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ACTUARIAL AND CLASSIFICATION & RATING COMMITTEES
RECORD OF JOINT MEETING

Not yet reviewed by the Committees and accepted by the Governing Board

A meeting of the Actuarial and Classification & Rating Committees of the Delaware Compensation Rating Bureau, Inc. (DCRB) was held in the Hagley Room of the DoubleTree by Hilton Hotel Downtown, Wilmington Delaware, 700 King Street, Wilmington, Delaware on Wednesday, September 18, 2013 at 10 a.m.

The following members were present:

Actuarial Committee

Ms. M. Gaillard	American Home Assurance Company
Not represented	Amguard Insurance Company
Mr. C. Szczepanski*	Donegal Mutual Insurance Company
Mr. A. Becker	Harleysville Mutual Insurance Company
Mr. S. Walsh	Liberty Mutual Insurance Company
Mr. K. Brady	PMA Insurance Company

Classification and Rating Committee

Mr. I. Feuerlicht	American Home Assurance Company
Mr. D. Hershman	Home Builders Association of Delaware
Mr. K. Van Elswyk*	Insurance Company of North America
Ms. S. Knight	Liberty Mutual Insurance Company
Mr. R. Edmunds	PMA Insurance Company
Not represented	Travelers Property & Casualty Company
Mr. J. Binkowski	XL Insurance Company
Mr. T. Wisecarver	Chair - Ex Officio

Also present were:

Ms. R. West	Delaware Insurance Department
Mr. J. Rhoades*	Delaware Health Care Advisory Panel
Mr. L. Dotsun*	Delaware Association/Insurance Agents & Brokers
Mr. S. Cooley	Duane Morris LLP
Mr. A. Schwartz	AIS Risk Consultants
Mr. R. Gardner	INS Consultants, Inc.
Mr. J. Pedrick	INS Consultants, Inc.
Ms. F. Barton	DCRB Staff

Ms. D. Belfus	DCRB Staff
Mr. K. Creighton	DCRB Staff
Mr. B. Decker	DCRB Staff
Mr. M. Doyle	DCRB Staff
Mr. P. Yoon	DCRB Staff

* Present for part of meeting

The Antitrust Preamble applicable to this meeting and private conversations occurring in the course of the meeting was read for all attendees. Participants gave brief self-introductions.

Staff provided some background and highlights of the analysis done for the December 1, 2013 Residual Market Rate and Voluntary Market Loss Cost Filing. Points addressed and emphasized included the following:

- The preliminary indicated overall average changes in rating values were for an increase of 39.50 percent in residual market rates and 42.75 percent in voluntary market loss costs.

- Savings from Senate Bill 238 of 2012 (SB238) were estimated to be approximately 0.42 percent of medical loss costs and 0.29 percent of total loss costs.

- Savings from House Bill 175 of 2013 (HB175) were estimated to be approximately 5.99 percent of medical loss costs and 4.20 percent of total loss cost. Staff expressed the expectation that this estimate would be refined as rapidly as possible to address information concerning some recent regulatory changes that had been obtained too late for incorporation into the meeting discussion materials.

- Medical experience (limited medical losses, limited medical trend and medical excess losses in combination) produced an indicated increase in residual market rates of approximately 22.61 percent.

- Indemnity loss experience (limited indemnity losses, limited indemnity trend and indemnity excess losses) accounted for an indicated increase in residual market rates of approximately 10.65 percent.

- Loss adjustment expenses contributed approximately 4.17 percent to the filing indication for residual market rates.

- Expense needs in the residual market resulted in a decrease of approximately 1.61 percent in residual market rates.

- The anticipated July 1, 2014 benefit change added approximately 0.32 percent to the overall residual market rate change.

Statutory requirements pertaining to the DCRB's rating value filings, processes and procedures applicable to the preparation and review of such proposals, including changes enacted as part of HB 175, were described to attendees.

The Committee discussion then moved to a review of staff work supporting the December 1, 2013 Residual Market Rate and Voluntary Market Loss Cost Filing. The discussion focused on a series of analytical steps supporting the derivation of the indicated overall changes in rating values. Each analytical step was supported by cited exhibits provided in the agenda materials for the filing. Key concepts derived from that supporting analysis were presented in the form of discussion exhibits provided in hard copy at the meeting and projected on a screen display to facilitate review of those points.

Staff encouraged interactive questions and comments as the meeting progressed. The more substantive elements of dialogue precipitated during the meeting in that regard are set forth as inserted Question, Comment and/or Answer exchanges in the description of the meeting proceedings following below.

ITEM (1) REVIEW OF THE INDICATED DECEMBER 1, 2013 RESIDUAL MARKET RATE AND VOLUNTARY MARKET LOSS COST FILING

EVALUATION OF IMPACTS OF SENATE BILL 238 OF 2012 AND HOUSE BILL 175 OF 2013

In conformance with provisions of HB 175 of 2013, the DCRB's filing analysis had explicitly and individually accounted for the impact of statutory changes contained in or authorized by HB 175 of 2013 or SB 238 of 2012. The impacts so identified were summarized as follows:

- SB 238 of 2012 revised the basis for hospital reimbursement rates from 85 percent of charges to 80 percent of charges, reduced reimbursement rates for emergency services from 100 percent of charges to 80 percent of charges, and established procedures to be used in determining allowable reimbursement rates for hospitals, emergency services and ambulatory surgical centers on a going forward basis.

  The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately 17 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 2.52 percent, resulting in an estimated reduction to medical expenditures of 0.42 percent.

- §2322B (3) (i) set fee schedule amounts for pathology, laboratory, and radiological services and durable medical equipment at 85 percent of 90 percent of the 75th percentile of actual charges, instead of the previous standard of 90 percent of the 75th percentile of actual charges.

  19 DE Admin. Code Section 1341, Paragraphs 4.12.1, 4.12.2, 4.26.1.1.1, 4.26.1.1.2, 4.26.1.3.5, 4.27.1.1.1, 4.27.1.1.2, 4.29.1, 4.29.2, 4.29.3, 4.29.4

  ****The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately seven percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 4.3 percent, resulting in an estimated reduction to medical expenditures of 0.3 percent.

- §2322B (12) directed that the formulary and fee methodology system developed by the Health Care Advisory Panel for pharmacy services, prescription drugs and other pharmaceuticals include a mandated discount from average wholesale price, a ban on repackaging fees, and adoption of a preferred drug list by September 1, 2013.

  19 DE Admin. Code Section 1341, Paragraphs 4.13.1, 4.13.2, 4.13.2.1, 4.13.2.2, 4.13.2.3, 4.13.3, 4.13.4, 4.13.5, 4.13.6, 4.13.7, 4.13.8, and 4.30

  The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately ten percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 4.6 percent, resulting in an estimated reduction to medical expenditures of 0.5 percent.

- §2322B (11) directed the Health Care Advisory Panel to adopt and recommend a reimbursement schedule for pathology, laboratory and radiological services and durable medical equipment (see also §2322B (3) (i) above) and to implement a specific limitation on drug screenings absent Pre-authorization and a specific limitation on per-procedure reimbursements for drug testing.

  19 DE Admin. Code Section 1341, Paragraphs 4.27.1.1.5

  The DCRB had determined that the drug screening services addressed by the above statutory and administrative code provisions represented approximately 0.5 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 65.5 percent, resulting in an estimated reduction to medical expenditures of 0.3 percent.

- §2322B (7) directed the Health Care Advisory Panel to implement a specific cap on fees for anesthesia by January 1, 2014.

  19 DE Admin. Code Section 1341, Paragraphs 4.20.1.1

  The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately two percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 20.3 percent, resulting in an estimated reduction to medical expenditures of 0.5 percent.

- HCAP changes to Fee Schedule

  During 2013 the Health Care Advisory Panel used information provided by the DCRB and obtained from other resources to develop fee schedule amounts for services previously published as “POC85” in the Delaware fee schedule. The DCRB had determined that the services addressed by those changes represented approximately 20 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30,

2012. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 2.8 percent, resulting in an estimated reduction to medical expenditures of 0.6 percent.

- Hot and Cold Pack Therapy

  19 DE Admin. Code Section 1342, Part B, Paragraph 6.4.12.8, Part C, Paragraph 6.10.8, Part D, Paragraph 5.10.8, Part E, Paragraph 6.10.8, Part F, Paragraph 5.10.8, Part G, Paragraph 6.15.10.3

  DCRB staff had understood that changes under review for these forms of therapy would eliminate such charges when they would be billed in conjunction with defined ranges of other CPT code services. Based on that understanding, the DCRB estimated that the services addressed by the above statutory and administrative code provisions represented approximately one percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012, and that the proposed changes would reduce expenditures for those subject services by approximately 97.9 percent, resulting in an estimated reduction to medical expenditures of 1.1 percent.

Actual changes adopted in treatment guidelines reduced the maximum numbers of visits for which hot and cold pack therapies could be provided and billed from either 24 or 18 to 12 but did not preclude separate billing for those services during the allowable numbers of visits. DCRB believes that the changes adopted will have somewhat less impact on the cost of Delaware workers compensation medical services than the approach which was evaluated for the filing, but this difference was discovered too late to be able to revise savings estimates while still complying with the filing deadline established by HB 175 of 2013. The DCRB will amend its estimates as soon as possible after the submission of the filing. The impacts of estimates of system changes that will be revised and/or added in this process are expected to be fractions of the estimates submitted with the DCRB's initial filing.

- §2322B (3) (v) provided that the health care payment system in Delaware not be adjusted for inflation between July 1, 2013 and January 1, 2016 and required that subsequent adjustments to the health care payment system not recoup the adjustments thus foregone.

  No Administrative Code Language

  The DCRB estimated the effects of this provision separately for four partitions of the medical expenditures reported through the Medical Data Call for the period July 1, 2010 through June 30, 2012. Those partitions and the evaluation of the effects of this provision were set forth as follows:

  <u>Professional services subject to specified fee amounts under the health care payment system implemented in 2008:</u>

  The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately 33 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012. Based on historical changes in the CPI-U index used to adjust the fee amounts for such services, the changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 2.2 percent.

Professional services reimbursable at 85 percent of charge under the health care payment system as revised in 2013:

The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately seven percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012. Based on historical changes in the CPI-U index used to adjust the fee amounts for such services, the changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 1.8 percent.

Other professional services:

The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately 20 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012. Based on historical changes in the CPI-U index used to adjust the fee amounts for such services, the changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 1.7 percent.

Hospital and ambulatory surgical centers:

Hospital reimbursements are regulated under procedures adopted under SB 238 of 2012, which compare changes in overall hospital charges to the prescribed statutory change (generally a change in a specified consumer price index value) and adjust the percentage factor applied against hospital charges to compute allowable reimbursements.

Ambulatory Surgical Center reimbursements are regulated under procedures adopted under SB 238 of 2012, which compare changes in each ambulatory surgical center's overall charges to the prescribed statutory change (generally a change in a specified consumer price index value) and adjust the percentage factor applied against that ambulatory surgical center's charges to compute allowable reimbursements

The DCRB had determined that hospital and ambulatory surgical centers services represented approximately 30 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012.

Using methodologies applied by the Department of Labor in prior revisions to hospital and ambulatory surgical center reimbursement levels, the DCRB estimated that the changes recently accomplished would reduce expenditures for those subject services by approximately 5.7 percent.

Overall, the DCRB estimated that the respective savings to medical cost described above for each partition of the medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012 would result in savings of approximately 2.9 percent of total medical expenditures.

- §2322B (8) changed the index applicable to revision of hospital reimbursement rates from CPI-Medical to CPI-U, provided that no increases to hospital reimbursement rates would be permitted between July 1, 2013 and January 1, 2016 and required that subsequent adjustments to hospital reimbursement rates not recoup the adjustments thus foregone.

No Administrative Code Language

DCRB staff was not able to complete its assessment of this change in time to reflect it in its initial assessment of changes enacted by or stemming from HB 175. Specific accounting for individual features of such system changes is required for the DCRB's December 1, 2013 filing, and the DCRB will advise the Insurance Commissioner of the status of those estimates in the filing that will be submitted on or before September 25, 2013. The DCRB will then amend its estimates as soon as possible after the submission of the filing. The impacts of estimates of system changes that will be revised and/or added in this process are expected to be fractions of the estimates submitted with the DCRB's initial filing.

- Code Section 1341, Paragraph 4.13.3 provides the following language pertinent to repackaging of prescription drugs or medicines:

  > Notwithstanding any other provision, if a prescription drug or medicine has been repackaged, the Average Wholesale Price used to determine the maximum reimbursement in controverted and uncontroverted cases shall be the Average Wholesale Price for the underlying drug product, as identified by its national drug code, from the original labeler.

  DCRB staff became aware of this change too late to reflect it in its initial assessment of changes enacted by or stemming from HB 175. Specific accounting for individual features of such system changes is required for the DCRB's December 1, 2013 filing, and the DCRB will advise the Insurance Commissioner of the status of those estimates in the filing that will be submitted on or before September 25, 2013. The DCRB will then amend its estimates as soon as possible after the submission of the filing. The impacts of estimates of system changes that will be revised and/or added in this process are expected to be fractions of the estimates submitted with the DCRB's initial filing.

- Code Section 1341, Paragraph 4.13.5 provides the following language pertinent to the use of specified narcotic drugs:

  > As of the effective date of this Regulation, Oxycontin as well as oxycodone extended release; and Actiq, as well as transmucosal fentanyl, are not on the Preferred or Non-Preferred Medication List and may only be used with prior written approval of the employer or its insurance carrier. However, an employee on a stable dose of Oxycontin prior to the effective date of this Regulation may continue the use of this medication after the effective date of this Regulation.

  DCRB staff became aware of this change too late to reflect it in its initial assessment of changes enacted by or stemming from HB 175. Specific accounting for individual features of such system changes is required for the DCRB's December 1, 2013 filing, and the DCRB will advise the Insurance Commissioner of the status of those estimates in the filing that will be submitted on or before September 25, 2013. The DCRB will then amend its estimates as soon as possible after the submission of the filing. The impacts of estimates of system changes that will be revised and/or added in this process are expected to be fractions of the estimates submitted with the DCRB's initial filing.

- §2322B (9) (c) directed the Health Care Advisory Panel to develop a system of maximum allowable payments for Ambulatory Surgical Centers that would be cost-neutral with respect to existing allowable payments for such facilities.

  Administrative Code changes pending

  As the forthcoming payment provisions for Ambulatory Surgical Centers are intended to be revenue-neutral, the DCRB has not included any estimated impacts for such changes in the derivation of its December 1, 2013 residual market rate and voluntary market loss cost filing.

- §2322B (9) (d) provided that no increases to allowable reimbursement rates for Ambulatory Surgical Centers would be permitted between July 1, 2013 and January 1, 2016 and required that subsequent adjustments to Ambulatory Surgical Center reimbursement rates not recoup the adjustments thus foregone.

  No Administrative Code Language

  The DCRB had included ambulatory surgical centers in its estimation of the effect of freezing fee schedule provisions under 2322 (B) (3) (v) above.

- §2322B (14) reiterated the prohibition on adjustments of the payment system for inflation between July 1, 2013 and January 1, 2016 or recoupment of the adjustments thus foregone in later adjustments to the payment system.

  No Administrative Code Language

  The DCRB had included ambulatory surgical centers in its estimation of the effect of freezing fee schedule provisions under 2322 (B) (3) (v) above.

Question: ***The observation was made that on Exhibit 12, the estimated impacts for Senate Bill 1 of 2007, SB 238 of 2012 and HB 175 of 2013 were all shown together. A question arose as to what the effective dates of those serial changes were.***

Answer: ***The principal provisions of Senate Bill 1 of 2007 were implemented in late 2008, and the DCRB's filings since that date had been prepared by adjusting experience data falling after the effective date of the law to a pre-Senate Bill 1 basis.***

SB 238 of 2012 was effective January 31, 2013. While HB 175 of 2013 was effective June 27, 2013, the various changes to the healthcare payment system either included in or authorized by the bill had various effective dates in 2013 and 2014. The filing's premise was that the cumulative impact of all those changes since the December 1, 2012 filing would be included in the DCRB's December 1, 2013 filing. Staff expressed the view that this approach would be significantly simpler for carriers and employers than having a series of rating value changes responsive to components of the several recent changes and that the intended approach was consistent with the language of HB 175 of 2013.

Question: ***Staff was asked whether all of the changes that had been discussed were the results of legislation and/or regulatory changes that had been made and adopted in final form.***

Answer: ***Attendees were advised that all of the supporting regulations that the DCRB would be evaluating for the filing had been passed, and most of those had also already been implemented. It was noted that development of a revised reimbursement system for The Ambulatory Surgical Centers remained in progress but that the legislative intent of those changes was that they be revenue-neutral.***

LOSS DEVELOPMENT

The topic of loss development was described as being presented in the work contained in the following meeting exhibits:

Exhibit 1: Table I – Summary of Financial Call Data
Exhibit 1a: Excess Loss Factor and Policy Year Loss Limitations
Exhibit 1b: Reported Losses in Excess of Loss Limitations

Exhibit 2: Paid and Incurred Loss Development and Trend
Exhibit 2a: Graphs of Selected Loss Development Projections

Staff noted that, consistent with numerous recent Delaware filings, loss development and trend analysis had been performed on a limited basis in order to mitigate potential effects of individual large claims or clustering of such claims within individual policy years. In recognition of this approach, a separate provision for excess loss was included in the derivation of rate and loss cost change indications.

Attendees were reminded of Senate Bill 1 enacted in 2007 in Delaware, which provided for processes related to the development of a medical fee schedule and treatment guidelines. In a prior filing (Bureau Filing No. 0806) the DCRB had evaluated the effects of the medical fee schedule that had subsequently been implemented in Delaware, and rating values effective on or after October 1, 2008 had reflected that estimated impact. For the December 1, 2013 filing, experience had been adjusted to a pre-Senate Bill 1 basis for purposes of such analyses as loss development and trend, and then a Senate Bill 1 Law Amendment Factor had been applied to the resulting indications to derive a December 1, 2013 indication.

Discussion Exhibit, Page 2 - Reported Incurred Losses Above Selected Loss Limits

This exhibit was offered with the following specific observations:

- With selected loss limits ranging from approximately $925,000 for Policy Year 1997 to slightly more than $2,300,000 for Policy Year 2012, most policy years included at least some losses in excess of the applicable limits.

- The effects of the selected loss limitations were significant for many policy years

- A substantial majority of the impact of selected loss limitations on reported losses occurred with respect to medical losses

***Question**: An attendee noted that Policy Years 2009 and 2010 showed relatively high amounts of losses reported in excess of the applicable loss limitation(s). Staff was asked if it knew how much of that result was due to extraordinary claims rather than inflation and other similar pressures on routine treatments.*

***Answer**: Staff observed that the loss limitation process was intended to address especially large cases and explained that all of the losses removed by virtue of those limitations were associated with large individual claims.*

***Question**: The attendee wondered about the extent to which cases exceeding the applicable loss limitations could be anticipated and/or planned for.*

***Answer**: The response indicated that the effects of large losses on experience needed to be evaluated over the long term. While some years would show relatively little data for large claims, other years might show much larger effects. The intent of the loss limitation procedure was to provide a more stable provision for large losses over a series of filings and coverage periods.*

***Question**: Staff was asked how the excess loss provision was established.*

***Answer**: The explanation focused on the use of size-of-loss distributions accumulated over a period of policy years and then smoothed using various statistical distributions and/or mathematical models. The selected loss distribution could then be used to compute the portion of losses expected to fall above various selected loss limitation levels.*

***Question**: It was observed that the discussion exhibit presented dollars of loss but not numbers of claims involved in the losses above the applicable limits. Staff was asked for the numbers of claims form which the excess loss amounts had been removed.*

***Answer**: The following counts of claims reported above the applicable loss limits by policy year were read to all attendees: 2012 - 0, 2011 - 3, 2010 - 3, 2009 - 1, 2008 - 1, 2007 - 2, 2006 - 0, 2005 - 1, 2004 - 4, 2003 - 4, 2002 - 9, 2001 - 2, 2000 - 11, 1999 - 5, 1998 - 2 and 1997 - 8.*

***Question**: Clarification was sought as to whether the years cited were calendar or policy years.*

***Answer**: Confirmation was given that the claims were grouped by policy year.*

***Question**: A further question was posed concerning whether the counts of claims now reflected on the discussion exhibit would be expected to grow over time.*

***Answer**: The reply noted that, as payments and case reserves evolved over time, reported loss amounts for a given policy year did tend to increase. As a result, it would be likely that some additional claims might pierce the applicable claim limits in future reporting periods.*

***Question**: An attendee wondered whether the impacts of large claims had been greater or lower than average for the four Policy Years 2008 through 2011, which served as the starting point in trending loss ratios for the determination of the rate change indication.*

Answer: ***Staff explained that in deriving the size-of-loss distributions the most recent five available years were reviewed, but the three most mature policy years (2006, 2007 and 2008 for the December 1, 2013 filing) were relied upon in developing the size-of-loss distributions.***

Comment: ***It was observed that Policy Years 2008 through 2011 were not very mature and that this immaturity might present problems in deriving or applying size-of-loss distributions for a small state like Delaware.***

Comment: ***Another attendee expressed interest in knowing how the last four policy years would compare to previous years in terms of the amounts and proportions of excess loss reflected in the data and suggested by the loss distributions derived from a longer term average.***

Answer: ***Staff explained that the size-of-loss distributions were developed using a procedure that developed open claims in amounts sufficient to make aggregate loss amounts consistent with the estimated ultimate loss by policy year. This approach was thought to be preferable to an alternative that might develop all claim amounts regardless of their open or closed status, but it was acknowledged that any small number of policy years would be unlikely to report experience closely replicated by the selected loss distribution. This volatility was, in fact, a key inspiration for the size-of-loss analysis in the first place.***

Question: ***An attendee asked whether the methodology applied by the DCRB to the derivation of excess loss factors had changed and, if so, when.***

Answer: ***Staff advised that the current procedure had been in place since 2009.***

A set of eight discussion exhibits were next presented serially, illustrating comparisons between loss development link ratios reported for the most recent available calendar year (December 31, 2011 to December 1, 2012) and counterpart ratios for the Calendar Year December 31, 2007 to December 31, 2008). The significance of these two calendar years was described in the context of the DCRB using a four-year average of age-to-age link ratios as the basis for its loss development analysis. Under this construct the 2011–2012 Year was being added to the analysis of the December 1, 2013 filing, while the 2007–2008 Year was being dropped from this year's filing. With the remaining three intervening calendar years being common to both the December 1, 2012 and December 1, 2013 filings, the comparisons illustrated on the discussion exhibits effectively highlighted the general change in indicated loss development for the current filing.

Key findings gleaned from the discussion exhibits as presented were as follow:

Discussion Exhibit, Page 3 – Indemnity Paid Link Ratios Less Unity

At early maturities (1st through 6th reports) indemnity paid loss development was consistently higher for the 2011–2012 Year than had been the case for the 2007–2008 Year.

Discussion Exhibit, Page 4 – Indemnity Paid Link Ratios Less Unity

At extended maturities (7th and later reports) indemnity paid loss development was generally lower for the most recent year for maturities to 11th report, with comparisons for later maturities being mixed as to whether 2011-2012 or 2007-2008 showed higher loss development. Staff pointed out that the 2007-2008 Year had not included reports for a 23rd maturity.

Together, Discussion Exhibits Pages 3 and 4 suggested that indemnity paid loss development may have increased somewhat for newer policy years in the December 1, 2013 filing, as compared to the data underlying the December 1, 2012 filing.

Discussion Exhibit, Page 5 – Incurred Indemnity Link Ratios Less Unity

Three of the earliest five link ratios shown were higher for the 2011-2012 Year than for the 2007-2008 Year, with all of the observed differences being nominal.

Discussion Exhibit, Page 6 – Incurred Indemnity Link Ratios Less Unity

At extended maturities (7th and later reports) incurred indemnity loss development was generally mixed as to whether 2011-2012 or 2007-2008 showed higher loss development. Similarly to the indemnity paid loss development, the 2007-2008 Year had not included reports for a 23rd maturity. The "beyond" tail factor for the 2007-2008 Year had been adjusted for purposes of comparison to the December 1, 2013 analysis.

Together, Discussion Exhibits Pages 5 and 6 suggested that incurred indemnity loss development had been relatively stable in the December 1, 2013 filing, as compared to the data underlying the December 1, 2012 filing.

Discussion Exhibit, Page 7 – Medical Paid Link Ratios Less Unity

At early maturities (1st through 6th reports) medical paid loss development was higher for the 2011–2012 Year than had been the case for the 2007–2008 Year for four of the five development periods.

Discussion Exhibit, Page 8 – Medical Paid Link Ratios Less Unity

At extended maturities (7th and later reports) medical paid loss development was generally mixed as to whether 2011-2012 or 2007-2008 showed higher loss development, although earlier maturities tended to show higher values for 2011-2012, and later maturities tended to show higher values for 2007-2008. Staff pointed out that the 2007-2008 Year had not included reports for a 23rd maturity.

Together, Discussion Exhibits Pages 7 and 8 suggested that medical paid loss development had increased somewhat for early maturities in the December 1, 2013 filing, as compared to the data underlying the December 1, 2012 filing.

Discussion Exhibit, Page 9 – Incurred Medical Link Ratios Less Unity

The middle three of the five development factors shown were higher for 2007-2008, while the earliest and latest factors from this group were higher for 2011-2012.

Discussion Exhibit, Page 10 – Incurred Medical Link Ratios Less Unity

At extended maturities (7th and later reports) incurred medical loss development was somewhat mixed with respect to differences between 2011-2012 and 2007-2008 development. As was true for earlier Discussion Exhibit pages, the 2007-2008 Year had not included reports for a 23rd maturity. The "beyond" tail factor had been adjusted for purposes of comparison to the December 1, 2013 analysis.

Together, Discussion Exhibits Pages 9 and 10 suggested that incurred medical loss development may have been slightly favorable in the December 1, 2013 filing, as compared to the data underlying the December 1, 2012 filing.

***Question**: An attendee inquired as to why the presentations under discussion used the age-to-age factors less one.*

***Answer**: Staff explained that this approach allowed use of a more expanded scale for the graphs and provided greater visibility of differences found between the selected development periods' experience.*

***Question**: A question was presented about alternative ways of presenting the impact of loss development on the projected ultimate losses and, in turn, the filing indication. A suggestion was made that development factors from the prior filing could be applied to the most recent reported paid and incurred losses to drive estimates that could be compared to those produced by the updated loss development work.*

***Answer**: It was noted that changes in the loss limitations used in successive filings might affect the analysis. Additional possibilities for exploring loss development results might include comparing ultimate loss projections from the current and prior filings, adjusting those of the prior filing for approved changes in rating values.*

***Comment**: The inquiring attendee stated that comparing ultimate loss ratios might be helpful and suggested using reported loss ratios and applying development factors to them. Another approach would be to separate the effects of changes in reported amounts from the impacts of revisions to the loss development factors alone.*

***Answer**: Staff opined that changes in both reported amounts and development factors did and should contribute to the updated loss estimates supporting each successive filing.*

***Comment**: Comparing medical loss experience reported by insurance companies to the ultimate losses arrived at using the DCRB's loss development approach was suggested as a test of the latter amounts.*

***Answer**: The 2011 - 2012 lines on the link ratio graphs were described as showing the actual loss development results from the most recent available period and the period most significantly affecting the ultimate loss estimates and the filing indication.*

***Comment**: An attendee added that the other factor in the differences between filing analyses issue was the oldest year of development from the previous filing being dropped from the current analysis.*

***Answer**: The response confirmed that both components of the discussion exhibits were important factors in arriving at the filing indications.*

***Comment**: A committee member noted that, as claims tended to remain open longer, higher paid loss development factors would likely result.*

***Answer**: Staff agreed, observing that, when settlement rates slowed down, both paid and incurred loss development factors would be likely to increase.*

***Question**: An attendee asked how carriers would report a claim for which no indemnity payments were ongoing or expected but with some continuing medical payments. Specifically, the question asked was whether such a claim would be considered "open" or "closed." Interest was also expressed in knowing what types of claims were contributing disproportionately to the observed extension of claim duration in Delaware.*

***Answer**: The explanation offered stated that the approved Statistical Plan did not include qualifications about separate types of benefits that might be considered "open" or closed." If a claim presented the expectation for some future payment(s), staff expected that the claim would be reported as "open." Analysis had been performed confirming the issuance of payments on a substantial majority of open claims subsequent to selected reports which identified the claims as being open, but that work had not differentiated between different types of payments. The possibilities of claim durations expanding in general or of claims migrating from one type to another with inherently longer durations were acknowledged.*

***Question**: Inquiry was made as to whether the development factors obtained from the age-to-age factors illustrated in the discussion exhibits were applied to open claims or to all claims.*

***Answer**: For the estimation of ultimate losses and loss ratios supporting the filing, loss development factors were derived from aggregate financial data and were applied to all losses. To the extent that claims remain open for longer periods of time than had previously been the case, they would be expected to contribute higher amounts to the reported paid and incurred loss development, but the DCRB was not differentiating between open and closed claims in its calculation of loss development factors or application of those factors to reported data.*

***Question**: An attendee observed that the factors being shown in the discussion exhibits were age-to-age factors and inquired what the cumulative effects of the differences shown had been.*

***Answer**: Staff indicated that the separate age-to-age factors had been used to derive cumulative development patterns and factors. Consistent with prior meeting discussion, the cumulative factors for this filing could be compared to those of the previous filing.*

***Comment**: Interest was expressed in knowing how loss development had impacted the rate change indication.*

***Answer**: It was noted that the four-year averages for loss development from the current filing and the 2012 filing would illustrate the effect of interest.*

***Comment**: An attendee confirmed that the link ratio exhibits from the respective filings could be reviewed as a means of gaining insight into the magnitude of changes that had occurred.*

Once indicated limited loss link ratios had been derived from reported data, the filing analysis had applied various curve fits to the observed factors less unity to smooth the loss development patterns.

Discussion Exhibit Page 11 – Limited Loss Development Analysis – Curves Fitted to Age-to-Age Loss Development Factors less Unity presented the following curve forms that had been selected as best accomplishing the objective without changing the overall level of observed development or reflecting an unreasonable shape or other behavior when extrapolated into an extended period of future reporting:

Indemnity Incurred Development Factors:

$y = a + b/x + c/(x^2) + d/(x^3) + e/(x^4)$ (fourth order inverse polynomial)

Indemnity Paid Development Factors:

$y = a + b/x + c/(x^2) + d/(x^3) + e/(x^4) + f/(x^5)$ (fifth order inverse polynomial)

Medical Incurred Development Factors:

$y = a + b/x + c/(x^2) + d/(x^3) + e/(x^4) + f/(x^5)$ (fifth order inverse polynomial)

Medical Paid Development Factors:

$y = a + b/x + c/(x^2) + d/(x^3) + e/(x^4) + f/(x^5)$ (fifth order inverse polynomial)

The need for factors converting from paid to case- incurred losses in completing the paid loss development estimates for both indemnity and medical losses was noted. For those purposes staff had applied the most recent actual four-year average paid-to-incurred age-to-age factors at the maturity at which this transition was made.

Discussion Exhibit Page 12 – Indemnity Paid & Incurred Ultimate Limited Loss Ratios by Policy Year presented the results of applying paid loss and case-incurred loss development methods to indemnity losses for the December 1, 2013 filing. This exhibit illustrated the fact that differences between these approaches were very modest with the paid loss development method tending to produce slightly higher results for Policy Years 2008 and 2011.

Discussion Exhibit Page 13 - Medical Paid & Incurred Ultimate Limited Loss Ratios by Policy Year presented the results of applying paid loss and case- incurred loss development methods to medical losses for the December 1, 2013 filing. This exhibit showed somewhat larger differences between these methods than had occurred for indemnity benefits, with the case-incurred method generally producing somewhat higher results than did the paid loss development approach. These observed differences were consistent with those of prior filings including the December 1, 2012 filing.

CLAIM FREQUENCY TREND

The topic of claim frequency was presented in the work contained in the following meeting exhibits:

Exhibit 23: Claim Frequencies
Exhibit 12: Indicated Change in Residual Market Rates and Voluntary Market Loss Costs (page 4)

Policy Year 2011 had now been reported and showed a decline of 7.6 percent in frequency. Despite this most recent value, the trends in claim frequency measured over periods longer than four years (three successive changes) were lower for the December 1, 2013 filing than those underlying the December 1, 2012 filing. This tendency resulted in part from a downward revision in the estimated claim frequency improvement for Policy Year 2010 between the 2012 and 2013 filings.

Discussion Exhibit Page 14 – Unit Statistical Plan Indemnity Claim Frequencies was reviewed, illustrating the nature of claim frequency declines in Delaware.

Using a seven-point exponential fit through the claim frequencies presented in Exhibit 23, staff had derived an annual claim frequency trend rate of -5.1 percent. It was noted that the claim frequency trend supporting the December 1, 2012 filing had been -6.5 percent.

Staff further observed that claim frequencies calculated using counts of work injuries, including all commercially insured accounts together with self-insured entities tabulated by the Delaware Department of Labor (DOL) and statewide payroll figures, had historically tracked DCRB claim frequencies reasonably well, and that the DOL frequencies had become virtually flat in the Fiscal Eears 2012 and 2013, time extending somewhat beyond the experience available in DCRB unit reports. Discussion Exhibit Page 15 – Department of Labor Claim Frequency by Fiscal Year Ending June 30th was noted.

Question: Confirmation was sought concerning the annual claim frequency trend factor that had been selected.

Answer: Staff advised that the current annual claim frequency trend was -5.1 percent based on a seven-point exponential trend.

Question: The attendee asked for the comparable value from the 2012 filing.

Answer: The response was that the 2012 filing used an annual claim frequency trend of -6.5 percent, which had also been derived using a seven-point exponential trend model.

Comment: The long-term decline in claim frequency apparent in Delaware and other states was remarked, with an attendee recalling holding the perception that this trend was not sustainable in the long term.

Answer: Industry analysis had found that improvement in claim frequency had been evident over an extended period of time.

SEVERITY TREND

The topic of severity trend was presented in the work contained in the following meeting exhibits:

Exhibit 2: Paid and Incurred Loss Development and Trend
Exhibit 3: Measures of Goodness of Fit in Trend Calculations Using Severity Ratios
Exhibit 5: Graphs of Ultimate and Trended Experience Components
Exhibit 6: Retrospective Test of Trend Projections for Severity Ratios
Exhibit 12: Indicated Change in Residual Market Rates and Voluntary Market Loss Costs (Pages 2 & 3)

Ultimate loss ratios derived from the DCRB's loss development analysis had been converted to severity ratios by adjusting loss ratios for known changes in claim frequency over the span of policy years provided in Exhibit 2. Key considerations pertaining to the severity trend analysis were noted as shown below:

Indemnity Severity – Through Policy Year 2011 (mid-point January 1, 2012) the DCRB had measured claim severity trend using a seven-point exponential trend model fitted through the severity ratios derived by adjusting estimated ultimate loss ratios for known changes in claim frequency. That analysis resulted in an annual change in indemnity severity of +4.7 percent per year, up from the 2012 filing's value of +3.8 percent per year.

Medical Severity – The DCRB remained mindful that, in the adjudication of the December 1, 2009 filing, both actuarial consultants who had reviewed the filing had anticipated some improvement in medical trends associated with the implementation of the medical fee schedule in late 2008. Such an adjustment had subsequently been included in the DCRB's December 1, 2010, December 1, 2011 and December 1, 2012 filings with the posited improvement of 1.8 percent in annual medical severity trend applied after September 1, 2008 (the effective date for full implementation of the medical fee schedule in prior DCRB filings).

Subsequent to the implementation of Senate Bill 1 it had been discovered that the intended regulation of fees for hospitals and ambulatory surgical centers had not been accomplished as envisioned under that law for both legal and practical reasons. SB 238 of 2012 had been enacted to establish a new mechanism to manage hospital and ambulatory surgical center reimbursements.

The DCRB estimated the contribution of hospital and ambulatory surgical center payments to the anticipated improvements in medical trend, deriving a result that, instead of a -1.8 percent annual improvement, the value excluding hospitals and ambulatory surgical centers would have been approximately -1.5 percent. Accordingly, for the December 1, 2013 filing the adjustment to severity trend attributed to Senate Bill 1 had been revised to be an improvement of 1.5 percentage points per year from September 1, 2008 (the implementation of the fee schedule under Senate Bill 1) through January 31, 2013 (the effective date of SB 238 of 2012). For time periods after January 31, 2013 the prior assumption of an improvement of 1.8 percent per year was applied for the December 1, 2013 filing.

The pre-Senate Bill 1 medical severity trend (measured prior to the application of the above adjustments) had been derived using a seven-point exponential fit, was +14.0 percent per year. Thus the annual medical severity trends used in the staff analysis were +14.0 percent through September 1, 2008, +12.5 percent per year from September 1, 2008 to January 31, 2013 and +12.2 percent thereafter.

Pages 2 and 3 of Exhibit 12 presented the derivation of severity trends as described above. Exhibits 3 and 6, respectively, provided results of the DCRB's review of goodness-of-fit and past projections of severity ratios.

Discussion Exhibit Page 16 – Indemnity and Medical Actual and Trended Severity Ratios, Average of Incurred and Paid to 23rd portrayed the results of the selected loss development methodologies for indemnity and medical losses, with the exponential fit trend indications also provided for illustrative purposes. It was noted that the medical severity trends applied respectively from September 1, 2008 to January 31, 2013 and after January 31, 2013 were nominally lower than the curve presented in this discussion exhibit.

Discussion Exhibit Page 17 – Indemnity Loss Experience Components, Indexed to 1.000 at Policy Year 1999, Annual Rates of Change was shown, noting that this material replicated the indemnity portion of the agenda package's Exhibit 5. The selected claim frequency and severity trends were illustrated, together with the resulting loss ratio trend (-0.6 percent).

Discussion Exhibit Page 18 – Medical Loss Experience Components, Indexed to 1.000 at Policy Year 1999, Annual Rates of Change was shown, noting that this material replicated the medical portion of the agenda package's Exhibit 5. The selected claim frequency and severity trends were illustrated, together with the resulting loss ratio trend (+8.2 percent to September 1, 2008, +6.8 percent to January 31, 2013 and +6.5 percent thereafter).

It was noted that Discussion Exhibit Pages 17 and 18 reflected information also presented in Exhibit 5 of the filing materials.

Question: ***An attendee observed that indemnity severity had increased about 30 percent for the latest point on the indemnity graph and that medical severity was up about 20-to-25 percent for each of the last two points. Staff was asked whether there was any explanation as to why these severity changes were so much higher than those for prior policy years.***

Answer: ***Factors that had contributed to these differences included closure rates slowing down, and cumulative payments and year-end case reserves going up compared to prior evaluations.***

Comment: ***The changes of note had happened for indemnity in Policy Year 2011 and for medical in Policy Years 2010 and 2011. The observed changes in reported amounts reflected what had happened more so than why the experience was markedly different from that of previous periods.***

Answer: ***Definitive explanation(s) for the available experience data were not available from information known to the DCRB.***

Expenses and Benefit On-Level Factor

The topics of expenses and benefit on-level factor were presented in the work contained in the following meeting exhibits:

Exhibit 8: Expense Study
Exhibit 9: Internal Rate of Return Model
Exhibit 10: Effect of 7/1/14 Benefit Change
Exhibit 11: Expense Loading

Exhibit 8 showed historical experience used to measure the following expense components:

Commission and Brokerage
Other Acquisition
General Expense
Loss Adjustment Expense
Premium Discount
Uncollectible Premium

The first four items noted above were reviewed over the three calendar years - 2009, 2010 and 2011.

The three-year average ratio of commission and brokerage expense to standard earned premium at DCRB rate level, including large deductible business on a net basis and excluding expense constant income, was used for that expense component of the analysis presented.

Other acquisition and general expenses were determined based on the three-year average ratio of those respective expenses to standard earned premium at DCRB rate level, including large deductible business on a gross basis and excluding expense constant income. Other acquisition and general expense provisions had been adjusted for the effects of the Court of Chancery decision, which would reduce premium income without offsetting these expense components.

The relationship between loss-adjustment expense and loss was derived based on the three-year average ratio of loss-adjustment expense to incurred losses, including large deductible on a gross basis. The premium discount provision in this analysis was based on size-of-risk distribution for Schedule Y carriers in Manual Year 2010, the most recent complete available year from unit statistical data. A provision for uncollectible premium had been selected after review of experience over the most recent available nine years.

Exhibit 8 also showed the allocation of the provisions for residual market expense constant income attributed to various expense components. The residual market expense constant proposal of $290 was noted in comparison to the currently-approved value of $280.

Exhibit 10 derived a provision in the indicated rates and loss costs to offset the impact of expected adjustment in benefit minimums and maximums effective July 1, 2014. As comparable prior effects of revisions in benefit schedules had been removed from the policy year loss ratios derived in loss development analysis and used to select trend provisions, a separate explicit provision for the prospective change was needed.

Exhibit 9 provided detail of the application of an internal rate-of-return analysis. Expense provisions for commission and brokerage, other acquisition, general expense, premium and other taxes, premium-based assessments and premium discount were based on DCRB analysis as described above, budgetary provisions or the most recent available assessment levels. Premium collection and loss-payout patterns were also provided from DCRB analysis.

The DCRB inputs were combined with an economic consultant's analysis of the following inputs and parameters to construct a cash flow model appropriate for the business of underwriting workers compensation business in Delaware:

Pre-Tax Return on Assets
Investment Income Tax Rate
Post-Tax Return on Assets
Reserve-to-Surplus Ratio
Cost of Capital

The internal rate-of-return model thus constructed was provided in detail within Exhibit 9. Key outputs derived from Exhibit 9 were:

Permissible loss ratio, including loss-adjustment expense and loss-based assessments

Indicated Value: 72.39 percent

Profit and contingencies

Indicated Value: -0.47 percent

Staff noted that the indicated profit and contingencies provision for the December 1, 2013 filing was slightly negative. The selection of a profit and contingency provision for the December 1, 2012 filing was described, in which this provision had been tempered by using the approximate average of the previous provision (-0.39 percent) and the indicated provision (+3.83 percent).

Discussion Exhibit Page 19 – Historical Expense Ratios, 12/1/2006 through 12/1/13 was reviewed. An overall decrease in the residual market expense need from 31.73 percent of premium for the December 1, 2012 filing to 29.91 percent of premium for the December 1, 2013 filing was noted, with the following components highlighted as contributing significantly to that change:

	December 1, 2012	December 1, 2013
Uncollectible Premium:	2.00 percent	1.00 percent
Profit & Contingencies:	1.75 percent	-0.47 percent

Overall Indicated Changes in Collectible and Manual Rating Values

The topics of the overall changes in collectible and manual rating values were presented in the work contained in the following meeting exhibits:

Exhibit 12: Indicated Change in Residual Market Rates and Voluntary Market Loss Costs
Exhibit 7: Closure Rates, Payout Ratios and Average Claim Costs

Staff briefly reviewed the approach used in this exhibit to derive indicated overall changes in residual market rates and voluntary market loss costs.

On-level loss and loss adjustment expense ratios in Lines 1(a) through 1(e) were noted as being higher than the counterpart values from the December 1, 2012 filing for all but the oldest respective policy year for both indemnity and medical. These comparisons reflected the approved December 1, 2012 rate change (+19.0 percent) and losses reported including loss development data since that filing.

The effects of trend on the filing indication (affecting indemnity projections favorably but increasing medical projections) were noted. In comparison to the trend adjustments included in the December 1, 2012 filing, the current indications for claim severity, claim frequency and loss ratio were all described as being less favorable for both indemnity and medical loss for the current submission.

The adjustments to medical loss ratios based on DCRB analysis of the effects of 2007, 2012 and 2013 legislative and regulatory changes were noted. Line (3ai) pertained to Senate Bill 1 of 2007, line (3aii) reflected SB 238 of 2012 and line (3aiii) included the collective components of HB 175 and subsequent regulatory changes. The adjustment for the effect of limiting losses in the underlying loss development and trend work was pointed out on Lines 4(a) and 4(b). Based on a permissible loss and loss adjustment ratio shown on Line 6, an indicated change in rates was derived on Line 7. Application of an estimated effect of the July 1, 2014 benefit change on Line 8 gave a final residual market rate change on Line 9. Removing the provisions for expenses other than loss adjustment expense from the residual market rate change gave the indicated voluntary market loss cost indication on Line 10.

Staff pointed out the indicated overall changes in residual market rates (+39.50 percent increase) and voluntary market loss costs (+42.75 percent increase).

Indicated changes in manual rates and loss costs were derived in Lines 11 through 18 by applying considerations of changes in collectible premium ratios arising from the ongoing application of the Experience Rating Plan and the effects of the approved residual market surcharge program on residual market premiums, which offset was applied to voluntary market loss costs to maintain revenue neutrality of that surcharge program.

Discussion Exhibit Page 20 – Components of December 1, 2013 Residual Market Rate Change was reviewed with attendees, with the combinations of factors underlying the overview described at the beginning of the meeting identified.

Exhibit 7 provided various metrics of loss experience derived from unit statistical data. Claim closure rates, claim frequencies and average closed, open and total claim amounts (with the latter statistics being generally volatile due to limited amounts of data and potential impacts of large losses) were displayed.

Discussion Exhibit Page 21 – Claim Settlement Rates, Ratio of Open to Reported Indemnity Claims by Policy Year showed ratios of open to reported claims for selected claim maturities. These ratios were generally trending up over time and, with the exceptions of 1st and 10th reports, had moved up to some extent with the most recent available report.

Unlimited Loss Exhibits Presented for Purposes of Comparison

While relying on limited loss development and trend as previously described, DCRB staff had performed counterpart analyses of the December 1, 2013 filing on an unlimited loss basis. That analysis was presented in the work contained in the following meeting Exhibits:

Unlimited Exhibit 1: Table I – Summary of Financial Call Data
Unlimited Exhibit 2: Paid and Incurred Loss Development and Trend
Unlimited Exhibit 2a: Graphs of Selected Loss Development Projections
Unlimited Exhibit 3: Measures of Goodness of Fit in Trend Calculations Using Severity Ratios
Unlimited Exhibit 6: Retrospective Test of Trend Projections for Severity Ratios

Unlimited loss development had used an eight-year average tail provision and paid-to-incurred factors for medical loss and had performed a separate series of curve fitting analyses which had resulted in the following selected curves for purposes of smoothing age-to-age factors (with the fits applied to the results of subtracting unity from the age-to-age factors themselves).

Discussion Exhibit Page 22 – Unlimited Loss Development Analysis – Curves Fitted to Age-to-Age Loss Development Factors less Unity disclosed the following curves selected to smooth unlimited loss development link ratios:

Indemnity Incurred Development Factors:

$y = a + b/x + c/(x^2) + d/(x^3) + e/(x^4)$ (fourth order inverse polynomial)

Indemnity Paid Development Factors:

$y = a + b/x + c/(x^2) + d/(x^3) + e/(x^4)$ (fourth order inverse polynomial)

Medical Incurred Development Factors:

$y = a + b/x + c/(x^2) + d/(x^3) + e/(x^4) + f/(x^5)$ (fifth order inverse polynomial)

Medical Paid Development Factors:

$y = a + b/x + c/(x^2) + d/(x^3) + e/(x^4) + f/(x^5)$ (fifth order inverse polynomial)

As had been the case for limited loss development, the need for factors converting from paid to case-incurred losses in completing the paid loss development estimates for both indemnity and medical losses was noted. For those purposes staff had applied the most recent actual four-year average paid-to-incurred age-to-age factors at the maturity at which this transition was made.

Delaware Insurance Plan

The topic of the Delaware Insurance Plan was presented in the work contained in the following meeting Exhibits:

Exhibit 19: Delaware Insurance Plan

Several features of the Delaware Insurance Plan (DIP), the residual market for workers compensation insurance in Delaware, were reviewed based on materials offered in this exhibit. These included the following:

Comparative loss ratios in the DIP by policy size over a five-year period
Comparative loss ratios in the DIP by policy year over a five-year period
Market share in the DIP
Effects of the approved surcharge program on risks insured in the DIP
A residual market subsidy multiplier to be included in retrospective rating plan tax multipliers

Experience Rating

The topic of experience rating was presented in the work contained in the following meeting exhibits:

Exhibit 13: Experience Rating Plan Performance
Exhibit 20: Review of Experience Rating Plan Parameters
Exhibit 21: Table B

The interpretation of Exhibit 13 was described for the participants in the contexts of determining whether credit or debit ratings were appropriate and the extent to which credibility was and should be assigned to individual risk experience.

Discussion Exhibit Pages 23 and 24 – Credit Risks and Debit Risks, respectively, provided overviews of loss ratio adjustments accomplished by the Experience Rating Plan on employers by premium size group.

Exhibit 20 was discussed as the means of deriving anticipated collectible premium ratios for use in Exhibit 12. It was noted that, consistent with recent practice, the average of the most recent two collectible premium ratios had been used for this purpose. Exhibit 20 also illustrated the computation of expected loss rate factors to adjust indicated residual market rates back to appropriate expected loss factors for use in the Experience Rating Plan and the determination of selected parameters for Experience Rating Plan credibility.

Staff advised attendees of analytical steps that had been taken to better understand the historical phenomenon of downward migration of collectible premium ratios and to confirm the reasonability of the selected values for this filing.

Staff referred briefly to Exhibit 21, which set forth the credibility table proposed for use in the Experience Rating Plan over the proposed rate period.

Delaware Construction Classification Premium Adjustment Program

The topic of the Delaware Construction Classification Premium Adjustment Program (DCCPAP) was presented in the work contained in the following meeting Exhibits:

Exhibit 14: DCCPAP

The history and purpose of DCCPAP were briefly described using Exhibit 14. Staff reviewed the analytical exhibits reflecting the extent to which employers in the respective eligible classifications had participated in the program and the magnitude of premium credits granted to such employers. Proposed adjustments in offsets for DCCPAP credits by classification were noted.

The table of qualifying wages was reviewed for the participants. Staff noted that the qualifying wages proposed to be effective for the DCCPAP June 1, 2014 reflected expected future wage level changes, resulting in a proposed wage table with a higher qualifying wage than was in effect for the June 1, 2013 Table.

Workplace Safety Program and Merit Rating

The topics of Workplace Safety Program and Merit Rating were presented in the work contained in the following meeting Exhibit:

Exhibit 29: Delaware Workplace Safety Program & Merit Rating Program

The background of the Workplace Safety Program was reviewed, noting 1999 changes expanding the eligibility for the program, instituting an overall offset to manual rating values to fund operation of the program and implementation of a Merit Rating Program for small employers.

Page 29.1 showed recent historical experience for participation in the Workplace Safety Program and derived an indicated offset to manual rates based thereon. Page 29.2 showed anticipated distributions of merit-rated risks between credits, no adjustments and debits and combined the indicated offset for net merit rating credits with that for the Workplace Safety Program. The combined indication was for a 3.33 percent adjustment to manual rating values, as compared to the 3.41 percent adjustment currently in effect.

Rating Values Based on Size-of-Loss Analyses

The topic of Rating Values Based on Size-of-Loss Analyses was presented in the work contained in the following meeting Exhibits:

Exhibit 16: Small Deductible Program
Exhibit 17a: Empirical Delaware Loss Distribution
Exhibit 17b: Excess Loss (Pure Premium) Factors
Exhibit 17c: Excess Loss (Pure Premium) Factors Adjusted to Include Allocated Loss Adjustment Expenses
Exhibit 17d: Excess Loss Premium Factors
Exhibit 17e: Excess Loss Premium Factors Adjusted to Include Allocated Loss Adjustment Expenses

Staff noted that DCRB loss cost filings typically include rating values pertinent to various rating plans affected by the size of loss for individual claims or occurrences. Some such plans provide limitations applicable to the amount(s) of loss that can be used in computing a retrospective premium. Other portions of this analysis facilitate the application of standard tables to Delaware business.

Staff further noted that many of the size-of-loss studies and rating values proposed in the filing vary by hazard group and that the hazard groups were modified and expanded from four (designated I, II, III and IV) to seven (designated A, B, C, D, E, F and G) hazard groups as part of the December 1, 2009 filing. Beginning with the December 1, 2012 filing the filing will only support analysis for the seven hazard groups (A-G).

Exhibit 16

Exhibit 16 presents the derivation of small deductible loss elimination ratios and premium credits for the expanded range of hazard groups. This is a mandatory offer to employers in Delaware but sees very limited use in the marketplace. The small deductible provisions are applicable to death and all medical losses.

Exhibits 17a, 17b, 17c, 17d and 17e

Staff briefly described changes to the processes and procedures used in the derivation of excess loss factors that was introduced as part of the December 1, 2009 filing. One result of those changes was a far greater emphasis on Delaware experience than had been used in the past. Exhibit 17a presented an empirical loss distribution based solely on Delaware data. The analysis indicated that actual loss experience could be used over a significant portion of the size-of-loss range for each type of injury (Death, PT, PP and Temporary Total). Various commonly-used distributions had been considered in fitting the empirical size-of-loss distributions, including Pareto, Lognormal, Gamma, Weibull and Exponential. Separate analyses of claim frequency and loss severity had been performed, and the lognormal distribution was used to estimate claim severity and claim frequency for each type of injury.

In generating final loss distributions and excess loss factors, actual data (claim counts and dollars of loss) for limits below $250,000 had been combined with fitted counts and dollars above $250,000 and re-accumulated. The resulting excess loss factors were also presented in Exhibit 17a.

Exhibit 17b derived indicated excess loss (pure premium) factors computed using results from Exhibit 17a. Values as of December 1, 2012 were also shown. Consistent with the 2009 study, Pennsylvania relativities had been used as benchmarks for loss amounts in excess of $1,000,000, owing to the limited amount of Delaware experience data available in those layers.

Exhibit 17d showed the derivation of excess factors related to premiums (rather than pure premiums). Exhibits 17c and 17e are comparable to 17b and 17d, respectively, but adjusted to include a provision for ALAE. The underlying loss distributions for each variation were identical to those found in Exhibit 17b.

Question: Staff was asked whether the excess loss factor procedures had been changed recently.

Answer: It was indicated that the current procedures had been in effect since 2009.

Question: The attendee characterized the changes obtained from the analysis as being predominantly increases and asked what that phenomenon might be attributable to.

Answer: ***Areas of the analysis that included decreases were noted, and the overall results were thought to be more mixed than the question might suggest.***

Question: ***Hazard Groups A and B had larger percentage changes in the areas of lower limits than did Hazard Groups E through G. An attendee wondered what was causing this result.***

Answer: ***Losses by type of injury are distributed differently over each hazard group. Permanent Partial losses (which get the largest weight in the distributions) were concentrated in the higher loss size ranges.***

Question: ***The treatment of Allocated Loss Adjustment Expenses (ALAE) in the analysis was questioned.***

Answer: ***Staff indicated that ALAE was loaded into the numerators of the Target Cost Ratios, as follows.***

Target Cost Ratio = (Loss + ALAE)/(Loss + ALAE + Loss-Based Assessments)

State & Hazard Group Relativities

This subject was addressed in the following meeting exhibit:

Exhibit 18: State & Hazard Group Relativities

Exhibit 18 shows the derivation of the December 1, 2013 indicated State & Hazard Group Relativities. DCRB and NCCI average costs were shown by hazard group and in total. A credibility weight was calculated for each hazard group based on the number of claims. A credibility weighted average cost was then calculated, and these average costs were related to the NCCI overall average cost to generate the indicated relativities. Selections were made where the indicated values for a given hazard group were inconsistent with indicated values for adjacent hazard groups. An adjustment was made to recognize the impact of recent legislation on Delaware average costs.

Retrospective Rating

The topic of Retrospective rating was presented in the work contained in the following meeting exhibits:

Exhibit 24: Retrospective Development Factors
Exhibit 25: Tax Multiplier

Exhibit 24 was described as providing indicated loss development factors proposed to be available for use on an optional basis. Specified factors were shown for no loss limitation and applicable to the expected loss portion of premium. In addition, a general procedure to derive loss development factors appropriate for use with various loss limitations was included in Exhibit 24.

Exhibit 25 presented the derivation of a retrospective rating plan tax multiplier, including the use of the DIP subsidy previously noted and shown on Exhibit 19.

Expected Loss Size Ranges – NCCI Filing Memorandum R-1405

This subject was addressed in the following meeting exhibit:

Exhibit 32: Expected Loss Size Ranges – NCCI Filing Memorandum R-1405

In order to maintain existing tables of insurance charges and savings for the effects of claim inflation, the expected loss size ranges used to define those tables are regularly updated to keep Delaware's rating values consistent with those of other jurisdictions. Exhibit 32 contains selected portions of NCCI Item Filing R-1405. The DCRB was proposing to file the table of Expected Loss Ranges shown on Page 4 of the exhibit.

Classification Relativities

The topic of classification relativities was briefly discussed along with the following meeting exhibit:

Exhibit 15: Rate and Loss Cost Formulae

Exhibit 15 described the formulae and procedures used for analysis of classification experience in the annual filing. Staff commented on a secondary capping procedure intended to avoid large fluctuations about the average changes in rating values from year to year.

Staff stated that the production of final classification rating values along with supporting exhibits is in progress and will be a part of the December 1, 2013 filing. The procedures used will be consistent with that of past years and as described in Exhibit 15.

Minimum and Maximum Corporate Officer Payrolls

Staff noted the minimum payroll amount for executive officers effective December 1, 2013 was proposed to be increased from $500 to $600 per week as the first step in a multi-year transition toward basing minimum executive officer payrolls on 100 percent of the Statewide Average Weekly Wage. Owing to changes in Statewide Average Weekly Wage data, the maximum executive officer payroll was proposed to be revised from $2,400 to $2,500 per week.

Proposed changes to Manual language were provided as part of a staff memorandum dated July 9, 2013 and included in the meeting agenda materials.

ITEM (2) REVIEW OF PROPOSED DECEMBER 1, 2013 F CLASSIFICATION FILING

Overall Indicated Changes in Collectible and Manual Rating Values for F Classifications

Exhibit 1 was reviewed, with the following points highlighted:

The estimate of a policy year loss ratio trended to the mid-point of the prospective rating period (Line 1)

A credibility-weighting procedure recognizing the limited amount of available historical experience in Delaware and applying the complement of Delaware experience credibility to the permissible loss ratio underlying current rates (Lines 2, 3 and 4)

Adjustment of the credibility-weighted trended loss ratio for loss adjustment expenses (Lines 5 and 6)

Comparison of the trended policy year loss and loss adjustment ratio to a permissible loss and loss adjustment ratio based on econometric analysis (Lines 7 and 8)

Adjustment for estimated effects of the October 1, 2014 benefit change (Lines (9) and (10))

In concert, the above steps produced the indicated change in F-Classification residual market rates. The proposed change in F-Classification voluntary market loss costs was derived from the indicated change in residual market rates by adjusting the latter indication for the effects of changes in the permissible loss ratio, including loss adjustment expense and loss-based assessments (Line 11).

Staff pointed out the proposed overall changes in F-Classification residual market rates (+3.91 percent) and F-Classification voluntary market loss costs (+1.01 percent) derived from the DCRB's analysis of the most recent available Delaware data.

Staff noted the proposed filing's accounting for effects of the Experience Rating Plan in the determination of proposed changes in manual rating values, as presented on Exhibit 1. This analysis started with the collectible premium ratios underlying presently-approved rating values (Line 12). The DCRB had then measured the collectible premium ratios that the Experience Rating Plan was expected to produce during the proposed rating period (Line 13). Using the relationships between these current and estimated future collectible premium ratios, staff had derived indicated changes in manual F-Classification residual market rates (Line 14). Indicated changes in manual F-Classification voluntary market loss costs (Line 15) had been similarly derived by accounting for the impact of changes in anticipated collectible premium ratios.

Analysis of Loss Experience

Staff described the content of Exhibit 5. Highlights from that description are set forth below.

Due to limitations and questions pertaining to the reporting of Financial Call data for F-Classification business, the DCRB's F-Classification filings had historically been prepared using unit statistical data. This filing continued that past practice.

Loss development data available for this filing was limited in the following ways:

Only case-incurred loss development was possible, as unit statistical reporting did not capture paid-loss amounts over the entire historical period in question.

Data reported extended from first through tenth reports, the maximum reporting period required under the approved Statistical Plan.

Three of the latest four policy years technically eligible for later reporting periods had reported zero losses and thus showed no loss development experience for use in this filing.

Delaware loss development experience had been used as the basis for this filing.

Staff had considered various trend models applied separately to the estimated indemnity and medical F-Classification loss ratios. Given the volatility of estimated loss ratios year-to-year and the effects of limited data on the exponential trend models in particular, eight-year average loss ratios (with no annual trend up or down) had been selected to estimate indemnity and medical trended loss ratios.

Expense Provisions

Expense data was not available to the DCRB separately for F-Classification and other business. Accordingly, the expense study supporting this filing was identical in many respects to that previously discussed by the Committees with regard to the December 1, 2013 Residual Market Rate and Voluntary Market Loss Cost Filing. Minutes of that discussion of this study are replicated here for ease of reference, with appropriate modification for the F-Classification business used to review premium discount provisions for the F-Classification filing.

Exhibit 3 showed historical experience used to measure the following expense components:

Commission and Brokerage
Other Acquisition
General Expense
Loss Adjustment Expense
Premium Discount

The first four items noted above were reviewed over the three Calendar Years 2009, 2010 and 2011. The three-year average ratio of commission and brokerage expense to standard earned premium at DCRB rate level, including large deductible business on a net basis and excluding expense constant income, was used for that expense component of the proposed filing. Other acquisition and general expenses were determined based on the three-year average ratio of those respective expenses to standard earned premium at DCRB rate level, including large deductible business on a gross basis and excluding expense constant income. The relationship between loss-adjustment expense and loss was derived based on the three-year average ratio of loss-adjustment expense to incurred losses, including large deductible on a gross basis. The premium discount provision in the proposed filing was based on size-of-risk distribution for F-Classification business written by Schedule Y carriers in Manual Year 2010, the most recent available year from unit statistical data.

Exhibit 3 also showed the derivation of the provisions for residual market expense constant income attributed to various expense components. The residual market expense constant proposal of $290 was based on the currently-approved value of $260 and recognition of the effects of wage inflation since approval of the current value.

Exhibit 4 provided detail of the application of an internal rate-of-return analysis to the proposed filing. Expense provisions for commission and brokerage, other acquisition, general expense, premium and other taxes, premium-based assessments and premium discount were based on DCRB analysis as described above, budgetary provisions, or the most recent available assessment levels. Premium collection and loss-payout patterns were also provided from DCRB analysis.

The DCRB inputs were combined with an economic consultant's analysis of the following inputs and parameters to construct a cash flow model appropriate for the business of underwriting F-Classification workers compensation business in Delaware:

Pre-Tax Return on Assets
Investment Income Tax Rate
Post-Tax Return on Assets
Reserve-to-Surplus Ratio
Cost of Capital

The internal rate-of-return model thus constructed was provided in detail within Exhibit 4. Key outputs derived there from for use in the proposed filing were:

Permissible loss ratio, including loss-adjustment expense and loss-based assessments : 75.15 percent
Profit and contingencies : +1.27 percent

Staff noted the change in profit and contingencies provision proposed in the filing from the provision in currently-approved rates (-1.64 percent) and attributed that change in substantial part to declines in the cost of capital derived for the present filing as compared to the previous filing's analysis. Attendees were reminded that, since F-Classification rating values, which are normally changed bi-annually, filing-to-filing changes could be more marked than might be expected with annual revisions.

Exhibit 2 provided side-by-side comparison of the expense structures underlying currently-approved F-Classification residual market rates and proposed F-Classification residual market rates. Staff observed that overall expense costs reported by its members were lower than those incorporated in the last Delaware F-Classification filing (32.97 percent, as compared to 34.23 percent in the previous filing). The most significant changes in expense components involved the areas of profit and contingency (up from -1.64 percent to a positive 1.27 percent in the 2010 filing), uncollectible premium (1.00 percent instead of the 2.50 percent applicable in 2010) and the Federal Assessment (8.12 percent in this filing compared to 11.54 percent in the 2010 F-Classification filing.)

Effect of October 1, 2014 Benefit Change

Staff reviewed Exhibit 14, which derived a provision in the proposed rates and loss costs to offset the impact of expected adjustment in benefit minimums and maximums effective October 1, 2014. As comparable prior effects of revisions in benefit schedules had been removed from the policy year loss ratios derived in loss development analysis and used to select trend provisions for the proposed filing, a separate explicit provision for the prospective change was needed.

U. S. Longshore & Harbor Workers (USL&HW) Coverage Factor

Referring to Exhibit 6, staff noted that the USL&HW Factor is based on a comparison of benefit levels between State Act coverage and the USL&HW Act. This comparison was performed by type-of-claim and type-of-benefit to measure the respective potential obligations arising from injuries occurring under the jurisdiction of federal, as compared to state, law. Such a comparison then serves as the basis for the factor to adjust premiums in state classifications for the contingency of exposure to federal benefits. This filing indicated that the current USL&HW coverage percentage of 58.00 percent should be increased to 58.78 percent for use effective December 1, 2013.

F-Classification Expected Loss Rate Factors

Exhibit 11

Exhibit 11 illustrated the computation of expected loss rate factors to adjust proposed F-Classification residual market rates back to appropriate expected loss factors for use in the Experience Rating Plan.

Classification Tax Multiplier

For policies underwritten on a retrospective (loss-sensitive) basis for F-Classification business, a tax multiplier is required. Exhibit 8 presented the derivation of the proposed tax multiplier for this filing, 1.1685.

F-Classification Residual Market Rates and Voluntary Market Loss Costs

While recognizing the limited experience data by classification available for purposes of this filing, an analysis of relative classification experience had been undertaken in support of these proposals. The rate formulae applied in that review were set forth in Exhibit 10.

Exhibit 7 provided unit statistical data by manual year, with exposures and losses trended and developed to an ultimate basis.

Individual F-Classification experience and the promulgation of indicated F-Classification residual market rates were presented in Exhibit 15 (including the F-Classification Class Book), Exhibit 9 and Exhibit 12.

Staff invited closing questions or comments.

Question: ***An attendee asked what the subsequent steps in the filing process would be.***

Answer: ***Staff explained that a filing was required to be made by September 25, 2013. That submission would be reviewed by the Insurance Department and by the Office of the Ratepayer Advocate. DCRB staff would discuss the information offered at this meeting and decide how to proceed in finalizing the filing. Work remained to be done on the Class Book and selected other portions of the filing documentation. Some details pertaining to the 2013 legislation were also subject to revision and/or addition to the analysis, although it was not expected that all of that work would be done in time for the September 25 date.***

Comment: ***An attendee remarked that the Committees' meeting this year was later than usual.***

Answer: ***Staff concurred, noting that, while the filing was mandated by September 25, the DCRB was also required to include accounting for regulatory provisions that had been finalized as late as early September. In combination, those requirements compressed the analysis into a rather narrow time frame.***

There being no further business for the Committee to conduct, the meeting was adjourned.

Respectfully submitted,

Timothy L. Wisecarver
Chair - Ex Officio

TLW/kg