



Pennsylvania Compensation Rating Bureau

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ACTUARIAL AND CLASSIFICATION & RATING COMMITTEES –

RECORD OF JOINT MEETING

A meeting of the Actuarial and Classification & Rating Committees of the Pennsylvania Compensation Rating Bureau was held in the offices of Duane Morris LLP, United Plaza Building, 12th Floor, Conference Rooms 12K/L, 30 South 17th Street, Philadelphia, Pennsylvania on Wednesday, December 5, 2007 at 10 a.m.

The following members were present:

Actuarial Committee

Ms. B. Higgins	American Home Assurance Company
Ms. J. Throm	Continental Casualty Company
Mr. C. Szczepanski.	Donegal Mutual Insurance Company
Mr. K. Russell	Erie Insurance Company
Mr. N. Leibowitz	Hartford Accident & Indemnity Company
Mr. J. Fratantaro	Insurance Company of North America
Mr. B. Herr .	Liberty Mutual Insurance Company
Mr. K. Brady	PMA Insurance Company
Mr. J. Schmidt	Travelers Property & Casualty Company

Classification and Rating Committee

Mr. I. Feuerlicht	American Home Assurance Company
Mr. R. Butera	Amerihealth Casualty Insurance Company
Mr. S. Reaser	Amguard Insurance Company
Mr. B. Thomas	Argonaut Insurance Company
Not represented	Graphic Arts Association
Mr. C. Hearl	Harleysville Mutual Insurance Company
Not represented	Lehigh Valley Business Conference on Health Care
Not represented	Pennsylvania Automotive Association
Mr. J. Willshier	Pennsylvania Chamber of Business & Industry
Mr. F. Preis	Pennsylvania Food Merchants Association
Not represented	Pennsylvania Newspaper Association
Mr. P. Cortese	Pennsylvania Retailers' Association
Mr. B. Blom	Penn National Insurance Company
Ms. C. Algeo	PMA Insurance Company
Mr. T. Wisecarver	Chair - Ex Officio

Also present were:

Mr. D. Broadwater	Coal Mine Compensation Rating Bureau of Pennsylvania
Mr. S. Cooley	Duane Morris LLP
Mr. A. Becker	Harleysville Mutual Insurance Company
Mr. K. Creighton	Pennsylvania Insurance Department
Mr. E. Zhou	Pennsylvania Insurance Department
Ms. K. Ayres	National Council on Compensation Insurance, Inc.
Mr. D. Asmus	Office of Small Business Advocate
Mr. R. Edmunds	PMA Insurance Company
Mr. A. Becker	Selective Insurance Company
Mr. M. Pozaic	State Workers' Insurance Fund
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

The Antitrust Preamble was read at the beginning of the meeting for the benefit of all participants.

All Committee members and other attendees made self-introductions.

Staff noted the electronic distribution of agenda materials in advance of the meeting and encouraged all Committee members and other attendees to participate in the meeting by raising questions or posing suggestions as those arose during the course of discussion.

The meeting discussion proceeded to first address the loss cost change indication and its supporting materials. Questions were posed, responses were given and/or discussion ensued as indicated by the "Question," "Answer," "Discussion" and "Comment" entries inserted below:

Overall Loss Cost Change Indication

Exhibit 12 of the agenda materials supported this section of the meeting discussion. Staff noted the presence of a revised version of this exhibit in the second mailing of agenda materials, and discussion used the second mailing counterpart of this exhibit.

Loss ratios selected for indemnity and medical benefits had been posted for each of the three most recent available completed policy years, i.e., 2003, 2004 and 2005. These loss ratios and the resultant average ratios were shown on Lines (1) through (4) on Page 12.1 of Exhibit 12.

Trended loss ratios based on each of the Policy Years 2003, 2004 and 2005 were presented on Lines (5) through (7) on Page 12.1 of Exhibit 12, with the resultant average trended loss ratio shown on Line (8) of that same page.

Trend procedures applied in the development of this filing had separated historical experience into frequency and severity components by adjusting policy year on-level loss ratios for actual changes in claim frequency. Historical claim frequencies and the derivation of a prospective claim frequency trend were presented on Page 12.3 of Exhibit 12. The measured annual claim frequency trend of -6.4 percent was pointed out. The resulting indemnity and medical “severity ratios” had been trended over seven-point experience periods using exponential trend models, as shown on Page 12.2. The annual indemnity severity trend thus obtained was noted as +3.3 percent, and the counterpart annual medical severity trend was observed to be +7.1 percent.

The average trended on-level loss ratio thus obtained was shown on Line (9) of Exhibit 12, and at 0.8978 this ratio produced an indicated 10.22 percent reduction in collectible loss costs.

Staff noted that nominal changes in Experience Rating Plan off-balances, measured using the currently-approved Experience Rating Plan and differing by industry group, had been applied to produce the indicated average changes in manual loss costs by industry group.

Question: *An attendee opined that a substantial reduction in indemnity severity trend was driving the filing indication and asked what staff felt was causing the change in this trend value.*

Answer: *Staff commented that the preliminary indication, while predominantly attributable to indemnity experience, was due in roughly equal amounts to favorable loss development and trend within the indemnity component of the filing. Medical experience, both as respects loss development and trend, had been relatively stable between the April 1, 2007 filing and this proposal.*

Question: *Staff was asked what the annual trend factors had been in the most recent previous filing.*

Answer: *For the April 1, 2007 filing the indemnity severity trend factor was +5.9 percent, compared to the +3.3 percent value in this proposal. The medical severity trend factor in the April 1, 2007 filing was 7.3 percent, very close to the value obtained for the current proposal (+7.1 percent).*

Question: *An attendee inquired about the annual frequency trend factor used in the April 1, 2007 filing.*

Answer: *The claim frequency trend in used in that filing was -6.1 percent.*

Question: *An attendee asked whether staff had computed severity trends using undeveloped losses at common maturities.*

Answer: *Staff responded in the negative, noting that recent indemnity loss development had been somewhat favorable.*

Comment: *The attendee reinforced the concept that such comparisons should be done for successive policy years each valued as of the same age, i.e., at 24 or 36 months after inception.*

Answer: Staff noted that the first complete evaluations reported to the Bureau were done at 24 months in financial data and approximately 18 months for unit statistical data. Making such an analysis of financial data would present various challenges in terms of matching reporting carriers between maturities and considering deductible and non-deductible business. The analysis was thought to be more straightforward for unit statistical data. Staff reiterated that age-to-age development factors, particularly for indemnity losses, were generally somewhat lower in the newest available calendar year.

Question: An attendee asked whether the agenda materials included statistics with respect to closure rates.

Answer: Staff noted that the data in question was not included in the meeting agenda materials, but ratios of open to reported claims were available from materials in the possession of staff attending the meeting. Staff read serial ratios of that nature expressed as whole percentages as follows:

At first report, open to reported ratios were 32 percent for Policy Year 1997, 33 percent for Policy Year 1998, 34 percent for Policy Year 1999, 34 percent for Policy Year 2000, 35 percent for Policy Year 2001, 34 percent for Policy Year 2002, 35 percent for Policy Year 2003 and 36 percent for Policy Year 2004, the latest available year.

For 3rd report, open to reported ratios were 14 percent for Policy Year 1995, 13 percent for Policy Year 1996, and 12 percent for each Policy Years 1997 through 2002.

For 5th report, open to reported ratios were nine percent for Policy Year 1993, eight percent for Policy Year 1994, seven percent for Policy Years 1995 and 1996, six percent for Policy Year 1997 and five percent for Policy Years 1998 through 2000.

Question: An attendee observed that the closure rate was slowing at first report.

Answer: Staff affirmed that observation.

Question: Staff was asked whether the -6.4 percent annual claim frequency trend was retrospective or prospective.

Answer: The basis for the selected claim frequency trend was noted as being historical Bureau data excluding large deductible business. Exhibit 8 was cited as the source for that history and the derivation of the claim frequency trend in question. The Bureau had applied the observed historical claim frequency trend over the most recent available seven policy years as the prospectively claim frequency trend for the filing. Staff observed that improving claim frequency trends had lasted over a 20-year period. The most recent available policy year showed a larger percentage decline in claim frequency than the seven-point value used in the proposed filing. Staff observed that the period of time over which claim frequency trends were projected in the filing was approximately four years.

In response to interest expressed by an attendee about the Bureau's analysis and treatment of claim frequency trend as introduced on Exhibit 12, staff identified Exhibit 8 as a key component of the agenda materials, providing claim frequency experience that the Bureau had used in support of its trend analysis for the proposed filing.

Staff had obtained counts of indemnity claims and exposures (measured by expected losses at a constant set of Bureau loss costs) from unit statistical reports. This data was available by policy year from 1987 through 2005, with the last year having a mid-point of January 1, 2006. Compilations of this experience were provided separately for non-deductible business (Pages 3 and 4 of Exhibit 8) and for all business including deductible coverages (Pages 5 and 6 of Exhibit 8.) Staff had also reviewed trends in claim frequency by industry group, and indications for that review were provided on Page 8 of Exhibit 8.

Previous Bureau filings had included reference to data provided by the Department of Labor & Industry (L&I) regarding counts of injuries and illnesses reported in the Commonwealth, together with non-federal payrolls. The work injuries and illnesses shown in those reports were incidents resulting in lost time beyond the day or shift of occurrence. For this filing, updates had been received from L&I through June 30, 2007. The history of these injury reports and payrolls was available on a calendar year basis from 1985 through 2006 and for the 12-month periods ending June 30 of each year from 1996 through 2007 inclusive.

Staff noted that data for counts of injuries and illnesses from L&I had previously exhibited fluctuations attributed to an unknown extent to changes in reporting practices by some of that Department's data sources and observed that recent data from the L&I again appeared to depart from claim experience manifest in Bureau sources. To date, Bureau staff had taken the impression from discussions with staff at L&I that the recent data was again not reflective of actual injury or claim experience in the Commonwealth. While it had been noted that recent experience had begun to be reported electronically (a change from prior hard copy reporting practices), Bureau staff was not clear whether, how and/or the extent to which this change might have contributed to the observed divergence between L&I claim frequencies and those derived from Bureau data.

For reference purposes, the historical data from L&I was provided on Pages 1 and 2 of Exhibit 8.

For use in conjunction with the indemnity severity trend factors, the Bureau had selected a prospective frequency trend based on non-deductible business over the Policy Years 1999 – 2005 inclusive from Exhibit 8, resulting in a frequency trend of –6.4 percent which had been used in trending claim frequency through the mid-point of the prospective rating period (April 1, 2009). The frequency trend factors consistent with this procedure were set forth on Page 6.6 of Exhibit 6. Staff noted that for any selected experience period from five through 12 years, the observed annual rate of change in claim frequency was within +/- 0.02 percent of that used in the filing exhibits. BUREAU data including large deductible business was presented on Pages 5 and 6 of Exhibit 8 and produced very similar claim frequency changes to those supporting the filing.

Question: *Staff was asked to discuss the marked differences between the L&I data and that reported to the Bureau as unit statistical data.*

Answer: *Exhibit 8 included L&I data for “work injuries and illnesses.” The reporting criteria applicable to the L&I data was to include any injury or illness with respect to which the worker missed some time from work outside the day or work shift in which the injury or illness occurred or arose. Staff observed an increase in the L&I counts occurring in 2001 and continuing over the next two subsequent years. The Bureau had been informed that L&I had discovered various data sources reporting indemnity claims (having time loss of seven days or more) instead of the cases where the worker missed any time beyond the day or shift of occurrence. Upon making that discovery, the Department had entered into an educational initiative to correct reporting practices. Beginning in 2004 L&I data had begun to show trends comparable to Bureau data, only to again reverse and show substantial increases in counts with the Year 2005. In that year the Bureau was told L&I had begun to collect injury and illness reports electronically instead of the legacy hard copy system. The Bureau had not been able to determine whether or why that change might be responsible for part or all of the observed changes in reported injuries and illnesses, but the Bureau did not believe that those reports reflected real changes in the volume of work injuries. Claim petitions and the previous disconnection between L&I data and Bureau unit statistical data were cited as bases for that belief. Staff also noted that the upper right hand quadrant of Page 3 of Exhibit 8 (Bureau data) showed that using any number of trend points from five to 12 points gave annual claim frequency trends within +/- 2 tenths of a percentage point from the Bureau selected value of -6.4 percent.*

Comment: *An attendee observed that the L&I data included time periods more current than that reflected in the Bureau data (running midway into Calendar Year 2007 instead of ending with Policy Year 2005).*

Question: *As it seemed unlikely that claim frequency could improve on a perpetual basis, staff was asked whether its projection of historical claim frequencies might be missing a near-term inflection point.*

Answer: *Staff reiterated its doubt that the L&I data reflected increases in current injuries. The enterprise of attempting to predict an inflection point(s) in observed trends that had been in place as persistently as that of claim frequency in Pennsylvania had been undertaken in a number of prior Bureau filings, always without success. Staff observed that judgmental tempering of such data could give rise to a variety of alternative judgments by reviewers of the Bureau’s filing and could (over time) give rise to counterpart rationales to ignore material changes in claim frequency trends, if and when those changes became observable in Bureau data. Staff hoped that regulators would take notice of those actual patterns in future filings and repeated the point that the L&I data had previously diverged from Bureau data and had been shown not to have represented increases in workers compensation claim volumes at the point of that divergence. Staff was also not seeing more “claim” petitions reported in L&I data, and carriers responding to the Bureau’s annual survey had not reported material increases in recent claim frequency experience.*

Question: *Staff was asked what denominator was used to compute claim frequencies on Page 3 of Exhibit 8.*

Answer: *The explanation was given that the claim frequencies shown used indemnity claims and on-level expected losses.*

Question: *An attendee asked whether the loss ratios used in the Bureau's trend analysis had been developed to an ultimate basis.*

Answer: *Staff answered affirmatively, stating that the loss ratios brought into the trend analysis were both developed to an ultimate basis and computed using current (on-level) loss costs.*

Question: *Staff was asked whether the analysis as presented might not be "double counting" between loss development and trend.*

Answer: *The opinion was expressed that the analysis did not inappropriately mix loss development and trend experience. Loss development factors were being used to estimate ultimate results for past periods, while trend analysis then used those prior estimates to forecast future periods.*

Question: *An inquiry was made as to whether the Bureau had analyzed its claim frequency experience by type of claim to see whether various claim types would show different trends.*

Answer: *Staff indicated that it had not performed such an analysis in detail but, by reference to some materials available at the meeting, provided the following claim frequency changes over periods of eight years:*

For 1st report: Death claims, Policy Year 1997 claim frequency of .0008 cases per \$1 million in payroll, Policy Year 2004 claim frequency of .0007 cases per \$1 million of payroll.

Permanent total claims at 1st report, Policy Year 1997 claim frequency of .0004 cases per \$1 million of payroll, Policy Year 2004 claim frequency of .0002 cases per \$1 million on payroll.

Major permanent partial claims at 1st report, Policy Year 1997 claim frequency of .0070 cases per \$1 million of payroll, Policy Year 2004 claim frequency of .0056 cases per \$1 million of payroll.

All serious claims at 1st report, Policy Year 97 claim frequency of .0082 cases per \$1 million of payroll, Policy Year 2004 claim frequency of .0064 cases per \$1 million of payroll.

Minor permanent partial claims at 1st report, Policy Year 1997 claim frequency of .0374 cases per \$1 million of payroll, Policy Year 2004 claim frequency of .0350 per \$1 million of payroll.

Temporary total disability claims at 1st report, Policy Year 1997 claim frequency of .4115 cases per \$1 million of payroll, Policy Year 2004 claim frequency of .2471 cases per \$1 million of payroll.

Comment: An observation was made that the changes in claim frequency for less-serious claim types were greater than those of more serious ones.

Comment: National Council on Compensation Insurance, Inc. (NCCI) had historically seen a concentration of claim frequency improvement in claim frequency in smaller, less serious claims. This tendency had largely disappeared from more recent data.

Comment: An attendee observed that the Bureau's measures of claim severity trend were in the range of expectations but that the claim frequency trend seemed more extraordinary.

Answer: Staff observed that claim frequency trends had fluctuated only nominally in recent years and that the procedure for measuring this trend had been consistent for some time.

Question: A dated article (of perhaps six years' vintage) was recalled, in which the impression was given that employers' changes in workplace conditions and processes were affecting the ongoing decline in claim frequency. Were that to be the case, one might expect that the effects of previous changes would become fully reflected in more recent data, causing improvements in claim frequency to flatten out. Staff was asked whether any retrospective tests had been done to measure or identify such a tendency.

Answer: Staff observed that the continuing reporting of data showed ongoing and persistent improvements in claim frequency. Claim frequency declines were noted as having transcended many other cycles of economic conditions, law changes, and other circumstances.

Comment: An attendee noted that there was literature available that supported the extrapolation of historical trends as the most reliable estimate of future results.

Comment: Staff recalled a comment from the carrier survey responses suggesting that the industry needed a leading indicator of claim frequency changes. Since claim frequency had declined consistently for so long, such a leading indicator might be difficult to define. Staff opined that for the trend to have persisted for so long it might well be attributable to a variety of factors working in concert rather than being a direct function of a specific cause.

Question: An attendee remarked that the Bureau's analysis excluded large deductible business, and asked whether the market share attributable to such business was stable.

Answer: Staff felt that the portion of the market written on a large deductible basis had been reasonably stable for some time. The comparative data on Pages 3 and 5 of Exhibit 8 were noted as allowing a computation of the portion of the market written as large deductible (on a gross basis) and also illustrating that the claim frequency trends for all business, including large deductible, were not substantially different from those derived by excluding large deductible business.

Comment: It was observed that, since the L&I data was more current than the Bureau data, it would have been helpful if that data could be relied upon in making decisions about claim frequency trend.

Answer: Staff felt that the vast and recurring differences between the Bureau data and reports from L&I made L&I's data of little value for purposes of Bureau filings. The adoption of an electronic reporting process seemed an inadequate explanation for the recent inflection of L&I counts.

Question: An attendee asked how the composition or mix of risks or classes of business being insured in Pennsylvania had been changing.

Answer: There had been some migration away from higher-hazard manufacturing and construction risks into service or clerical work over time. The use of on-level expected losses in computing claim frequencies was cited as taking such shifts into account.

Comment: An interest in seeing claim frequency by injury type over time was expressed.

Answer: By reference to non-agenda materials, staff observed that medical-only cases, the smallest and least serious of cases, were declining even faster than temporary total cases.

Comment: Observing that claims might not be filed unless and until a worker went to a doctor, an attendee wondered about factors contributing to the observed experience.

Question: The Bureau was asked whether it had tracked the utilization of small deductible coverages.

Answer: While specific data was not readily at-hand, staff expressed certainty that the volume of small deductible business had been and remained very limited.

Comment: Since the decline in claim frequency is concentrated on smaller claim sizes, the view was expressed that some injuries might not be reported at all in the current environment.

Answer: Staff reiterated that the volume of small deductible policies was so limited that it could not account for any material changes in statewide claim frequency.

Question: An attendee asked the Bureau to analyze claim frequency by injury type.

Answer: Staff agreed to look into this, noting that the basis for the Bureau's claim frequency data was indemnity claims, and, since temporary total claims were a substantial majority of such claims, it was expected that the temporary total frequency trend would be very similar to the total trend. If material differences were observed, it might be possible to re-weight trends by type of injury.

Question: Staff was asked whether loss development could also be investigated by type of injury.

Answer: Recognizing limitations in financial data (no separation of losses by type of injury) and unit statistical data (a maximum of ten annual reports by policy year) and the limited volumes of cases that would be present for some types of injury, it was thought to be impossible to do a meaningful analysis on this basis.

Comment: The historical shift away from construction jobs was noted as a possible factor in terms of expected or actual loss development.

Question: The question was posed whether contracting was showing more of a drop in claim frequency than other industries.

Answer: Page 8 of Exhibit 8 showed claim frequency data by industry group. Contracting seemed to show somewhat slower improvement in claim frequency than the manufacturing or other industry groups. The predominant shift in exposure seen on Page 8 was from manufacturing to "other" industries.

Comment: If most of the claim frequency improvement is in temporary total claims (which would develop less than other injury types), historical link ratios might understate ultimate losses.

Answer: In the most recent year, development at most maturities had come down somewhat. If there were additional proportionally-more-serious claims in recent policy periods and those cases did develop more than less serious ones, the link ratios would be expected to be at least creeping upward over time, but thus far they were not.

Comment: There is a more serious mix of injuries reported currently than was true before. More claims are thus open and active for longer periods of time.

Comment: The development on newer claims may be different than that of older ones for many reasons. Many claims from prior policy years could not be compromised and released when their maturities would have made them viable candidates for this process, a difference that might speed up development and reduce average costs for newer policy periods.

Answer: Staff used a seven-point exponential model in the April 1, 2007 filing, and in the data supporting this proposal any of the choices of trend period from five to 12 points give similar claim frequency trends.

The Committees continued discussion of supporting analyses contributing to the overall loss cost change indication as outlined below.

Trended Ultimate Loss Ratios - Indemnity

Exhibit 5 was identified as providing historical financial data upon which the proposed filing's analysis was based. The exclusion of large deductible experience and Catastrophe Code 48 (September 11, 2001) losses from Exhibit 5 was noted.

Participants were reminded that for numerous previous loss cost filings the Bureau had adopted an approach of adjusting financial data to "post-law" levels, as respects the medical provisions of Act 44 of 1993 (Act 44) and the indemnity provisions of Act 57 of 1996 (Act 57). This methodology, which offered efficiencies in the overall filing analysis, was continued for purposes of the analysis offered for discussion at this meeting.

Page 1 of Exhibit 5 provided the two most recent calendar years of premium development data, which staff noted was supplemented by additional older experience taken from previous filings' documentation for the analysis supporting this proposed filing.

Reported indemnity losses were identified as appearing on Page 3 (case-incurred indemnity loss) and Page 5 (paid indemnity loss) of Exhibit 5. Pages 7 through 21 of Exhibit 5 were noted as presenting details of the adjustment of indemnity experience to a post-Act 57 basis. The original such adjustments had been prepared using data from the April 1, 1999 Loss Cost Filing. Those adjustments had been balanced, so that indications obtained using historical data adjusted to a "post-law" level were comparable to alternative indications derived using historical data stated on a "pre-law" level, in combination with savings factors related to legislation. Adjustments for subsequent calendar years' data had been constructed serially based on policy year distributions of data and impacts attributable to the Act 57 law changes. Adjustments for calendar years prior to 2005 in this filing reflected factors that had been derived in previous Bureau filings. The adjustment for Calendar Year 2005 shown on Page 20 of Exhibit 5 in this filing had been recomputed using the most recent available data, and the adjustment for Calendar Year 2006 shown on Page 21 of Exhibit 5 had been made for the first time in this proposed filing. The revised Calendar Year 2005 adjustments and the Calendar Year 2006 adjustments applied in this filing had been performed in a manner similar to adjustments for prior years, using parameters consistent with those prior adjustments and/or ongoing assumptions about the extent to which data had responded to the effects of the law change.

The adjusted indemnity financial data, stated on a post-Act 57 basis, was shown on Pages 39 (incurred loss) and 41 (paid loss) of Exhibit 5.

Exhibit 6 presented the Bureau's loss development analysis in support of the filing, as well as significant portions of the special trend procedure proposed for use therein. Staff reviewed the pertinent portions of Exhibit 6 and related supporting documentation for indemnity benefits as follows.

Page 6.1 of Exhibit 6 provided premium and/or expected loss development history and estimated ultimate, on-level expected losses for use in computing loss ratios. Pages 6.2 through 6.6 provided steps in the application of incurred and/or paid loss development approaches to indemnity benefits. Staff advised that, consistent with a proposal first advanced and agreed upon during discussion of the April 1, 2005 Loss Cost Filing, the underlying loss data had been adjusted for the limited indemnity provisions of Act 44 for purposes of the analysis presented at this meeting. The benefit factors applied for the purpose of stating indemnity loss data on a post-Act 44 basis were shown on Page 6.4.

One of the approaches shown in Exhibit 6 used a case-incurred loss development method to estimate ultimate indemnity losses. Another estimate had been constructed using paid loss development for the maximum period of reporting supported by available financial data (to 20th report) and then converting cumulative paid losses to equivalent case-incurred losses and applying case-incurred loss development for the remaining development period to ultimate. Finally, the Bureau had derived estimates using the average of the case-incurred loss development method and the paid loss development method applied to 20th report. Results of these methods were presented at the top of Page 6.6 in Exhibit 6.

Staff noted that public comments submitted in regard to recent Bureau loss cost filings had focused in substantial part on the differences between the case-incurred and paid loss development methods when applied to indemnity losses. Authors of those comments had argued that those differences were attributable to effects of prior reforms that were reflected more fully and appropriately in case reserve estimates than in payment data. Those comments asserted that these reform changes caused the paid loss development method to be overstated and called for greater or exclusive reliance on incurred loss development estimates of indemnity loss as a basis for the Bureau's filings. In response, Bureau staff had observed that the indemnity reforms of note in Pennsylvania were approaching ten years' vintage and questioned whether and how assimilation of those changes into the system could still have not been fairly represented in changes to paid loss development patterns. The Committees were asked to provide thoughts about these respective positions and their ramifications for the April 1, 2008 filing.

Question: *An attendee inquired whether the Bureau could partition data by industry group.*

Answer: *Financial data, the basis for loss development and trend work underlying the Bureau's rating value filings, cannot be partitioned by industry group.*

Comment: *The Bureau could review unit statistical data over a period of time.*

Question: *Staff was asked whether the Bureau could describe the adjustments made in financial data in response to prior law changes.*

Answer: *Immediately after the significant law changes in 1993 and 1996, filing analyses were done on a "pre-law" basis consistent with reported data, and then savings factors were applied to the resulting indications. After accumulation of some post-law experience, the Bureau had undertaken a change in procedure that adjusted pre-law experience to a post-law basis and then proceeded with a straightforward analysis to*

derive rating value change indications without need for a separate savings factor(s). The initial change in method had constructed adjustments to pre-law experience such that the rating value indications obtained from either approach were as similar as possible. Adjustments had been made to historical paid losses and to reserve levels in order to accomplish the intended balance in indications. Exhibit 5 showed these adjustments.

Question: A question was presented whether changes in rating value indications could be attributed to the effects of the Bureau's adjustments.

Answer: Staff noted that the adjustment process had been consistent for many years and that many of the adjustments themselves used in support of this filing had been part of prior proposals.

Question: On Page 10.1, it was seen that the paid and incurred loss development methods as applied to indemnity losses were diverging for more recent policy periods. It was suggested that the known paid amounts could be subtracted from the Bureau's ultimate loss estimates to get an indicated IBNR. The questioner indicated that they would like to see ratios of paid-to-reported loss, ultimate loss and/or IBNR and to determine whether those ratios were stable or changing over time.

Answer: Staff responded that analytics, including ratios of paid-to-reported incurred and paid-to-ultimate loss, were routinely included in the Bureau's review of loss development. Staff did not recall noteworthy results of observations emanating from those reviews for this filing. It was observed that the IBNR for paid loss development might be thought of as being larger than for case-incurred loss development, since case reserve amounts were included in incurred values but omitted from paid amounts.

Question: An attendee asked whether the Bureau could separate paid losses between paid amounts spent on open claims and paid amounts spent on closed claims.

Answer: This separation would be possible to some extent in unit statistical data. For financial data, the Bureau had only collected the necessary components of paid loss for a limited time.

Comment: It was suggested that the Bureau could look at a common evaluation point and determine whether there was more or less paid on open claims now than had been the case historically. It was thought that this approach might indicate what degree of reliance should be placed on various loss development methods.

Answer: Staff observed that, with closure rates reflecting the benefits of compromise and release activity, payment amounts might have grown relative to prior experience as settlements accelerated payment of benefits previously extended over longer periods of time.

Comment: It was stated that, if temporary disability cases were closing but bigger claims were remaining open and if paid amounts on open claims is increasing, then both paid loss development and incurred loss development could be understated.

Answer: Staff agreed to consider these comments further, with the caveat that obtaining the necessary information from financial data could be difficult. Staff asked whether the NCCI had done this kind of analysis.

Comment: NCCI did look at paid amounts on open and closed claims. NCCI thought that it may have been collecting data responsive to this question longer than the Bureau. NCCI used these analytics as a guide in deciding which method(s) to use for loss development.

Question: It was observed that for incurred data many companies discounted their reserves. Staff was asked how the Bureau went about unwinding those discounts.

Answer: Staff felt that, as paid losses emerged, the gradual replacement of discounted reserves with actual disbursements would reflect the unwinding of discounts. Recognizing the limit on the number of policy years for which loss reports were submitted individually, staff maintained that the “all prior” policy year line would continue to be affected by the unwinding of the discount.

Question: Staff was asked whether it thought that “all prior” line would be representative of the current mix of business.

Answer: Staff conceded that, if proportionally more claims in the newer policy years were discounted than had been the case before, unwinding of discounts would become a more important component of loss development. The industry had not had the ability to compromise and release many, if any, of the claims now subject to reporting in the “all prior” line. That difference was thought to work in the opposite direction of the disproportionate decline in frequency of temporary total cases in terms of loss development.

Question: Staff was asked whether it could provide the ultimate losses underlying Exhibit 10.

Answer: Staff responded that the ultimate losses in question could be found in Exhibit 6.

Exhibit 7 presented the Bureau’s derivation of “tail factors” for use in its array of possible loss development methods. The methodology applied had been used in prior filings in response to recommendations in regulatory examinations. Pages 2, 4, 6 and 8 of this exhibit each provided a tail factor estimate for indemnity benefits based on a different calendar year of development experience. An indemnity tail factor for the proposed filing had been selected as the average of these four separate indications, as shown on Page 1 of Exhibit 7.

Comment: If companies are discounting and the system is growing, the opinion was advanced that the “all prior” line would underestimate the effect of the discount.

Answer: The Bureau's tail factor methodology was changed some time ago in response to concerns about the effect of growth in the system on tail factor methodology. The adjusted method does produce a larger tail factor than did the previous approach, as illustrated in Exhibit 7.

Question: Staff was asked whether the Bureau had always used a four-year average in computing tail factors.

Answer: Staff responded that this approach had been in use for some time and that departures from this approach would have looked at more than four years but not fewer.

Question: The Bureau's financial data analysis was noted as combining all companies together. Staff was asked whether separate analysis by company or company group might reveal material influences arising from a limited population of carriers.

Answer: Staff stated that the Bureau did, in fact, perform separate analyses for a number of larger carrier groups and that a broad divergence of results was thus obtained. This was thought to reflect the volatility of smaller, company-specific data more so than identifying isolated causes for observed overall results.

Staff recalled the proposed filing's approach to trend analysis which adjusted estimated ultimate on-level loss ratios derived in Exhibit 6 for the effects of changes in claim frequency presented in the Bureau data, excluding deductible business from Exhibit 8. The results of these adjustments were referred to as "severity ratios" and were presented on the bottom of Page 6.6 of Exhibit 6. The Bureau had then applied its customary linear and exponential trend models to the severity ratios thus derived over numbers of data points ranging from four to ten. For each trend model and loss development method in combination, severity trend factors were calculated for each of the three most recent policy years. This severity trend analysis for indemnity was shown on Pages 6.7 through 6.10 of Exhibit 6.

In Exhibits 9a and 9b, goodness-of-fit tests had been applied to trend models applied to loss ratios (Exhibit 9a) and severity ratios (Exhibit 9b). Staff observed that using severity ratios had significantly improved the results of fitting tests, with r-squared values for severity ratios being materially higher than those of counterpart efforts to fit loss ratios for almost all tested trend periods. Severity ratios also showed somewhat smaller proportional residual differences in the goodness-of-fit testing done by the Bureau for the trend model and period underlying the proposed filing.

Exhibits 11a and 11b, respectively, provided further examinations of the effectiveness of trend models by testing predictive abilities of the respective models and trend periods prepared in support of this proposed filing. Staff noted that for the trend period and model selected for use in this filing, limited comparisons could be made between projections of loss and severity ratios and that the results thus obtained were evenly divided.

Indemnity loss ratio trend factors computed as the product of the indemnity severity trend factors and frequency trend factors described above were shown on Page 6.11 of Exhibit 6.

Exhibit 10 provided graphs of indemnity loss ratios (Page 10.1) and indemnity severity ratios (Page 10.3). In addition, Exhibit 10 provided a graph of indemnity loss ratios, indemnity severity ratios and claim frequency each indexed to a common starting point (Policy Year 1994) on Page 10.5.

Pages 6.12 and 6.13 of Exhibit 6 showed arrays of possible trended indemnity loss ratios produced by the methods described above, with the Bureau's selected result (0.3985) highlighted with a border on Page 6.13. The selected result was produced using the average of a case-incurred loss development approach and the paid loss development method to 20th report loss development. An exponential seven-point severity trend was used in combination with the selection of an annual claim frequency trend rate of -6.4 percent to trend selected policy year results forward through the mid-point of the prospective rating period, April 1, 2009.

Trended Ultimate Loss Ratios - Medical

Staff indicated that the analysis done for medical losses paralleled that described above for indemnity losses in most important respects. It was observed that the alternative loss development methods had not produced material differences in estimated ultimate losses for medical benefits, in contrast to the prior discussion of indemnity loss. Staff noted the inclusion of counterpart exhibits in the meeting agenda materials for medical loss pertaining to each of the analytical steps previously addressed for indemnity loss.

For the sake of reference, the pertinent exhibit and page references for medical loss development and trend analysis in support of the proposed filing are provided below. (These detailed references were not read, provided or requested at the time of the meeting discussion.)

<u>Exhibit</u>	<u>Content</u>	<u>Page(s)</u>
5	Medical financial data - Table I reported data Adjustment of medical financial data to post-Act 44 basis Adjusted medical financial data	4 (case incurred), 6 (paid) 22 through 36 40 (case incurred), 42 (paid)
6	Medical loss development Trending of medical severity ratios Medical loss ratio trend factors Trended medical loss ratios	6.14 through 6.18 6.19 through 6.22 6.23 6.24 (linear), 6.25 (exponential)
7	Medical loss development tail factors	Summary on Page 1, detail on Pages 3, 5, 7 and 9
8	Claim frequency	Per indemnity discussion

<u>Exhibit</u>	<u>Content</u>	<u>Page(s)</u>
9a, 9b	Goodness-of-fit tests 9a for loss ratios, 9b for severity ratios	9a1, 9a4, 9a5, 9a8 and 9a9 9b1, 9b4, 9b5, 9b8 and 9b9
	NOTE: Test fits for medical severity ratios, using seven-point projections, had results proportionally somewhat closer to actual values than do loss ratio fits.	
11a, 11b	Retrospective tests of prediction for loss ratios (Exhibit 11a) and severity ratios (Exhibit 11b)	11a6 – 11a10 and 11b6 – 11b10
	NOTE: Test projections using severity ratios were closer than loss ratio projections for two tests, with results for the other possible comparison using seven-point projections favoring use of loss ratios.	
10	Graphs of medical loss ratios	10.2
	Graphs of medical severity ratios	10.4
	Graph of indexed medical loss ratios, severity ratios and frequency trends combined	10.6

Staff noted that the trend model used for medical severity ratios was an exponential fit through the most recent seven policy year data points estimated, based on the average of the case incurred and paid to 20th report development methods. In combination with the selected claim frequency trend previously described with the analysis of indemnity experience, this approach gave the trended medical loss ratio (0.4993) highlighted with a border on Page 6.25 of Exhibit 6.

Terrorism Provisions in Pricing

Staff noted that the Bureau had implemented a loss cost rating value related to terrorism effective April 1, 2003. That implementation had been supported by terrorism modeling analysis done at the time by and/or for the NCCI. The Bureau has subsequently understood that NCCI has generally held rating values related to TRIA level at their original filing levels. Under these circumstances, the Bureau has also elected to retain the existing loss cost rating value for terrorism in Pennsylvania.

Staff noted that congressional hearings and votes were in progress pertaining to a possible extension of the Terrorism Risk and Insurance Extension Act, with HR 2761 providing the vehicle for much of the recent progress. Staff acknowledged the possibility that revisions to existing Manual language and/or endorsement forms and/or introduction of new language and/or forms would be needed once the specific form of any extension to the Terrorism Risk Insurance Extension Act was known.

Domestic Terrorism, Natural Catastrophes and Major Industrial Accidents

Staff noted existing Manual language, endorsement forms and rating values applicable to these exposures.

Size-of-Loss Analyses

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 insured there under. 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 Pennsylvania business.

Staff briefly described the methods used for the derivation of size-of-loss distributions and excess loss factors in prior filings. Those methods relied on an overall empirical loss distribution based on Pennsylvania data, together with relativities by hazard group using loss distributions provided by the NCCI. NCCI indications were also used to adjust Pennsylvania data for loss limitations above \$1 million. It was further noted that the NCCI loss distributions available to the Bureau were holdovers from the early 1990s.

Staff then proceeded to describe the study of the topic performed by the Bureau over the past year. The types of injury (or combinations of types) separately considered were expanded from death, permanent total/major combined, and minor/temporary combined in the prior approach, to death, permanent total, permanent partial and temporary total each being treated individually. An analysis of hazard group experience was also performed, although the expansion of detail to hazard group by type-of-injury did not yield meaningful results. It was determined that actual loss experience could be used over a significant portion of the size-of-loss range for each type of injury. Consideration was then focused on determining an appropriate threshold above which curve-fitting techniques would be used to estimate the loss distribution for higher limits. A limit of \$500,000 was selected after consideration of that limit, along with \$250,000 and \$1 million.

In choosing appropriate curves, various commonly-used distributions were considered. Among them were the following: Single Parameter Pareto, Generalized Pareto, Lognormal, Gamma, Weibull and Exponential. Separate analyses of claim frequency and loss severity were performed. For claim frequency the single parameter pareto distribution was selected for death, permanent partial and temporary total claims. A lognormal distribution performed best for permanent total claims. For claim severity a single parameter pareto distribution was chosen based on the experience for all types of injury combined. In generating final loss distributions and excess loss factors, actual data (claim counts and dollars of loss) for limits below \$500,000 were combined with fitted counts and dollars above \$500,000 and re-accumulated. The resulting excess loss factors by type of injury are displayed in Exhibit 22.

Exhibit 22 presented the most recent available Pennsylvania size-of-loss distribution, derived by tabulating reported loss amounts and developing open claims so as to produce ultimate loss estimates on a case-by-case basis consistent with the Bureau's analysis of aggregate financial

data. The exhibit also includes actual excess loss factors based on empirical loss distributions by type of injury (death, permanent total, permanent partial, and temporary total), along with excess loss ratios tied to fitted curves for loss limitations of \$500,000 and higher.

The study tracked and tested experience over three consecutive loss cost revision data bases (April 1, 2006 filing, April 1, 2007 filing and the current proposal) and monitored results with particular focus on stability across successive filings. Staff found that, while significant changes were indicated by hazard group when comparing indications for a given filing using the revised processes with actual filed excess loss factors, the year-to-year results using the revised loss distributions were relatively stable.

Exhibit 23 showed current and proposed excess loss (pure premium) factors computed using results in Exhibit 22, together with the indicated percentage changes therein by loss limitation and hazard group. Indicated changes based on a comparison of proposed excess loss factors with those indicated for the April 1, 2007 filing but based on revised loss distributions are also provided. Note that the process for calculating excess factors in Exhibit 23 is unchanged from prior years, although the loss distributions on which the analysis relies have been updated.

Size of loss considerations also applied to the determination of state and hazard group relativities that allow a single table of insurance charges and savings to be used in different jurisdictions where benefit levels and statutory provisions may vary significantly. The proposed filing continued a procedure first implemented for the April 1, 2003 filing, which assigned credibility weights by hazard group rather than on a statewide basis. Exhibit 24 presented the derivation of state and hazard group relativities for the proposed filing.

Offering of small deductible coverages at certain specified amounts is mandatory in Pennsylvania. Bureau filings thus provide loss elimination ratios computed consistent with the mandatory deductible levels. Exhibit 25 presented the derivation of loss elimination ratios as the complements of excess loss (pure premium) factors. Staff noted the fact that the mandatory \$1,000 deductible offer fell below the threshold for required individual claim reporting under the approved Statistical Plan, requiring some special treatment and consideration in the course of the analysis of loss elimination ratios. The revised loss distributions of Exhibit 22 have been incorporated in the derivation of values for limits of \$5,000 and \$10,000.

Staff directed attention to Exhibit 32, a copy of NCCI's Item Filing No. R-1396. The Bureau proposed filing the Table of Expected Loss Size Ranges shown as Exhibit 1 on Page 5 of that filing memorandum for use in Pennsylvania effective April 1, 2008.

Question: *It was noted that the information shown on these exhibits could be used to calculate average severities by injury type. Staff was asked if it would be possible to use this data and frequency trends by injury type to create an alternative rate level indication.*

Answer: *Staff noted that trends by type of injury were derived from unit statistical data but that the available data is older and was also limited to five years in the data base applied to this purpose. Using the shorter period of available data would derive a trend*

which would have to be projected over a longer period of time than is required at present. Staff indicated that further thought and possible research would be required to respond to this suggestion.

Question: The Bureau was asked whether it had given any thought to expanding the number of hazard groups used in Pennsylvania to seven, in light of a similar expansion accomplished by NCCI.

Answer: The Bureau was actively considering these issues. It expected to make some changes in prevailing hazard group assignments over time. Such a change would require a review of NCCI's distribution of classes in each hazard group and recognition of the fact that the Bureau's classification plan was very different than that of NCCI.

Loss-Based Assessments and Employer Assessment Factor

Exhibit 13 of the agenda material addressed the above referenced items.

Effective October 1, 1999, the provisions for the Administration Fund, Subsequent Injury Fund and Supersedeas Fund, previously included in published Bureau loss costs, had been removed from those loss costs. Consistent with requirements of HB 1027, these amounts were now treated as a separate charge to insured employers collected through insurers. Loss-based assessments applicable to funding for the Office of the Small Business Advocate remained part of published Bureau loss costs under provisions of this law.

With the enactment of HB 2738, an Uninsured Employers Guaranty Fund had been established, with initial funding granted by legislative appropriation and authority given to the Bureau of Workers' Compensation to issue assessments to insurers and self-insurers for additional funding as the need might arise. A first assessment of this nature had been issued in 2007, and the proposed filing used that assessment as the basis for an additional component of the Employer Assessment Factor effective April 1, 2008. Also consistent with past practice, the Bureau continued to include offset provisions for merit rating and credits granted under the Certified Safety Committee Program in published and proposed Bureau loss costs.

Exhibit 13 provided parameters used to compute the proposed employer assessment factor effective April 1, 2008 (0.0226) and the proposed loading to Bureau loss costs to provide for Merit Rating Plan credit offset, Certified Safety Committee Program credit offset and the Office of Small Business Advocate funding effective April 1, 2007 (0.0142). Staff noted that the proposed employer assessment factor was higher than the current level (0.0192) due to an increase in Bureau member share of the budgetary amounts for Administration Fund, Subsequent Injury fund and Supersedeas Fund as compared to the previous year, budgetary increases in amounts attributable to those same funds, and the introduction of the Uninsured Employers Guaranty Fund as a component of the Employer Assessment Factor. The loading in Bureau loss costs for the remaining factors listed above was noted as being up from 0.0136, attributable to increased credit activity in the Certified Safety Committee Credit Program.

Pennsylvania Construction Classification Premium Adjustment Program (PCCPAP)

Exhibit 14 of the agenda materials was reviewed with all attendees.

The purpose of the PCCPAP program was described as responding to wage differentials within the construction industry, providing a program of premium credits to higher-wage employers. These credits were offset by loadings applied to construction classifications, reflecting the portion of employers participating in the program and the average premium credit obtained by those participating businesses, thus maintaining the required premium level in each classification.

The table of qualifying wages applicable to the PCCPAP was regularly amended based on actual changes on statewide average wage levels, with such filings subject to review and approval by the Insurance Department and typically effective each July 1.

Staff noted that the average PCCPAP loading indicated, based on the most recent available data, was higher than that currently in effect (3.35 percent proposed vs. 2.75 percent current). This was attributed to the effects of increases in participation in the program and/or average credits being generated by participating employers.

Staff noted that the PCCPAP program had been revised effective January 1, 2002 to eliminate adjustment of experience modifications in recognition of the effects of PCCPAP credits as the approved means of avoiding providing redundant credits. The adjustment of experience modifications had been seen as a potential impediment to participation on the program. The revised plan made adjustment within the computation of the credits themselves for the effect of high wages on experience modifications.

Merit Rating Plan

Exhibit 15 of the agenda materials was used as the basis for this discussion.

The Merit Rating Plan was noted as a statutory requirement intended to provide incentive for the maintenance of safe workplaces for businesses too small to qualify for the uniform Experience Rating Plan. Exhibit 15 presented the offset to manual loss costs required to compensate for the net credit received by all eligible employers under this plan (0.31 percent), a slight decrease from the level currently in effect (0.33 percent).

Certified Safety Committee Credit Program

Exhibit 16 of the agenda materials addressed recent experience under the Certified Safety Committee Credit Program. Experience was available for Policy Years 1994 – 2005 inclusive.

Staff noted that until mid- to late-1996 this program did not allow employers to qualify for credit in more than one policy period. As a result, 1995, 1996 and 1997 data were expected to understate the prospective experience under this program after Act 57 had provided for up to five annual credit periods for qualifying employers. Subsequently, in 1999 and 2000 some

employers began to reach the limit of five years' of credit application under current law. In 2002 new legislation (Senate Bill 813) was passed that removed the limit on the number of times an employer could receive such credits. Based on a monitoring of ongoing certification activity, staff proposed a change in the loading to offset ongoing credits from 1.02 percent to 1.10 percent.

Retrospective Rating Plan Optional Loss Development Factors

Carriers may apply loss development factors to early evaluations in order to include a provision for maturation of loss values at subsequent reports. Exhibit 26 of the agenda materials provided such development factors applicable without limitation of losses, as well as a procedure that could be used to apply excess loss factors to compute appropriate loss development factors for various loss limitations and hazard groups.

Hepatitis C Surcharges for Selected Classifications

Staff noted legislation enacting a presumption of work-related causality for Hepatitis C incurred by selected sets of workers (HB 1633) that was passed in 2002. For its April 1, 2003 Loss Cost Filing, the Bureau had conducted an analysis based on available statistics concerning incidence of HCV in the general population in concert with projected costs for Hepatitis C cases in healthcare workers under various scenarios by an independent consulting group (Milliman U.S.A., formerly Milliman & Robertson, Inc.). These projections had been compared with existing loss cost estimates for affected classifications, and indicated surcharges had been derived. The Insurance Department's review of the April 1, 2003 filing had suggested that the incidence of HCV in the affected classifications could arguably be comparable to those of the general U.S. population and thus lower than those originally proposed by the Bureau. Ultimately, the Bureau had adjusted the applicable surcharges to be consistent with the incidence of HCV in the general U.S. population. This filing proposed to continue that procedure, as presented in Exhibit 31.

Various proposals under consideration by the Pennsylvania legislature at the time of this filing were noted, including HBs 465, 763 and 1025. These proposals would invoke various expansions of the population of workers to which the presumption of work causality for Hepatitis C would apply, with many of those groups being employees of the Commonwealth of Pennsylvania (a self-insured entity).

Proposed Loss Cost Relativities by Classification

Exhibits 17, 20a, 20b, 20c, 28, 29 and 30 of the agenda materials and the Class Book were reviewed with the attendees as follows.

Exhibit 17 presented a narrative discussion of the procedures applied to derive classification loss cost relativities. Staff noted that these procedures were generally unchanged from those of the most recent previous loss cost filing. With respect to certain "test correction factors," which had historically been applied as matrices of factors differing by type-of-loss and industry group, the Bureau's April 1, 2003 Loss Cost Filing had completed a transition begun with the

April 1, 2001 filing to implement a process of applying test correction factors uniformly across all types of loss and industry groups. The proposed filing would maintain and continue the procedure first used in final form with last year's loss cost filing.

Exhibits 20a, 20b and 20c of the agenda materials were offered as summary tabulations based on unit statistical data used to derive certain parameters applied in the determination of classification loss cost relativities.

Exhibit 28 showed proposed classification loss costs and expected loss factors by classification consistent with the proposed overall change in loss cost level. Exhibit 29 provided insight into the derivation of the proposed classification rating values by showing a test of indicated and selected classification rating values, including effects of capping and application of loadings for the various assessments, which would remain a part of published Bureau loss costs.

Exhibit 30 showed a histogram of proposed classification rating value changes based on the proposed overall change in loss cost levels. Staff noted that desirable features of classification loss cost changes included relatively narrow distribution around the average change and few, if any, classifications which materially shift from better to worse than average or vice-versa between successive filings.

A Class Book providing detail of historical experience and derivation of proposed rating values had been distributed with agenda materials prior to the meeting. This exhibit contained tabulations of prior experience data by classification, together with the detail of the derivation of individual loss cost proposals in the draft filing. An exhibit labeled "Index and Supporting Classification Exhibits" was provided for use in conjunction with the Class Book.

Experience Rating Plan

Staff reminded the Committees that substantial revisions to the existing Experience Rating Plan had been approved by the Insurance Department effective April 1, 2004. Attendees were advised that the Experience Rating Plan exhibits provided for discussion at this meeting had been constructed by applying the revised Experience Rating Plan to rating periods occurring prior to the actual implementation of the new plan.

Staff referred to Exhibits 18a, 18b, 19 and 27 of the agenda materials.

Exhibit 18a showed historical results of applying the Experience Rating Plan over a period of five successive years, organized by year, industry group, and premium size and modification range. It was noted that Exhibit 18a presented Experience Rating Plan results prior to the effects of capping, recognizing that the selected capping procedures were intended to mitigate year-to-year movement in experience modifications but would not improve the accuracy of the modifications thus issued. An illustration of some of the effects of the new Experience Rating Plan was provided by reference to Exhibit 18a.

Exhibit 18b was referenced as a summary page formatted identically to Exhibit 18a but reflecting the impacts of capping procedures adopted incrementally with initial swing limits adopted in 2004 and additional transition capping procedures added effective April 1, 2006.

Exhibit 19 presented derivation of selected parameters within the current Experience Rating Plan. It was noted that the collectible premium ratios derived on Page 19.1 of Exhibit 19 were the basis for the relativities by industry group of manual changes in loss costs previously discussed in Exhibit 12.

Exhibit 27 provided the proposed Table B or credibility table for the current Experience Rating Plan, consistent with parameters developed in Exhibit 19.

Auditable Payroll Values Indexed to the Statewide Average Weekly Wage

Staff noted that maximum remunerations for premium computation purposes with respect to executive officers and salaried police or firefighters were maintained in specified relationships to the statewide average weekly wage. In addition, presumed remuneration for premium computation purposes for some taxicab operators was similarly derived. A staff memorandum outlining appropriate revisions to the currently-approved parameters in these cases was presented for discussion. Changes proposed would move the minimum individual payroll for an executive officer from \$350 per week to \$400 per week, the maximum individual payroll for an executive officer from \$1,850 per week to \$1,950 per week and the minimum payroll for auxiliary police or special school police appointed by municipalities or townships from \$3,700 to \$3,900 per year.

There being no further business for the Committees to consider, the meeting was adjourned.

Respectfully submitted,

Timothy L. Wisecarver
Chair - Ex Officio

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