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October 10, 2014

VIA OVERNIGHT DELIVERY

The Honorable Karen Weldin-Stewart, CIR-ML
Insurance Commissioner
Insurance Department
State of Delaware
841 Silver Lake Boulevard
Dover, DE 19904-2465

Attention: Gene Reed

RE: DCRB Filing No. 1404
Workers Compensation Residual Market Rate and Voluntary Market Loss Cost Filing
Proposed Effective December 1, 2014 (Selected Portions Effective June 1, 2015)

Dear Commissioner Weldin-Stewart:

On behalf of the members of the Delaware Compensation Rating Bureau, Inc. (DCRB), I am filing herewith proposed revisions to:

- Delaware's Residual Market Plan for workers compensation insurance.
- Loss costs and related rating values for use in the voluntary workers compensation insurance market in Delaware.
- Selected Manual rules and forms in Delaware.

This filing is made in compliance with provisions of House Bill 241 (HB241), workers compensation insurance legislation enacted in 1993. Most of these revisions are proposed to be **effective** on a new and renewal basis for workers compensation insurance policies with normal anniversary rating dates on or after 12:01 a.m., **December 1, 2014**. The portions of this filing updating the table of qualifying wages and credits for the Delaware Construction Classification Premium Adjustment Program are proposed to be **effective** on a new and renewal basis for workers compensation policies with normal anniversary rating dates on or after 12:01 a.m., **June 1, 2015**.

Since 2007, several significant pieces of legislation have been enacted in Delaware. These bills have invoked a series of changes in the Delaware workers compensation system. As this filing recognizes the effects of all law changes enacted through the 2014 legislative session, a brief overview of each of those bills is provided below:

Senate Bill 1 of 2007 (SB1): Signed into law on January 17, 2007, SB1 included the following notable components:

- Established a Health Care Advisory Panel
- Provided for a health care payment system intended to control health care costs in connection with workers compensation
- Provided for the establishment of health care practice guidelines
- Provided for the development of certification standards for health care providers treating employees in the workers compensation system
- Provided for the adoption of forms and a consistent and uniform reporting system among employees, employers, insurance carriers and health care providers
- Adopted standards for billing and payment of health care services
- Required contractors and other parties doing substantial work within Delaware to adequately insure their employees for workers compensation under the laws of Delaware
- Authorized payment of indemnity benefits or health care benefits without prejudice against the right to later contest the employer's obligation to pay the expense in question
- Established new procedures for attorney fees in workers compensation matters
- Clarified the obligations of independent contractors and subcontractors with respect to maintaining workers compensation insurance
- Clarified the calculation of wage rates, especially in cases where employees had limited work histories
- Implemented procedures for the collection of data relevant to workers compensation including injury reports, mandatory insurance requirements and health care treatments and costs

Senate Bill 238 of 2012 (SB238): Signed into law on August 7, 2012, SB238 revised procedures used to determine payments to hospitals and ambulatory surgery centers for services provided to workers compensation claimants.

House Bill 175 of 2013 (HB175): Signed into law on June 27, 2013, HB175 included the following notable components arising from work done by the Workers' Compensation Task Force created by House Joint Resolution 3:

- Provided the Data Collection Committee with more frequent reports of medical cost data and allowed that committee to review carrier-specific medical cost information
- Implemented a two-year freeze on fees that would otherwise have been entitled to annual inflation increases
- Reduced the annual inflation index applicable to hospitals
- Added many procedures to the medical fee schedule
- Provided for cost control provisions pertaining to pharmaceuticals, drug testing and anesthesia
- Revised procedures pertaining to light-duty or modified employment while injured workers were unable to perform their previous job
- Created a statute of limitations for utilization review decisions
- Made certain changes to Delaware's Workplace Safety Credit Program
- Provided for the Data Collection Committee to direct that examinations be done of certain insurance carriers' oversight of medical costs
- Created the position of Ratepayer Advocate to participate in the review of rate and loss cost filings filed by the licensed advisory organization

House Bill 373 of 2014 (HB373): Signed into law on July 15, 2014, HB373 included the following notable components:

- A 33 percent reduction in medical expenditures phased in over a three-year period
- Imposition of caps expressed as percentages of Medicare per-procedure reimbursements beginning on January 31, 2017
- Revised certain procedures pertaining to the position of Ratepayer Advocate

The following narrative will provide you with a summary discussion of the content, background and supporting information for this filing. Attachments to this letter comprise the balance of the filing and provide pertinent information regarding the proposed residual market rates, voluntary market loss costs, rating values, supplementary rate information and classification procedures and supporting information for this filing.

I: CONTENT OF THE FILING

The proposed residual market rates, voluntary market loss costs and minimum premiums by classification submitted herewith reflect DCRB's actuarial analysis of all available experience data, enacted legislation and other relevant factors to establish appropriate and lawful rating values for the policy period beginning December 1, 2014.

A: RESIDUAL MARKET RATES

Delaware law requires that a "residual market plan" be filed with the Insurance Commissioner by the advisory organization. Residual market coverage is provided under the auspices of the Delaware Workers Compensation Insurance Plan (Plan). Employers unable to obtain workers compensation insurance in the voluntary market may apply to the Plan, whereupon an insurance carrier is assigned to administer coverage for that employer, either as a servicing carrier on behalf of the Plan or on a direct assignment basis.

Historically, rates for the Plan have been promulgated based on statewide experience. Since August 1, 1997, those employers insured in the Plan, which are eligible for experience rating and produce an experience modification greater than 1.000 in accordance with the approved Experience Rating Plan, have been subject to a surcharge program. This surcharge program is intended to provide incentives for employers to improve their workers compensation loss experience and/or to secure workers compensation coverage from the voluntary market. In the DCRB's residual market rate and voluntary market loss cost filings since the inception of the surcharge program, the expected amounts of such Plan surcharges were accounted for in the form of nominal offsets to proposed voluntary market loss costs. This filing proposes to continue the practice of using statewide experience for purposes of deriving the indicated overall residual market rate change. The filing also proposes to maintain a Plan surcharge program sensitive to individual risk experience and to reduce voluntary market loss costs to the extent necessary to offset the expected amount of Plan surcharges thus generated. The average change in collectible rate level for the residual market prior to the effect of Plan surcharges proposed in this filing is a decrease of 1.56 percent.

The components of the proposed overall change in residual market rates are set forth below, with the effects of SB1, SB238, HB175 and HB373 shown first, and the remaining components in descending order of their impact on the filing indication:

Component Analysis of Indicated December 1, 2014 Change in Residual Market Rates

(1)	Effects of Senate Bill 1 of 2007	0.872451
(2)	Effects of Senate Bill 238 of 2012	0.997086
(3)	Effects of House Bill 175 of 2013	0.948582
(4)	Effects of House Bill 373 of 2014	0.780532
(5)	Indicated change in rates from limited medical loss experience	1.209702
(6)	Indicated change in rates from excess medical loss provision	1.175772
(7)	Indicated change in rates from limited indemnity loss experience	1.063276
(8)	Indicated change in rates from loss adjustment expense	1.047650
(9)	Indicated change in rates from expenses other than loss-based assessments	1.020829
(10)	Indicated change in rates from excess indemnity loss provision	1.004222
(11)	Indicated change in rates from July 1, 2015 benefit change	0.999200
(12)	Indicated change in rates from loss-based assessments	0.999001
(13)	Indicated change in rates from limited indemnity trend	0.994120
(14)	Indicated change in rates from limited medical trend	0.948274
	Indicated overall change in rates	0.9844

(1) x (2) x (3) x (4) x (5) x (6) x (7) x (8) x (9) x (10) x (11) x (12) x (13) x (14), rounded to 4 decimal places

In preparing the preceding decompositions of the proposed overall change in residual market rates into discrete components, it was necessary to serially measure the impact of the change in each component of interest, while keeping all other variables constant. In this exercise, nominal differences in the attributed impact of most specific variables occur when the sequence of calculating the effects is changed. Thus, the above values are reasonable representations of the observed impacts of each variable, but some differences in results could be obtained through alternative analytical approaches. Such differences would be offsetting, however, and would not affect the overall rate level change itself.

There are intrinsic relationships between some of the factors listed above which are significant in characterizing the impacts various system features have on this filing's indication. For example, Items (5) limited medical loss experience, (6) excess medical loss provision and (14) limited medical trend all pertain to medical loss experience. In combination, these three factors reflect the effect of medical benefits on this filing's indication, and compounding the factors shown above results in an estimated effect of medical benefits of an increase of approximately 35 percent.

Similarly, Items (7) limited indemnity loss experience, (10) excess indemnity loss provision and (13) limited indemnity trend are all related to indemnity loss experience. In combination, these three factors reflect the effect of indemnity benefits on this filing's indication, and compounding the factors shown above results in an estimated effect of indemnity benefits of an increase of approximately six percent.

The factors (9) expense other than loss-based assessments and (12) loss-based assessments in combination contribute an increase of approximately two percent to the residual market indication.

Item (8) loss adjustment expense produces a residual market rate increase of approximately five percent, while Item (11) the July 1, 2015 benefit change accounts for a fraction of a percent reduction of the proposed change.

By virtue of the above-described treatment of individual factors in the residual market rate change, the following rough attributions of rate level effect are derived:

Legislative Changes 2007 through 2014:	-36%	
Medical loss experience:	+35%	
Indemnity loss experience:	+6%	
Loss adjustment expense:	+5%	
Expenses other than loss adjustment:	+2%	
July 1, 2015 benefit change:	0%	(-0.08%)

The above approximations compound to a reduction of approximately two percent, within a rounding difference of the actual residual market rate change indication submitted in this filing, as shown below:

$$0.64 \times 1.35 \times 1.06 \times 1.05 \times 1.02 \times 1.00 = 0.98.$$

B: VOLUNTARY MARKET LOSS COSTS

Since the enactment of HB241 in 1993, Delaware law has applied a "loss cost" approach to pricing of workers compensation insurance written in the voluntary market. Under this system, the advisory organization (i.e., the DCRB) filings are limited to prospective loss costs, policy forms, uniform classification and experience rating plans and rules and supporting information relating thereto. Advisory organization filings specifically exclude provisions for profit or for expenses other than loss adjustment expenses and loss-based assessments. Provisions for profit and expenses other than loss adjustment expenses and loss-based assessments are incorporated into voluntary market workers compensation rates by virtue of competitive filings made by each insurer. Insurer expense filings may adopt by reference, with or without deviation, loss costs filed by the advisory organization or the rates and supplementary information filed by another insurer.

Consistent with past practice, in this filing the DCRB has derived indicated changes in voluntary market loss costs directly from the proposed residual market rate change discussed above. This derivation is accomplished by removing from those rate proposals the combined effects of all provisions for profit and expenses other than loss adjustment expenses and loss-based assessments. As a result, like the proposed changes in Plan rates, these proposed revisions in overall voluntary market loss costs are based on statewide experience.

The proposed premium structure for residual market rates in this filing is shown below, with comparative values from the approved current rates for ease of reference.

Item	Current Provision As a Percent of Premium	Proposed Provision As a Percent of Premium
Loss	58.54	57.08
Loss Adjustment Expense	11.55	11.63
Commission	5.51	5.97
Other Acquisition	2.74	2.85
General Expenses	3.11	3.44
Premium Discount	8.86	9.15
State Premium Tax	2.00	2.00
Other State Taxes	0.36	0.35
Uncollectible Premium	1.00	1.00
Administrative Assessment*	2.30	2.24
Workers Compensation Fund	4.50	3.50
Underwriting Profit	(0.47)	0.79

* Denotes loss-based assessment

Under Delaware law, loss adjustment expenses and loss-based assessments are included in the loss costs filed by the DCRB. Thus, in combination, the provisions for loss, loss adjustment expense and loss-based assessments account for 70.95 percent of the DCRB's proposed Plan rates (57.08 + 11.63 + 2.24 = 70.95). The DCRB's proposed voluntary market loss costs in this filing are thus based on rating values computed by multiplying the proposed Plan rates (before application of some applicable surcharges) by a factor of 0.7095. This approach produces an average indicated decrease in voluntary market loss costs of 3.52 percent that can be computed as follows:

$$0.9844 \times 0.7095 / 0.7239 = 0.9648$$

In the above equation, 0.7095 is the portion of proposed residual market rates attributable to loss costs, loss adjustment expense and loss-based assessments, and 0.7239 is the portion of current residual market rates attributable to loss costs, loss adjustment expense and loss-based assessments (i.e., 58.54 + 11.55 + 2.30 = 72.39).

The proposed increase in voluntary market loss costs is attributable to the same factors previously identified in the discussion of residual market rates, except that the effects of expense provisions other than loss adjustment expense and loss-based assessments do not apply to loss costs.

It is important to note that the net effect of the proposed loss costs on ultimate prices for employers that will be insured in the voluntary market (the majority of all insured risks) may differ significantly from employer-to-employer and from insurer-to-insurer. Workers compensation insurance prices for

these employers will be a function of individual carrier decisions as respects benefits, profit and expense provisions. Further, each carrier may elect to use the DCRB's loss costs by reference, to deviate from those loss costs, to file independent loss costs or to use loss costs filed by another insurer by reference. In addition, employers may obtain their future workers compensation insurance from a different insurance carrier than the carrier providing their current policy, further expanding the range of possible price changes that individual risks may experience. These variables in the determination of the ultimate price impact of the DCRB's filing are natural consequences of the competitive pricing system implemented under HB241 in Delaware. They are also analogous to circumstances in many other states also having adopted competitive pricing systems for workers compensation insurance.

C: RESIDUAL MARKET SURCHARGE

Experience of employers insured under the Plan in Delaware has historically presented an aggregate loss ratio higher than that of employers insured in the voluntary market. Consistent with that observation, the loss ratio of Plan accounts was higher than that of voluntary business by more than 77 percent in the period 2007–2011.

During the late 1980s and early 1990s, Delaware had seen persistent increases in the portion of the market insured in the Plan. In previous response to these concerns, the DCRB filed and the Insurance Commissioner approved a Plan surcharge program in 1997 that incorporated the following features:

- Surcharges are limited to risks eligible for experience rating and only apply to risks with debit experience modifications (i.e., those employers with demonstrably worse than average experience).

- To avoid redundant or inequitable penalties, surcharges are applied only to the extent that each employer is not fully credible in the Experience Rating Plan. This procedure assesses larger proportional surcharges to small employers, who are largely protected from the effects of their own experience in the Experience Rating Plan, but reduces surcharges applicable to larger employers whose premiums significantly respond to their own loss records.

- Surcharges are limited to the debit portion of each risk's experience modification. This limitation provides a smooth transition from non-rated to experience-rated risks and/or from small experience rating credits to small experience rating debits.

The surcharge expressed as a factor to be applied to standard premium is computed using the following formula:

0.50 x (1.000 - risk credibility in the Experience Rating Plan)

As noted above, Plan loss ratios continue to be higher than those of the voluntary market. Since 2004, the portion of the Delaware workers compensation market insured under the Plan declined from a peak of approximately 22 percent to a low of about five percent in 2010. For this filing, the Plan market share is estimated at 13.05 percent. This estimate is based on the most recent available policy year, 2013, the third consecutive year in which the Plan market share increased compared to the previous year.

This filing retains the above-described Plan surcharge program as a disincentive for employers to have their Delaware workers compensation insurance coverage placed in the Plan.

The DCRB estimates that the above-described surcharge program will produce an average surcharge for subject risks of approximately 21.8 percent of premium. Recognizing that some employers insured in the Plan do not qualify for experience rating and that other employers insured in the Plan qualify for experience rating but produce credit modifications, the surcharges produced by the proposed procedure would represent approximately 11.1 percent of total Plan premium.

The full amount of this surcharge premium is recognized in the promulgation of proposed voluntary market loss costs for this filing. This approach allows a reduction of manual loss costs by approximately one percent and essentially produces three different benchmark loss cost levels underlying workers compensation insurance rates in Delaware. These different underlying loss cost levels are as defined below:

1. Plan risks subject to surcharges (highest level depending on individual risk experience)

2. Plan risks not subject to surcharges (based on statewide average experience)

3. Voluntary market risks (based on statewide average experience reduced by offset for surcharges applied to first group above)

The DCRB believes that this Plan surcharge proposal remains an equitable and reasonable step toward reducing Plan subsidies and providing meaningful disincentives for placement of employers in the Plan.

D: MANUAL LANGUAGE AND AUDITABLE PAYROLLS

This filing includes proposals to update prevailing Manual language in Delaware. A brief synopsis of those proposals is set forth following for ease of reference.

Delaware Construction Classification Premium Adjustment Program (DCCPAP)

It is proposed to update the reference to calendar quarter(s) used as the basis for determining qualifying wages for the DCCPAP and to update the table of qualifying wages underpinning that program consistent with recent changes in the Statewide Average Weekly wage in Delaware.

Corporate Officer Weekly Minimum and Maximum Payrolls to be Audited in Delaware and Premium Determination for Sole Proprietors or Partners

Last year (2013) the DCRB began an incremental process intended to revise the basis for determining minimum corporate officer payrolls from effectively representing one-half of an annual payroll amount for a worker earning the Statewide Average Weekly Wage to a full annual payroll amount for a worker earning the Statewide Average Weekly Wage. This revision will take place over a period of a few years, and 2014 will be the second year of that planned transition. Based on a change to the minimum premium factor from 0.60 to 0.70 and also including changes in the Statewide Average Weekly Wage since the DCRB's last revisions to auditable payrolls, this filing proposes revisions to Manual language related to auditable payrolls (the minimum and maximum weekly payrolls applicable to corporate officers and to sole proprietors and partners absent records of actual remuneration).

Treatment of Automated Service Charges for Premium Computation Purposes

Tips are currently excluded from DCRB's Manual definition of remuneration for premium computation purposes. The Audit Committee of the Pennsylvania Compensation Rating Bureau (PCRB) has reviewed a recent Internal Revenue Service (IRS) Ruling (2012 – 18) that indicates when a business adds service charges to customers' bills (such as "auto-gratuities") and distributes those charges to its employees, the business should characterize the distributed service charges as social security wages, and not as social security tips. The IRS Ruling further provides that payments must meet all of the following criteria in order to be considered tips:

- The customer must freely determine the payment.
- The customer must be able to determine the amount without restriction.
- The payment cannot be determined by negotiations between the customer and the employer, or dictated by the employer.
- The customer should generally have the right to decide who receives the payment.

In recognition of this IRS Ruling, the PCRB proposed, and the Audit Committee agreed, that such service charges as defined above should be treated as wages and included in remuneration for premium computation purposes. During discussion by the Audit Committee, it was agreed that gratuitous payments made by a customer would still be considered "tips" and would thus be excluded from premium calculations. Staff opined that the impact of this change in procedure would be minimal, as only a small number of employers routinely applied automatic service charges.

The DCRB hereby proposes that this change also be adopted in Delaware.

Approximately a year ago, the Committee reviewed DCRB's proposed language on the payroll to be used when auditing insured sole proprietors, partners or members of their immediate family when payroll information is not available. That proposal was overlooked in the preparation of DCRB Filing No. 1305. The DCRB now includes that proposal in the proposed 2014 Housekeeping revisions. There is a single revision to the 2013 proposal, which is to correctly show the Delaware Department of Labor's name.

E: OTHER FILING PROVISIONS

In addition to proposed Plan rates, voluntary market loss costs and residual market surcharges, this filing addresses a number of rating values, programs, rules and procedures which are integral parts of the Delaware workers compensation insurance system. In general, the filing's proposals simply reflect parametric changes in various rating values consistent with the most recent available Delaware experience. Detailed information supporting each of these proposals is provided elsewhere in this filing. Brief synopses of each of these issues and their purposes are provided immediately following for reference purposes.

ITEM	PROPOSAL	PURPOSE
DCCPAP Program	Revise manual rating value offsets and wage table	Maintain revenue balance of program

NOTE: The table of qualifying wages and credits for DCCPAP is proposed to be effective **June 1, 2015.**

ITEM	PROPOSAL	PURPOSE
Minimum premium (residual market)	Update minimum premium parameters	Update values for wage inflation
Excess loss factors	Update ELFs	Maintain accuracy of rating values per current data
Excess loss premium factors	Update ELPFs	Maintain accuracy of rating values per current data
State & Hazard Group Relativities	Update Rating Values	Reflect current experience
Experience Rating Plan	Update rating values	Reflect current experience
Small Deductible Program	Revise existing premium credit and loss elimination ratio schedules	Reflect current experience
Workplace Safety Program	Revise manual rating value offsets	Maintain revenue balance in program
Merit Rating Plan	Revise manual rating value offsets	Maintain revenue balance in program
Retrospective Rating Plan	Revise optional development factors and tax multiplier	Reflect current experience
Minimum and Maximum Corporate Officer Payrolls	Revise current values	Second year of transition to new basis for determining minimum corporate officer payrolls, update values for wage inflation
Manual Revisions, Sections 1 & 2 Housekeeping	Revise selected Manual entries, add language pertaining to treatment of tips for purposes of premium computation	Clarify and update Manual language

II: SUPPORTING INFORMATION FOR THE FILING

Attached exhibits and materials provide technical support for each of the proposals advanced in this filing. For purposes of understanding and in order to highlight some of the more important aspects of the technical analysis that the DCRB has undertaken in the preparation of this filing, the following discussion will address each of the listed topics in turn:

A: Impacts of legislative and regulatory changes on this filing
B: Effects of large losses on experience analysis
C: Estimation of policy year ultimate loss and loss adjustment expense ratios
D: Trend provisions

E: Determination of proper permissible loss ratio for proposed residual market rates
F: Considerations pertaining to the approved Experience Rating Plan

These subject areas embrace the primary determinants of the proposed changes in residual market rates and voluntary market loss costs.

A: IMPACTS OF LEGISLATIVE AND REGULATORY CHANGES ON THIS FILING

Since the DCRB's December 1, 2013 filing was implemented, HB373 became effective in Delaware.

HB373 requires changes in Delaware's medical fee schedule such that the following benchmarks are all achieved:

- By October 1, 2014, the Workers' Compensation Oversight Panel (WCOP) must establish a fee schedule for all Delaware workers compensation funded procedures, treatments, and services based on the Resource Based Relative Value Scale ("RBRVS"), Medical Severity Diagnosis Related Group (MS-DRG), Ambulatory Payment Classification (APC), or equivalent scale used by the Centers for Medicare and Medicaid Services. The RBRVS, MS-DRG, APC, or other equivalent factor shall be multiplied by a Delaware specific geographically adjusted factor to ensure adequate participation by providers. The fee schedule shall result in a reduction of 20% in aggregate workers compensation medical expenses in the year beginning January 31, 2015, an additional reduction of 5% of 2014 expenses by the year beginning January 31, 2016, and an additional reduction of 8% of 2014 expenses by the year beginning January 31, 2017.

- The aggregate workers compensation medical expenses required by the law must be attained through reimbursement reductions of equal percentages among hospitals, ambulatory surgical centers, and other health care providers. Therefore, by January 31, 2015, the fee schedule shall reflect a reduction of 20% in workers compensation medical expenses paid to hospitals, a reduction of 20% in workers compensation medical expenses paid to ambulatory surgical centers, and a reduction of 20% in workers compensation medical expenses paid to other health care providers. This formula shall also be used for the 5% reduction required by January 31, 2016 and the 8% reduction required by January 31, 2017.

- By January 31, 2017, no individual procedure in Delaware paid for through the workers compensation system (as identified by HCPCS level 1 or level 2 code) shall be reimbursed at a rate greater than 200% of that reimbursed by the federal Medicare system, provided that radiology services may be reimbursed at up to 250% of the federal Medicare reimbursement and surgery services may be reimbursed at up to 300% of the federal Medicare reimbursement.

- The Workers' Compensation Oversight Panel shall report to the Governor and General Assembly by January 31, 2016 with respect to medical savings recognized as a result of this paragraph (3) and possible unforeseen consequences of the procedure-specific caps required by subparagraphs (3)(b) and (5), and the General Assembly may at that time reconsider the specific percentage caps required by subparagraphs (3)(b) and (5).

- The cost reductions required by subparagraph (3)(a) shall be permanent, with the exception of inflation increases beginning in 2018 as permitted by paragraph 5 of this section.

The WCOP and/or subgroups assigned specific tasks by the WCOP have invested, and continue to apply, extensive time and effort toward accomplishing the mandate(s) of HB373. Notwithstanding that ongoing work, however, a fee schedule complying with HB373 was NOT established on or before October 1, 2014. Therefore, the DCRB did not have a fee schedule(s) to review and consider when preparing the required prospective loss cost filing. That filing was required to be submitted not later than October 13, 2014, and was needed in draft form some time in advance of a joint meeting of the DCRB's Actuarial and Classification & Rating Committees, which was held on September 30, 2014.

The above circumstances place the DCRB in the position of being required to propose prospective loss costs that account for the effect of a fee schedule(s) that does/do not yet exist.

Available Literature

The DCRB is aware of numerous publications which speak to the efficacy of fee schedule changes as a tool to help contain health care costs. Among these are the following references, with a brief summary of the findings or recommendations reflected in each.

Physician Volume & Intensity Response, August 13, 1998 Memorandum to Chief Actuary of the Health Care Financing Administration (HCFA).

The Volume-and-Intensity Response Team within the Office of the Actuary for HCFA reviewed Medicare data and preceding studies of physicians' behavioral responses to changes in Medicare fees. Based on their work, the team recommended use of a 30-percent volume-and-intensity response to Medicare price decreases for physicians' services. That is, through changes in the number and/or type (intensity) of services billed, physicians were expected to offset approximately 30 percent of reductions enacted in Medicare fee schedules.

National Council on Compensation Insurance, Inc. (NCCI) Research Brief, *The Impact on Physician Reimbursement of Changes to Workers Compensation Medical Fee Schedules*, April 2011.

Based on review of workers compensation and group health expenditures for selected types of services in specific states and periods of time, this paper concluded with remarks including the following:

- The change in average workers compensation reimbursements resulting from a change in a state physician fee schedule depends heavily on the relationship between the fee schedule and the market prices for medical services.

- Workers compensation fee schedules are more effective at controlling the cost of high-volume low-priced procedures than low-volume high-priced procedures.

- The impact of increasing a workers compensation fee schedule maximum reimbursement is not simply the reverse of decreasing the schedule amount.

The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States, 2013 National Council on Compensation Insurance, Inc. (NCCI) Research Paper.

This paper analyzed data from 31 jurisdictions. Based on the research presented, NCCI estimates that when fee schedule amounts are increased, approximately 80 percent of the increase in fees is reflected in system costs. However, NCCI estimates that when fee schedule amounts are reduced, only approximately 45 percent of the decrease in fees is reflected in system costs.

Medicare Part B Intensity and Volume Offset, Article in Health Economics authored by Christopher S. Brunt, February 28, 2014.

This paper found that alteration of billed or provided services, when Medicare fees are reduced, was supported by strong evidence, while there was little to no evidence of "volume offsetting" (increasing the number of procedures billed or provided in response to changes in fees).

Simulating a 10% reduction in the Medicare fee schedule, the study estimated that, across different procedures, between 22% and 59% of the fee reduction would be offset through alterations in service intensity.

Delaware Issues

Among the factors that may impact the efforts of the WCOP (promulgating fee schedules for January 31, 2015, January 31, 2016 and January 31, 2017) and the DCRB (deriving prospective loss costs that account for the effects of the WCOP's forthcoming fee schedules) are the following:

Payer-Provider Contracts: §2322B (6) provides that "If an employer or insurance carrier contracts with a provider for the purpose of providing services under this chapter, the rate negotiated in any such contract shall prevail." To the extent that such contracts apply to medical services and supplies provided to injured workers in Delaware, payments made pursuant to such contracts may not respond to WCOP fee schedules, or may respond to WCOP fee schedules differently than will payments made in the absence of a contract. If, and to the extent that, contracts limit the effect of fee schedule values on overall medical costs, further reductions in fee schedule amounts will be necessary to accomplish the reductions in medical expenses required under HB373.

Distribution of charges above and below the current and/or new fee schedule(s): Providers may charge above, at or below any given fee schedule. Generally, each provider has a schedule of established charges that applies to all patients regardless of the form of insurance coverage that may be responding to bills and expenses for any given patient. For charges that are equal to or higher than an existing fee schedule, a reduction in the fee schedule amount would presumably be fully reflected in lower payments made after the change in the fee schedule. For charges that fall below both the current and reduced fee schedules, the change in fee schedule would presumably have no effect on payment amounts. For charges that are less than the existing fee schedule but higher than the reduced fee schedule, the new fee schedule would reduce payments but to a lesser degree than fees are being reduced.

While the magnitude of the effect of the distribution of charges on savings realized from a given reduction in fee schedule amounts depends on the relationships between previous fees, the reduced fees and provider charges, the direction of this effect is clear. It may reduce the savings attributable to a reduction in medical fees or it may allow realization of savings proportional to the reduction in fees, but it cannot produce savings greater than the proportional reduction in medical fee amounts.

Changes to the Coding of Medical Payments under the New Fee Schedule: HB373 requires the use of scales consistent with the Centers for Medicare and Medicaid Services. Since the inception of Delaware's workers compensation fee schedules, hospitals and ambulatory surgery centers have been reimbursed for services on workers compensation claims using different scales than those that will be required effective January 31, 2015. (Hospitals have largely been reimbursed on the basis of revenue codes, while ambulatory surgery centers have generally been reimbursed based on CPT codes with separate bill records being used to submit professional and facility fee charges respectively.)

This change in the basis for payment complicates the establishment and/or evaluation of revised fee amounts, because payment experience prior to the change does not include the codes that will determine payment amounts under the new fee schedule.

Practices in Use by Other Jurisdictions:

National Council on Compensation Insurance, Inc. (NCCI): NCCI serves as the advisory organization for workers compensation insurance in a substantial number of states across the country. NCCI estimates the effects of changes to fee schedule provisions quite often, either in the context of preparing rating value filings or evaluating proposed legislative or administrative changes. NCCI's approach to the enterprise of preparing such estimates is consistent and quite straightforward. Its analysis proceeds as described below:

NCCI obtains or determines the average percentage change (increase or decrease) in fee levels incorporated in the fee schedule revision being evaluated. If fees are increased, NCCI estimates that system costs will increase by 80 percent of the fee schedule increase percentage. For example, if fees are increased ten percent then NCCI would expect an eight percent increase in system costs.

If fees are reduced, NCCI estimates that system costs will decline by one-half of the fee schedule decrease percentage. For example, if fees are reduced ten percent then NCCI would expect a five percent decrease in system costs.

The relationships between fee schedule changes and system costs used by NCCI are based on its research in the paper *The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States* cited previously.

The DCRB perceives NCCI's approach as implicitly recognizing the effects of charge distributions (market prices) and contractual arrangements that may govern reimbursements for medical services differently than fee schedule provisions per se, with the parametric adjustments being derived from the referenced analysis.

Workers Compensation Inspection and Rating Bureau of California (WCIRB): California has a large and extremely dynamic workers compensation system which has experienced a variety of changes over time. The WCIRB is the advisory organization in California, and is charged with the task of evaluating proposed system changes and, when specific changes are adopted, reflecting such revisions in proposed prospective loss costs on an ongoing basis.

The DCRB has inquired of the WCIRB and has been advised that its evaluations of medical fee schedule changes proceed along the following lines:

Transactional medical data is used to weight changes in medical fee amounts. This is done using only the old and new fee amounts, and may also be done on a sampling basis to account for the distribution of charges around the fee schedule amounts. WCIRB then considers the results of that work and selects a value for the fee schedule change when the two alternative approaches give different results.

WCIRB does not separate transactional data into contract and non-contract components and, to date, has not taken a position regarding possible indirect effects of changes in fee schedules that might arguably amplify or attenuate savings from fee schedule changes.

DCRB Approach to Evaluating HB373

The DCRB is aware of what HB373 requires in terms of revisions to the medical fee schedule – savings in aggregate medical expenses of 20 percent by the year beginning January 31, 2015, 25 percent of 2014 expenses by the year beginning January 31, 2016 and 33 percent of 2014 expenses by the year beginning January 31, 2017.

The DCRB does not know what specific values the new fee schedules will use, or what overall changes in medical fee amounts will be reflected in those fee schedules. It is clear that medical fees would have to be reduced by percentages that are larger than the statutory reductions in medical expenses in order to achieve the necessary savings in expenses, for the reasons previously set forth in this discussion.

The DCRB cannot presently either corroborate or dispute the accomplishment of HB373's mandates for medical expense reductions through the construct of future fee schedules. Accordingly, the December 1, 2014 DCRB filing of prospective loss costs incorporates savings estimates based entirely on the assumption that the savings specified in the law will be fully realized.

The DCRB will carefully assess the new fee schedules when they become available. The DCRB's review will include a request(s) for supporting information from the WCOP regarding the bases for, and information used in the course of, developing those new schedules. It is expected that the DCRB's review will confirm that the revised fee schedules are consistent with HB373 in all material respects. However, in the event that our review suggests otherwise, the DCRB reserves its right to submit, at any time following the completion of that review, a filing of prospective loss costs and residual market rates consistent with the DCRB's evaluation of the effects of HB373.

Law changes often impose quantum changes in benefits or costs at specified points in time. Such changes, which are not of a recurring nature, need to be separated from ongoing trends in system features such as claim frequency, claim severity or loss ratios. The DCRB accomplishes this necessary separation by adjusting experience data occurring after the effective date of a law change to a "pre-law" level, adding back the estimated savings from each law change to develop an experience base for use in loss development and trend analysis. For this filing there are several pieces of legislation that must be taken into account in addition to HB373. The following discussion addresses the handling of such law changes for purposes of this filing.

SB238 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.

Exhibit 33 included with this filing sets forth the DCRB's evaluation of the effects of SB238 on Delaware workers compensation costs. The overall impact of this legislation on workers compensation medical loss costs is currently estimated as a savings of 0.42 percent.

Exhibit 34 included with this filing provides the DCRB's evaluation of numerous components of HB175 and/or regulatory changes undertaken consistent with provisions of that law. System changes addressed in this fashion include the following:

- §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.

- §2322B (12) directed that the formulary and fee methodology system developed by the HCAP 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.

- §2322B (11) directed the HCAP 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.

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

- HCAP changes to Fee Schedule. During 2013, the HCAP 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.

- 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.

- §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.

- §2322B (8) changed the index applicable to revision of hospital reimbursement rates from CPI-Medical to CPI-U.

- 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.

Exhibit 34 included with this filing sets forth the DCRB's current evaluation of the effects of the above provisions of HB175 on Delaware workers compensation costs. The overall impact of those portions of this legislation on workers compensation medical loss costs is a savings of 7.42 percent.

SB1 created several features of the health care payment system in Delaware. Savings attributable to SB1 were estimated in DCRB filing No. 0806, and those estimates were approved by the Insurance Department as filed. Accordingly the savings factor developed in DCRB Filing No. 0806 (17.40 percent of medical losses) has been retained and applied for purposes of this filing.

B: EFFECTS OF LARGE LOSSES ON EXPERIENCE ANALYSIS

Workers compensation benefits include partial wage replacement during periods of inability to work, various forms of permanent disability awards, and payment of costs of medical and rehabilitative services necessary to gain maximum medical improvement from the effects of work-related injuries and illnesses. In concert, these benefits and, in particular, medical benefits can produce extremely large obligations in individual cases. Claims incurring benefits totaling millions of dollars can and do occur. The Delaware experience with respect to such large claims and the potential impacts of such claims in future coverage periods are contributing factors to the rising cost levels underlying this filing.

The analysis performed by the DCRB in reviewing prevailing residual market rates and voluntary market loss costs must include reasonable provisions for the potential for such occurrences but attempts to avoid being unduly impacted by the occurrence (or absence) of rare or unusual claims. Historically, the DCRB has considered the extent to which large claims have been present in Delaware experience and has employed various techniques designed to accomplish these stated objectives. The DCRB's prior filings had, on occasion, excluded a specific policy year from the determination of prospective trend factors when the policy year in question contained an unusually large loss, since such a policy year would tend to overstate future trends if it were to be included as a new trend point, and it would subsequently understate those trends if it were included as an old trend point.

In its annual experience filings effective December 1, 2004 and later, the DCRB has applied procedures that perform loss development and trend analyses on a "limited" basis and then account for the expectation that claims exceeding the selected limit would occur from time-to-time by adding an excess loss factor to the rate level analysis.

This filing has again approached loss development and trend analysis on a limited loss basis. This work was initially performed with loss amounts stated prior to the estimated effects of SB1. Prior to determining the effect of loss limitation on the indicated rating value changes, the loss limit was adjusted to be stated on a post-HB373 basis (reflecting benefit levels and system provisions expected to be attained when the successive changes to Delaware's medical fee schedule are completed on January 31, 2017). The methods and steps applied to that purpose are outlined briefly below:

- The December 1, 2004 loss limit ($1,500,000) and the associated excess loss factor (0.0757) were taken as a key reference point for determination of appropriate loss limitations for this filing.

- Approved excess loss factor tables prior to December 1, 2004 were used to establish loss limitations consistent with an excess loss factor of 0.0757.

- An annual trend rate was computed for the series of loss limits established in the previous step described above.

- Loss limits were interpolated for each policy period prior to December 1, 2004 based on the trend in loss limits through December 1, 2004.

- Loss limitations consistent with an excess loss factor of 0.0757 for filings through December 1, 2013 were used to derive a post-2004 annual trend rate.

- Loss limits were projected for each policy period subsequent to December 1, 2004 based on the trend in loss limits through December 1, 2013.

- A series of loss limitations was selected for previous policy years consistent with the trend through December 1, 2004, applied retrospectively from that date and consistent with the trend from December 1, 2004 through December 1, 2013, applied prospectively from December 1, 2004, such that losses were capped at successively lower levels for older policy years, recognizing the impacts of wage and price inflation and potential changes in utilization over time. For policy years prior to 1983, a constant loss limitation of $395,600 was applied.

- Reported paid and case incurred losses were adjusted as needed to limit underlying loss data to the selected limitations by policy year.

- Loss development analysis was performed using the limited loss data produced above.

- Trend analysis was accomplished by dividing the observed limited loss ratios into separate components for claim frequency and claim severity, and prospective trends were selected for each component.

- A loss limitation was selected for the prospective rating period based on the post-2004 projections. This selection was $2,830,000 on a pre-SB1 basis (reflecting benefit levels and system provisions in effect immediately prior to the implementation of Delaware's medical fee schedule on or about September 1, 2008). This loss limitation was then adjusted to a basis reflecting the combined effects of SB1, SB238, HB175 and HB373, which resulted in a loss limitation of $1,441,569.

- The percent of losses that the selected loss limitations would be expected to remove from Delaware experience was determined.

- Trended limited loss ratios were adjusted to an unlimited basis by application of an excess loss factor, from which point the rate level analysis could proceed in the usual fashion.

Limiting losses in the course of the filing analysis and accounting separately for expected losses in excess of the effect of the applied limit(s) is a viable means of tempering the potential effects of relatively rare, large claims on rating value change indications. The intent of this approach is to smooth year-to-year results without either raising or lowering rating values over the longer term. In any given filing, the use of a limited loss approach may give either higher or lower results than would

a counterpart unlimited method. While other methods could also be considered for this purpose, the DCRB believes that a limited loss technique is the most appropriate available approach to the current filing.

Discussion of the DCRB's estimation of policy year ultimate loss and loss adjustment expense ratios and trend provisions following below are offered and should be read in the context of the loss limitation procedure outlined above.

C: ESTIMATION OF POLICY YEAR ULTIMATE LOSS AND LOSS ADJUSTMENT EXPENSE RATIOS

Much of the analytical effort required in workers compensation insurance ratemaking is devoted to the evaluation of loss experience from prior periods of time. The following points are important in considering this aspect of workers compensation ratemaking:

- Results of past experience form a vitally important base of knowledge from which prospective estimates pertinent to ratemaking are generally made.

- Because workers compensation losses may be paid out over an extended period of time after the occurrence of an accident and the filing of a claim, results of recent periods of experience must themselves be estimated before ratemaking analysis based on those prior periods of time may proceed.

The DCRB has considered the matter of estimating ultimate policy year loss and loss adjustment expense ratios at length in the preparation of this filing. Various actuarial methods were tested prior to the final selection of estimates used in support of this filing. In evaluating results of these methods, information gleaned from the DCRB's Unit Statistical Plan data was also taken into account.

In estimating ultimate policy year loss ratios for indemnity benefits, the paid loss development and case incurred loss development methods gave similar results across all policy years. Differences between these approaches were less than two percent in 16 of the 24 policy years for which ultimate losses were estimated using both of these methods and were less than four percent in all but four of those policy years.

In five policy years, the case incurred loss development method gave a higher result than did paid loss development, while in 16 policy years the reverse was true. Adding the indemnity loss ratio estimates for the two methods across the 24 most recent policy years gave totals that were different by slightly less than 1.4 percent with the paid loss estimates producing the higher total.

The DCRB customarily uses a four-year average of age-to-age development factors in its estimation of ultimate loss and loss adjustment expense ratios. In maintaining this process for successive filings, one new year of development experience is added for each filing while a year of development four years prior to the most recent available year is removed from the filing analysis. With three of the same years of development experience being used in any pair of successive filings, it is the difference in loss development between the respective years being added and dropped that most influences whether ultimate loss estimates will tend to increase or decrease between successive filing analyses. For this filing the latest available year of development experience which was first available for this filing is Calendar Year 2013.

Review of Unit Statistical Plan data compiled in conjunction with the preparation of this filing shows claim closure rates that tended to be deteriorating somewhat over time.

With the benefit of extensive staff review and discussion by both the Actuarial and Classification and Rating Committees, the DCRB has based estimates of ultimate indemnity losses in the filing on the average of the case incurred loss development method and paid loss development applied over as long a development period as is available from the DCRB's data, with case incurred loss development used for the remaining development to an ultimate basis.

This filing's indemnity loss development methodology has been used as the basis for the DCRB's annual rating value filings made each year since and including 2002.

For medical loss estimates, differences between the paid loss development and case incurred loss development estimates exceeded two percent in 12 of the 24 completed policy years for which ultimate losses were estimated using both methods. The differences were more than two percent and less than four percent for five policy years, and were more than four percent but less than eight percent for seven policy years. The case incurred loss development method gave higher results in 13 of those 24 policy years. Adding the medical loss ratio estimates for the two methods across the 24 policy years gave totals that were different by a little more than one percent, with the case incurred method's total being the higher of the two.

The DCRB cannot ascertain what factor(s) are resulting in the divergence between the paid loss and case incurred loss development methodologies observed in this filing for medical losses, nor can it develop a basis for selecting one of those methodologies to the exclusion of the other. Consistent with practices in numerous prior DCRB filings, medical ultimate loss estimates for this filing have been determined using the average of the case incurred loss development method and paid loss development applied over as long a development period as is available from the DCRB's data.

In applying its loss development methods for both indemnity and medical benefits, the DCRB has again used the following procedures to smooth fluctuations arising due to the limited volume of data available for the analysis:

- Use of four-year average loss development factors
- Smoothing of loss development factors using various mathematical models and curves fitted through the observed multi-year averages
- Using trend procedures which rely on multi-year averages rather than individual year ultimate loss and loss adjustment expense ratios

A comparison of results of loss development methods used in the filing may be seen on the enclosed Exhibit 2 at the top of Page 2.5 for indemnity loss and at the top of Page 2.17 of the same exhibit for medical loss.

D: TREND PROVISIONS

Historical data available for ratemaking relates to prior periods ending some time before the preparation of a filing. Often the available historical data will exhibit a propensity to change in some general fashion over time. Each DCRB filing applies to a prospective period of time beginning well after the end of the available historical data. Thus, it is necessary to account for any anticipated

continuation of (or deviation from) observed historical tendencies for loss ratios to change over time during the period between the end of the available data and the policy period to which the proposed rates will apply. This accounting is accomplished using various forms of "trend" analysis.

In support of each of its rating value filings submitted in the Years 2002 – 2013 inclusive, the DCRB adopted a trend approach that separated policy year loss ratio trends into "severity" and "frequency" components. As this alternative approach provides greater detail about significant features of Delaware workers compensation experience and allows more informed and specific judgments about probable future experience, the DCRB has also applied this approach to the preparation of this filing. The procedure used and results thus obtained are described further below.

Policy year on-level ultimate loss ratios were adjusted to a series of "severity ratios" by removing the effects of actual observed changes year-to-year in the frequency of indemnity claims per unit of expected loss at a constant DCRB rate level. The series of severity ratios thus obtained are representative of the policy year loss ratios that would have applied absent any change in underlying claim frequency and, thus, may be thought of as a series of indices of claim severity. Loss ratio trends, then, are derivable as the combined result of separately determined trend provisions applicable to claim frequency and claim severity.

In reviewing claim frequency data for this filing, the DCRB observed that Policy Years 2009 and 2010 showed very little change in claim frequency. Those policy years were thought to have been influenced by recessionary conditions, and DCRB had treated Policy Year 2009 separately in a previous filing (DCRB Filing No. 1105, effective December 1, 2011).

Using a seven-point exponential trend model and claim frequency data including Policy Years 2009 and 2010 gave an annual rate of claim frequency improvement of 5.0 percent. That rate of improvement was less than had been observed in any Policy Year since 2003, with the exception of the two recessionary years 2009 and 2010. The DCRB decided that using Policy Years 2009 and 2010 with equal weight in the trend model was unduly pessimistic, but was also not inclined to remove those years entirely from the determination of a claim frequency trend for this filing. Accordingly, a second seven-point exponential trend was computed using the Policy Years 2004 through 2012 but excluding 2009 and 2010. That approach gave an annual claim frequency change of -8.1 percent. The DCRB then averaged the seven point trend including Policy Years 2009 and 2010 (-5.0 percent) and the seven point trend excluding Policy Years 2009 and 2010 (-8.1 percent) and selected that average change, -6.6 percent, as the claim frequency trend for this filing.

In estimating claim severity trends, the DCRB applied both linear and exponential trend models to the policy year severity ratios produced by the loss development methods referred to previously. Indemnity and medical ratios were treated separately, and for each method the linear and exponential models were applied to all possible numbers of policy years from four through ten.

For indemnity benefits, a review of alternative trend model indications, including graphic presentations of indemnity loss and severity ratios over the past several years for selected models, supported the selection of an exponential trend model applied to the most recent available seven policy year severity ratios. Accordingly, the DCRB used a seven-year exponential trend model applied to indemnity claim severity ratios for the Policy Years 2006 – 2012, inclusive, and derived an annual trend rate of +5.8 percent.

Indemnity loss ratios for this filing were then trended to December 1, 2015, the mid-point of the prospective rating period, by applying the above-described annual rates of change in claim frequency and claim severity to each of the most recent four policy year loss ratios. The filing is based on the average trended policy year indemnity loss and loss adjustment expense ratio thus obtained, effectively the average trended indication for the most recent four policy years in combination.

For medical benefits, the same trend analysis as was applied for indemnity loss was also used. While the DCRB's measure of claim frequency uses only indemnity claims, the vast majority of medical benefits are attributable to indemnity cases, and many prior filings have also used this approach.

The adjudication of the DCRB's December 1, 2009 filing had included an adjustment to medical trend based on the Insurance Department's expectation that such trend would be more favorable after the implementation of the Delaware medical fee schedule than they had been before that transition. The trend adjustment so required was in the amount of a 1.8 percent reduction in annual loss ratio or claim severity trend.

While the DCRB could not and cannot estimate whether or the extent to which the provisions of SB1 affected medical trend, the opinion that some mitigation of medical trends should be applied upon the implementation of the medical fee schedule was widely held by the Department and its consultants in their review of the 2009 filing. After considering analytical and administrative alternatives, the DCRB elected to incorporate the mandated improvement in medical trend from the 2009 filing's adjudication in each subsequent annual rating value filing through, and including, DCRB Filing No. 1305 last year.

Subsequent to the enactment of SB1, it came to light that the regulation of provider charges for hospitals and ambulatory surgical centers intended under that legislation had not been accomplished by virtue of both legal and practical limitations. Providers could not separate workers compensation cases from other services and charge them different amounts than were applicable to other patients due to Medicare requirements. Further, neither providers nor payers were possessed of the extent of historical information that would have been required to index charges or reimbursements back to historical benchmarks envisioned under SB1.

SB238 addressed these issues by changing the regulation of hospitals and ambulatory surgical centers from specifying allowable charges to providing a mechanism for adjusting reimbursements from prevailing charges at levels consistent with the original intent of SB1. These changes became effective January 31, 2013.

The DCRB evaluated the impacts of hospital and ambulatory surgical center charges escaping the intended effects of SB1 and found that the trend adjustment previously posited for enhanced control of inflationary changes would have been 1.5 percent instead of 1.8 percent from the implementation of SB1 to the effective date of SB238.

HB175 included a provision changing the applicable inflationary index for hospital payments from CPI-M to CPI-U effective June 27, 2013. The DCRB measured the effect of the change in CPI index, weighted by the portion of medical payments made to hospital providers. The result of that calculation was to change the trend adjustment after June 27, 2013 from -1.8 percent to -2.2 percent.

Without conceding either the amount or direction of influences of SB1, SB238 and/or HB175, the DCRB has included the adjustments described above to medical severity trends in the preparation of this filing.

Since the medical fee schedule became fully operational on or about September 1, 2008 in Delaware, for this filing, the DCRB has applied the 1.5 percent change in medical trend to time periods extending from September 1, 2008 to January 31, 2013, the 1.8 percent change in medical trend to the period from January 31, 2013 to June 27, 2013 and the 2.2 percent change in medical trend to the period after June 27, 2013.

Up to September 1, 2008, the DCRB used a seven-point exponential trend fit through policy year medical claim severity ratios from Policy Years 2006 – 2012 inclusive, resulting in an annual trend rate of +13.6 percent. Between September 1, 2008 and January 31, 2013, the 1.5 point decrement in that trend resulted in an annual medical claim severity trend of +12.1 percent. From January 31, 2013 to June 27, 2013, the 1.8 point decrement produced a medical severity trend of +11.8 percent. After June 27, 2013, the applied medical severity trend was (+13.6 – 2.2) or +11.4 percent.

The filing is based on the average trended policy year medical loss and loss adjustment expense ratio obtained from the most recent four available policy years, with the claim frequency and claim severity trends described above applied for the respective time periods needed to project each policy year to the mid-point of the rating period, December 1, 2015.

E: DETERMINATION OF PROPER PERMISSIBLE LOSS RATIO FOR PROPOSED RESIDUAL MARKET RATES

The use of methodologies that explicitly recognize investment income in concert with anticipated cash flows, benefit costs and expense needs in preparing workers compensation rate filings is well established. The precise manner in which these methods may be applied in the preparation of such filings, however, differs from jurisdiction to jurisdiction. The DCRB's approach in previous filings has been to use such methods to directly compute a permissible loss and loss adjustment expense ratio consistent with an independently established target rate of return. This approach has previously been approved by the Insurance Department and has been retained for the development of this filing as well.

The prospective determination of an appropriate overall rate of return, which workers compensation insurers should be entitled to earn given the risk they assume in underwriting this line of business, is accomplished by a variety of economic analyses which are generally based on expected returns of businesses subject to risk levels comparable to that of underwriting workers compensation insurance. These methodologies next proceed by establishing a set of cash flows representing the various transactions related to the underwriting of workers compensation insurance. These cash flows include the expected patterns for the receipt of premiums, payment of losses and expenses, use of tax credits and/or payment of tax obligations, and maintenance of surplus funds in support of the business. Expense needs to which the expense cash flows will apply are determined based on historical experience.

Estimates of the probable investment results that an insurer underwriting workers compensation insurance may expect to achieve were made by reviewing existing insurer investment portfolios and prevailing investment returns on various forms of investments held therein. Applying these estimates to the cash flows previously established allows an explicit presentation of the effects of investment income throughout the life of a book of workers compensation policies and an estimated accounting of the value of that income to the insurer.

Based on the set of cash flows determined to apply to prospective policies and the estimated parameters of investment yields, federal tax laws, etc., these methods model all expected cash flows over the entire period during which payments attributable to a given policy period are expected to continue. For any given loss provision in rates, the present value of these cash flows can then be consolidated and compared to the target rate of return. The loss provision accomplishing a balance between the expected and target rates of return then becomes the basis for the permissible loss ratio. Within the concept of the Internal Rate of Return (IRR) Model used by the DCRB, the loss provision includes provision for amounts generally related to losses such as loss adjustment expense and loss-based assessments.

This filing, as have an extended series of previous DCRB filings, recognizes investment income on reserve and surplus funds in determining the overall expected return for carriers from writing workers compensation business in Delaware. This process establishes an underwriting profit provision which has historically been negative – that is, investment income has not only been the sole source of carrier profits but has also at least nominally offset other loss and expense costs for insurers.

The analysis supporting this filing indicates a needed underwriting profit provision of +0.79 percent. For the December 1, 2013 filing the DCRB had derived an underwriting profit provision of -0.47 percent.

For this filing, the DCRB has again retained an independent economic consultant to perform the above-described analyses. Results of this work are presented in complete detail in attachments to this filing letter but are also summarized for ease of reference following:

INTERNAL RATE OF RETURN MODEL INPUTS & RESULTS
December 1, 2014 Residual Market Rate Filing

(1) Target Rate of Return	+8.85%
(2) Indicated Expense Provisions	
(a) Commissions	+5.97%
(b) Other Acquisition	+2.85%
(c) General	+3.44%
(d) Premium Discount	+9.15%
(e) State Premium Tax	+2.00%
(f) Uncollectible Premium	+1.00%
(g) Other State Taxes	+0.35%
(h) Workers Compensation Fund Assessment	+3.50%
(3) Investment Income	
(a) Pre-Tax Return on Assets Net of Investment Expenses	+4.31%
(b) Post-Tax Return on Assets Net of Investment Expenses	+3.38%
(4) Profit & Contingencies	+0.79%
(5) Permissible Loss Ratio	+70.95% *

*70.95% includes loss (57.08%), loss adjustment expense (11.63%) and loss-based assessment (2.24%)

F: CONSIDERATIONS PERTAINING TO THE APPROVED EXPERIENCE RATING PLAN

The DCRB reviews the performance of the Experience Rating Plan as part of its analysis supporting each annual rating value filing submitted to the Insurance Department. Fluctuations in results of the plan, in particular movement in the average experience modification produced by the plan, are measured and accounted for in the derivation of proposed changes in manual rates and loss costs, so that the Experience Rating Plan can reallocate premium obligations among insureds based on the merits of their past experience but not either increase or reduce the total amount of premium indicated by the DCRB's benchmark filings of residual market rates and voluntary market loss costs.

In previous filings, the DCRB has made use of its Market Profile Reports as a supplement to available unit statistical data to gauge recent and ongoing trends in the important system metric of Collectible Premium Ratios. For this filing, the DCRB has based the Collectible Premium Ratios used to derive manual rating values for purposes of this filing on the most recent three completed available years of Market Profile data, as shown in Exhibit 20. This approach is intended and expected to support the proposed collectible rate and loss cost changes and to provide more current recognition of the probable impact of experience rating for the forthcoming rating period.

In conformance with provisions of Forms and Rates Bulletin No. 1, as amended April 15, 1992, two copies of the cover letter of this filing are provided with each set of supporting materials. The cover letter identifies the line of insurance (workers compensation), the effective date of the filing (generally December 1, 2014 with selected portions effective June 1, 2015) and the name and telephone number of the person to be contacted by the Insurance Department in regard to the filing (Timothy L. Wisecarver, 215-320-4413). An interrogatory in the format provided with the referenced forms and rates bulletin has been completed and is included herewith. Two CDs, each containing a copy of the entire filing in PDF format, are also enclosed.

In addition, the following materials accompany this filing letter and present supplementary rating information and supporting information pertinent to the proposals advanced in this filing.

1. Record of Meeting - Actuarial and Classification & Rating Committees, September 30, 2014. *Note that these minutes are in the process of being reviewed and approved by the two committees and accepted by the Governing Board. If there are any changes resulting from this process, a revised final copy will be promptly forwarded to the Insurance Department.*

2. Summary of material for modification of experience (Brown Book)

3. The following exhibits taken from the Actuarial and Classification & Rating Committees' September 30, 2014 meeting agenda package or prepared or modified in consideration of discussions at that meeting:

Exhibit	1	Limited Losses	Table I - Summary of Financial Call Data
Exhibit	1a		Excess Loss Ratios and Loss Limitations
Exhibit	1b		Table I Reported Losses in Excess of Loss Limitations
Exhibit	2	Limited Losses	Paid and Incurred Loss Development and Trend
Exhibit	2a	Limited Losses	Graphs of Selected Loss Development Projections
Exhibit	3	Limited Losses	Measures of Goodness of Fit in Trend Calculations Using Severity Ratios
Exhibit	5		Graphs of Ultimate and Trended Experience Components
Exhibit	6	Limited Losses	Retrospective Test of Trend Projections for Severity Ratios

Exhibit 7	Open Claim Ratios, Payout Ratios and Average Claim Costs
Exhibit 7a	Financial Data Open Claim Ratios
Exhibit 8	Expense Study
Exhibit 9	Internal Rate of Return Model
Exhibit 10	Effect of 7/1/15 Benefit Change
Exhibit 11	Expense Loading
Exhibit 12	Indicated Residual Market Rate Change
Exhibit 13	Experience Rating Plan
Exhibit 14	Delaware Construction Classification Premium Adjustment Program
Exhibit 15	Rate and Loss Cost Formulae
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 ALAE
Exhibit 17d	Excess Loss Premium Factors
Exhibit 17e	Excess Loss Premium Factors Adjusted to Include ALAE
Exhibit 18	State and Hazard Group Relativities
Exhibit 19	Delaware Insurance Plan
Exhibit 20	Review of Experience Rating Plan Parameters
Exhibit 21	Table B
Exhibit 22a	Table II - Unit Statistical Data
Exhibit 22b	Table III - Unit Statistical Data
Exhibit 22c	Table IV - Unit Statistical Data
Exhibit 23	Claim Frequencies
Exhibit 24	Retrospective Development Factors
Exhibit 25	Tax Multiplier
Exhibit 27	Manual Rates, Loss Costs and Expected Loss Rates
Exhibit 28	Index to Classification Exhibits
Class Book	
Exhibit 29	Delaware Workplace Safety Program & Merit Rating Program
Exhibit 30	Distribution of Residual Market Rate Changes and Classifications with Proposed Capped Changes
Exhibit 31a	Summary of Indicated and Proposed Residual Market Rates by Class Code
Exhibit 31b	Summary of Indicated and Proposed Residual Market Rates by Percentage Change
Exhibit 33	Evaluation of Senate Bill 238 of 2012
Exhibit 34	Evaluation of House Bill 175 of 2013
Exhibit 35	Evaluation of House Bill 373 of 2014
Exhibit 1 Unlimited Losses	Table I – Summary of Financial Call Data
Exhibit 2 Unlimited Losses	Paid and Incurred Loss Development and Trend
Exhibit 2a Unlimited Losses	Graphs of Selected Loss Development Projections
Exhibit 3 Unlimited Losses	Measures of Goodness of Fit in Trend Calculations Using Severity Ratios
Exhibit 6 Unlimited Losses	Retrospective Test of Trend Projections for Severity Ratios

Proposed Manual Language Pertaining to Calendar Quarters Used to Determine Qualifying Wages for Delaware Construction Classification Premium Adjustment Program

Proposed Housekeeping Revisions – Sections 1 & 2 – Staff Memorandum Dated May 19, 2014

Proposed Manual Language Pertaining to Auditable Payrolls – Staff Memorandum Dated July 11, 2014

Completed Copies of the Following Property & Casualty Filing Forms

Filing Fee Form
State-Specific Requirements
Property & Casualty Transmittal Document
Rate/Rule Filing Schedule

III: SUMMARY

In preparing this filing, the DCRB has carefully considered current Delaware experience and has applied a variety of actuarial and economic analytical techniques that collectively support the proposals advanced herein.

DCRB staff will be pleased to cooperate with and assist the Insurance Department in its prompt consideration of these proposals.

Sincerely,

Timothy L. Wisecarver
President

TLW/jf
Enclosures