



**NOTE: These minutes not yet reviewed by the Committees and accepted by the Governing Board.**

**ACTUARIAL & CLASSIFICATION AND RATING COMMITTEES**  
**RECORD OF JOINT MEETING**

A meeting of the Actuarial and Classification & Rating Committees of the Delaware Compensation Rating Bureau, Inc. was held in Salon L, Second Floor, of The DoubleTree Hotel Wilmington Downtown, 700 King Street, Wilmington, Delaware on Tuesday, July 28, 2009 at 10 a.m.

The following members were present:

Actuarial Committee

Ms. M. Gaillard*	American Home Assurance Company
Mr. A. Kerin*	Amguard Insurance Company
Not Represented	Hartford Accident & Indemnity Company
Mr. W. Herr*	Liberty Mutual Insurance Company
Mr. K. Brady	PMA Insurance Company
Mr. J. Schmidt	Travelers Property & Casualty Company

Classification and Rating Committee

Ms. M. Gaillard*	American Home Assurance Company
Mr. A. Kerin*	Amguard Insurance Company
Mr. R. Schrum	Harleysville Mutual Insurance Company
Mr. D. Soja	Hartford Accident & Indemnity Company
Mr. W. Herr*	Liberty Mutual Insurance Company
Mr. J. Fitzgerald	New Castle County Chamber of Commerce
Mr. R. Prybutok**	National Federation of Independent Business
Mr. R. Edmunds	PMA Insurance Company
Mr. T. Wisecarver	Chair - Ex Officio

Also present were:

Mr. S. Cooley	Duane Morris LLP
Mr. G. Reed, Jr.	Delaware Department of Insurance
Mr. J. Neidermyer	INS Consultants, Inc.
Mr. M. Minkowitz	Strook & Strook & Lavan LLP
Ms. F. Barton	Bureau Staff
Ms. D. Belfus	Bureau Staff
Mr. B. Decker	Bureau Staff
Mr. M. Doyle	Bureau Staff
Mr. P. Yoon	Bureau Staff

\* Member of both committees

\*\* Present for part of meeting

The Antitrust Preamble was read at the beginning of the meeting for the benefit of all participants. Participants gave brief self-introductions.

The Committee discussion then moved to a review of staff work supporting the December 1, 2009 Residual Market Rate and Voluntary Market Loss Cost Filing. 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 PROPOSED DECEMBER 1, 2009 RESIDUAL MARKET RATE AND VOLUNTARY MARKET LOSS COST FILING**

Participants had been provided with electronic agenda materials in advance of the meeting. Those materials provided supporting information, analysis and results of Bureau staff's preparation of a residual market rate and voluntary market loss cost filing effective December 1, 2009.

Staff briefly described the content, context and application of supporting information for this filing. Bureau Filing No. 0806, previously submitted to the Department of Insurance, had addressed estimated impacts of the health care payment system being implemented under Senate Bill 1 (SB1). The December 1, 2008 Residual Market Rate and Voluntary Market Loss Cost Filing, Bureau Filing No. 0807, had been based on data predating implementation of SB1 and, accordingly, the overall indication derived in that filing was applied to the rating values ultimately approved under Bureau Filing No. 0806. Attendees were briefly updated with respect to ongoing litigation pertaining to Bureau Filing No. 0807.

For this filing, very limited amounts of data from the most recent available portions of the experience history reflected effects of the medical payment system implemented under SB1. Staff noted that the supporting financial data for this filing had been adjusted to be stated on a pre-SB1 basis, loss development and trend analysis had been performed using that adjusted data, and then SB1 savings factors consistent with Bureau Filing No. 0806 had been applied to derive final rating value change indications.

The Committee heard summary descriptions of those materials organized in topical groups as shown following. Questions posed during the meeting, with staff responses given and participant discussion ensuing, are set forth in the chronology of the presentation below.

**Minimum and Maximum Corporate Officer Payrolls**

A staff memorandum dated June 5, 2009, proposing Manual language revisions updating the current limitations on payrolls reported by corporate officers for premium determination purposes was referenced. The proposed revisions continued to maintain parameters in conformance with prevailing wage levels.

**Overall Indicated Changes in Collectible and Manual Rating Values**

**Exhibit 12**

A handout was distributed amending previous versions of Exhibit 12, and attendees were advised of the revision made to the indicated change in voluntary market loss costs thereon. Exhibit 12 was reviewed. Estimates of historical ultimate on-level policy year loss and loss-adjustment expense ratios (Lines (1a) through (1e)) and ultimate on-level policy year loss and loss-adjustment expense ratios trended to the mid-point of the prospective rating period (Lines (2a) through (2e)) were

noted as having been evaluated, subject to a schedule of loss limitations by policy year reflecting the expectation that loss size would increase over time as wages, benefits and prices were subject to both ongoing economic inflation and changes in utilization. Staff outlined considerations that had led to the adoption of a limited-loss analysis for purposes of the December 1, 2004 filing proposal, adaptations of loss limitation procedures applied in subsequent filings and the proposals currently under discussion. An adjustment factor reflecting anticipated savings due to SB1 was presented on Line 3(a), consistent with the statement of experience data on a pre-SB1 basis. The average trended loss and loss adjustment expense ratio on a post-SB1 basis was shown on Line 3(b).

***Question:*** *An attendee noted the adjustment for SB 1, characterizing that factor as being significant. Staff was asked when information would be available to allow a critical assessment of the magnitude of that factor.*

***Answer:*** *The estimate of savings used in Exhibit 12 was consistent with the Bureau's previous Filing No. 0806. It was noted that following the future course of system costs was a different and easier matter than attributing components of changes in those costs to discrete causes. Staff noted that the Bureau was in the process of obtaining a more current complement of detailed medical data, including the first half of 2009, and that it would continue to monitor experience with the eventual benefit of the Medical Data Call information. Interest in that kind of analysis was thought to be widespread and to include the Delaware Healthcare Advisory Panel constituted under SB1.*

An excess loss factor (Line 4(a)) was included in the analysis to account for the effects of the limitations applied in the Bureau's loss development and trend analyses. Comparison of the trended loss and loss-adjustment expense ratio to a permissible loss and loss-adjustment expense ratio based on econometric analysis (Lines 5(a) and (6), respectively) produced an indicated overall average change in residual market rate level prior to effects of the July 1, 2010 benefit change (Line (7)). Adjustment for the estimated effects of the July 1, 2010 benefit change (Line (8)) resulted in the indicated change in residual market rates (Line (9)).

The proposed change in voluntary market loss costs (Line (10)) 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.

Staff pointed out the proposed overall changes in residual market rates (6.01 percent decrease) and voluntary market loss costs (5.22 percent decrease).

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 12. This analysis started with the collectible premium ratios underlying presently-approved rating values (Line 11). The Bureau had then measured the collectible premium ratios that the Experience Rating Plan had produced in previous periods. Using the relationships between the currently-approved and updated collectible premium ratios (Line 13), staff had derived indicated changes in manual residual market rates (Line 14). Indicated changes in manual voluntary market loss costs (Line 18) had been derived by also accounting for the nominal impact of changes in the offset to voluntary market rating values for continuation of the approved surcharge program in the Delaware Insurance Plan (Lines 16 and 17).

***Question:*** *Staff was asked about the representation and effect of very large employers in the Bureau's data.*

***Answer: Attendees were advised that the Bureau's financial data excluded self-insured and large deductible business. This approach notwithstanding, staff commented that there was a broad range of employer sizes included in that database. For purposes of classification ratemaking, the Bureau used all commercially insured data, with large deductible business being reported on a first-dollar basis.***

### **Loss Development**

Exhibits 1 (Limited Loss), 1a, 1b, 2 (Limited Loss), 2a (Limited Loss) and 7

Staff described the content of each of the referenced exhibits from the meeting agenda materials. Highlights from those descriptions are set forth below.

Exhibit 1 (Limited Loss) (Table I) provided summaries of financial data reported by Bureau members for the calendar years ending December 31, 2004 through 2008, inclusive. Successive calendar year evaluations of premiums, indemnity incurred losses, medical incurred losses, indemnity paid losses and medical paid losses were compared to derive age-to-age development factors or "link ratios" to be used in the Bureau's estimation of ultimate premiums and losses for prior policy years. In making the comparisons producing specific link ratios, data for all carriers with available and credible data was used, with the result that each calendar-year-end evaluation could show two different amounts; one for purposes of comparison to the prior calendar year-end and the other for purposes of comparison to the subsequent calendar year-end.

Staff noted that the data in Table I, consistent with previous Bureau filings, excluded data for large deductible coverages. That exclusion was noted as being responsive to the lack of independent sources for loss data gross of large deductible reimbursements and the potential for significant differences in underlying hazard and loss potential inherent in large deductible business, as compared to business insured on a first-dollar basis.

Attendees were reminded that the data in Table I had been adjusted to a pre-SB1 basis, an adjustment affecting only limited amounts of payments made in late 2008 and having a small impact on case reserves as of December 31, 2008.

Claims exceeding selected limit values in paid and/or incurred values had been identified using large claim data separately reported by carriers, and the effect of capping such losses at the selected limitations was reflected in the combined paid and/or incurred amounts in Table I. By reference to Exhibit 1b, this adjustment process was described as having affected every complete policy year except 1996, 2000, 2001, 2006 and 2008 on a paid basis, and every complete policy year except 2006 on an incurred basis for at least one evaluation.

Exhibit 1a provided background analysis of trend in loss limitations consistent with an excess ratio of 0.0757 (the excess factor applicable for a selected loss limitation of \$1,500,000 in the December 1, 2004 filing, when limited loss analysis was first applied to a Bureau filing) and the series of loss limits applied by policy year in producing Exhibit 1 on a limited basis. Staff emphasized that the loss limit analysis for this filing had been done first on a pre-SB1 basis and that the final loss limitation pertinent to Exhibit 12 had then been computed on a post-SB1 basis. For policy years prior to December 1, 2004, loss limits had been computed using historical trends in excess loss factors from previously-approved loss limit tables. For subsequent policy years, trend indications for excess loss factors, including experience since December 1, 2004, had been applied to project appropriate loss limitation levels consistent with those observed trends. Staff noted that this procedure had been initiated for purposes of the December 1, 2008 filing as a means of stabilizing historical loss limitations. Exhibit 1b showed the reductions to reported loss amounts produced by application of the limits from Exhibit 1a.

**Question:** *An attendee inquired as to how the loss limit of \$2.3 million had been established.*

**Answer:** *Staff referred attendees to Exhibit 1a for the calculation in question. When a limited loss approach was initially applied to Bureau filings in 2004, the impact on loss amounts of the selected loss limit had been 7.57 percent. Using historical schedules of excess loss factors approved in Delaware, annual trends had been computed for the periods 1981 through 2004 and 1981 to date. The shorter-term rate of change had been used to derive a series of declining loss limitations going back in time from 2004. The longer-term trend was used to project increasing loss limitations forward in time from 2004. The \$2.3 million loss limit was the result of this latter projection method and was stated on a pre-SB1 basis. The pre-SB1 loss limit had been adjusted to a post-SB1 basis, and Page 3 of Exhibit 1a showed the weighting by exposures across hazard groups of excess loss factors at the post-SB1 limit to derive the excess loss provision used on Exhibit 12.*

**Question:** *A committee member asked whether the loss limitation process was removing losses above the applicable loss limits, rather than removing entire claims which exceeded those limitations.*

**Answer:** *Staff confirmed that the Bureau was removing only amounts of loss above the applicable limits.*

**Question:** *A question was posed seeking clarification of the loss limit applicable to the prospective period subject to the filing under review.*

**Answer:** *Staff provided loss limits on both a pre-SB1 basis (\$2.3 million) and a post-SB1 basis (\$1.979 million). Available data had been used to produce pre-SB1 loss distributions. Savings factors consistent with the Bureau's previous evaluation of SB1 had been applied to that distribution to derive a post-SB1 loss distribution.*

Exhibit 2 (Limited Loss) presented premium and loss development experience from Table I (including the application of the adjustments described above), supplemented by age-to-age factors taken from calendar evaluations of financial data predating those included in Table I. This data had been used to review development patterns and ultimately derive estimates of prior policy year premiums, losses and loss ratios. Staff described procedures used to develop estimates of ultimate premiums stated at a constant (current) rate level on Page 2.1 of this exhibit. Pages 2.2 through 2.13 presented the derivation of estimates of ultimate indemnity loss and loss-adjustment expense ratios for prior policy years.

Indemnity age-to-age paid loss development factors, incurred loss development factors and paid-to-incurred development factors were shown on Page 2.2. Factors for the most recent four development periods were based on the limited loss data from Table I (Limited Loss). After verifying that no subsequent changes to underlying data had been received, factors for previous development periods were taken from prior Bureau filings and were shown on a limited basis.

In application of each loss development method, the Bureau had sought to smooth the observed age-to-age link ratios in a variety of ways. Methods applied in this endeavor included the use of multi-year averages (generally the most recent four years) as the basis for selecting age-to-age factors and the fitting of mathematical curves through the observed average actual ratios. A broad variety of curve forms had been tested for this purpose. Curves that had given among the best and generally consistent results in this fitting process had been selected for use in support of the proposed filing. The selected curve forms used to smooth observed indemnity loss development age-to-age factors in the proposed filing were described as follows:

Indemnity Incurred Development Factors:

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

In the above expression, “y” represents the variable to be estimated, and “x” is an index of the maturity of the observed and/or projected stages of policy year development for which the variable values were observed. The terms “a,” “b,” “c,” “d,” “e” and “f” are constants derived using the curve-fitting procedures and are established to obtain the best possible fit of the selected curve to the observed actual data.

Better results were obtained by subtracting unity (1.000) from the observed indemnity paid loss development factors before using the above curve form. The estimated or smoothed “y” values were then added to unity to derive smoothed indemnity paid loss development factors.

Indemnity Paid Development Factor:

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

In the above expression, “y” represents the variable to be estimated, and “x” is an index of the maturity for the observed and/or projected stages of policy year development at which the values of “y” were observed. The terms “a,” “b,” “c,” “d” and “e” are constants derived using the curve-fitting procedures and are established to obtain the best possible fit of the selected curve to the observed actual data.

Better results were obtained by subtracting unity (1.000) from the observed indemnity paid loss development factors before using the above curve form. The estimated or smoothed “y” values were then added to unity to derive smoothed indemnity paid loss development factors.

Indemnity Paid-to-Incurred Development Factors:

The most recent actual four-year average paid-to-incurred age-to-age factor was selected for this transition. In this year’s analysis, as had been the case for several previous filings, loss development approaches converting to a case-incurred basis at varying points in development were not used.

Page 2.3 showed selected incremental development factors, cumulative development factors computed by successive multiplication of the incremental factors, and factors to bring indemnity losses on-level (benefit change factors) by policy year and to add loss-adjustment expense to loss.

Page 2.4 presented indemnity limited paid and incurred losses by policy year, projected ultimate losses using both paid-loss development, case-incurred loss development and an average of those two separate approaches, and adjusted ultimate loss and loss adjustment expense obtained by applying benefit on-level factors and loss adjustment expense factors to projected ultimate losses.

Page 2.5 showed ultimate limited indemnity loss ratios resulting from the work on Pages 2.1 through 2.4 and the calculation of limited severity ratios from ultimate limited loss ratios using an index of claim frequencies per unit of on-level expected losses derived from unit statistical data. Claim frequency trend factors for selected policy years to December 1, 2010, based on a review of unit statistical data, were also shown on this page. Staff noted that additional detail concerning the Bureau’s analysis of claim frequencies would be discussed in the context of trend analysis later in the meeting.

Page 2.6 showed fitted limited severity ratios for indemnity loss using linear models applied over various numbers of policy years. Severity ratios consistent with paid-loss development, case-incurred loss development, and an average of these two approaches were presented separately.

Page 2.7 showed trended limited severity ratios for indemnity loss based on various combinations of development approach and number of policy year points used as the basis for trending, all using a linear trend model. Trend factors derived from these trended loss ratios were shown for each of the most recent four policy years for each of the previously-mentioned loss development approaches.

Pages 2.8 and 2.9 were described as being alternatives to Pages 2.6 and 2.7, using an exponential model rather than the linear model previously discussed.

Page 2.10 showed indicated loss ratio trend factors derived by combining linear severity trend factors with the claim frequency trend factors from Page 6.

Page 2.11 showed indicated loss ratio trend factors derived by combining exponential severity trend factors with the claim frequency trend factors from Page 6.

Page 2.12 showed trended limited loss ratios based on the linear loss ratio trend factors from Page 2.10.

Page 2.13 showed trended limited loss ratios based on the exponential loss ratio trend factors from Page 2.11. The four-year average trended loss ratio, based on a seven-point exponential model applied to limited loss ratios consistent with the average of paid-loss and case-incurred loss development approaches, was highlighted with a border on this page, indicating that this was the basis for the discussion proposal's rate level change indication.

Pages 2.14 through 2.25 provided analysis of medical loss in the same fashion and organization as described previously for indemnity loss (Pages 2.2 through 2.13).

Staff provided a brief background of considerations related to medical loss development analysis in previous filings. It was noted that previous Bureau filings had included instances in which cumulative medical-incurred loss development factors had exceeded cumulative paid loss development factors at several common maturities. The problematic nature of this result (having both larger loss development factors and a higher statistical base for incurred losses than paid losses) was discussed.

Staff recalled work done in response to this issue for the December 1, 2007 and December 31, 2008 filings, wherein medical case-incurred loss development experience for Calendar Years 2003 and 2004 had been omitted from the filing analysis.

It was noted that for the December 1, 2009 filing, four years of medical case-incurred loss development data subsequent to Calendar Year 2004 was available, and thus it was no longer necessary to use Calendar Years prior to 2005 in obtaining four calendar years of age-to-age development factors. Medical loss development factors had been subject to the same complement of smoothing techniques as had been used for indemnity loss, for much the same reasons. The curve forms used to accomplish smoothing of four-year average medical loss development factors were as follow:

Medical Incurred Development Factors:

$$y = a * x^4 + b * x^3 + c * x^2 + d * x + e$$

In the above expression, “y” represents the variable to be estimated, and “x” is an index of the maturity for the observed and/or projected stages of policy year development for which the variable values were observed. The terms “a,” “b,” “c,” “d” and “e” are constants derived using the curve-fitting procedures and are established to obtain the best possible fit of the selected curve to the observed actual data.

Better results were obtained by subtracting unity (1.000) from the observed indemnity paid loss development factors before using the above curve form. The estimated or smoothed “y” values were then added to unity to derive smoothed indemnity paid loss development factors.

Medical Paid Development Factors:

$$y = a + b * x^{-5} * \log(x) + c/(x^{1.5})$$

In the above expression, “y” represents the variable to be estimated, and “x” is an index of the maturity for the observed and/or projected stages of policy year development for which the variable values were observed. The terms “a,” “b” and “c” are constants derived using the curve-fitting procedures and are established to obtain the best possible fit of the selected curve to the observed actual data.

Better results were obtained by subtracting unity (1.000) from the observed indemnity paid loss development factors before using the above curve form. The estimated or smoothed “y” values were then added to unity to derive smoothed indemnity paid loss development factors.

Medical Paid-to-Incurred Development Factors:

The most recent actual four-year average paid-to-incurred age-to-age factor was selected for this transition. In this year’s analysis, as had been the case for several previous filings, loss development approaches converting to a case-incurred basis at varying points in development were not used.

On Page 2.25, the four-year average trended loss ratio, based on a seven-point exponential model applied to limited loss ratios consistent with the average of paid-loss and case-incurred loss development approaches, was highlighted with a border on this page, indicating that this was the basis for the discussion proposal’s rate level change indication.

Page 2.26 showed indicated annual limited severity trends, based on both linear and exponential models, applied to each of the three loss development methods previously discussed.

Page 2.27 showed indicated annual limited loss ratio trends based on both linear and exponential models in the same format as used on Page 2.26 for limited severity trends.

Exhibit 2a provided graphical comparisons of the results of the limited loss development approaches used in the preparation of the filing separately for indemnity and medical losses.

Staff reviewed pertinent portions of Exhibit 7 with the participants. Based on available unit statistical data, Exhibit 7 showed claim closure rates, claim frequencies per million dollars of payroll, and ratios of paid losses to case-incurred loss and to estimates of ultimate-incurred loss. Payout ratios were shown on both limited and unlimited bases.

Staff noted that the financial data valuations at 12-months maturity were not used in producing ultimate estimates for proposed filings in Delaware.



Average claim cost statistics were shown for open indemnity claims, closed indemnity claims and all indemnity claims. These pages exhibited considerable volatility, due in substantial part to the limited amount of experience data available in Delaware.

Staff advised participants that, based on the collective information presented in the exhibits described above, the Bureau had selected ultimate loss estimates based on the average of a case-incurred loss development method and a paid-loss development method applied over as long a development period as possible, converting to a case-incurred approach for the remaining development to ultimate.

**Question:** *A Committee member noted the publication of recent papers addressing the subject of tail factor estimation. Staff was asked about its perception about the calculation of tail factors used in the proposed filing.*

**Answer:** *The filing calculated tail factors using a straightforward process. Calendar year development for all policy years not reported individually was compared to the oldest available single policy year to derive a tail factor indication. Staff noted that this approach effectively assumed that the range of policy years represented in the all prior report line were of equal size.*

**Comment:** *It was noted that the development tail could extend many years prior to the oldest available individual policy year and that the selected denominator in the tail factor calculation was very important.*

**Answer:** *Staff agreed with the observation but added that uncertainties about the sources of the observed development, as well as the relative magnitudes of individual prior policy years, complicated this analysis. A brief description was provided of an alternative tail factor approach used in Pennsylvania, which was described as nominally increasing tail factors from those derived using the Bureau's current approach.*

**Question:** *An attendee sought confirmation that the curve-fitting approach had been used only for the purpose of smoothing the series of age-to-age factors and not also as a means of projecting the loss development tail.*

**Answer:** *Staff responded affirmatively, observing that some curves considered and even used in this smoothing procedure would be problematic if extrapolated to the purpose of estimating tail factors.*

**Question:** *An attendee asked about loss development procedures applied in previous filings in response to observed case reserve strengthening.*

**Answer:** *Staff noted that special procedures invoked in previous filings for loss development and inspired by perceived strengthening in case reserves had been used in estimating ultimate medical losses rather than indemnity losses. With that said, staff disclosed that anomalies observed in previous filings had abated substantially, and the current draft filing did not include special considerations to address those kinds of concerns.*

**Question:** *Staff was asked how frequently the curve-fitting procedures described for loss development were reviewed.*

**Answer:** *Staff performed fresh analysis of the curve fits in questions every year. We try to keep the same curves if possible but sometimes we need to change them.*

## **Trend**

### Exhibits 2 (Limited Loss), 3 (Limited Loss), 5, 6 (Limited Loss) and 23

Staff referred to the cited exhibits as they pertained to the trend provisions included in the proposed filing. Key observations made are summarized below.

Portions of Exhibit 2 pertinent to trend analysis and presented in the discussion of loss development were noted.

Exhibit 3 showed various measures of the goodness-of-fit, obtained by applying linear and exponential trend models to varying numbers of policy year, limited severity ratio points from the loss development approaches considered in preparing the proposed filing. R-squared statistics were derived for each such trend model application (Page 3.1). Indemnity r-squares were notably lower than medical r-squares. Successive pages developed fitted values for linear and exponential models (Pages 3.2 through 3.5), followed by “residuals” (the result of subtracting fitted values from the actual observed values for policy year severity ratios) on Pages 3.6 through 3.9. Residual values for most methods and fitting periods tended to show persistence above or below unity over time rather than changing sign frequently as would be desired.

Exhibit 6 applied the tested trend methods to project policy year limited severity ratios for which subsequent estimates were available based on the Bureau’s loss development analyses. This exercise tested the comparative ability of such methods to predict subsequent severity ratios.

Page 6.1 showed indemnity severity ratios by policy year for each loss development approach.

Page 6.2 showed trended limited indemnity severity ratios using various numbers of policy years applying a linear trend model.

Page 6.3 showed differences between linear-trended and actual policy year limited indemnity severity ratios.

Page 6.4 showed trended limited indemnity severity ratios using various numbers of policy years applying an exponential trend model.

Page 6.5 showed differences between exponential-trended and actual policy year limited indemnity severity ratios.

Pages 6.6 through 6.10 presented results for limited medical severity ratios in the same sequence and format as had been discussed for indemnity losses above.

After consideration of the collective information discussed above, staff had selected an annual severity ratio trend of approximately +0.1 percent for use in projecting for indemnity loss ratios and had selected an annual severity ratio trend of approximately +6.2 percent for use in projecting medical loss ratios. Each of these trends was based on results of applying a seven-point exponential trend model to severity ratios taken from the average of the paid-loss and case-incurred loss development approaches.

Claim frequency data based on Unit Statistical Plan reports was presented in Exhibit 23. Staff described the exposure base used in this analysis as being on-level expected losses and noted that this measure included wage level changes, exposure growth and shifts in employment between different kinds of businesses. Consistent with the severity trend approach described above, the Bureau had derived a

historical indemnity claim frequency trend by application of an exponential trend model through observed indemnity claim frequencies over the seven most recent available policy years, resulting in an annual frequency trend of -7.6 percent. The Bureau had then applied the indicated severity and claim frequency trend rates in combination to indemnity and medical loss ratios for each of the most recent four policy years and had selected the average of the resulting trended loss ratios for purposes of the proposed filing.

**Question:** *A Committee member noted that the annual frequency trend factor was -7.6 percent and asked what the comparable factor had been in the prior year's filing.*

**Answer:** *Staff observed that the annual rate of change in claim frequency for the December 1, 2008 filing had been -7.8 percent.*

**Question:** *The Committee member questioned whether use of these claim frequency trends might become problematic as the effects of reform began to be reflected in the Bureau's data.*

**Answer:** *Staff questioned what provision(s) of SB1 were perceived as impacting claim frequency. Discussion indicated that links between the recent Delaware reforms and claim frequency were not likely to be material.*

**Question:** *Staff was asked how the Bureau counted claims for purposes of its frequency calculations.*

**Answer:** *The Bureau use indemnity (lost time) claims reported in unit statistical data as the basis for its claim frequency calculations. While medical-only claims occurred in substantially greater numbers than indemnity losses, all indemnity losses and a large preponderance of medical losses were attributable to indemnity claims, leading to this convention of measuring claim frequency.*

**Question:** *An attendee wondered if the observed claim frequency trends were attributable entirely or disproportionately to a few very large carriers dominating the data.*

**Answer:** *Staff indicated that it had not studied this question but noted that the rating values desired from this filing were intended to be applicable to and appropriate for the entire Delaware market and could not provide carrier-specific considerations.*

**Question:** *An attendee inquired whether claim frequency decreases could be attributed to effects of the Workplace Safety Program.*

**Answer:** *Staff expressed the view that claim frequency declines were the result of a variety of factors over time and observed that, while incentives such as those offered by the Workplace Safety Program could have contributed to improvements in claim frequency, much of those changes over time were almost certainly a result of a combination of factors. It was noted that long-term declines in claim frequency had been observed in almost all jurisdictions and in states with or without a number of programs or market features.*

Exhibit 5 was reviewed. This exhibit presented a time series of limited loss ratio points indexed to Policy Year 1995 based on the selected trends and models described. Fitted points and projected future results were superimposed on Exhibit 5 as dashed lines through and extending beyond the policy year loss ratios from which they had been derived. The frequency and severity components of these loss ratio trends were also provided in the graphs shown.

**Unlimited Loss Exhibits Presented for Purposes of Comparison**

Exhibits 1 (Unlimited Loss), 2 (Unlimited Loss), 2a (Unlimited Loss), 3 (Unlimited Loss) and 6 (Unlimited Loss)

Staff noted that Table I and selected exhibits pertaining to loss development and trend on an unlimited basis, as well as on a limited basis, had been provided to the Committees.

**Expenses and Benefit On-Level Factor**

Exhibits 8, 9, 10 and 11

Staff reviewed these exhibits to summarize the measurement and estimation of expense provisions incorporated into the proposed filing.

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 - 2005, 2006 and 2007. The three-year average ratio of commission and brokerage expense to standard earned premium at Bureau 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 Bureau 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 Schedule Y carriers in Manual Year 2006, the most recent complete available year from unit statistical data.

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 \$265 was noted as being nominally lower than the currently-approved value of \$270 due to continued declines in wage level changes observed in Delaware.

**Question:** *A questioner sought information concerning the source of the data supporting the provision for uncollectible premium.*

**Answer:** *Staff responded that the experience shown had been developed in the Delaware Insurance Plan (the assigned risk mechanism in Delaware) and was reported to the Bureau by the National Council on Compensation Insurance, Inc. (NCCI).*

**Comment:** *It was noted that the exhibit showed deteriorating experience with respect to uncollectible premium for recent periods, suggesting that the selected provision for this contingency could have been set at a higher level than was being proposed.*

***Answer:*** Staff acknowledged this possibility and recalled discussion about the data and implications of recent experience in making the initial selections for this parameter. While the data was troubling in such respect, staff advocated taking a longer-term view of the data by using selections in a range of multiple-year historical averages rather than attempting to anticipate possibly volatile changes in results on a year-to-year basis.

***Question:*** An attendee asked how premiums were collected within the Delaware Insurance Plan and specifically the extent to which such premiums were collected (or intended to be collected) in advance.

***Answer:*** Staff explained that premium payment depended upon the size of each risk placed in the Plan, with the smallest risks paying annual premiums in advance, but other larger employers (representing a majority of premium insured in the plan) were eligible for installment payments.

Exhibit 10 derived a provision in the proposed rates and loss costs to offset the impact of expected adjustment in benefit minimums and maximums effective July 1, 2010. 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.

Exhibit 9 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 Bureau analysis as described above, budgetary provisions or the most recent available assessment levels. Premium collection and loss-payout patterns were also provided from Bureau analysis.

The Bureau 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 for use in the proposed filing were:

- Permissible loss ratio, including loss-adjustment expense and loss-based assessments – 75.74 percent
- Profit and contingencies – minus 3.84 percent

Staff noted that the profit and contingencies provision proposed in the filing was more negative than the provision in currently-approved rates (minus 2.55 percent). This change was attributed in principal part to a drop in the cost of capital as determined through an internal rate of return model.

***Question:*** A Committee member remarked on the levels of pre-tax return on assets used in the Internal Rate of Return Model and recalled lower rates having been presented at a recent industry program. This member asked about the determination of those rates of return for the filing.

***Answer:*** Staff referred attendees to Page 19 of Exhibit 9, showing a weighting of anticipated returns for various categories of invested assets. The pre-tax rate of return of 4.95 percent was shown on the next to last line of that page and was the result of the weighting calculation. Staff indicated that the anticipated rates of return by asset category had been established by an economic consultant using recognized sources and procedures.

***Question:*** An attendee reiterated the sense that a pre-tax rate of return of 4.95 percent seemed high given current market conditions.

***Answer:*** Staff observed that the pertinent rate of return would reflect an average return over the extended period of time during which losses and expenses associated with the underwriting of a year of workers compensation business would be paid out. The endpoint to such a process could be 30 years or more after the beginning of the year in question.

***Question:*** A question was posed as to whether the pre-tax rate shown was intended or expected to be a risk-free rate of return.

***Answer:*** Staff replied in the negative, characterizing the pre-tax rate of return as being reflective of the composition and perceived riskiness of an industry-wide portfolio of invested assets.

***Comment:*** Concern was expressed about using a rate of return based on investments presenting their own exposure to risk, given the riskiness of workers compensation business from an underwriting perspective.

***Answer:*** Staff acknowledged that the investment return did include asset types subject to risk but observed that recognition of the riskiness of the workers compensation line of business had also been taken into account in establishing the cost of capital used in the model.

***Comment:*** An attendee pointed out that the cost of capital was evaluated on a current rather than a long-term basis.

Exhibit 11 provided side-by-side comparison of the expense structure underlying current approved residual market rates and proposed rates. Staff observed that overall expense costs reported by its members were nominally lower than those incorporated in the last Delaware filing (26.85 percent, as compared to 27.73 percent last year) and that the most notable differences were the provisions for profit and contingency (-3.84 percent compared to -2.55 percent for the December 1, 2008 filing), uncollectible premium (up to 3.00 percent from a level of 2.00 percent in current rates), commission (down from 6.82 percent last year to 6.53 percent), the administrative assessment (2.84 percent for current rates, down to 2.59 percent) and general expense (proposed at 2.97 percent, currently 3.17 percent).

### **Delaware Insurance Plan**

#### **Exhibit 19**

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

**Question:** *Staff was asked whether the voluntary market premium shown in this exhibit was presented on a calendar year or policy year basis.*

**Answer:** *Staff answered that the measures of market share used in this exhibit were shown on a policy year basis.*

**Comment:** *An attendee stated their understanding that neither Maryland nor Pennsylvania surcharged assigned risk accounts.*

**Answer:** *This observation was attributable to the fact that both Maryland and Pennsylvania have competitive state funds and so are not comparable to Delaware's Insurance Plan, which is a residual market pool.*

**Question:** *Inquiry was made about the impact of eliminating the approved surcharge program in the Delaware Insurance Plan.*

**Answer:** *Staff noted that risks actually paying the surcharge in the year presented in the exhibit under discussion would have saved 23 percent had the surcharge not been in effect but that voluntary market insureds would then have made up that difference in higher loss cost levels. Eliminating the surcharge would reallocate but not decrease or increase total premium payments.*

**Comment:** *A Committee member observed that there were a number of states with assigned risk pools that had surcharges and/or rate differentials much more aggressive than the Delaware surcharge program.*

**Comment:** *Another attendee remarked that such pricing differentials helped to reduce residual market size and control losses and subsidies associated with residual market business.*

**Comment:** *It was observed that Delaware's surcharges gave an incentive for employers to avoid or leave the residual market, as well as promoting equity.*

**Comment:** *A comment was offered confirming that Delaware's surcharge was a relatively moderate approach to the purposes of providing a disincentive for placement in the pool.*

**Question:** *The dramatic reduction in residual market share in Delaware over the past few years was noted, and possible reasons for that trend were sought. Recent rate reductions were offered as a possible factor.*

**Answer:** *Staff expressed doubt that rate reductions would explain the decline in residual market share, in part because the residual market had shared in those reductions. A depopulation program started about two years ago was noted, as was the Bureau's publication of the Carrier Pricing Benchmark to assist employers in finding attractive prices in the voluntary market.*

**Comment:** *An attendee opined that educating agents about the surcharge program would be helpful.*

**Answer:** *Staff added that consideration had been given to proposing reduction or elimination of renewal commissions within the Delaware Insurance Plan as a further incentive toward reducing plan volume.*

**Question:** *Staff was asked what commissions were paid to agents servicing the pool.*

**Answer:** *Staff referred to a graduated scale found in the Delaware Insurance Plan Handbook. That scale was related as follows: First \$1,000=8%, next \$4,000=5%, next \$95,000=3%, over \$100,000=2%.*

### **Experience Rating**

Exhibits 13, 20 and 21

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.

**Question:** *Staff was asked whether the actual and manual loss ratios were for the same period(s) of time.*

**Answer:** *The answer was in the affirmative.*

**Question:** *A question arose about results of similar tabulations in Pennsylvania.*

**Answer:** *Staff acknowledged that at present the two states' Experience Rating Plans were quite different. In Delaware, possibly owing to the limited amount of experience data available for testing, the quintile testing used successfully by NCCI and Pennsylvania was not very informative. Because of inconclusive results of recent efforts to test and validate various plan alternatives, the Delaware Experience Rating Plan had not been revised.*

**Question:** *A Committee member asked how the credibility scale in Pennsylvania compared with that of Delaware.*

**Answer:** *Staff observed that the two states' credibility functions were notably different. Pennsylvania's scale does not go as high as Delaware's. The most recent changes in Pennsylvania had been designed to increase credibility for small to mid-sized risks and reduce credibility assigned to larger accounts.*

Exhibit 20 was discussed as the means of deriving anticipated collectible premium ratios for use in Exhibit 12. It was noted that three-year average collectible premium ratios had been used for this purpose. Exhibit 20 also illustrated the computation of expected loss rate factors to adjust proposed 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 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**

#### **Exhibit 14**

The history and purpose of this rating program 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 table of qualifying wages proposed to be effective for the DCCPAP June 1, 2010 reflected diminishing wage change trends such that current estimated wage levels were lower than prior estimates, resulting in a proposed wage table with a nominally lower qualifying wage than was in effect for the June 1, 2009 table.

### **Workplace Safety Program and Merit Rating**

#### **Exhibit 29**

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 2.75 percent adjustment to manual rating values.

***Question: Inquiry was made as to the percentage of risks participating in the Workplace Safety Program.***

***Answer: By reference to Exhibit 29, staff noted that 20.1 percent of eligible risks participate in this program and that those participating accounts represent 28.7 percent of eligible premium.***

### **Rating Values Based on Size-of-Loss Analyses**

Exhibits 16, 17a, 17b, 17c, 17d, 17e, 18, 18a

#### **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.

#### **Exhibit 18 and 18a**

Staff noted that Bureau 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.

Many of the size-of-loss studies and rating values proposed in this filing vary by hazard group. Exhibit 18a presented a proposal for modifying and expanding the hazard groups to which classifications may be assigned. The proposal calls for an expansion from four hazard groups (designated I, II, III and IV) to seven hazard groups (designated A, B, C, D, E, F and G). Those seven hazard groups can also be combined to form four new hazard groups (A&B = 1, C&D = 2, E&F = 3, and G = 4) for use by carriers during a transition period that will provide time for systems changes to be made.

In matching classifications to hazard groups, staff noted that the intention was to be as consistent as possible with National Council on compensation Insurance, Inc. (NCCI) assignments, while acknowledging that the DCRB and NCCI classification plans are significantly different. Assignments were made based on a mapping of DCRB and NCCI classifications. Since the Delaware and Pennsylvania class plans are almost identical, the Delaware hazard group reassignments tracked very closely with those recently accomplished in Pennsylvania. Exhibit 18a showed current and proposed hazard group assignments by classification, as well as the movement based on number of classes and premium amounts between old and new hazard group definitions.

***Comment:*** *An attendee noted that NCCI was planning to stop supporting the transitional four hazard group option in the near future.*

***Answer:*** *Staff agreed with this observation and expressed the expectation that at some point Delaware would do likewise. However, staff thought it advisable to provide a reasonable transition period within which the new seven hazard groups were available in Delaware before requiring use of that expanded number of hazard groups by all carriers.*

Exhibit 18 showed the derivation of the December 1, 2009 proposed 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 (and selected) relativities. An adjustment was made to recognize the impact of SB 1 on Delaware average costs.

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

Staff described changes to the processes and procedures used in the derivation of excess loss factors. Staff discussed a study of Delaware size-of-loss data that began in 2008 and resulted in the proposed excess loss factors presented in this section. 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 proposed excess loss (pure premium) factors computed using results from Exhibit 17a and based on the proposed new hazard group assignments. Values as of December 1, 2008 had also been recalculated using new hazard group definitions and Delaware based size-of-loss distributions,

so that a more meaningful indicated change in excess loss ratios for December 1, 2009 could be shown. 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.

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

**Question:** *A question was asked regarding how many years of data were used in developing the Delaware size-of-loss distributions.*

**Answer:** *Staff advised that three years of data, one at third unit report level, one at fourth unit report level and one at fifth unit report level, had been used. Data at less mature reports had not been used because of the substantial loss development occurring for those early report levels.*

**Question:** *Staff was asked whether the change in process applied this year had been undertaken because of the changes in hazard group structure.*

**Answer:** *Staff answered that this was partly the case. The Pennsylvania Bureau had previously taken this approach, incorporating both the change in methodology and change in hazard group structure. The exercise of making these changes in Pennsylvania with a larger database had been very instructive toward the work subsequently accomplished in Delaware.*

**Comment:** *An attendee observed that the changes in excess loss factors appeared to be larger in Delaware than had been the case in Pennsylvania.*

**Answer:** *Staff observed that large percentage changes were common for excess factors, especially at higher limits where small numeric changes can produce large percentage changes.*

**Question:** *A Committee member noted that the Bureau had used the Lognormal distribution in deriving its loss distributions and asked whether NCCI had also used that approach.*

**Answer:** *An attendee noted that NCCI had used a mixed exponential distribution. Staff added that the Pennsylvania Bureau had used a Pareto distribution for claim frequency and a Lognormal distribution for claim severity.*

**Comment:** *Some concern was expressed concerning the magnitude of the proposed changes (reductions).*

**Answer:** *Staff pointed out that the exhibit's comparison showed what 2008 would have been with the new methodology but not the absolute changes between current and proposed factors. Such comparisons would involve both the changes in size-of-loss analysis and the revised hazard group compositions, making conclusions difficult to attain.*

### **Retrospective Rating**

#### **Exhibits 24 and 25**

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.

### **Classification Relativities**

#### **Exhibits 15, 22a, 22b, 22c, 27, 28, Class Book, 30, 31a and 31b**

Exhibit 15 described the formulae and procedures used for analysis of classification experience in the proposed filing. Staff commented on a secondary capping procedure intended to avoid large fluctuations about the average changes in rating values from year-to-year. This procedure, while applied in the proposed filing, did not result in the capping of any additional classifications.

Exhibits 22a, 22b and 22c each provided unit statistical data by manual year and industry group over the most recent available five years. These tabulations were used in the derivation of certain factors applicable to determining classification-specific rating values. Exhibit 22a showed losses including loss-adjustment expenses trended and developed to an ultimate basis, Exhibit 22b showed losses including loss-adjustment expenses developed to an ultimate basis but not trended, and Exhibit 22c showed reported losses without loss-adjustment expenses.

Exhibit 28 provided parameters derived for and applied in the execution of the prescribed procedures for derivation of classification rating values. The Class Book presented detailed five-year histories of experience by classification and showed calculation of indicated rating values based on Delaware experience alone. Staff noted that a separate procedure applied to those Delaware classifications where available experience warranted less than five percent credibility for non-serious losses and that the application of those special procedures was not reflected in the Class Book pages.

Four of the referenced exhibits were noted as providing various summaries of the results of the Bureau's derivation of proposed classification rating values. Exhibit 27 showed proposed residual market rates, voluntary market loss costs and expected loss rates by classification number. Exhibit 30 was a histogram showing the incidence of indicated and proposed changes in residual market rates by percentage range. Exhibits 31a and 31b showed current, indicated and proposed residual market rates before DCCPAP and applicable surcharges for the Workplace Safety Program and Merit Rating Plan. These exhibits also showed percentage changes in proposed rates before the DCCPAP, Workplace Safety Program and Merit Rating Plan surcharges and final proposed residual market rates (including surcharges). Exhibit 31a was shown sorted by classification code number. Exhibit 31b was shown sorted in ascending sequence by proposed percentage change.

**Question:** *Staff was asked what happens if a classification hit the maximum or minimum cap.*

**Answer:** *The response indicated that the rating value would be capped this year. That capped value would then become the current rating value going into the next year.*

**Question:** *An attendee asked whether the Bureau looked for explanatory circumstances concerning classes that were capped.*

**Answer:** *Staff responded that, since classifications are often small and thus credibilities are low in Delaware, very few classifications were capped. But if a classification is capped repeatedly, we would point it out to our Classification Department. On occasion interim classifications are formed because of prevailing limitations on rating value changes, and in those cases maximum changes may be expected to occur over a transitional period of time.*

**Comment:** *A similar exploration of possible causal factors was suggested if a particular classification(s) is/are overrepresented in the Delaware Insurance Plan.*

**PEO/Executive Officer Salary Limitations**

A staff memorandum was reviewed, explaining the Bureau's historical position and revised thinking with respect to executive officers of an entity that leased its employees, including those officers from a PEO. Because the individuals in question were not executive officers of the PEO through which the policy was being obtained, the revised thinking was that executive officer minimum and maximum payroll amounts would not apply.

**Agreement by Executive Officer(s)/LLC Member(s) Not to be Subject to the Delaware Workers' Compensation Law**

Staff provided a handout page reflecting proposed changes to the subject form. The addition of address information and clarification of the use of the bottom portion of the form were discussed.

**Question:** *A question was posed to ascertain the implications of this form if an entity has four officers who are excluded on this form and that entity is then retained by a general contractor.*

**Answer:** *Staff indicated that the form was intended to verify which executive officer(s) were excluded for the entity submitting the form.*

**Question:** *An attendee asked who would have responsibility for coverage in a contractor-subcontractor situation.*

**Answer:** *Staff stated that the general contractor would need a workers compensation policy if that entity had employees. In Delaware employees of a subcontractor are the responsibility of the subcontractor. Delaware has no statutory employer rule, and thus there is a separation between a subcontractor(s) and a general contractor.*

**Question:** *A Committee member noted that the proposed form was dated 12/09 and asked the reason for that.*

**Answer:** *Staff offered that the date shown on the form was the proposed effective date.*

Staff invited closing questions or comments.

**Question:** *A Committee member asked about the status of the additional rating value reductions ordered by the previous Delaware Insurance Commissioner.*

**Answer:** *Staff replied that the matter had been decided very recently by the Court of Chancery and that that decision was presently under review by the Bureau and its counsel.*

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

Respectfully submitted,

Timothy L. Wisecarver  
Chair - Ex Officio