
Originally estimated	2,226,000	2,212,368	2,193,439	2,284,542	2,349,981	2,307,755	2,269,710	2,506,478	2,425,658	2,279,729	2
Gross cumulative amounts paid as of:											
One year later	128,066	128,462	137,968	142,632	152,006	152,879	170,626	258,412	269,771	260,799	
Two years later	215,176	224,740	243,203	252,379	264,430	272,478	304,146	449,206	466,398		
Three years later	291,099	306,006	331,731	342,748	361,524	377,459	422,862	599,176			
Four years later	360,535	379,881	407,845	424,811	452,955	473,828	522,296				
Five years later	427,307	447,687	480,283	504,918	537,175	556,978					
Six years later	490,296	514,091	554,408	579,585	611,093						
Seven years later	553,103	583,226	624,114	647,276							
Eight years later	619,373	649,241	687,757								
Nine years later	682,656	710,168									

Ten years later	741,301										
Gross reserves re-estimated as of:											
One year later	2,211,566	2,121,867	2,148,829	2,178,514	2,233,077	2,233,176	2,200,689	2,470,746	2,373,479	2,299,653	
Two years later	2,089,850	2,072,205	2,088,437	2,138,648	2,170,292	2,162,695	2,148,399	2,405,837	2,370,646		
Three years later	2,049,340	2,024,790	2,084,764	2,110,481	2,119,764	2,110,615	2,110,230	2,386,424			
Four years later	2,000,560	2,032,553	2,072,428	2,078,223	2,084,854	2,074,466	2,094,050				
Five years later	2,009,608	2,028,211	2,050,124	2,050,937	2,053,869	2,050,177					
Six years later	2,009,480	2,012,943	2,030,945	2,027,187	2,027,729						
Seven years later	1,997,550	2,000,610	2,011,945	2,001,243							
Eight years later	1,990,116	1,986,694	1,990,684								
Nine years later	1,979,480	1,970,936									
Ten years later	1,969,508										
Gross cumulative redundancy (deficiency):	$256,492	$241,432	$202,755	$283,299	$322,252	$257,578	$175,660	$120,052	$55,012	$(19,923	)$

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. Excess of loss reinsurance may be written in layers, in which a reinsurer or group of reinsurers accepts a band of coverage in excess of a specified amount, or retention, and 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 reinsurers' 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. Such reinsurance reduces the magnitude of such losses on net income and the capital of our insurance subsidiaries.

Excess of Loss Reinsurance

Our current reinsurance program applies to all covered losses occurring between 12:01 a.m. July 1, 2011 and 12:01 a.m. July 1, 2012. The reinsurance program consists of one treaty covering excess of loss and catastrophic loss events in five layers of coverage. Our reinsurance coverage is $195.0 million in excess of our $5.0 million retention on a per occurrence basis, subject to a $2.0 million annual aggregate deductible and certain exclusions. We are solely responsible for any losses we suffer above $200.0 million except those covered by the Terrorism Risk Insurance Program Reauthorization Act of 2007 (TRIPRA). 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.

The agreement includes 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; and any loss or damage caused by any act of terrorism involving biological, chemical, nuclear or radioactive pollution or contamination. Our underwriting guidelines generally require that insured risks fall within the coverage provided in the reinsurance program. Any risks written outside the reinsurance program require executive review and approval.

The agreement provides 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.

LPT Agreement

In 1999, Nevada enacted Senate Bill 37. That bill 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%.

The Fund entered into a retroactive 100% quota share reinsurance agreement through a loss portfolio transfer transaction with third party reinsurers. 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 reinsurers' 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, EICN 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 $1.5 billion in liabilities for the incurred but unpaid losses and LAE related to claims incurred prior to July 1, 1995, for consideration of $775.0 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 $2.0 billion, excluding losses for

burial and transportation expenses. The estimated remaining liabilities subject to the LPT Agreement were approximately $807.5 million and $846.7 million, as of December 31, 2011 and 2010, respectively. Losses and LAE paid with respect to the LPT Agreement totaled approximately $569.9 million and $530.7 million through December 31, 2011 and 2010, respectively.

The reinsurers agreed to assume responsibilities for the claims at the benefit levels which existed in June 1999. The LPT Agreement required each reinsurer to place assets supporting the payment of claims by them in a trust that requires 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,

2011 and 2010 was $896.1 million and $962.1 million, respectively.

The reinsurers currently party to the LPT Agreement are ACE Bermuda Insurance Limited, XL Reinsurance Limited, and National Indemnity Company. The contract provides that during the term of the agreement all reinsurers need to maintain a rating of not less than "A-" as determined by A.M. Best. Currently, each of the reinsurers party to the LPT Agreement have a rating of A- or higher.

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 as Deferred reinsurance gain–LPT Agreement (Deferred Gain). The Deferred 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 in our consolidated financial statements.

We are also entitled to receive a contingent profit commission under the LPT Agreement. The contingent profit commission is estimated based on both actual paid results to date and projections of expected paid losses under the LPT Agreement. Since the inception of the agreement, we have recognized approximately $28 million in contingent profit commission. Increases and decreases in the estimated contingent profit 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 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. We monitor the financial strength of our reinsurers and we do not believe that we are currently exposed to any material credit risk through our reinsurance arrangements because our reinsurance is recoverable from generally large, well-capitalized reinsurance companies. At December 31, 2011, $896.1 million was in trust accounts for reinsurance related to the LPT Agreement and an additional $11.6 million, not related to the LPT Agreement, was collateralized by cash or letter of credit.

The following table provides certain information regarding our ceded reinsurance recoverables as of December 31, 2011.

Reinsurer	A.M. Best Rating[1]	Total Paid	Total Unpaid Losses and LAE, net	Total
		(in thousands)		
ACE Bermuda Insurance Limited	A+	$952	$80,754	$81,706
Ace Property & Casualty Insurance Company	A+	—	2,608	2,608
Alterra Bermuda Limited	A	146	3,741	3,887
American Healthcare Indemnity Company	B++	—	2,486	2,486
Aspen Insurance UK Limited	A	55	8,047	8,102
Everest Reinsurance Company	A+	122	2,727	2,849
Finial Reinsurance Company	A-	—	7,221	7,221
Hannover Rueckversicherung-AG	A	98	15,933	16,031
Munich Reinsurance America, Inc	A+	190	9,402	9,592
National Indemnity Company	A++	5,235	444,146	449,381
National Union Fire Insurance Co of Pittsburg	A	72	1,657	1,729
PartnerRe Group	A+	20	1,294	1,314
Relia Star Life Insurance Company	A	68	2,619	2,687
ST Paul Fire & Marine Insurance Company	A+	17	3,915	3,932
Swiss Reinsurance America Corporation	A+	96	12,409	12,505
Tokio Marine & Nichido Fire Insurance Ltd (US)	A++	96	5,859	5,955
Westport Insurance Corporation	A+	52	1,151	1,203
XL Reinsurance Limited	A	3,331	282,638	285,969
Lloyds Syndicates	A	4	44,898	44,902
All Other	Various	175	7,335	7,510

Total	$10,729	$940,840	$951,569

(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, 2011, 0.4% of our reinsurance recoverables on paid losses were greater than 90 days overdue.

Inter-Company Reinsurance Pooling Agreement

Our insurance subsidiaries are parties to an inter-company pooling agreement for statutory reporting purposes. 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%

Transactions under the pooling agreement are eliminated on consolidation and have no impact on our consolidated GAAP financial statements.

Investments

As of December 31, 2011, the total amortized cost of our investment portfolio was $1.8 billion and the fair value of the portfolio was $2.0 billion. These investments provide a source of income, although short-term changes in interest rates and our current investment strategies affect the amount of investment income we earn and the fair value of our portfolio. Our investment strategy balances consideration of duration, yield, and credit risk.

We seek 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. We also utilize Conning's investment advisory services. 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.

Additional information regarding our investment portfolio, including our approach to managing investment risk, is set forth under “Item 7 –Management's Discussion and Analysis of Financial Condition and Results of Operations –Liquidity and Capital Resources –Investments” and “Item 7A –Quantitative and Qualitative Disclosures about Market Risk.”

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, Inc. (ADP) and Anthem Blue Cross of California (Anthem), and through relationships with national and regional trade groups and associations, including the National Federation of Independent Business (NFIB).

Independent Insurance Agents and Brokers

We establish and maintain strong, long-term relationships with independent insurance agencies that actively market our products and services. We offer ease of doing business, provide responsive service, and pay competitive commissions. Our sales representatives and underwriters work closely with independent agencies to market and underwrite our business. This results in enhanced understanding of the businesses and risks we underwrite and the needs of prospective customers. We do not delegate underwriting authority to agents or brokers. We are not dependent on any one agency and the loss of any one agency would not be material.

The following table sets forth the number of independent agencies that marketed and sold our insurance products, the percentage of in-force premiums generated by those agencies, and the percentage of in-force premium generated by our largest agency.

	At December 31,		
	2011	2010	2009
Number of independent agencies	3,742	2,610	2,290
Percentage of in-force premiums generated by independent agencies	75.7 %	77.2 %	80.4 %
Percentage of in-force premiums generated by our largest agency	0.9 %	1.2 %	0.7 %

Strategic Partnerships and Alliances

We have developed important strategic relationships with companies that have established sales forces and common markets to expand our reach to alternative distribution channels. We jointly market our workers' compensation

insurance products with ADP's payroll services and with Anthem's group health insurance plans. Additionally, we have entered into other strategic partnerships and alliances with payroll service providers and insurance brokerages. These relationships have allowed us to access new customers and to write attractive business in an efficient manner, and we are actively pursuing additional strategic partnership and alliance opportunities. We do not delegate underwriting authority to our strategic distribution partners.

Our strategic partnerships and alliances generated 23.8%, 22.1%, and 18.8% of our in-force premiums as of December 31, 2011, 2010, and 2009, respectively.

ADP. ADP is the largest payroll services provider in the United States servicing small and medium-sized businesses. As part of its services, ADP sells our workers' compensation insurance product along with its payroll and accounting services through its insurance agency and field sales staff primarily to small businesses. 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 received 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. The workers' compensation premium is deducted each time ADP processes the policyholders' payrolls along with its 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.

Our relationship with ADP is non-exclusive; however, 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.

Anthem. The Integrated MediComp℠ joint marketing program is an exclusive relationship that allows us to combine our workers' compensation product with Anthem's group health coverage through a single bill in most cases. 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. As the largest group health carrier in California, Anthem has negotiated favorable rates with its medical providers and associated facilities, which we benefit from through reduced claims costs. We pay Anthem fees that are a percentage of premiums received for services provided under the Integrated MediComp program.

Our agreement with Anthem automatically renews for one-year periods unless terminated by either party with at least 60 days notice prior to the expiration of the then current term and has been renewed through January 1, 2013.

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. Policies underwritten directly generated $2.0 million, $2.3 million, and $3.2 million of our in-force premiums at December 31, 2011, 2010, and 2009, respectively.

Competition and Market Conditions

The insurance industry is highly competitive, and there is significant competition in the national workers' compensation industry that is based on price and quality of services. We compete with 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 competitors are significantly larger, are more widely known, and/or possess considerably greater financial resources. Our three primary competitors in California are The Hartford Financial Services Group, Inc., Travelers Insurance Group Holdings Inc., and Meadowbrook Insurance Group, Inc.

Our competitive advantages include our strong reputation in the markets in which we operate, excellent claims service, experienced and professional independent agents and brokers, our strategic partnerships and alliances, and the ease of doing business with us. We also strive to maintain the high quality of our care management services, and to provide consultation services to our agents and insureds on loss prevention and loss reduction strategies. We also compete on price, based on our actuarial analysis of current and anticipated loss cost trends.

The workers' compensation sector continued to see average medical and indemnity claims costs and claim frequency increase in 2010, the most recent year for which industry data is available. We continue to have concerns related to the volatility and uncertainty in the financial markets and current economic conditions, including the high rate of unemployment.

Regulation

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. 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 principles (SAP), 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. California, Florida, and Nevada are currently examining ECIC, EPIC and EAC, and EICN, respectively.

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.

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.

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. All transactions within a holding company system affecting an insurer must have fair and reasonable terms, the charges or fees for services performed must be reasonable, the insurer's total statutory surplus following any transaction must be both reasonable in relation to its outstanding liabilities and adequate for its needs, and the transactions are subject to other standards and requirements established by law and regulation. 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.

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). Under these laws, the respective state insurance departments may examine us at any time, require disclosure of material transactions and require prior notice for, or approval of, certain transactions.

Change of Control. Our insurance subsidiaries are domiciled in Florida, California and Nevada. The insurance laws of these states generally require that any person seeking to acquire control of a domestic insurance company obtain the prior approval of the state's insurance commissioner. 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. 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. In addition, insurance laws in many states in which we are licensed require pre-notification to the state's insurance commissioner of a change in control of a non-domestic insurance company licensed in those states.

Statutory Accounting and Solvency Regulations. State insurance regulators closely monitor the financial condition of insurance companies reflected in financial statements based on SAP and can impose significant financial and operating restrictions on an insurance company that becomes financially impaired under SAP guidelines. State insurance regulators can generally 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.

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 EICN and 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. Additional information regarding financial, dividend, and investment restrictions is

set forth in Note 14 in the Notes to our Consolidated Financial Statements.

Guaranty Fund Assessments. All of the states where our insurance subsidiaries are licensed to transact business require property and casualty insurers doing business within the respective state to 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. Various mechanisms exist in some of these states for assessed insurance companies to recover these assessments. Additional information regarding guaranty fund assessments is set forth in Note 11 to our Consolidated Financial Statements.

Pooling Arrangements. As a condition to conduct business in some states 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.

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. Under the Model Laws, insurers are required to maintain minimum levels of capital based on their investments and operations. These risk-based capital (RBC) requirements provide a standard by which regulators can assess the adequacy of an insurance company's capital and surplus relative to its operations. An insurance company must maintain capital and surplus of at least 200% of the RBC computed by the NAIC's RBC model, known as the “Authorized Control Level” of RBC. At December 31, 2011, each of our insurance subsidiaries had total adjusted capital in excess of the minimum RBC requirements.

The key financial ratios of the NAIC's Insurance Regulatory Information System (IRIS) were developed to assist state regulators in overseeing the financial condition of insurance companies. These ratios are reviewed by financial examiners of the NAIC and state insurance regulators for the purposes of detecting financial distress and preventing insolvency and to select those companies that merit highest priority in the allocation of the regulators' resources. IRIS identifies 13 key financial ratios and specifies a “usual range” for each. Departure from the usual ranges on four or more of the ratios can lead to inquiries from individual state insurance regulators as to certain aspects of an insurer's business. None of our insurance subsidiaries are currently subject to any action by any state regulator with respect to IRIS ratios.

Federal Regulation

We are affected by a variety of federal legislative and regulatory measures and judicial decisions.

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. The 2002 Act was extended by TRIPRA, with the inclusion of 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 or radiological 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 may be provided to the insurance industry for certain acts of foreign and domestic terrorism, including nuclear, biological, chemical or radiological attacks.

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. Small businesses constitute a large portion of our policies, and we monitor the geographic concentration of our policyholders to help mitigate the risk of loss from terrorist acts.

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, 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.

The financial market volatility experienced worldwide that began in 2008 continued into 2011. Although the U.S. and foreign governments have taken various actions to stabilize the financial markets, it is uncertain whether those actions will be effective over the long-term. Therefore, the financial market volatility could continue, resulting in a prolonged negative economic impact.

We cannot predict future market conditions or their impact on our stock price, investment portfolio, or our workers' compensation business. In addition, continuing financial market volatility and economic downturn could have a material adverse affect on our insureds, agents, claimants, reinsurers, vendors, and competitors. Depending on financial market conditions, we could incur additional realized and unrealized losses in the future in our investment portfolio, which could have an adverse effect on our results of operations and financial condition. Selection of customers is more complex as certain businesses are facing unprecedented challenges in sustaining their operations. Over time we expect that recovery from the recession will improve hiring and payroll trends, but we cannot predict when this will occur.

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 legislative reforms. 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 regarding claims emergence and payment patterns, 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 reserves for losses and LAE. As we receive new information and update our assumptions over time regarding the ultimate liability, our loss reserves may prove to be inadequate to cover our actual losses. Any changes in these estimates could be material and could have an adverse effect on our results of operations and financial condition during the period the changes are made.

The insurance business is subject to extensive regulation and legislative changes, which impact the manner in which we operate our business.

Our insurance business is subject to extensive regulation by the applicable state agencies in the jurisdictions in which we operate, most significantly by the insurance regulators in California, Florida, and Nevada, the states in which our insurance subsidiaries are domiciled. As of December 31, 2011, over one-half 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. Insurance regulators have broad regulatory powers designed to protect policyholders and claimants, not stockholders or other investors. Regulations vary from state to state, but typically address or include:

- standards of solvency, including RBC 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 and procedures for adjusting claims;
- 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 for 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 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.

In addition, workers' compensation insurance is statutorily provided for in all of the states in which we do business. State laws and regulations specify the form and content of policy coverage and the rights and benefits that are available to injured workers, their representatives, and medical providers. 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 are administered pricing states. Additionally, we are exposed to the risk that other states in which we operate will adopt administered pricing laws.

Legislation and regulation also impact our ability to investigate fraud and other abuses of the workers' compensation system in the states in which we do business. Our relationships with medical providers are also impacted by legislation and regulation, including penalties for failure to make timely payments.

Federal legislation typically does not directly impact our workers' compensation business, but our business can be indirectly affected by changes in healthcare, occupational safety and health, and tax regulations. Since healthcare costs are the largest component of our loss costs, we may be impacted by changes in healthcare legislation, such as the Affordable Care Act. There is also the possibility of federal regulation of insurance.

This 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 desire to maintain our profitability. In addition, we may be unable to maintain all required approvals or comply fully with applicable laws and regulations, or the relevant governmental authority's interpretation of such laws and regulations. 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.

If we fail to price our insurance policies appropriately, our business competitiveness, financial condition, and 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 could put 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. 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, natural perils, and regulatory conditions in that state.

Our business is concentrated in California, where we generated 56% of our in-force premiums as of December 31, 2011. Accordingly, unfavorable business, economic, demographic, competitive, or regulatory conditions in California could negatively impact our business.

California has been greatly affected by the overall economic downturn and tightening of the credit markets. California is also experiencing budget deficits. 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 and results of operations. California is also exposed to climate and environmental changes, natural perils such as earthquakes, along with the possibility of pandemics or terrorist acts. Accordingly, we could suffer losses as a result of catastrophic events in this state. Because our business is concentrated in this manner, we may be exposed to economic and regulatory risks or risk from natural perils that are greater than the risks associated with greater geographic diversification.

We rely on independent insurance agents and brokers.

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. The loss of a number of our independent agents and brokers or the failure or inability of these agents to successfully market our insurance programs could have a material adverse effect on our business, financial condition and results of operations. 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.

We rely on our principal strategic partners.

We have agreements with two principal strategic partners, ADP and Anthem, to market and service our insurance products through their sales forces and insurance agencies. ADP and Anthem generated 10% and 12%, respectively, of our total in-force premiums as of December 31, 2011. Our agreement with ADP is not exclusive, and ADP may terminate the agreement without cause upon 120 days notice. Although our distribution agreements with Anthem are exclusive, Anthem may terminate its agreements with us if the A.M. Best financial strength rating of ECIC is downgraded and we are not able to provide coverage through a carrier with an A.M. Best financial strength rating of "B++" or better. Anthem 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 could have a material adverse effect on our results of operations. 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 Anthem, as they collect premiums on our behalf for the workers' compensation products that are marketed together with their own products. 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.

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. A reduction in our A.M. Best rating could adversely affect the amount of business we could write, as well as our relationships with independent agents and brokers and 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.

One of our strategic partners, Anthem, 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. 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, Anthem 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 or collect on ceded reinsurance, 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.

At December 31, 2011, we had $952 million of reinsurance recoverables for paid and unpaid losses and LAE of which $11 million was due to us on paid claims.

We purchase reinsurance to protect us against the costs of severe claims and catastrophic events, including natural perils and acts of terrorism, excluding nuclear, biological, chemical, and radiological events. On July 1, 2011, we entered into a new reinsurance program that is effective through June 30, 2012. The reinsurance program consists of one treaty covering excess of loss and catastrophic loss events in five layers of coverage. Our reinsurance coverage is $195 million in excess of our $5 million retention on a per occurrence basis, subject to a $2 million annual aggregate deductible and certain exclusions.

The availability, amount, and cost of reinsurance depend on market conditions and our loss experience and may vary significantly. 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, which could have a material adverse affect on our financial condition and results of operations.

In addition, we are subject to credit risk with respect to our reinsurers, and they may refuse to pay or delay payment of losses we cede to them. We remain liable to our policyholders even if we are unable to make recoveries that we believe we are entitled to under our reinsurance contracts. 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 can recover amounts that we are entitled to, see “Item 1 –Business –Reinsurance.” The inability of any of our reinsurers to meet their financial obligations could have a material adverse affect on our financial condition and results of operations.

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, EICN assumed all of the assets, liabilities, and operations of the Fund, including losses incurred by the Fund prior to such date. EICN 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, see “Item 1 –Business –Reinsurance –LPT Agreement.” 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. As of December 31, 2011, the estimated remaining liabilities subject to the LPT Agreement were $808 million. If we are unable to collect on these reinsurance recoverables, our financial condition and results of operations could be materially adversely affected.

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 one of the reinsurers becomes 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 $33 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, 2011 was $896 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 $649 million at December 31, 2011, in a trust to secure the reinsurer's obligation of $444 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.

Intense competition and the fact that we write only a single line of insurance 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-insured employers, and state insurance funds. Our main competitors 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. Greater financial resources also 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 they offer at a loss in order to obtain other lines of business at a profit. This creates a competitive disadvantage for us, as we only offer a single line of insurance. For example, a business may find it more efficient or less expensive to purchase multiple lines of commercial insurance coverage from a single carrier.

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. We believe the workers' compensation industry currently has excess underwriting capacity resulting in lower rate levels and smaller profit margins.

Because of cyclicality 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 are unable to compete effectively, our business and financial condition could be materially adversely affected.

We may be unable to realize our investment objectives and economic conditions in the financial markets could lead to investment losses.

Investment income is an important component of our revenue and net 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. These and other factors affect the capital markets and, consequently, the value of our investment portfolio.

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

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 or the value of our investments as a result of changes in interest rates, deterioration in the credit of companies in which we have invested, decreased dividend payments, general market conditions, or events that have an adverse impact on any particular industry or geographic region in which we hold significant investments could have an adverse effect on our net income and, as a result, on our stockholders' equity and policyholder surplus.

The valuation of our investments, including the determination of the amount of impairments, include estimates and assumptions and could result in changes to investment valuations that may adversely affect our financial condition and results of operations.

Our estimates 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 use of internally developed valuation techniques may have a material effect on the estimated fair value amounts of our investments and our financial condition.

Additionally, we regularly review our entire investment portfolio, including the identification of other-than-temporary declines in fair 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 we have accurately determined the level of other-than-temporary impairments reflected in our financial statements and additional impairments may need to be taken in the future. Historical trends may not be indicative of future impairments. Additional information regarding the determination of impairments on our investments is set forth under “Item 7 –Management's Discussion and Analysis of Financial Condition and Results of Operations –Investments.”

We may require additional capital in the future, which may not be available to us or may be available only on unfavorable terms.

Our future capital requirements will depend on many factors, including state regulatory requirements, our ability to write new business successfully, and to establish premium rates and reserves at levels sufficient to cover losses. 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, there could be dilution to our stockholders and the securities may have rights, preferences, and privileges senior to the 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 be unable to implement our future growth or operating plans and our business, financial condition, and results of operations could be materially adversely affected.

The capital and credit markets continue to experience volatility and disruption that have negatively affected market liquidity conditions. In some cases, the markets have produced downward pressure on stock prices and limited the availability of credit for certain issuers without regard to those issuers' underlying financial strength. 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 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” and Note 14 in the Notes to our Consolidated Financial Statements. 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.

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 financial 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 use a portion of our cash flow from operations to pay principal and interest on our debt; 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 or cyber attacks on our 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. The failure of any of our systems could interrupt our operations or materially impact our ability to evaluate and write new business. Our information technology and telecommunications systems interface with and depend on third-party systems; and we could experience service denials if demand for such services exceeds capacity or such third-party systems fail or experience interruptions.

Certain events outside of our control, including cyber attacks on our systems, could render our systems inoperable such that we would be unable to service our agents, insureds, and injured workers, or meet certain regulatory requirements. If such an event were to occur and our systems were unable to be restored or secured within a reasonable timeframe, our results of operations and financial condition could be adversely affected. Additionally, cyber attacks, resulting in a breach of security, could jeopardize the privacy, confidentiality, and integrity of our data or our customers' data, which could harm our reputation and expose us to possible liability.

Acts of terrorism and catastrophes 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 (see “Item 1–Business –Regulation –Federal Legislative Changes”) and could suffer substantial losses as a result.
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.
Administrative proceedings or legal actions involving our insurance subsidiaries could have a material adverse effect on our business, financial condition and 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.
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, 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 maintain key man life insurance for our Chief Executive Officer. 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 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 that can be expected to continue in the future in the states in which we operate. Many states also have laws that established second injury funds to provide compensation to injured employees for aggravation of a prior condition or injury, which are funded by either assessments based on paid losses or premium surcharge mechanisms. In addition, as a condition to the ability to conduct business in some states, insurance companies are required to participate in mandatory workers' compensation shared market mechanisms or pooling arrangements, which provide workers' compensation insurance coverage from private insurers. The effect of these assessments and mandatory shared market mechanisms or changes

in them could reduce our profitability in any given period or limit our ability to grow our business.

State insurance laws, certain provisions of our charter documents, and Nevada corporation law could prevent or delay a change of control that could be beneficial to us and our stockholders.

Our insurance subsidiaries are domiciled in Florida, California, and Nevada. The insurance laws of these states generally require that any person seeking to acquire control of a domestic insurance company obtain the prior approval of the state's insurance commissioner. 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. 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. In addition, insurance laws in many states in

which we are licensed require pre-notification to the state's insurance commissioner of a change in control of a non-domestic insurance company licensed in those states. Because we have insurance subsidiaries domiciled in Florida, California, 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 insurance commissioners of these states and may require pre-notification of the change of control. The time required to obtain 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 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 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 fo