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NOT YET REVIEWED 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. (DCRB) was held in the Winterthur Room of the Double Tree by Hilton Hotel Downtown, Wilmington Delaware, 700 King Street, Wilmington, Delaware on Tuesday, September 30, 2014 at 10 a.m.

The following members were present:

Actuarial Committee

Ms. M. Gaillard	American Home Assurance Company
Mr. C. Szczepanski	Donegal Mutual Insurance Company
Mr. A. Becker	Harleysville Mutual Insurance Company
Mr. S. Walsh	Liberty Mutual Insurance Company
Mr. K. Brady	PMA Insurance Company
Mr. R. Willsey	Travelers Property & Casualty Company

Classification and Rating Committee

Ms. M. Buck	Accident Fund Ins. Co. of America
Mr. I. Feuerlicht	American Home Assurance Company
Not Represented	Home Builders Association of Delaware
Not Represented	Insurance Company of North America
Mr. S. Walsh	Liberty Mutual Insurance Company
Mr. R. Edmunds	PMA Insurance Company
Mr. G. Fox	XL Insurance Company
Mr. T. Wisecarver	Chair - Ex Officio

Also present were:

Mr. G. Reed	Delaware Insurance Department
Mr. R. Heffron*	Chair, Workers' Compensation Oversight Panel
Mr. J. Rhoades*	Vice Chair, Workers' Compensation Oversight Panel
Mr. F. Townsend	Delaware Ratepayer Advocate
Mr. A. Schwartz*	AIS Risk Consultants
Mr. J. Pedrick	INS Consultants, Inc.
Mr. C. Tait	Milliman, Inc.
Mr. W. Vogel	Milliman, Inc.
Mr. L. Dotsun*	Delaware Association of Insurance Agents and Brokers
Mr. B. King	QBE
Mr. S. Cooley	Duane Morris LLP
Ms. F. Barton	DCRB Staff
Ms. D. Belfus	DCRB Staff
Mr. K. Creighton	DCRB Staff
Mr. B. Decker	DCRB Staff
Mr. P. Yoon	DCRB Staff

* Present for part of meeting

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

Staff provided some background and highlights of the analysis done for the December 1, 2014 Residual Market Rate and Voluntary Market Loss Cost Filing. Points addressed and emphasized included the following:

- The preliminary indicated overall average changes in rating values were decreases of 1.56 percent in residual market rates and 3.52 percent in voluntary market loss costs.

- The effects of a series of legislative changes had been accounted for in the derivation of the indicated changes in rating values. It was noted that, absent the combined benefits of 2007, 2013 and 2014 legislation, the December 1, 2014 residual market rate change indication would have been an increase of approximately 53 percent.

- Savings from Senate Bill 1 of 2007 (SB1) were estimated to be approximately 17.40 percent of medical loss costs and 12.75 percent of overall loss costs. Accordingly, SB1 produced an indicated decrease in residual market rates of approximately 12.75 percent.

- Savings from Senate Bill 238 of 2012 (SB238) were estimated to be approximately 0.42 percent of medical loss costs and 0.29 percent of total loss costs. Accordingly, SB238 produced a decrease in residual market rates of approximately 0.29 percent.

- Savings from House Bill 175 of 2013 (HB175) were estimated to be approximately 7.42 percent of medical loss costs and 5.14 percent of total loss cost. Accordingly, HB175 produced a decrease in residual market rates of approximately 5.14 percent. These estimates reflected changes in applicable CPI index values and in weights assigned to various partitions of medical payments from those applied in the development of the December 1, 2013 DCRB filing.

- House Bill 373 of 2014 (HB373) required revisions to Delaware fee schedules such that prescribed levels of reductions in medical expenses were attained in 2015, 2016 and 2017. Work continued on the development of those mandated fee schedules, and they were not available for review or evaluation as part of the preparation of this filing. The DCRB had elected to price HB373 based solely on its interpretation of the legislative intent, and would reserve the right to amend or replace the filing indications if subsequent analysis of the actual fee schedule(s) adopted in Delaware appeared to produce different results from those prescribed in the statute. On that basis, savings from HB373 were estimated to be approximately 32.45 percent of medical loss costs and 21.95 percent of total loss costs. Accordingly, HB373 produced a decrease in residual market rates of approximately 21.95 percent.

- Medical experience (limited medical losses, limited medical trend and medical excess losses in combination) produced an indicated increase in residual market rates of approximately 34.88 percent.

- Indemnity loss experience (limited indemnity losses, limited indemnity trend and indemnity excess losses) accounted for an indicated increase in residual market rates of approximately 6.15 percent.

- Loss adjustment expenses contributed an increase of approximately 4.76 percent to the filing indication for residual market rates.

- Expense needs in the residual market resulted in an increase of approximately 1.98 percent in residual market rates.

- The anticipated July 1, 2015 benefit change resulted in a reduction of approximately 0.08 percent to the overall residual market rate change.

***Question:** Staff was asked to confirm or clarify the status of the fee schedules called for under HB373, and when those fee schedules would be available for review and evaluation.*

***Answer:** Attendees were advised that the DCRB had been following and attending meetings of the Workers Compensation Oversight Panel (WCOP) charged with the development of the new fee schedules. Staff was of the impression that fee schedule values might not be finished until mid-December 2014 or mid-January 2015.*

A representative of the WCOP stated that framework for the required fee schedules had been adopted at a meeting of the WCOP held on September 29, 2014. That framework provided for three fee schedules to be created: one for Ambulatory Surgical Centers, one for Hospitals and one for other Healthcare Providers. OptumInsight was involved with this effort as a contractor for the WCOP. Preliminary work toward the required January 31, 2015 reduction of 20 percent in medical expenses would be subject to further consideration of factors including Medicare adjustments and the impact of contract payments on provider reimbursements under the revised fee schedule(s). This representative expressed keen awareness that a 20 percent reduction in medical expenses was to be delivered by January 31, 2015.

Staff advised the Committees and other attendees that the December 1, 2014 filing was expected to include savings estimates based on the intent of the law while revised fee schedules continued to be developed. When the DCRB was able to access the new fee schedules, an evaluation of the prospective savings associated with their implementation would be done. The DCRB's December 1, 2014 filing would reserve the right to amend or replace that proposal based on subsequent findings with respect to the fee schedule(s) actually adopted in response to HB373.

***Question:** An attendee inquired how the 20 percent reduction in medical costs could be reconciled with the 0.6755 adjustment factor shown in Exhibit 12.*

***Answer:** Staff observed that 2015 policies would be affected by each of the successive reductions of 20 percent, 25 percent and, finally, 33 percent of 2014 medical expenses. The latter two reductions appeared to pre-empt otherwise applicable increases in medical fees associated with changes in the applicable Consumer Price Index for healthcare payments under the Delaware Workers Compensation Act, resulting in the savings level reached in the third year of successive fee schedule revisions exceeding 33 percent.*

***Question:** The observation was made that SB1 had been enacted several years ago. Staff was asked to confirm that the filing analysis continued to adjust experience subsequent to the enactment of that legislation to a pre-SB1 level, and to explain why such an approach continued to be used.*

***Answer:** Staff opined that the effects of law or administrative changes that could be credibly quantified required adjustment to maintain the applicability of customary loss development and trend analyses. While adjustments were always needed, there was a choice between adjusting experience incurred after the law change to a pre-law level or adjusting experience incurred before the law change to a post-law level.*

In Pennsylvania, the PCRB had addressed Act 44 of 1993 and Act 57 of 1996 by adjusting newer data to the pre-law level for five or six years after the enactment of those changes. Once a significant body of data following the law changes became available, prior data was adjusted to a post-law level, with the adjustment being designed to be of as limited affect as possible on rating value change indications thus obtained.

Staff aspired to use a similar approach for Delaware, but acknowledged that the rapid serial enactment of multiple bills complicated the adjustments to some extent. While data for a few years post-SB1 was now available, little or no data after the 2013 or 2014 legislative changes was available. It remained to be seen whether the transition from adjusting post-law data to a pre-law basis to adjusting pre-law data to a post-law basis would be accomplished serially for separate bills or for several or all such legislation in a coordinated fashion at one point in time.

Question: An inquiry was made as to whether staff had an analysis in which pre-SB1 data had been adjusted to a post-SB1 level.

Answer: Staff responded that such an alternative analysis had not yet been conducted.

Comment: The opinion was expressed that assumptions and calculations previously applied to the estimation of effects of legislative changes needed to be tested and verified.

Answer: Staff observed that even after the fact observed changes in system cost metrics could not be attributed precisely to an individual cause, or even to specific combined causes. Staff felt that using prior evaluations of legislative changes consistently in subsequent filings was consistent with practices countrywide.

Statutory requirements and administrative procedures expected to be applied to the DCRB's filing were described to attendees.

The Committee discussion then moved to a review of staff work supporting the December 1, 2014 Residual Market Rate and Voluntary Market Loss Cost Filing. The discussion focused on a series of analytical steps supporting the derivation of the indicated overall changes in rating values. Each analytical step was supported by cited exhibits provided in the agenda materials for the filing. Key concepts derived from that supporting analysis were presented in the form of Discussion Exhibits provided in hard copy at the meeting and projected on a screen display to facilitate review of those points.

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

ITEM (1) REVIEW OF THE PROPOSED DECEMBER 1, 2014 RESIDUAL MARKET RATE AND VOLUNTARY MARKET LOSS COST FILING

A Discussion Package of materials had been distributed to meeting attendees and was shown as a series of PowerPoint slides during the meeting. By reference to Discussion Package Page 1, staff gave an overview of the key analytical steps applied in the development of the draft filing indication being offered for review at the meeting. Those steps included:

- Estimating ultimate on-level limited losses for prior policy years,
- Trending prior policy year results to the prospective period to which the proposed residual market rates and voluntary market loss costs would apply,
- Recognizing the estimated impacts of specified legislative changes on expected system costs,
- Adjusting results for the effect of limitations applied in the earlier analysis,
- Using a permissible loss and loss adjustment expense ratio to derive indicated changes in residual market rates,
- Applying estimated effects of the July 1, 2015 change in indemnity benefits, and

- Deriving the indicated change in voluntary market loss costs by removing the effects of expense needs from the residual market rate change indication.

EVALUATION OF IMPACTS OF PRIOR LEGISLATION ON THE DECEMBER 1, 2014 RATING VALUE INDICATIONS

The DCRB's filing analysis had explicitly and individually accounted for the impact of statutory changes contained in or authorized by the referenced pieces of Delaware legislation. The impacts so identified were summarized as follows:

HB373

HB373 was the most significant of the legislative changes applicable to the DCRB's analysis for this filing. HB373 included the following provisions:

- §2322B sets forth procedures and requirements applicable to the health care payment system for workers compensation claims. Among those procedures and requirements are the following notable elements:

- §2322B (3)(a): The Workers' Compensation Oversight Panel (WCOP) shall, by October 1, 2014, establish a fee schedule for all Delaware workers compensation funded procedures, treatments and services based on the Resource Based Relative Value Scale ("RBRVS"), Medical Severity Diagnosis Related Group (MS-DRG), Ambulatory Payment Classification (APC), or equivalent scale used by the Centers for Medicare and Medicaid Services.

  The fee schedule shall result in a reduction of 20% in aggregate workers compensation medical expenses by the year beginning January 31, 2015, an additional reduction of 5% of 2014 expenses by the year beginning January 31, 2016 and an additional reduction of 8% of 2014 expenses by the year beginning January 31, 2017.

- §2322B (3)(b): By January 31, 2017, no individual procedure in Delaware paid for through the workers compensation system shall be reimbursed at a rate greater than 200% of that reimbursed by the federal Medicare system, provided that radiology services may be reimbursed at up to 250% of the federal Medicare reimbursement and surgery services may be reimbursed at up to 300% of the federal Medicare reimbursement.

Although HB373 required the establishment of medical fee schedules by October 1, 2014, the extensive work required to accomplish that task was ongoing as of the date of the meeting and was expected to continue for some time after the DCRB was required to submit a residual market rate and voluntary market loss cost filing explicitly and individually accounting for the impact of any statutory changes in that act.

Under these circumstances, the DCRB was aware of what HB373 required in terms of revisions to the medical fee schedule – cumulative savings in aggregate medical expenses of 20 percent by the year beginning January 31, 2015, 25 percent of 2014 expenses by the year beginning January 31, 2016 and 33 percent of 2014 expenses by the year beginning January 31, 2017.

The DCRB did not know what specific values the new fee schedules would use, or what overall changes in medical fee amounts would be reflected in those fee schedules.

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

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

The DCRB's evaluation of the potential effects of HB373 was illustrated on Discussion Package Page 2. Using a medical payout pattern based on the DCRB's analysis of ultimate medical losses for prior policy years, the savings that would arise from accomplishment of the serial reductions in medical expenses required under HB373 had been estimated. That procedure had produced an overall savings of 32.45 percent. It was noted that the savings factor approached the required savings in the third and final year of the fee schedule reductions, and staff explained that during the second and third years of that process, the mandated reductions would be taking place instead of increases in fees based on changes in specified CPI indices, thereby increasing the effect of the new fee schedules on otherwise expected costs.

***Question:** Staff was asked whether the savings factors were being applied uniformly to losses and to loss adjustment expenses.*

***Answer:** Because the DCRB's filings treated loss adjustment expenses as a percentage of loss, the loss adjustment provision would move in concert with losses when savings factors were applied.*

***Comment:** This approach was questioned, with the observation that facets of loss adjustment and claims handling would not be mitigated by changes in fee schedule amounts.*

***Answer:** Staff expressed an understanding of the assertion being made, and indicated that consideration could be given to an approach that separated losses from loss adjustment expense in evaluating the impact of legislative or other similar changes.*

***Comment:** A follow-up point was made that the law changes and subsequent revisions to fee schedules would not impact claim frequency, but would only address loss severity.*

***Comment:** Another attendee shared their impression that unallocated loss adjustment expenses in the DCRB's filings were based on countrywide data.*

***Comment:** The observation was made that Discussion Package Page 22 showed that loss adjustment expenses were contributing approximately a 5 percent increase to the overall residual market rate change indication.*

***Question:** Noting that Discussion Package Page 21 showed that loss adjustment expenses had been increasing as a percent of premium over time, an attendee asked whether the DCRB had explanations for that observed phenomenon.*

***Answer:** Staff referred to ongoing increases in duration of claims that were being observed in Delaware, and stated that issues pertaining to the determination of benefits involved numerous steps and considerations that might be increasingly difficult to satisfy. The DCRB did not have specific company perspectives at hand in considering this question.*

Question: ***An attendee expressed the impression that the old fee schedule was relatively novel and complicated. It was hoped that the new structure for the fee schedule would be simpler to administer, and this attendee wondered if such changes would favorably affect loss adjustment activity and expense.***

Answer: ***Staff observed that the new fee schedule would be based on a relative value resource-based system, as was Medicare. Accordingly, the new structure might be more familiar and more consistent with other payment systems than had previously been the case.***

Comment: ***It was noted that changes of the type under discussion often invoked a need for programming and system changes to be made by insurers, and that claims adjusters would be required to learn and adapt to the new fee schedule. There could also be work involved in monitoring utilization patterns to detect shifts that would otherwise offset available savings, and additional costs could arise with respect to such efforts.***

HB175

HB175 included a broad spectrum of changes directed at various components and/or features of the medical benefit system for workers compensation in Delaware. Staff's estimation of specified elements of that law change were summarized on Discussion Package Page 3, and were described at follows

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

The estimated effects of this change were reflected in the first line of discussion Package Page 3. The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately 7 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 4.3 percent, resulting in an estimated reduction to medical expenditures of 0.3 percent.

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

The estimated effects of this change were reflected in the second line of Discussion Package Page 3. The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately 11 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 4.8 percent, resulting in an estimated reduction to medical expenditures of 0.5 percent.

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

The estimated effects of this change were summarized on the third line of Discussion Package Page 3. The DCRB had determined that the drug screening services addressed by the above statutory and administrative code provisions represented approximately 0.7 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 65.5 percent, resulting in an estimated reduction to medical expenditures of 0.3 percent.

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

The estimated effects of this change were reflected in the fourth line of Discussion Package Page 3. The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately 2 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 20.3 percent, resulting in an estimated reduction to medical expenditures of 0.5 percent.

- HCAP changes to Fee Schedule

During 2013 the Health Care Advisory Panel used information provided by the DCRB and obtained from other resources to develop fee schedule amounts for services previously published as "POC85" in the Delaware fee schedule. The estimated effects of this change were reflected in the fifth line of Discussion Package Page 3. The DCRB had determined that the services addressed by those changes represented approximately 18 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. The changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 2.8 percent, resulting in an estimated reduction to medical expenditures of 0.5 percent.

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

The estimated effects of this change were reflected in the sixth line of Discussion Package Page 3. The DCRB had determined that hospital and ambulatory surgical centers services represented approximately 25 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. These changes were estimated to reduce expenditures for those subject services by approximately 8.4 percent, resulting in an estimated reduction to medical expenditures of 2.1 percent.

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

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

The estimated effects of this change were reflected on the seventh line of Discussion Package Page 3. The DCRB had determined that repackaged products represented approximately 2 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. These changes were estimated to reduce expenditures for those subject services by approximately 30.0 percent, resulting in an estimated reduction to medical expenditures of 0.5 percent.

- Hot and Cold Pack Therapy

Changes adopted in treatment guidelines reduced the maximum numbers of visits for which hot and cold pack therapies could be provided and billed from either 24 or 18 to 12, but did not preclude separate billing for those services during the allowable numbers of visits. The estimated effects of this change were reflected in the eighth line of Discussion Package Page 3. The DCRB had estimated that the services addressed by the above statutory and administrative code provisions represented approximately 1 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013, and that the proposed changes would reduce expenditures for those subject services by approximately 24.5 percent, resulting in an estimated reduction to medical expenditures of 0.3 percent.

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

The DCRB estimated the effects of this provision separately for four partitions of the medical expenditures reported through the Medical Data Call for the period July 1, 2011 through June 30, 2013. Those partitions and the evaluation of the effects of this provision were set forth as follows:

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

The effect of this change was reflected in the first line in the bottom section of Discussion Package Page 3. The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately 32 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. Based on historical changes in the CPI-U index used to adjust the fee amounts for such services the changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 1.8 percent.

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

The effect of this change was reflected in the second line in the bottom section of Discussion Package Page 3. The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately 7 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. Based on historical changes in the CPI-U index used to adjust the fee amounts for such services the changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 1.4 percent.

Other professional services:

The effect of this change was reflected in the third line in the bottom section of Discussion Package Page 3. The DCRB had determined that the services addressed by the above statutory and administrative code provisions represented approximately 18 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013. Based on historical changes in the CPI-U index used to adjust the fee amounts for such services the changes recently accomplished were estimated to reduce expenditures for those subject services by approximately 1.4 percent.

Hospital and ambulatory surgical centers:

Hospital reimbursements are regulated under procedures adopted under SB238, which compare changes in overall hospital charges to the prescribed statutory change (generally a change in a specified consumer price index value) and adjust the percentage factor applied against hospital charges to compute allowable reimbursements.

Ambulatory Surgical Center reimbursements are regulated under procedures adopted under SB238, which compare changes in each ambulatory surgical center's overall charges to the prescribed statutory change (generally a change in a specified consumer price index value) and adjust the percentage factor applied against that ambulatory surgical center's charges to compute allowable reimbursements

The effect of this change was reflected in the fourth line in the bottom section of Discussion Package Page 3. The DCRB had determined that hospital and ambulatory surgical centers services represented approximately 31 percent of medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013.

Using methodologies applied by the Department of Labor in prior revisions to hospital and ambulatory surgical center reimbursement levels, the DCRB estimated that the changes recently accomplished would reduce expenditures for those subject services by approximately 4.3 percent.

Overall, the DCRB estimated that the respective savings to medical cost described above for each partition of the medical expenditures reported in the Medical Data Call for the period July 1, 2011 through June 30, 2013 would result in savings of approximately 2.3 percent of total 2011 medical expenditures.

Question: ***Inquiry was made with respect to whether, and if so, how, the DCRB assumed that patients and/or doctors might change behavior in response to the forthcoming fee schedule changes.***

Answer: ***The DCRB's approach had separated contract payments from reimbursements made without the application of contract provisions. For contract payments, the statute provided that the contract would prevail, and the DCRB's calculations had retained those historical charges and payments without adjustment. For non-contract payments, the analysis had mechanically applied the revised fee schedule parameters to historical payments to calculate the effect of fee schedule changes.***

Question: ***An attendee wondered whether the Medical Data Call identified contract as compared to non-contract payments.***

Answer: ***Staff expressed the belief that the Medical Data Call included an indicator relevant to this determination.***

Question: ***A follow-up question asked whether the DCRB could use data for contract payments to determine amounts that might have been paid absent the contract provisions.***

Answer: ***Staff expected that a mechanical comparison of charges made on medical bills to the reimbursement allowed under the fee schedule could be made as a measure of probable payments for contract reimbursements under a scenario in which the contract had not been in effect.***

SB238

- SB238 had revised the basis for hospital reimbursement rates from 85 percent of charges to 80 percent of charges, reduced reimbursement rates for emergency services from 100 percent of charges to 80 percent of charges, and established procedures to be used in determining allowable reimbursement rates for hospitals, emergency services and ambulatory surgical centers on a going forward basis.

The estimated effect of this legislation was reflected in Discussion Package Page 4. The DCRB had divided available data for medical expenditures reported in the Medical Data Call for the period July 1, 2010 through June 30, 2012 between the various services addressed in SB238, and had applied savings factors based on the intended revisions to reimbursement procedures to each partition of the data. The result thus obtained was an estimated reduction to medical expenditures of 0.42 percent.

LOSS DEVELOPMENT

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

Exhibit 1: Table I – Summary of Financial Call Data
Exhibit 1a: Excess Loss Factor and Policy Year Loss Limitations
Exhibit 1b: Reported Losses in Excess of Loss Limitations
Exhibit 2: Paid and Incurred Loss Development and Trend
Exhibit 2a: Graphs of Selected Loss Development Projections

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

Attendees were reminded of SB1 enacted in 2007 in Delaware, which provided for processes related to the development of a medical fee schedule and treatment guidelines. In a prior filing (Bureau Filing No. 0806) the DCRB had evaluated the effects of the medical fee schedule that had subsequently been implemented in Delaware, and rating values effective on or after October 1, 2008 had reflected that estimated impact. For the December 1, 2014 filing, experience had again been adjusted to a pre-SB1 basis for purposes of such analyses as loss development and trend, and then Law Amendment Factors specific to SB1, SB238, HB175 and HB373 had been applied to derive a December 1, 2014 indication.

The data adjustments for SB1, SB238 and HB175 had been made to paid and case incurred losses reported after the respective effective dates of each piece of legislation or administrative action by assuming that the estimated effect of the changes would be reflected immediately in paid medical losses and would become incorporated into case reserve values gradually over a three-year period of time.

Discussion Exhibit, Page 5 - Reported Incurred Losses Above Selected Loss Limits

This exhibit was offered with the following specific observations:

- With selected loss limits ranging from approximately $985,000 for Policy Year 1998 to slightly more than $2,500,000 for Policy Year 2013, every complete policy year included at least some losses in excess of the applicable limits.

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

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

A set of eight Discussion Exhibits were next presented serially, illustrating comparisons between loss development link ratios reported for the most recent available calendar year (December 31, 2012 to December 1, 2013) and counterpart ratios for the calendar year December 31, 2008 to December 31, 2009. The significance of these two calendar years was described in the context of the DCRB using a four-year average of age-to-age link ratios as the basis for its loss development analysis. Under this construct the 2012–2013 year was being added to the analysis of the December 1, 2014 filing while the 2008–2009 year was being dropped from this year's filing. With the remaining three intervening calendar years being common to both the December 1, 2013 and December 1, 2014 filings, the comparisons illustrated on the Discussion Exhibits effectively highlighted the general change in indicated loss development for the current filing.

Key findings gleaned from the Discussion Exhibits as presented were as follows:

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

At early maturities (first through sixth reports), indemnity paid loss development factors were mixed, with three values being higher for the 2012–2013 year and two being higher for the 2008–2009 year.

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

At extended maturities (after sixth report) indemnity paid loss development factors were fairly evenly balanced, with incidences of the newest year being lower than the 2008-2009 year becoming somewhat more common as the maturity of claims increased. Overall, six maturities after sixth report showed indemnity paid loss development factors higher for 2012-2013 than 2008-2009, and 11 maturities after sixth report showed indemnity paid loss development factors lower for 2012-2013 than for 2008-2009. Staff pointed out that the 2008-2009 year had not included reports for a 24th maturity.

Together, Discussion Exhibits Pages 6 and 7 suggested that paid indemnity loss development had been reasonably stable between the December 1, 2013 and December 1, 2014 filings.

Discussion Exhibit, Page 8 – Indemnity Incurred Link Ratios Less Unity

Three of the five earliest link ratios shown were higher for the 2012-2013 year than for the 2008-2009 year.

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

At extended maturities (after sixth report) incurred indemnity loss development showed general improvement for the 2012-2013 year compared to 2008-2009. Of the 17 link ratios shown after sixth report, 14 were lower for the 2012-2013 year than they were in 2008-2009. Similarly to the indemnity paid loss development, the 2008-2009 year had not included reports for a 24th maturity.

Together, Discussion Exhibits Pages 8 and 9 suggested that incurred indemnity loss development had improved somewhat in the December 1, 2014 filing as compared to the data underlying the December 1, 2013 filing.

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

At early maturities (first through sixth reports) medical paid loss development was higher for the 2012–2013 year than had been the case for the 2008–2009 year for four of the five development periods.

Discussion Exhibit, Page 11 – Medical Paid Link Ratios Less Unity

At extended maturities (after sixth report) medical paid loss development was generally mixed as to whether 2012-2013 or 2008-2009 showed higher loss development. Staff pointed out that the 2008-2009 year had not included reports for a 24th maturity.

Together, Discussion Exhibits Pages 10 and 11 suggested that paid medical loss development had increased somewhat for early maturities in the December 1, 2014 filing as compared to the data underlying the December 1, 2013 filing.

Discussion Exhibit, Page 12 – Incurred Medical Link Ratios Less Unity

Three of the five earliest development factors were lower for 2012-2013 and two were higher for 2012-2013.

Discussion Exhibit, Page 13 – Incurred Medical Link Ratios Less Unity

At extended maturities (seventh and later reports) incurred medical loss development generally showed improvement in the 2012-2013 year. For 13 of the 17 link ratios shown, the 2012-2013 values were lower than those of 2008-2009. As was true for earlier Discussion Exhibit Pages, the 2008-2009 year had not included reports for a 24th maturity.

Together, Discussion Exhibits Pages 12 and 13 suggested that incurred medical loss development may have been slightly more favorable in the December 1, 2014 filing as compared to the data underlying the December 1, 2013 filing.

Comment: ***A Committee member suggested that it would be helpful for future meetings to show differences in cumulative loss development factors between successive filings. It was thought that those values would be more instructive than the age-to-age link ratios less unity.***

Question: ***Staff was asked to clarify what data was being shown in the red and blue lines respectively.***

Answer: ***Staff noted that each line reflected age-to-age factors based on a specific calendar year of development.***

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

Discussion Exhibit Page 14 – Limited Loss Development Analysis – Curves Fitted to Age-to-Age Loss Development Factors less Unity presented the following curve forms that had been selected as best accomplishing the objective without changing the overall level of observed development or reflecting an unreasonable shape or other behavior when extrapolated into an extended period of future reporting:

Indemnity Incurred Development Factors:

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

Indemnity Paid Development Factors:

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

Medical Incurred Development Factors:

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

Medical Paid Development Factors:

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

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

Discussion Exhibit, Page 15 – Indemnity Paid & Incurred Ultimate Limited Loss Ratios by Policy Year presented the results of applying paid loss and case incurred loss development methods to indemnity losses for the December 1, 2014 filing. This exhibit illustrated the fact that differences between these approaches were very modest with the paid loss development method tending to produce slightly higher results for policy years 2007, 2008 and 2011.

Discussion Exhibit, Page 16 - Medical Paid & Incurred Ultimate Limited Loss Ratios by Policy Year presented the results of applying paid loss and case incurred loss development methods to medical losses for the December 1, 2014 filing. This exhibit showed comparable results for the two methods with case incurred estimates tending to higher than the paid method for recent policy years.

Question: ***An attendee pointed out that loss ratios appeared to have started to increase noticeably after 2008 and inquired whether the DCRB could offer an explanation for that change.***

Answer: ***Although a definitive explanation was not available, staff had considered the changes in loss ratios by policy year during its analysis of the forthcoming filing. Lengthening durations of claims and continuing increases in the incidence of relatively large claims were possible contributors to these observed patterns.***

Question: ***An attendee pointed out estimated improvements in ultimate losses estimated for Policy Year 2011 in the current filing as compared to the December 1, 2013 filing. Staff was asked why that improvement might have taken place.***

Answer: ***Staff concurred in the observation, and described changes in policy year loss estimates as arising from the continuing collection and analysis of experience data including benefit payments, case reserves, settlement rates, etc.***

Question: ***Staff was asked whether it had tried to measure the predictability of loss data for the filing.***

Answer: ***Staff acknowledged that the limited volume of experience data available in Delaware lent itself to volatile estimates. Without the benefit of HB373, the indication would have been approximately a 26 percent increase.***

CLAIM FREQUENCY TREND

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

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

Policy Year 2012 had now been substantially reported, and indicated a decline of 8.8 percent in frequency. Policy years 2009 and 2010, a recessionary period within which notable disruptions of long-term claim frequency trends had been observed in many jurisdictions, showed essentially flat claim frequency.

Discussion Exhibit, Page 17 – Unit Statistical Plan Indemnity Claim Frequencies was reviewed, illustrating the nature of claim frequency experience in Delaware.

Including policy years 2009 and 2010 in a seven-point exponential regression to derive claim frequency trend produced an annual rate of change of -5.0 percent. This value was less than the changes observed for any year since 2003 except for the recessionary years of 2009 and 2010. Staff felt that including those extraordinary years at full value was unduly pessimistic, but was also disinclined to remove those two years from the determination of claim frequency trend altogether. Accordingly, a selection of claim frequency trend for the December 1, 2014 filing had been made by averaging the results of two seven-year exponential regressions, the first using all policy years 2006 through 2012 and the other using the years 2004 through 2012 excluding 2009 and 2010. The resulting claim frequency trend was -6.6 percent.

It was noted that the claim frequency trend for the December 1, 2013 filing had been -5.1 percent.

SEVERITY TREND

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

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

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

Indemnity Severity – Through Policy Year 2012 (mid-point January 1, 2013) the DCRB had measured claim severity trend using a seven-point exponential trend model fitted through the severity ratios derived by adjusting estimated ultimate loss ratios for known changes in claim frequency. That analysis resulted in an annual change in indemnity severity of +5.8 percent per year, up from the 2013 filing's value of +4.7 percent per year.

Medical Severity – The DCRB remained mindful that, in the adjudication of the December 1, 2009 filing, both actuarial consultants who had reviewed the filing had anticipated some improvement in medical trends associated with the implementation of the medical fee schedule in late 2008. Such an adjustment had subsequently been included in the DCRB's December 1, 2010, December 1, 2011, December 1, 2012 and December 1, 2013 filings with the posited improvement of 1.8 percent in annual medical severity trend applied after September 1, 2008 (the effective date for full implementation of the medical fee schedule in prior DCRB filings).

Subsequent to the implementation of B1 it had been discovered that the intended regulation of fees for hospitals and ambulatory surgical centers had not been accomplished as envisioned under that law for both legal and practical reasons. SB238 was enacted to establish a new mechanism to manage hospital and ambulatory surgical center reimbursements.

The DCRB estimated the contribution of hospital and ambulatory surgical center payments to the anticipated improvements in medical trend, deriving a result that instead of a -1.8 percent annual improvement the value excluding hospitals and ambulatory surgical centers would have been approximately -1.5 percent. Accordingly, the December 1, 2014 filing had used an adjustment to severity trend attributed to SB1 reflecting an improvement of 1.5 percentage points per year from September 1, 2008 (the implementation of the fee schedule under SB1) through January 31, 2013 (the effective date of SB238). For time period from January 31, 2013 to June 27, 2013, the prior assumption of an improvement of 1.8 percent per year was applied for the December 1, 2014 filing. Provisions of HB175 had replaced the use of the CPI-Medical for determining annual changes in hospital reimbursement rates to the CPI-Urban, All Items. That change, effective June 27, 2013, was estimated to reduce medical trend overall by approximately 0.4 percent.

The pre-SB1 medical severity trend (measured prior to the application of the above adjustments), derived using a seven-point exponential fit, was +13.6 percent per year. Based on the above considerations, the annual medical severity trends used in the staff analysis were +13.6 percent through September 1, 2008, +12.1 percent per year from September 1, 2008 to January 31, 2013, +11.8 percent from January 31, 2013 to June 27, 2013 and +11.4 percent thereafter.

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

Discussion Exhibit, Page 18 – Indemnity and Medical Actual and Trended Severity Ratios, Average of Incurred and Paid to 24th portrayed the results of the selected loss development methodologies for indemnity and medical losses, with the exponential fit trend indications also provided for illustrative purposes. It was noted that the medical severity trends applied respectively from September 1, 2008 to January 31, 2013, January 31, 2013 to June 27, 2013 and after June 27, 2013 were nominally lower than the curve presented in this Discussion Exhibit.

Discussion Exhibit, Page 19 – Indemnity Loss Experience Components, Indexed to 1.000 at Policy Year 2000, Annual Rates of Change was shown, noting that this material replicated the indemnity portion of the agenda package's Exhibit 5. The selected claim frequency and severity trends were illustrated, together with the resulting loss ratio trend (-1.2 percent).

Discussion Exhibit, Page 20 – Medical Loss Experience Components, Indexed to 1.000 at Policy Year 2000, Annual Rates of Change was shown, noting that this material replicated the medical portion of the agenda package's Exhibit 5. The selected claim frequency and severity trends were illustrated, together with the resulting loss ratio trend (+6.1 percent to September 1, 2008, +4.7 percent to January 31, 2013, +4.4 percent to June 27, 2013 and 4.0 percent thereafter).

Question: ***An attendee observed that the 5.8 percent annual indemnity severity trend was higher than the annual wage trend. The question was posed whether staff had identified a cause for this change and if the DCRB had spoken to insurers about this aspect of the draft filing.***

Answer: ***Staff reiterated the observation that claim durations were becoming longer in Delaware over time and expressed the view that this could contribute to higher severity trends.***

Question: ***A follow-up question asked whether claim durations were changing because of a different mix of claims being presented, or similar types of cases were remaining open longer, or if Medicare Set-Aside requirements were slowing claim closures in Delaware, or if some other reason(s) were causing these changes. Another attendee wondered whether the DCRB could identify types of claims that were staying open longer. Such information could be helpful in considering additional system changes to manage costs. It was noted that catastrophic claims might defy a readily-available solution.***

Answer: ***The response indicated that data by Death, Permanent Total, Major Permanent Partial, Minor Permanent Partial and Temporary Total types could be obtained. Staff noted that, to the extent that Medicare Set-Aside requirements were a consideration for claim settlements, in Pennsylvania, claims were nonetheless closing faster, rather than more slowly, over time.***

Comment: ***An observation was made to the effect that it was difficult to keep people in total temporary disability status for extended periods of time. The Industrial Accident Board was characterized as being motivated to achieve return to work outcomes. It was suggested that a breakdown(s) by injury type might be helpful to see if there are patterns suggesting certain types of cases warranting special attention.***

Expenses and Benefit On-Level Factor

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

Exhibit 8: Expense Study
Exhibit 9: Internal Rate of Return Model
Exhibit 10: Effect of 7/1/15 Benefit Change
Exhibit 11: Expense Loading

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

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

The first four items noted above were reviewed over the three calendar years 2010, 2011 and 2012.

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

Other acquisition and general expenses were determined based on the three-year average ratio of those respective expenses to standard earned premium at DCRB rate level, including large deductible business on a gross basis and excluding expense constant income.

The relationship between loss adjustment expense and loss was derived based on the three-year average ratio of loss adjustment expense to incurred losses, including large deductible on a gross basis. The premium discount provision in the proposed filing was based on size-of-risk distribution for Schedule Y carriers in Manual Year 2011, the most recent complete available year from unit statistical data. A provision for uncollectible premium had been selected after review of experience over the most recent available ten years.

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

Exhibit 10 calculates an estimate of the effect of changes in the expected benefit minimum and maximum effective July 1, 2015. This provision was used in Exhibit 12 to calculate the indicated change in residual market rates and voluntary market loss costs.

A separate provision for the July 1, 2015 benefit change was needed as the losses underlying the loss development and trend analyses included the effect of such benefit changes through July 1, 2014.

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

The DCRB also provided input based on industry data for the Pre-Tax and Post-Tax rates of return on assets and a Reserve-to-Surplus Ratio.

These DCRB inputs were combined with an economic consultant's analysis to construct a cash flow model appropriate for the business of underwriting workers compensation business in Delaware.

Key results derived from Exhibit 9 for use in the proposed filing were:

Cost of Capital: 8.85 percent

Permissible loss ratio, including loss adjustment expense and loss-based assessments: 70.95 percent

Profit and contingencies: +0.79 percent

Staff noted that the indicated profit and contingencies provision for the December 1, 2014 filing was slightly positive while the counterpart value for the December 1, 2013 filing had been slightly negative.

Exhibit 11 compared the loss, loss adjustment expense and underwriting expense provisions in the December 1, 2013 filing to those proposed for the current filing.

Discussion Exhibit, Page 21 – Historical Expense Ratios, 12/1/2007 through 12/1/2014 was reviewed. An overall increase in the residual market expense need from 29.91 percent of premium for the December 1, 2013 filing to 31.29 percent of premium for the December 1, 2014 filing was noted, with the following components highlighted as contributing increases toward that net change:

	December 1, 2013	December 1, 2014
Profit & Contingencies:	-0.47 percent	+0.79 percent
Commission	5.51 percent	5.97 percent
General Expense	3.11 percent	3.44 percent
Premium Discount	8.86 percent	9.15 percent
Other Acquisition	2.74 percent	2.85 percent

Overall Indicated Changes in Collectible and Manual Rating Values

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

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

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

On-level loss and loss adjustment expense ratios in Lines 1(a) through 1(e) were noted as being higher than the counterpart values from the December 1, 2013 filing for all but the newest respective policy year for both indemnity and medical. These comparisons reflected the approved December 1, 2013 rate change (+11.4%) and losses reported including loss development data since that filing.

The effects of trend on the filing indication (affecting indemnity projections favorably but increasing medical projections) were noted. In comparison to the trend adjustments included in the December 1, 2013 filing, the current indication for indemnity claim severity was less favorable for the current submission while claim frequency and medical claim severity were described as being more favorable for the current submission.

The adjustments to medical loss ratios based on DCRB analysis of the effects of 2007, 2012, 2013 and 2014 legislative and regulatory changes were noted. Line (3ai) pertained to SB1, line (3aii) reflected SB238, line (3aiii) included the collective components of HB175 and subsequent regulatory changes and line (3aiv) reflected HB373. 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, 2015 benefit change on Line 8 gave a final residual market rate change on Line 9. Removing the provisions for expenses other than loss adjustment expense from the residual market rate change gave the indicated voluntary market loss cost indication on Line 10.

Staff pointed out the proposed overall changes in residual market rates (1.56 percent decrease) and voluntary market loss costs (3.52 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, with the impact of the surcharge program being applied to voluntary market loss costs to maintain revenue neutrality of that surcharge program.

Discussion Exhibit, Page 22 – Components of Proposed December 1, 2014 Residual Market Rate Change was reviewed with attendees, with the combinations of factors underlying the overview described at the beginning of the meeting identified.

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

Discussion Exhibit, Page 23 – Claim Settlement Rates, Ratio of Open to Reported Indemnity Claims by Policy Year showed ratios of open to reported claims for selected claim maturities. These ratios were generally trending up over time and, with the exceptions of first and tenth reports, had moved up to some extent with the most recent available report. Except for first and tenth reports, the open claim ratios had increased for the most recent two policy years compared to previous policy years.

Unlimited Loss Exhibits Presented for Purposes of Comparison

While relying on limited loss development and trend as previously described, DCRB staff had performed counterpart analyses of the December 1, 2014 filing on an unlimited loss basis. That analysis was presented in the work contained in the following meeting Exhibits:

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

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

Discussion Exhibit Page 24 – Unlimited Loss Development Analysis – Curves Fitted to Age-to-Age Loss Development Factors less Unity disclosed the following curves selected to smooth unlimited loss development link ratios:

Indemnity Incurred Development Factors:

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

Indemnity Paid Development Factors:

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

Medical Incurred Development Factors:

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

Medical Paid Development Factors:

y = a + b/x^1.5 + c*log(x)/x^2

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

Delaware Insurance Plan

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

Exhibit 19: Delaware Insurance Plan

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

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

Experience Rating

The topic of Experience Rating was presented in the work contained in the following meeting Exhibits:

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

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

Discussion Exhibit, Pages 25 and 26 – Credit Risks and Debit Risks respectively provided overviews of loss ratio adjustments accomplished by the Experience Rating Plan on employers by premium size group.

Exhibit 20 was discussed as the means of deriving anticipated collectible premium ratios for use in Exhibit 12. It was noted that Market Profile Report data (based on policy reports for early maturities) had been used as the basis for determining Collectible Premium Ratios for this year's filing. Market Profile Report data was available sooner than unit data, and captured observed decreases in average modifications in recent policy years. 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 if Delaware had restrictions on the extent to which experience modifications could be changed in any one year.*

***Answer:** Staff responded that while credibility assignments were generally low in Delaware, lending some stability to experience ratings, there was no capping of modification changes in Delaware like the procedure applied in Pennsylvania.*

Comment: ***The inquirer observed that in Pennsylvania, if you are a debit risk, you cannot get to a credit in one year.***

Answer: ***Staff clarified the procedures used in capping modification swings in Pennsylvania, particularly as those addressed questions of credit or debit modifications. In instances in which the indicated modification was a credit but the swing limit would require assigning a debit modification, the modification was assigned at 1.000 for the rating in question.***

Delaware Construction Classification Premium Adjustment Program

The topic of the Delaware Construction Classification Premium Adjustment Program was presented in the work contained in the following meeting Exhibit:

Exhibit 14: DCCPAP

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

The table of qualifying wages was reviewed for the participants. Staff noted that the qualifying wages proposed to be effective for the DCCPAP June 1, 2015 reflected expected future wage level changes, resulting in a proposed wage table with a lower qualifying wage than was in effect for the June 1, 2014 Table.

Workplace Safety Program and Merit Rating

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

Exhibit 29: Delaware Workplace Safety Program & Merit Rating Program

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

Page 29.1 showed recent historical experience for participation in the Workplace Safety Program and derived an indicated offset to manual rates based thereon. Page 29.2 showed anticipated distributions of merit-rated risks between credits, no adjustments and debits and combined the indicated offset for net merit rating credits with that for the Workplace Safety Program. The combined indication was for a 3.27 percent adjustment to manual rating values, as compared to the 3.33 percent adjustment currently in effect.

Rating Values Based on Size-of-Loss Analyses

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

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

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

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

Exhibit 16

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

It was noted that in past filings selected factors had been rounded to the nearest 0.005. In this filing values were shown to the nearest 0.001 as some adjacent deductible amounts otherwise produced identical loss elimination ratios.

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

Staff briefly described changes to the processes and procedures used in the derivation of excess loss factors that was introduced as part of the December 1, 2009 filing. One result of those changes was a far greater emphasis on Delaware experience than had been used in the past. Exhibit 17a presented an empirical loss distribution based solely on Delaware data. The analysis indicated that actual loss experience could be used over a significant portion of the size-of-loss range for each type of injury (Death, Permanent Total, Permanent Partial 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. Values as of December 1, 2013 were also shown. Consistent with the 2009 study, Pennsylvania relativities had been used as benchmarks for loss amounts in excess of $1,000,000 owing to the limited amount of Delaware experience data available in those layers.

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

It was observed that HB373 had been particularly significant for the results obtained in Exhibits 17b through 17e.

State & Hazard Group Relativities

This subject was addressed in the following meeting exhibit:

Exhibit 18: State & Hazard Group Relativities

Exhibit 18 shows the derivation of the December 1, 2014 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 relativities. Review was conducted to assure that the indicated values for a given hazard group were consistent with indicated values for adjacent hazard groups. An adjustment was made to recognize the impact of recent legislation on Delaware average costs.

Staff advised attendees that the credibility weighting between NCCI and Delaware average costs underlying the December 1, 2013 filing contained an adjustment for Delaware's recent legislation. That adjustment was applied to NCCI's average costs and to Delaware's average cost in the denominator of a fraction, the numerator of which was NCCI's overall average cost. The numerator had not been adjusted for Delaware legislation. In preparing the current filing, the adjustment was not applied to NCCI average costs in either the denominator or numerator of the calculation. But for this revision in procedure, the State and Hazard Group Relativities for the current filing would have been little changed from those currently in effect.

Question: Staff was asked to verify that the adjustments made for HB373 in the State and Hazard Group Relativity analysis were similar to those applied in deriving the overall residual market rate and voluntary market loss cost indications.

Answer: Staff responded affirmatively.

Retrospective Rating

The topic of retrospective rating was presented in the work contained in the following meeting Exhibits:

Exhibit 24: Retrospective Development Factors
Exhibit 25: Tax Multiplier

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

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

Classification Relativities

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

Exhibit 15: Rate and Loss Cost Formulae
Exhibit 22a: Table II – Unit Statistical Data
Exhibit 22b: Table III – Unit Statistical Data
Exhibit 22c: Table IV – Unit Statistical Data
Exhibit 27: Manual Rates, Loss Costs and Expected Loss Rates
Exhibit 28: Index and Supporting Classification Exhibits
Exhibit 30: Distribution of Residual Market Rate Changes and Classifications with Proposed Capped Changes
Exhibit 31a: Summary of Indicated and Proposed Residual Market Rates by Class Code
Exhibit 31b: Summary of Indicated and Proposed Residual Market Rates by Percentage Change

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

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 including medical savings from legislation through HB373, 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 DCRB'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.

Minimum and Maximum Corporate Officer Payrolls

Staff noted the minimum payroll amount for executive officers effective December 1, 2014 was proposed to be increased from $600 to $700 per week as the second step in a multi-year transition toward basing minimum executive officer payrolls on 100 percent of the Statewide Average Weekly Wage. Owing to changes in Statewide Average Weekly Wage data, the maximum executive officer payroll was proposed to be retained at the current value of $2,500.

Proposed changes to Manual language were provided as part of a staff memorandum dated July 11, 2014 and included in the meeting agenda materials.

***Question:** An attendee asked for confirmation that the loss ratios shown on Discussion Package page 16 were stated on level.*

***Answer:** Staff advised that the loss ratios in question had been adjusted to be on the current residual market rate level.*

***Question:** Staff was asked when SB1 had been implemented.*

***Answer:** SB1 had been enacted in 2007, but the medical fee schedule adopted in conformance with that law had been implemented in the latter part of 2008.*

<u>Question</u>: A Committee member asked whether the proposed effective date for the forthcoming filing would be December 1.

<u>Answer</u>: Staff answered affirmatively, noting that it was very likely that the adjudication of the filing might not be completed by the effective date. There was precedent from other recent filings for retroactive application of approved changes in rating values in Delaware.

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

Respectfully submitted,

Timothy L. Wisecarver
Chair - Ex Officio