Delaware Compensation Rating Bureau, Inc.

United Plaza Building • Suite 1500
30 South 17th Street
Philadelphia, PA 19103-4007
(302) 654-1435 (215) 568-2371
FAX (215) 564-4328
www.dcrb.com

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 the Winterthur Room of The DoubleTree Hotel Wilmington Downtown, 700 King Street, Wilmington, Delaware on Wednesday, August 4, 2010 at 10 a.m.

The following members were present:

Actuarial Committee

Ms. M. Gaillard	American Home Assurance Company
Not Represented	Amguard Insurance Company
Not Represented	Hartford Accident & Indemnity Company
Mr. J. Grunin *	Liberty Mutual Insurance Company
Ms. A. Himmelberger	PMA Insurance Company
Mr. J. Schmidt	Travelers Property & Casualty Company

Classification and Rating Committee

Mr. E. Capadanno	Associated Builders & Contractors of Delaware
Mr. I. Feuerlicht	American Home Assurance Company
Not Represented	Amguard Insurance Company
Ms. M. Innocenti	Crum & Forster
Mr. C. Hearl	Harleysville Mutual Insurance Company
Mr. J. Grunin *	Liberty Mutual Insurance Company
Mr. R. Prybutock	National Federation of Independent Business
Mr. W. Carney	PMA Insurance Company
Mr. T. Wisecarver	Chair - Ex Officio

Also present were:

Ms. J. Tornquist	American Home Insurance Company
Mr. S. Cooley	Duane Morris LLP
Mr. R. Gardner	INS Consultants, Inc.
Mr. J. Randall	Liberty Staffing
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.

Staff provided some background and highlights of the analysis done for the December 1, 2010 Residual Market Rate and Voluntary Market Loss Cost filing. Points addressed and emphasized included the following:

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

- Attendees were reminded of Senate Bill 1 enacted in 2007 in Delaware, which provided for processes related to the development of a medical fee schedule and treatment guidelines. In a prior filing (No. 0806) the Delaware Compensation Rating Bureau, Inc. (the Bureau) had evaluated the effects of the medical fee schedule that had subsequently been implemented in Delaware, and rating values effective on or after October 1, 2008 had reflected that estimated impact. For the December 1, 2010 filing, experience had generally been adjusted to a pre-Senate Bill 1 basis for purposes of such analyses as loss development and trend, and then a Senate Bill 1 Law Amendment Factor had been applied to the resulting indications to derive a December 1 2010 indication.

- Staff described litigation that had taken place in 2009 concerning the effects of Senate Bill 1 on claims incurred prior to the effective date of the Delaware medical fee schedule, and noted that the Bureau's underlying analysis for the December 1, 2010 filing had been performed without recognizing the reductions in rates and loss costs that had ultimately been ordered in that litigation. Consistent with past practices, such mandated reductions would be applied after the technical analysis supporting the filing had been concluded.

- Adjudication of the December 1, 2009 filing had required adjusting annual medical loss ratio trend indications by approximately -1.8% on the premise that future cost trends would be improved by virtue of various features of Senate Bill 1 including a mandated basis for maintaining fee schedule amounts for inflation. Bureau staff had concluded that irrespective of the merits of arguments that such a change must necessarily occur and/or the difficulty of estimating the prospective effects of such changes, some adjustment of this nature would again be imposed on the December 1, 2010 filing. Accordingly, staff had incorporated the negotiated adjustment from the resolution of the December 1, 2009 filing in the filed indications for December 1, 2010.

- Bureau staff had observed marked changes in wage trends in recent years for Delaware, with historical increases first moderating and most recently turning negative. Such changes had implications of both claim frequency trend and indemnity severity trend, and staff had incorporated the outlook for smaller increases in wages going forward than had been seen in much of the available historical data in those respective portions of the Bureau's analysis.

<u>Question</u>: An attendee asked whether the Bureau was able to quantify the benefits of Senate Bill I of 2007, or if it was too early to make such an evaluation.

<u>Answer</u>: Staff noted that residual market rates and voluntary market loss costs had been reduced on a new and renewal and outstanding basis effective October 1, 2008 based on the Bureau's evaluation of the impacts of the medical fee schedule adopted under the provisions of Senate Bill 1. The October 1, 2008 reductions in residual market rates and voluntary

market loss costs had been based upon an estimated reduction in medical loss costs of more than 17 percent. It was noted that those same reductions had applied to the December 1, 2009 rating values, and that they were again proposed to be continued in the rating values under discussion at this meeting.

It was observed that data reflecting the early periods of experience subject to various provisions of Senate Bill 1 were now included in the Bureau's analysis, and that the extent to which such post-Senate Bill 1 data would be part of each filing would increase over time. Staff cautioned that while the full effects of Senate Bill 1 would come to be included in the analysis and indications of future filings, separate identification of the incremental impacts of specific portions of the legislation, or of many other factors potentially affecting system costs, would be difficult and uncertain at best.

Question: Staff was asked whether it had assessed the state of the Delaware economy in the course of its preparation of the filing.

Answer: The response indicated that except for changes in the Statewide Average Weekly Wage, economic metrics such as unemployment data had not been explicitly taken into account in work supporting the filing. Aspects of the filing data that could be affected by economic conditions including payroll volumes, numbers of claims and duration of claims were noted.

Question: Inquiry was made as to whether the Bureau had been able to separate changes in time worked and wages per unit of time as factors in the observed changes in payrolls.

Answer: Staff briefly described the data available for the filing and indicated that it was not able to separate changes in the Statewide Average Weekly wage into the suggested components.

Comment: It was observed that the State of Delaware had imposed a 2.5% salary reduction effective July 1, 2009, with that reduction having been subsequently restored effective July 1, 2010. Implications for these actions on the Bureau's wage analysis and possible future changes in the Statewide Average Weekly Wage were discussed.

Comment: Another attendee opined that Delaware employers were starting to go back to hiring people on a full time basis.

The Committee discussion then moved to a review of staff work supporting the December 1, 2010 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, 2010 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, 2010.
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.

Overall Indicated Changes in Collectible and Manual Rating Values

Exhibit 12

Two versions of Exhibit 12 had been provided in the agenda materials, one with each of two mailings sent out in advance of the meeting. Staff noted differences between these respective pages (excess loss factor and provision for excess loss on lines 4(a) and 4(b) respectively) and additional information included in the page distributed with the second mailing (total values for several components of the changes in manual premium level on lines 13, 14, 15 and 18).

The favorable effect of trend on the filing indication was noted, and described as being attributable to continuing declines in claim frequency, moderating wage trend for indemnity severity, inclusion of an adjustment to medical severity imposed on the adjudication of the December 1, 2009 filing and updating of historical claim severity trend data.

The line 3(a) adjustment to medical loss ratios based on previous Bureau analysis of the effects of the medical fee schedule was noted. The adjustment for the effect of limiting losses in the underlying loss development and trend work was pointed out on lines 4(a) and 4(b). Based on a permissible loss and loss adjustment ratio shown on line 6, an indicated change in rates was derived on line 7. Application of an estimated effect of the July 1, 2011 benefit change on line 8 gave a final residual market rate change on line 9. Staff briefly discussed the reasons for the benefit change factor being less than unity. Removing the provisions for expenses other than loss adjustment expense from the residual market rate change gave the indicated voluntary market loss cost indication on line 10.

Staff pointed out the proposed overall changes in residual market rates (2.91 percent decrease) and voluntary market loss costs (1.45 percent decrease).

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

Loss Development

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

Staff described the analysis presented in these exhibits and key considerations applicable to the use of those components of the filing analysis in deriving the proposed indications. 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, 2005 through 2009, 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 medical data in Table I had been adjusted to a pre-SB1 basis, with such adjustments affecting limited amounts of payments made in late 2008 and all payments made in calendar year 2009, and also impacting case reserves as of December 31, 2008 and December 31, 2009 with the effects on case reserves as of December 31, 2009 estimated to be more significant than those for the earlier evaluation..

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, 2001 and 2006 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. The reductions in loss displayed on Exhibit 1b were based upon the series of loss limitations shown in Exhibit 1a to reported paid and incurred loss.

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.

Premiums had been developed to an ultimate basis using an average of the most recent four available development factors for each maturity through eighth report, with development after eighth report assumed to be flat. Ultimate premiums at the designated statistical reporting level were then adjusted to be on-level with the current residual market rates, reduced to remove the effects of expense constant income, loadings for the Delaware Construction Classification Premium Adjustment Program off-balances, and increased to correct for the temporary reductions mandated by the 2009 Court of Chancery decision to derive appropriate ultimate premiums for the derivation of loss and severity ratios used further in the filing.

Indemnity and medical losses had been developed to ultimate using two methods, one being a case incurred loss development approach and the other being a paid loss development method applied

through 19th report with a tail provision derived by adjusting cumulative paid losses at 19th report to a case incurred basis at 20th report and then applying the tail development after 20th report from the case incurred loss development method.

Loss development had been estimated using the average of the most recent available four calendar years' age-to-age factors. In application of each loss development method, the Bureau had sought to further smooth the observed average age- to-age link ratios by fitting mathematical curves through the observed average actual ratios. A broad variety of curve forms had been tested for this purpose. Better results were obtained by subtracting unity (1.000) from the observed indemnity paid loss development factors before using the various curve forms under consideration. The estimated or smoothed "y" values were then added to unity to derive smoothed loss development factors. 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 loss development age-to-age factors in the proposed filing were described as follows:

Indemnity Incurred Development Factors:

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

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.

Indemnity Paid Development Factor:

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

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.

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.

Medical Incurred Development Factors:

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

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.

Medical Paid Development Factors:

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

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.

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. Exhibit 2a provided graphic comparisons of the results (loss ratios and severity ratios) of applying the case incurred loss development method and the paid loss development method to both indemnity and medical losses, together with the average of the two methods. These pages showed that the two alternative approaches produced nominal differences, with the case incurred method tending to give somewhat lower results for indemnity loss and somewhat higher results for medical loss than did the paid loss development method.

Exhibit 7 provided various metrics of loss experience derived from unit statistical data. Claim closure rates (generally improving at earlier maturities and showing some slowing down at later maturities), claim frequencies (improving) and average closed, open and total claim amounts (generally volatile due to limited amounts of data and potential impacts of large losses) were displayed. In addition, some analytics derived from financial data were provided (ratios of reported paid loss to reported incurred loss and reported paid loss to estimated ultimate loss using the average of the case incurred and paid loss development methods.)

***Question:** A Committee member asked for an explanation of the loss limitation procedures used in the filing, observing the reference to a loss limitation of $2,610,000 in Exhibit 1a and the title of Exhibit 1 which stated that losses had been limited to a value of $2,370,000.*

***Answer:** Staff expounded upon the footnote included in Table I which advised that the loss limitations applied varied by policy year, and confirmed that the complete schedule of such loss limitations was presented in Exhibit 1a. The loss limitation of $2,370,000 was described as being the limitation on a pre-Senate Bill 1 basis from the December 1, 2009 filing consistent with the loss elimination percentage of 7.57%. Finally, staff identified the value shown in the title of Table I as being a typographical error (a number inadvertently retained from the prior year's filing exhibits) and noted that the value shown as $2,370,000 should have been $2,610,000.*

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.

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

Claim Frequency – While generally declining, the year-to-year changes in claim frequency based on unit statistical data were quite volatile, with several instances of double-digit declines appearing in the history, often followed by much smaller than average drops or even small increases in subsequent years. For claim frequency trend through the mid-point of policy year 2008 (January 1, 2009) the Bureau had selected an average annual change based on a seven-point exponential fit through claim frequencies based on numbers of indemnity claims per unit of on-level expected losses.

Noting recent slowdowns in changes in the Statewide Average Weekly wage, the Bureau had forecast slower wage growth subsequent to January 1, 2009, and that forecast had been accounted for in the selected annual change in claim frequency. Accordingly, the claim frequency trend used in the filing include an annual rate of decline of 8.8 percent up to January 1, 2009 and an annual rate of decline of approximately 6.4 percent after January 1, 2009.

Indemnity Severity – Through policy year 2008 (mid-point January 1, 2009) the Bureau had measured claim severity trend using a seven-point exponential trend model fitted through the severity ratios derived by adjusting estimated ultimate loss ratios for known changes in claim frequency. That analysis resulted in an annual change in indemnity severity of +0.9 percent per year. Adjusting that trend rate for expected lower changes in wage levels after January 1, 2009 resulted in an annual indemnity severity trend after January 1, 2009 of -1.65 percent.

Medical Severity – Changes in wage trend did not affect medical severities directly, but the Bureau was mindful that in the adjudication of the December 1, 2009 filing both actuarial consultants who had reviewed the filing had anticipated some improvement in medical trends associated with the implementation of the medical fee schedule in late 2008. Staff had concluded that such an adjustment was virtually certain to again be required for the December 1, 2010 filing, and had decided to include the amount of trend improvement imposed for the December 1, 2009 filing as part of its analysis of the current filing, with that improvement in medical severity trend applied after September 1, 2008 (the effective date for full implementation of the medical fee schedule in prior Bureau filings.) That adjustment, an improvement of 1.8 percentage points per year, was applied in conjunction with a measured pre-Senate Bill 1 medical severity trend of +7.2 percent per year. Thus the medical severity trends used in the staff analysis were +7.2 percent per year through September 1, 2008 and +5.4 percent per year subsequent to September 1, 2008.

Question: A Committee member inquired as to whether or not the selected claim frequency trend was more negative than it had been in the most recent filing.

Answer: Staff responded that the comparable (seven point exponential) claim frequency trend in the December 1 2009 filing had been -7.6 percent. For this filing, the seven point exponential claim frequency trend was -8.8 percent. The Bureau was proposing using the -8.8 percent claim frequency trend to January 1, 2009 and then applying a claim frequency trend of -6.37 percent after January 1, 2009. Exhibit 23 showed the derivation of these frequency trends. The -6.37 percent trend rate was the result of using a lower estimate for future wage inflation than had been observed during the historical period upon which the -8.8 percent claim frequency trend had been based. The Bureau's selected value for wage trend after January 1, 2009 was based on the most recent available eight quarters of data, and was equal to an annual wage trend of +0.4 percent.

Question: Staff was asked whether the prompt payment provisions of Senate Bill 1 might be affecting certain of the filing's parameters.

Answer: Staff discussed possible implications of the prompt payment provision on loss development in particular, noting that it was possible for the implementation of a prompt payment provision to accelerate the timing of certain payments somewhat but adding that such acceleration would likely not be significant, if it had any impact at all, over the annual periods

of loss development used in the filing. The focus of this provision of the law on new claims was pointed out.

Question: A question was posed concerning whether employer concerns about expense levels during difficult economic times might impair employers' abilities to maintain existing and/or support additional safety programs. The projected change in claim frequency of -6.37 percent adjusted for wage inflation was noted.

Answer: Staff noted the long-term nature of the ongoing phenomenon of claim frequency improvement and its persistence over economic cycles. The suggested revision of historical claim frequency trend on account of changes in wage inflation notwithstanding, staff felt that an expectation of further and continuing claim frequency improvement was reasonable in light of all available information. It was pointed out that the claim frequency trend of -6.37 percent did not exclude all effects of changing wages, but rather included provision for a lower level of wage changes than had occurred in past years.

Question: An attendee asked how the medical trends derived by the bureau compared to similar projections from other states countrywide.

Answer: Staff noted that published medical trends from other states were generally expressed as loss ratio trends (as distinct from claim frequency or claim severity trends as were used by the Bureau in its filings.) Usually, national publication of trends showed loss ratio trends. Staff emphasized that the Bureau's medical loss ratio trend was negative, and opined that this trend indication would compare favorably to most if not all states countrywide.

Question: An attendee asked whether this exceptionally favorable trend might be attractive to carriers considering writing business in Delaware.

Answer: Staff declined to speculate on this point, reminding all participants of the focus of the meeting on matters pertaining only to the business of the Bureau.

Exhibits 3 and 6 respectively provided results of the Bureau's review of goodness-of-fit and past projections of severity ratios. Exhibit 5 showed graphs of indemnity and medical loss ratio histories and projections, with claim severity and claim frequency components of the projections also displayed for comparison purposes.

Question: Observing that some provisions of Senate Bill 1 dealt with standards of care or treatment protocols, an attendee inquired when those measures would affect filing analyses.

Answer: Five treatment guidelines were put into effect at the same time as the Medical Fee Schedule (late in the third quarter of 2008). Staff reiterated that as data subject to any provision(s) of the law was reported to the Bureau it would be included in subsequent filing analyses. Staff described anecdotal observations about the system that had been offered to the Bureau or in its presence that had dramatically different perspectives about the efficacy of such features of Senate Bill 1 as the treatment of injured workers.

Question: ***Staff was asked about ongoing data collection initiatives at the Bureau.***

Answer: ***Status of the Medical Data Call initiative was briefly discussed, with the expected benefits including the availability of a more detailed and broader-based database of medical costs than had previously been available. Staff noted that initial reports would be submitted for the third quarter of 2010. The ability to glean meaningful information from that data would improve over time as a more extensive history became available. The Medical Data Call resource was compared to data previously obtained by the Bureau for purposes of its initial evaluation of the medical fee schedule, and the possibilities and difficulties associated with comparing these two different sources were briefly addressed.***

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.

Unlimited loss development had used an 8-year average tail provision and paid-to-incurred factors for medical loss, and had performed a separate series of curve fitting analyses which had resulted in the following selected curves for purposes of smoothing age-to-age factors (with the fits applied to the results of subtracting unity from the age-to-age factors themselves:

Indemnity Incurred Development Factors:

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

Indemnity Paid Development Factor:

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

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.

Medical Incurred Development Factors:

$y = a * x^b$ (exponential)

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 term "b" is a constant derived using the curve-fitting procedures and are established to obtain the best possible fit of the selected curve to the observed actual data.

Medical Paid Development Factors:

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

Medical Paid-to-Incurred Development Factors:

The most recent actual eight-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.

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 - 2006, 2007 and 2008. 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. Other acquisition and general expense provisions had been adjusted for the effects of the Court of Chancery decision, which would reduce premium income without offsetting these expense components. The relationship between loss-adjustment expense and loss was derived based on the three-year average ratio of loss-adjustment expense to incurred losses, including large deductible on a gross basis. The premium discount provision in the proposed filing was based on size-of-risk distribution for Schedule Y carriers in Manual Year 2007, 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 $260 was noted as being nominally lower than the currently-approved value of $265 due to continued declines in wage level changes observed in Delaware.

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, 20111. 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 – 76.88 percent
Profit and contingencies **–** minus 4.65 percent

Staff noted that the profit and contingencies provision proposed in the filing was more negative than the provision in currently-approved rates (minus 3.84 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.

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 (25.60 percent, as compared to 26.85 percent last year) and that the most notable differences were the provisions for the Workers compensation Fund assessments (3.00 percent compared to 2.00 percent for the December 1, 2009 filing), profit and contingency (-4.65 percent compared to -3.84 percent last year), commission expense (5.76 percent for December 1, 2010 compared to 6.53 percent for December 1, 2009) and uncollectible premium (down to 2.50 percent compared to 3.00 percent in current rates.)

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: ***It was mentioned that certain independent contractors have become required to purchase workers' compensation insurance, and staff was asked whether the Bureau was seeing any material effects of this change.***

Answer: ***Staff indicated an awareness of the changes described, and observed that such individuals might attempt to obtain overage from the residual market in Delaware. The continuing decreases in Residual Market Share were occurring despite any upward pressure on policy counts and/or premium that the independent contractor issue might be exerting. Staff reminded participants that under the terms of the Delaware law, some of the potentially***

affected individuals had available options (generally involving various forms of business reorganization) besides simply buying workers compensation insurance.

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.

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.

Question: A Committee member asked about the degree of volatility that was allowed for experience modifications under the Experience Rating Plan.

Answer: Staff described some of the analytics applied to the annual review of the Experience Rating Plan and affirmed that the stability of experience ratings was one consideration in maintaining the Experience Rating Plan. It was noted that the desired stability was somewhat at odds with other objectives such as being reasonably responsive to employer experience and providing incentives for the active pursuit of loss prevention and claims management programs. The Experience Rating Plan applied several factors including loss limitations and risk credibility to mitigate shifts in experience modifications from year to year, but the Experience Rating Plan did not include any explicit limitations on movements in experience modifications from one evaluation to the next.

Question: Clarification was sought in terms of how changes in experience modifications were controlled.

Answer: Staff referred to the Experience Rating Plan's limitation on the amount of any single claim or accident that could be used in an employer's experience, but reaffirmed that there were no specific limits on the extent to which experience modifications could either increase of decrease.

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 as had been the case for the 2010 table, the qualifying wages proposed to be effective for the DCCPAP June 1, 2011 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, 2010 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 2.78 percent adjustment to manual rating values, only nominally different from the 2.75 percent adjustment currently in effect.

Rating Values Based on Size-of-Loss Analyses

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

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. Delaware's December 1, 2009 Residual Market Rate and Voluntary Market Loss Cost Filing modified and expanded the hazard groups to which classifications may be assigned. The filing expanded the number of hazard groups to seven (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.

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

Exhibit 18 shows the derivation of the December 1, 2010 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 briefly described changes to the processes and procedures used in the derivation of excess loss factors that was introduced as part of the December 1, 2009 filing. One result of those changes was a far greater emphasis on Delaware experienced than had been used in the past. Exhibit 17a presented an empirical loss distribution based solely on Delaware data. The analysis indicated that actual loss experience could be used over a significant portion of the size-of-loss range for each type of injury (Death, PT, PP and Temporary Total). Various commonly-used distributions had been considered in fitting the empirical size-of-loss distributions, including Pareto, Lognormal, Gamma, Weibull and Exponential. Separate analyses of claim frequency and loss severity had been performed, and the lognormal distribution was used to estimate claim severity and claim frequency for each type of injury. In generating final loss distributions and excess loss factors, actual data (claim counts and dollars of loss) for limits below $250,000 had been combined with fitted counts and dollars above $250,000 and re-accumulated. The resulting excess loss factors were also presented in Exhibit 17a.

Exhibit 17b derived 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, 2009 were also shown. Consistent with the 2009 study, Pennsylvania relativities had been used as benchmarks for loss amounts in excess of $1,000,000 owing to the limited amount of Delaware experience data available in those layers.

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: Staff was asked to confirm that the relativities for higher loss limits used in the filing were the same as those in effect in Pennsylvania.

Answer: Staff answered in the affirmative.

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.

Question: A Committee member asked if the Bureau intended to adopt part or all of the recent changes in classification ratemaking procedures that had been implemented by the National Council on Compensation Insurance, Inc. (NCCI).

Answer: ***Staff professed awareness of NCCI's recent work in this area, and expressed interest in the concepts involved. Attendees were advised that the current procedures used in Delaware included many differences, some significant, from the legacy approach that NCCI had recently revised, including aspect of loss development and loss limitation. Staff expected consideration of possible benefit to adopting or adapting any of the NCCI changes for use in Delaware to take place after some study, and that those changes, if they were to occur, would not take place in the near future.***

Comment: ***Another Committee member observed that an exhibit identifying key classification ratemaking procedures in Delaware and NCCI jurisdictions, highlighting areas of difference, would be helpful in considering those respective approaches.***

Answer: Staff concurred.

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, adjusted to current benefit levels, trended and developed to an ultimate basis. Exhibit 22b showed losses including loss-adjustment expenses developed to an ultimate basis but not trended or on-level, 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 if the amounts of the reductions mandated by the Chancery Court decision were known.***

Answer: ***The response indicated that a complete schedule of adjustments by classification had been previously established, filed with the Department of Insurance and approved. A constant set of adjustments were applicable to the 2008, 2009 and 2010 filings, while a second set of adjustments would be used in 2011.***

<u>Question</u>: A meeting participant asked for elaboration on the Bureau's swing limits procedures.

<u>Answer</u>: Staff described the metrics of its swing limits procedures as allowing changes up to 25 points above or below the Industry Group average change in any filing. Page 2 of Exhibit 30 was identified as presenting the (few) classes subject to such limitations in the current proposals. Staff described a secondary capping procedure intended to prevent classification rating value changes from fluctuating from extreme increases to extreme decreases or vice-versa in successive filings, and noted that no classes were affected by the secondary capping procedure in the current filing. Three classifications had been capped, all at the upper bound of the allowed swing limitations. Staff further observed that no risks had reported exposure in any of these classifications in the current five-year experience period.

<u>Minimum and Maximum Corporate Officer Payrolls</u>

Staff noted that no revisions were being proposed to minimum or maximum payroll amounts for executive officers effective December 1, 2010 owing to very slight recent changes in Statewide Average Weekly Wage data.

ITEM (2) REVIEW OF PROPOSED DECEMBER 1, 2010 F CLASSIFICATION FILING

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

Exhibit 1 was reviewed, with the following points highlighted:

> The estimate of a policy year loss ratio trended to the mid-point of the prospective rating period (Line 1)
>
> A credibility-weighting procedure recognizing the limited amount of available historical experience in Delaware and applying the complement of Delaware experience credibility to the permissible loss ratio underlying current rates (Lines 2, 3 and 4)
>
> Adjustment of the credibility-weighted trended loss ratio for loss adjustment expenses (Lines 5 and 6)
>
> Comparison of the trended policy year loss and loss adjustment ratio to a permissible loss and loss adjustment ratio based on econometric analysis (Lines 7 and 8)
>
> Adjustment for estimated effects of the October 1, 2011 benefit change (Lines (9) and (10))

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

Staff pointed out the proposed overall changes in F-Classification residual market rates (-1.79 percent) and F-Classification voluntary market loss costs (+2.98 percent) derived from the Bureau's analysis of the most recent available Delaware data.

Staff noted the proposed filing's accounting for effects of the Experience Rating Plan in the determination of proposed changes in manual rating values, as presented on Exhibit 1. This analysis started with the collectible premium ratios underlying presently-approved rating values (Line 12). The Bureau had then

measured the collectible premium ratios that the Experience Rating Plan was expected to produce during the proposed rating period (Line 13). Using the relationships between these current and estimated future collectible premium ratios, staff had derived indicated changes in manual F-Classification residual market rates (Line 14). Indicated changes in manual F-Classification voluntary market loss costs (Line 15) had been similarly derived by accounting for the impact of changes in anticipated collectible premium ratios.

Analysis of Loss Experience

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

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

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

> Only case-incurred loss development was possible, as unit statistical reporting did not capture paid-loss amounts over the entire historical period in question.
>
> Data reported extended from first through tenth reports, the maximum reporting period required under the approved Statistical Plan.
> Several older policy years technically eligible for later reporting periods had reported zero losses and thus showed no loss development experience for use in this filing.

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

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

Expense Provisions

Expense data was not available to the Bureau separately for F-Classification and other business. Accordingly, the expense study supporting this filing was identical in many respects to that previously discussed by the Committees with regard to the December 1, 2010 Residual Market Rate and Voluntary Market Loss Cost Filing. Minutes of that discussion of this study are replicated here for ease of reference, with appropriate modification for the F-Classification business used to review premium discount provisions for the F-Classification filing.

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

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

The first four items noted above were reviewed over the three Calendar Years, 2006, 2007 and 2008. 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 F-Classification business written by Schedule Y carriers in Manual Year 2007, the most recent available year from unit statistical data.

Exhibit 3 also showed the derivation of the provisions for residual market expense constant income attributed to various expense components. The residual market expense constant proposal of $260 was based on the currently-approved value of $270 and recognition of the effects of wage inflation since approval of the current value.

Question: ***Changes in expense constants (from $265 to $260 in the Delaware State Act filing and from $270 to $260 in the F-Classification filing) were noted, with the question posed why these rating values were decreasing.***

Answer: ***Staff noted that the recent trend in wage changes had resulted in a series of wage level forecasts being revised downward as additional data became available, and indicated that wage changes were a significant determinant of proposed changes in expense constants. Clarification was provided that in maintaining expense constants the Bureau gave 2/3 weight to changes in the Statewide Average Weekly Wage and 1/3 weight to changes in the Consumer Price Index.***

Exhibit 4 provided detail of the application of an internal rate-of-return analysis to the proposed filing. Expense provisions for commission and brokerage, other acquisition, general expense, premium and other taxes, premium-based assessments and premium discount were based on 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 F-Classification workers compensation business in Delaware:

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

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

Permissible loss ratio, including loss-adjustment expense and loss-based assessments – 77.31 percent
Profit and contingencies – 1.64 percent

Staff noted the change in profit and contingencies provision proposed in the filing from the provision in currently-approved rates (+0.83 percent) and attributed that change in substantial part to declines in the cost of capital derived for the present filing as compared to the previous filing's analysis. Attendees were reminded that, since F-Classification rating values were changed only bi-annually, filing-to-filing changes could be more marked than might be expected with annual revisions.

Exhibit 2 provided side-by-side comparison of the expense structures underlying currently-approved F-Classification residual market rates and proposed F-Classification residual market rates. Staff observed that overall expense costs reported by its members were lower than those incorporated in the last Delaware F-Classification filing (34.23 percent, as compared to 38.71 percent in the previous filing). The most significant changes in expense components involved the areas of profit and contingency (down to -1.64 percent from a positive 0.83 percent in the 2008 filing), commission expense (5.76 percent instead of the 6.82 percent applicable in 2008) and the Federal Assessment (11.54 percent in this filing compared to 12.44 percent in the 2008 F-Classification filing.)

Effect of October 1, 2011 Benefit Change

Staff reviewed Exhibit 14, which derived a provision in the proposed rates and loss costs to offset the impact of expected adjustment in benefit minimums and maximums effective October 1, 2011. As comparable prior effects of revisions in benefit schedules had been removed from the policy year loss ratios derived in loss development analysis and used to select trend provisions for the proposed filing, a separate explicit provision for the prospective change was needed.

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

Referring to Exhibit 6, staff noted that the USL&HW Factor is based on a comparison of benefit levels between State Act coverage and the USL&HW Act. This comparison was performed by type-of-claim and type-of-benefit to measure the respective potential obligations arising from injuries occurring under the jurisdiction of federal, as compared to state, law. Such a comparison then serves as the basis for the factor to adjust premiums in state classifications for the contingency of exposure to federal benefits. This filing indicated that the current USL&HW coverage percentage of 58.0 percent should be retained for use effective December 1, 2010.

F-Classification Expected Loss Rate Factors

Exhibit 11

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

Classification Tax Multiplier
For policies underwritten on a retrospective (loss-sensitive) basis for F-Classification business, a tax multiplier is required. Exhibit 8 presented the derivation of the proposed tax multiplier for this filing, 1.2409.

F-Classification Residual Market Rates and Voluntary Market Loss Costs

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

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

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

Staff invited closing questions or comments.

Question: ***Staff was asked when it expected to submit the filing(s) discussed at this meeting.***

Answer: ***The response indicated that consideration would first be given to input obtained at this meeting before a decision would be made about whether, and if so, how, the draft materials might be revised prior to proceeding to submit the filing. Accordingly, staff was not in a position to set forth a schedule at this point in time.***

Question: ***The inquirer asked what understandings, if any, were in place between the Bureau and the Department of Insurance for the timing of filing submission and adjudication.***

Answer: ***Staff related prior discussions between the parties that had contemplated a 120 day timeframe between submission of the filing and its effective date, with the intent that a decision would be rendered 60 days prior to the filing's effective date. It was noted that for a December 1, 2010 effective date the filings would not be able to be submitted a full 120 days in advance of their effective dates this year, but staff indicated that it would make every effort to expedite both the submission and review processes.***

Question: ***Staff was asked if it knew who might be involved in reviewing the filings.***

Answer: ***Noting that INS Consultants, Inc. was in attendance at the meeting and had participated in the review of past filings, staff expected that INS would be involved in this process. It was further stated that in some instances public hearings had been held as part of the filing review process in Delaware.***

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

Respectfully submitted,
Timothy L. Wisecarver
Chair - Ex Officio

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