STATE OF CALIFORNIA

WORKERS' COMPENSATION RATE STUDY COMMISSION

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VOLUME V
SUB-CONTRACT RESOURCE REPORT
AIS RISK CONSULTANTS, INC.

MARCH 1992

STATE OF CALIFORNIA

WORKERS' COMPENSATION RATE STUDY COMMISSION

COMMISSION REPORT

VOLUME V
SUB-CONTRACT RESOURCES REPORT
AIS RISK CONSULTANTS, INC.

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In addition to this Volume, the Workers' Compensation Rate Study Commission Report includes the following four Volumes:

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CONSULTING TECHNICAL RESOURCES 1

ALLAN SCHWARTZ, AIS RISK CONSULTANTS, INC.
SUB-CONTRACT SCOPE 1

COMMISSION INTRODUCTION

CONSULTING TECHNICAL RESOURCES

Additional assistance in the form of technical resources was requested by the Workers' Compensation Rate Study Commission. The desired technical resource was in the area of actuaries or economists who were retained as subcontractors to the Soper & Associates consulting organization.

The Commission approved and retained technical resource organization which served as a sub-contractor is as follows:

ALLAN I. SCHWARTZ, FCAS, ASA, MAAA, FCA (Project Manager)
President
AIS Risk Consultants, Inc.
Freehold, New Jersey

Senior Support Staff:
J. Richard Boer, CPCU, Associate Actuary
Marianne E. Papay, Assistant Actuary

ALLAN SCHWARTZ, AIS RISK CONSULTANTS, INC. SUB-CONTRACT SCOPE

The Commission Approved Study was under the direction of Allan I. Schwartz, FCAS, ASA, MAAA, FCA, President and the sub-contract within the study involved the following scope of work:

1.0 Technical Aspects of Manual Rate Level Calculation

Contractor will evaluate procedures used in California to analyze several factors critical to ratemaking calculation, including: a) loss development; b) trend factors; c) benefit level analysis; d) expense loadings; and e) underwriting profit provision. The analysis would investigate other factors relevant to setting the overall rate of compensation insurance rates, including investment income, and dividends provisions. The contractor will compare and contrast the system of rate level calculation used in California with that of other states to highlight differences and similarities, and to evaluate the impact of specific differences.

2.0 Procedural Aspects of Rate Analysis

The contractor would assess the degree to which rating statutes are implemented in various jurisdictions, including California. For a sample of states, the contractor will: a) determine which parties are involved in the rate adjudication process (e.g., insurance carriers, rating bureau, insurance department, attorney general, public advocate, other intervenors); b) the role played by the insurance commission or department (party, decision maker, both); c) the time frames involved in analyzing the filing,; d) data required by the regulator for submission in support of the filing, or required during review; e) analytic standards required to be followed in determining decision (e.g. how is investment income considered, how much does experience of competitive state fund get considered); and f) the degree to which rate requests have been approved or disapproved in past.

3.0 Data Base Available to Analyze Needed Rates

Contractor will review and describe data available for use in analyzing workers' compensation rates in California. Data evaluated will include: a) financial data (e.g. losses and expenses, useful in determining what rate levels should be); b) unit classification data; c) injury table distributions (useful in determining effects of changes in law); d) detailed claim information (to determine reasons that costs are at given level); and e) other special data collection. Contractor will also research data used in other states that might be useful in determining need for rate changes.

4.0 Rating Systems that Encourage Safety and Health

Contractor will review, describe and evaluate the rating plans already in existence in California, especially as they pertain to giving incentives for health and safety activities and improved outcomes. The contractor will focus especially on plans that create financial incentives for small and medium sized employers. The contractor will review and evaluate rate plans in existence in other states that directly affect safety incentives. The contractor will evaluate other factors that have impact on premium such as individual risk rating plans, policyholder dividends, and other plans, except for experience rating.

5.0 State Funds

Contractor will describe the operation of six exclusive state funds for workers' compensation operating in U.S., with respect to financial condition, level of rates, rate changes in recent years, and other factors related to

service. A comparison of exclusive state fund operation with the operation of competitive funds will also be made.

6.0 Self-Insurance

Contractor will review, describe and evaluate how self-insurance functions in California, with respect to eligibility of individual and groups of companies, restrictions on self-insurance, regulatory requirements of self-insurance such as minimum security depositions and reinsurance, and trends in self-insurance. Contractor will contrast and compare California experience with that of other states.

7.0 Inter-Company Profitability

Contractor will analyze profitability of workers' compensation carriers within California to determine whether profits earned were relatively uniform across all companies or if some companies consistently did better than others. The contractor will analyze differences to determine whether variations in profitability, if any, were due to any particular aspect (e.g. losses, expenses, investment income, dividends) of the companies' operation.

The contractor will work with Commission staff in designing a survey for mailing to state insurance and worker compensation officials to collect primary data for use in sections 1-4. Staff will assist contractor in mailing survey forms and compiling information as it comes in. Contractor will present interim results of surveys and other analyses at regular meetings of the Commission, will be available for questions, and will provide up to three days of consulting time to assist Commission staff, as needed, in conducting financial or market performance analyses.

RHS/vrs

ACTUARIAL REPORTS PREPARED BY AIS RISK CONSULTANTS FOR
THE CALIFORNIA WORKERS' COMPENSATION RATE STUDY COMMISSION

Report Volume	Report Description
1	Profitability by Insurance Company Group
2	Rate Review Process
3	Ratemaking Data
4	Ratemaking Methodology
5	Safety and Health Rating Systems
6	Self-Insurance
7	State Funds

SECTION 1.0

ANALYSIS OF CALIFORNIA WORKERS' COMPENSATION INSURANCE PROFITABILITY BY INSURANCE COMPANY GROUP

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ANALYSIS OF CALIFORNIA WORKERS' COMPENSATION INSURANCE PROFITABILITY BY INSURANCE COMPANY GROUP

January 14, 1992

Prepared by
AIS Risk Consultants, Inc.
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908-303-7470

ANALYSIS OF CALIFORNIA WORKERS' COMPENSATION INSURANCE PROFITABILITY BY INSURANCE COMPANY GROUP

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Calendar Year Investment Income Ratios by Company Group	AIS-1.6
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ANALYSIS OF CALIFORNIA WORKERS' COMPENSATION INSURANCE PROFITABILITY BY INSURANCE COMPANY GROUP

I Summary

AIS Risk Consultants was retained by the California Workers' Compensation Rate Study Commission (WCRSC) to analyze the profitability of California Workers' Compensation Insurance by insurer. In performing our analysis we have relied upon data and information supplied by the Workers' Compensation Insurance Rating Bureau of California (WCIRBC), the WCRSC and other generally accepted sources. While we used our overall knowledge and experience to assess the reasonableness of the information provided, we have not performed an independent audit of the information supplied.

The goal of this project was to determine whether there are consistent variations in the profitability of California workers' compensation insurance between insurers. In addition, if the profitability results across insurance carriers show a consistent difference, we would examine various characteristics which might explain this non-random behavior.

This task consisted of three phases:

A. Database compilation,

B. Company group selection for use in the analysis, and

C. Statistical testing and interpretation.

The attached exhibits display the analysis performed for this project. In Exhibit AIS-1.1 an analysis of variance on the operating ratios, shown in Exhibit AIS-1.2, is performed. This shows that there is non-random fluctuation among companies with 99% certainty.

Exhibits AIS-1.3 to AIS-1.8 contain the components of the operating ratio:

Operating Ratio = Loss Ratio + Expense Ratio + Dividend Ratio + Tax Ratio - Investment Income Ratio

The operating ratio and profit ratio are related by the following formula:

Profit Ratio = 1 - Operating Ratio

This profit ratio is measured in relation to premium, not to surplus. In addition, the profit ratio does not take into account investment income on surplus. Only investment income on reserves is considered. Finally, the profit ratio is before federal income taxes. While all these factors should be considered in the context of the total profitability of the workers' compensation insurance industry, they are not needed for a comparison of the profit level across companies.

The source exhibit for each component of the operating ratio is as follows:

Exhibit	Description	Source
1.3	Calendar Year Loss Ratios by Company Group	Expense** file
1.4	Calendar Year Expense Ratios by Company Group	Expense** file
1.5	Calendar Year Earned Premium Distributions by Company Group	Expense** file
1.6	Calendar Year Investment Income Ratios by Company Group	Form46** file
1.7	Calendar Year Dividend Ratios by Company Group	Form46** file
1.8	Calendar Year Premium plus Other Tax Ratios by Company Group	See footnote on Exhibit AIS-1.8

Also, in order to examine the non-random variations among companies, the following possible explanatory variables were used in a regression against the 1983 to 1990 weighted average operating ratios for the selected company groups:

X1 = Direct versus Agent Writer
X2 = Domestic versus Foreign Company
X3 = Stock versus Non-Stock Company

Exhibit AIS-2.2 displays the data underlying these explanatory variables and the weighted average operating ratios. The source for columns X1 and X2 is the "Rate Study Commission Key to Carrier Codes and Groups 1990" exhibit. The X3 variable was obtained from the Expense** file. In addition, shown in the last column of Exhibit AIS-2.2 are weights derived from Exhibit AIS-1.5 and based on total earned premium for calendar years 1983 to 1990.

Exhibit AIS-2.1 displays the results of the following regression model:

$$Y = A*X1 + B*X2 + C*X3 + D.$$

The R-squared value is very small (i.e., 0.025). This indicates that the model does not explain the difference in operating ratios among the selected company groups. Furthermore, the T-Statistic ('X' variable coefficient divided by the standard error of the coefficient) for each of the variables is small. This indicates that the individual 'X' variables do not explain the differences in the insurer operating ratios. Exhibit AIS-2.1 also shows the overall operating ratios and premium distributions for each of the categories discussed above (i.e., direct vs. agency, domestic vs. foreign and stock vs. non-stock). These calculations are based on the data displayed in Exhibit AIS-2.2.

We also examined the individual components of the operating ratio (i.e., losses, expenses, investment income and dividends) to determine which of these had a significant impact on the operating ratio. The results of the regression analysis are contained in Exhibit AIS-2.3. All of the R-squared values are small, indicating that each component by itself only explains a small part of the profit variation. The T-statistics for the four variables varied from marginal to very significant.

Summarizing the results of our analysis:

(1) There appears to be a consistent difference between insurer profitability results for California workers' compensation.

(2) The differences in profitability are not explained by whether the company is direct vs. agency, domestic vs. foreign or stock vs. non-stock.

(3) Of the various components of the operating profit, differences in the losses among companies was the most significant item. A weaker correlation existed between profits and expenses. The correlation across insurers between profits and either investment income or dividends was only marginally significant.

A more complete description of the various phases of our analysis is given in the following sections.

II Database Compilation

Sixteen computer files were used as the source of data for this project. They were:

Expense83,..., Expense90
Form4683,..., Form4690.

The Expense** files contained the following information:

(i) Earned Premium, (ii) Incurred Losses, (iii) Loss Adjustment Expense, (iv) Commission and Brokerage, (v) Other Acquisition Expense, (vi) General Expense, (vii) Stock/Non-Stock Indicator and (viii) Carrier Code.

The Form46** files contained:

(i) Net Earned Premium, (ii) Investment Income, (iii) Dividends, (iv) Carrier Code and (v) Group Code.

In order to use these data the following procedures were carried out:

1. Created a master list of all companies appearing in at least one of the Expense** files.

2. Added companies to each Expense** file not included in the master list obtained in #1 above.

3. Sorted on the Carrier Code Column in each Expense** file to obtain "Expense**" information in Carrier Code ascending order.

4. Computed Loss Ratios, Expense Ratios and Premium Percentages for each of the Carrier Codes in each Expense** file.

It was then observed that company reporting of data as a group or individually was not consistent over time in the Expense** and Form46** files. Therefore, it became necessary to perform the analysis on a group basis. The 1990 group definitions from the Study90 data file were used to aggregate company data into groups for each of the years 1983 to 1990.

The following procedures were then performed on the Form46** file:

5. Aggregated the Form46** data into company groups for each year.

6. Extracted from the Form46** files those groups which reported data in the Expense** files.

7. Added to the Form46** file those companies contained in Expense** file but which did not report data to Form46** file.

8. Sorted on company group in each Form46** file to obtain a consistent set of company groupings for each year. This sorted company group list is in agreement with the Expense** company group list from #1 above.

9. Computed Investment Income and Dividend Ratios for each year.

10. Merged the statistics in #9 with those obtained in step #4.

III Company Group Selection for use in Analysis

A company group was selected for use in the analysis if (a) its reported premium over the eight years from 1983 to 1990 represented at least 0.5% of the total premium reported by all companies, (b) it had relatively stable market shares over the time period and (c) it had reported data in both the Expense** and Form46** for at least five years.

Exhibit AIS-3.1 displays the premium distribution of all companies. Exhibit AIS-3.2 lists the company groups and years in which data were not reported in the Expense** files or the Form46** files. In Exhibit AIS-3.3, the market shares of the selected companies are computed for each year.

IV Statistical Testing and Interpretation

The analysis of variance test shown in Exhibit AIS-1.1 follows the format of that presented in Intermediate Business Statistics (Miller, Wichern), Chapter 4. The formulas underlying the table are from Page 139 of that text.

An analysis of variance proceeds in the following manner. The distribution of the average results across companies is compared to the spread of the observations for each individual company. If that difference is significant, the hypothesis of equal population means (or, in our case, equal average operating ratios among company groups) is rejected since such an event is unlikely if the population means are identical.

The assumptions underlying this test are:

1. Each company group's operating ratios has an underlying normal distribution.

2. The company groups involved have the same underlying variance.

3. The operating ratios within company groups are independent.

The equality of variance assumption in the analysis could possibly be affected by the fact that variance of the operating ratios for each company could be a function of the company group premium size. There is a test for equal variance in the text mentioned above but more observations within each sample are necessary in order for the test to be valid.

The results of the analysis of variance test is set forth in Exhibit AIS-1.1. The F ratio of 1.68 indicates that the difference in operating results across companies is so large, that it is highly unlikely that the profitability across companies are equal. Hence, the conclusion from this test is that there is some non-random difference in operating results across companies.

The next step in our analysis was to examine various factors that may explain the difference in operating results across companies. The three variables analyzed were whether the insurer was a (i) direct vs. agency writer, (ii) domestic vs. foreign company (i.e., California vs. non-California) and (iii) stock vs. non-stock company. We ran a regression analysis of the average 1983 to 1990 operating result by insurer against these variables.

The results of this regression analysis are contained in Exhibit AIS-2.1. The R-squared value of 0.025 is very small. This shows that these variables do a very poor job of explaining the variation of operating profits across companies. In addition, the T-statistic for each of these variables is not significant. That is, none of the variables has any explanatory influence on the operating profit differences among insurers.

The final portion of our project was examining which of the components of the operating ratio (i.e., losses, expenses, investment income and dividends) effected the differences in profitability across insurers. To do this, we performed a regression analysis of the operating ratio against each of the four components.

The results of these regression analyses are shown in Exhibit AIS-2.3. The R-squared for each component is relatively small. This shows that by themselves, each component explains only a small portion of the variation in operating results. The T-statistics indicate how much of an influence each component has on the operating profit. The loss ratio has a very strong influence on the operating results. The expense ratio has a weaker, but still statistically significant influence on the profit. The investment income and dividend ratios have a marginally significant impact on explaining the difference in profits between insurers.

ANALYSIS OF VARIANCE TABLE FOR OPERATING RATIOS

	Sum of Squares	Degrees of Freedom	Mean Squares	F Ratio
Between Companies	1.4784	32	0.0462	1.68
Within Companies	5.8168	212	0.0274	

The F ratio (F = 1.68) exceeds the upper 1-percent point of an F distribution with 32 and 212 degrees of freedom. Therefore, the hypothesis that the mean operating ratios are equal for the 33 selected groups is rejected at the 1-percent significance level.

Calendar Year Operating Ratios By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990
4534	0.880	0.988	0.986	0.925	0.951	0.943	0.955	0.969
1334	0.869	0.921	1.072	N/A	1.017	0.995	0.896	0.907
684	0.874	0.774	1.052	0.906	0.905	0.807	0.999	1.034
1424	0.958	N/A	1.054	1.023	0.898	0.903	0.934	1.097
524	1.139	1.054	0.977	0.847	1.310	1.029	0.909	0.940
529	0.913	1.170	1.071	1.227	1.030	0.901	0.873	0.930
1209	0.671	1.118	1.105	0.898	0.929	0.923	0.980	0.850
794	0.864	0.933	0.720	0.863	0.970	1.007	0.880	N/A
949	1.136	1.134	0.957	N/A	1.052	0.900	0.989	0.986
829	0.810	0.927	0.946	N/A	1.070	1.141	1.098	1.035
954	0.988	1.086	1.152	0.858	0.849	0.878	0.868	0.871
519	1.346	N/A	N/A	N/A	0.901	1.039	0.736	0.934
674	0.905	0.869	0.867	1.255	0.986	0.664	0.921	N/A
539	0.736	0.855	1.044	1.138	1.005	0.909	0.922	1.016
729	0.763	0.916	1.027	1.145	0.927	0.873	1.013	1.120
554	0.956	0.965	0.862	1.016	0.933	0.817	0.991	0.871
1574	1.073	1.072	0.939	0.819	0.206	0.858	0.635	0.880
1874	1.086	1.040	0.988	0.967	1.053	0.934	0.973	0.820
629	0.754	1.380	1.092	1.612	0.735	0.789	1.057	0.943
1379	0.953	N/A	N/A	1.086	1.066	0.996	0.950	1.553
549	0.951	1.073	1.066	1.129	0.903	0.983	0.737	0.722
899	0.541	0.842	0.767	N/A	0.964	0.694	0.786	0.617
1644	0.870	N/A	N/A	1.048	0.945	0.929	0.715	0.877
894	1.104	1.124	0.953	1.183	1.020	1.098	0.828	0.894
579	0.907	0.916	1.098	1.126	1.369	0.999	0.855	0.877
1594	N/A	N/A	1.167	1.728	1.116	0.927	0.913	0.833
3269	0.814	0.850	0.968	0.981	0.904	0.832	0.824	0.843
1359	N/A	N/A	N/A	0.982	1.309	0.936	1.218	1.083
3564	N/A	0.937	0.936	0.912	1.004	0.943	0.947	0.903
849	0.898	0.885	1.010	1.067	1.184	0.899	1.111	1.161
2924	1.097	0.990	N/A	1.123	1.014	1.056	1.044	0.960
1029	0.785	1.216	1.320	1.043	0.632	0.631	0.597	0.886
2859	0.997	1.094	1.370	0.910	0.914	0.812	0.734	0.924

N/A represents data not reported in either the Form46** File or the Expense** File.

Calendar Year Loss Ratios By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990
4534	0.687	0.750	0.788	0.797	0.766	0.787	0.853	0.844
1334	0.583	0.605	0.806	N/A	0.709	0.618	0.557	0.593
684	0.627	0.597	0.814	0.707	0.693	0.579	0.677	0.737
1424	0.523	N/A	0.686	0.753	0.642	0.599	0.575	0.733
524	0.692	0.743	0.611	0.565	1.033	0.884	0.677	0.701
529	0.553	0.812	0.846	1.040	0.723	0.730	0.670	0.666
1209	0.535	0.901	0.862	0.748	0.834	0.727	0.817	0.721
794	0.540	0.518	0.455	0.533	0.580	0.620	0.561	N/A
949	0.720	0.800	0.586	N/A	0.724	0.641	0.688	0.651
829	0.518	0.641	0.658	N/A	0.842	0.996	0.834	0.767
954	0.448	0.602	0.683	0.557	0.483	0.508	0.495	0.511
519	0.985	N/A	N/A	N/A	0.655	0.812	0.524	0.676
674	0.526	0.550	0.546	0.909	0.713	0.516	0.706	N/A
539	0.539	0.622	0.813	0.905	0.772	0.654	0.729	0.790
729	0.415	0.597	0.757	0.873	0.717	0.624	0.723	0.819
554	0.564	0.586	0.603	0.751	0.645	0.540	0.652	0.758
1574	0.665	1.015	0.839	0.677	0.392	0.722	0.448	0.664
1874	0.450	0.567	0.606	0.612	0.714	0.607	0.488	0.468
629	0.551	1.109	0.827	1.313	0.540	0.574	0.877	0.655
1379	0.505	N/A	N/A	0.668	0.706	0.709	0.733	1.280
549	0.604	0.686	0.717	0.832	0.664	0.762	0.559	0.554
899	0.461	0.732	0.626	N/A	0.805	0.551	0.633	0.489
1644	0.289	N/A	N/A	0.721	0.645	0.633	0.418	0.484
894	0.711	0.767	0.584	1.031	0.655	0.816	0.497	0.805
579	0.471	0.494	0.663	0.790	0.881	0.703	0.584	0.612
1594	N/A	N/A	0.600	1.180	0.617	0.626	0.714	0.595
3269	0.404	0.582	0.667	0.685	0.663	0.552	0.574	0.582
1359	N/A	N/A	N/A	0.536	0.851	0.635	0.892	0.739
3564	N/A	0.593	0.615	0.571	0.689	0.634	0.577	0.570
849	0.472	0.547	0.636	0.719	0.781	0.567	0.655	0.681
2924	0.490	0.505	N/A	0.652	0.632	0.660	0.688	0.644
1029	0.546	0.927	0.998	0.717	0.324	0.303	0.346	0.515
2859	0.564	0.680	1.040	0.741	0.719	0.565	0.466	0.568

N/A represents data not reported in either the Form46** File or the Expense** File.

Calendar Year Expense Ratios By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990
4534	0.146	0.147	0.142	0.137	0.132	0.132	0.139	0.161
1334	0.271	0.258	0.243	N/A	0.325	0.379	0.321	0.334
684	0.232	0.218	0.225	0.248	0.246	0.257	0.314	0.297
1424	0.171	N/A	0.151	0.149	0.128	0.133	0.139	0.152
524	0.367	0.281	0.317	0.303	0.294	0.191	0.275	0.259
529	0.318	0.273	0.239	0.250	0.322	0.336	0.289	0.316
1209	0.189	0.260	0.247	0.152	0.120	0.232	0.214	0.167
794	0.256	0.255	0.231	0.211	0.269	0.292	0.262	N/A
949	0.355	0.315	0.397	N/A	0.312	0.304	0.309	0.312
829	0.218	0.196	0.178	N/A	0.224	0.212	0.265	0.277
954	0.292	0.303	0.368	0.246	0.296	0.314	0.307	0.306
519	0.315	N/A	N/A	N/A	0.284	0.243	0.281	0.306
674	0.250	0.258	0.185	0.185	0.186	0.148	0.215	N/A
539	0.240	0.229	0.210	0.241	0.214	0.255	0.194	0.192
729	0.220	0.190	0.229	0.239	0.217	0.228	0.235	0.284
554	0.253	0.286	0.233	0.210	0.203	0.229	0.257	0.129
1574	0.429	0.477	0.411	0.317	0.225	0.290	0.173	0.261
1874	0.266	0.278	0.299	0.277	0.293	0.325	0.336	0.276
629	0.314	0.360	0.303	0.322	0.269	0.258	0.295	0.295
1379	0.398	N/A	N/A	0.448	0.331	0.306	0.242	0.345
549	0.284	0.323	0.257	0.304	0.315	0.309	0.255	0.309
899	0.183	0.186	0.232	N/A	0.281	0.245	0.228	0.191
1644	0.747	N/A	N/A	0.299	0.282	0.269	0.241	0.356
894	0.291	0.259	0.235	0.318	0.300	0.336	0.419	0.327
579	0.295	0.294	0.324	0.311	0.388	0.393	0.347	0.270
1594	N/A	N/A	0.394	0.495	0.505	0.382	0.257	0.206
3269	0.312	0.270	0.298	0.312	0.262	0.260	0.230	0.211
1359	N/A	N/A	N/A	0.291	0.347	0.253	0.238	0.271
3564	N/A	0.304	0.295	0.316	0.315	0.305	0.316	0.305
849	0.306	0.298	0.255	0.279	0.270	0.215	0.249	0.278
2924	0.465	0.358	N/A	0.372	0.336	0.342	0.332	0.331
1029	0.359	0.391	0.422	0.417	0.418	0.426	0.347	0.463
2859	0.307	0.375	0.325	0.212	0.256	0.278	0.276	0.304

N/A represents data not reported in either the Form46** File or the Expense** File.

Calendar Year Earned Premium Distributions By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990
4534	15.0%	15.7%	17.9%	21.8%	24.1%	24.7%	23.2%	21.9%
1334	6.8%	7.1%	8.0%	N/A	6.4%	5.3%	5.4%	4.6%
684	5.8%	6.0%	6.1%	6.2%	5.5%	5.3%	4.7%	4.7%
1424	4.3%	N/A	5.4%	6.1%	6.6%	6.1%	5.2%	4.8%
524	5.2%	5.0%	4.4%	4.0%	3.8%	3.9%	3.6%	3.3%
529	5.1%	4.8%	4.0%	3.4%	3.1%	2.8%	2.8%	2.8%
1209	2.0%	1.8%	2.1%	4.2%	4.3%	3.8%	4.4%	4.9%
794	2.1%	2.1%	3.0%	3.8%	3.9%	3.6%	3.8%	N/A
949	2.0%	2.0%	2.2%	N/A	3.7%	3.5%	4.1%	3.9%
829	3.3%	3.1%	3.8%	N/A	2.9%	2.6%	2.5%	2.3%
954	3.6%	3.3%	3.3%	2.6%	2.4%	2.5%	2.4%	2.5%
519	3.1%	N/A	N/A	N/A	2.4%	2.4%	2.0%	1.8%
674	3.0%	3.0%	3.1%	2.7%	2.2%	2.1%	2.0%	N/A
539	1.3%	1.6%	1.9%	2.3%	2.2%	2.9%	2.9%	3.2%
729	2.2%	2.2%	2.5%	2.3%	2.1%	2.1%	2.2%	2.0%
554	1.8%	1.7%	2.3%	2.0%	2.1%	2.5%	2.5%	2.7%
1574	2.3%	2.2%	2.4%	1.4%	1.1%	1.1%	1.7%	1.4%
1874	1.3%	1.3%	1.4%	1.7%	1.6%	1.4%	1.1%	1.0%
629	1.2%	0.7%	1.2%	1.4%	1.2%	1.5%	1.6%	1.6%
1379	1.5%	N/A	N/A	1.2%	1.2%	1.3%	1.3%	0.7%
549	1.2%	1.3%	1.1%	1.1%	0.8%	1.0%	1.2%	1.0%
899	0.9%	1.2%	1.1%	N/A	0.8%	1.1%	0.9%	1.2%
1644	0.3%	N/A	N/A	1.0%	1.2%	1.2%	1.1%	0.9%
894	1.0%	1.1%	1.3%	1.1%	0.8%	0.6%	0.4%	0.3%
579	0.5%	0.6%	0.7%	0.7%	0.5%	0.4%	0.7%	2.2%
1594	N/A	N/A	0.7%	0.7%	0.6%	0.6%	0.9%	1.0%
3269	0.5%	0.5%	0.6%	0.7%	0.7%	0.7%	0.8%	1.1%
1359	N/A	N/A	N/A	0.7%	0.7%	0.8%	0.8%	0.7%
3564	N/A	0.2%	0.6%	0.7%	0.7%	0.7%	0.7%	0.6%
849	0.5%	0.5%	0.5%	0.6%	0.5%	0.6%	0.5%	0.4%
2924	0.6%	0.7%	N/A	0.5%	0.5%	0.5%	0.5%	0.6%
1029	0.4%	0.5%	0.5%	0.6%	0.5%	0.5%	0.4%	0.5%
2859	0.6%	0.5%	0.5%	0.5%	0.4%	0.4%	0.4%	0.4%

N/A represents data not reported in either the Form46** File or the Expense** File.

Calendar Year Investment Income Ratios By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990
4534	0.313	0.295	0.271	0.215	0.165	0.168	0.205	0.230
1334	0.107	0.109	0.119	N/A	0.124	0.123	0.103	0.137
684	0.121	0.193	0.173	0.207	0.152	0.133	0.170	0.176
1424	0.147	N/A	0.130	0.117	0.098	0.103	0.127	0.128
524	0.130	0.133	0.142	0.137	0.138	0.146	0.164	0.170
529	0.146	0.174	0.227	0.228	0.209	0.189	0.222	0.184
1209	0.112	0.113	0.081	0.066	0.078	0.104	0.112	0.088
794	0.120	0.125	0.189	0.103	0.075	0.093	0.124	N/A
949	0.083	0.098	0.103	N/A	0.062	0.113	0.087	0.082
829	0.100	0.095	0.064	N/A	0.100	0.123	0.155	0.180
954	0.045	0.020	0.060	0.089	0.057	0.082	0.088	0.088
519	0.137	N/A	N/A	N/A	0.196	0.161	0.199	0.174
674	0.127	0.140	0.157	0.098	0.115	0.092	0.117	N/A
539	0.203	0.143	0.154	0.135	0.150	0.135	0.180	0.154
729	0.085	0.096	0.163	0.145	0.158	0.140	0.119	0.139
554	0.083	0.089	0.079	0.094	0.087	0.078	0.102	0.106
1574	0.253	0.619	0.457	0.331	0.607	0.304	0.130	0.185
1874	0.173	0.180	0.163	0.150	0.110	0.142	0.182	0.233
629	0.241	0.247	0.127	0.113	0.154	0.117	0.204	0.155
1379	0.117	N/A	N/A	0.148	0.103	0.113	0.126	0.219
549	0.158	0.107	0.157	0.219	0.189	0.162	0.165	0.199
899	0.200	0.183	0.160	N/A	0.212	0.155	0.133	0.132
1644	0.226	N/A	N/A	0.123	0.116	0.095	0.112	0.149
894	0.143	0.101	0.062	0.384	0.111	0.196	0.335	0.440
579	0.085	0.080	0.091	0.103	0.107	0.165	0.116	0.062
1594	N/A	N/A	0.091	0.093	0.111	0.122	0.089	0.083
3269	0.122	0.155	0.145	0.125	0.115	0.136	0.124	0.104
1359	N/A	N/A	N/A	0.077	0.092	0.103	0.140	0.186
3564	N/A	0.070	0.053	0.051	0.055	0.072	0.113	0.101
849	0.143	0.123	0.112	0.088	0.071	0.042	0.044	0.045
2924	0.094	0.074	N/A	0.116	0.088	0.083	0.096	0.131
1029	0.151	0.133	0.163	0.151	0.140	0.129	0.127	0.124
2859	0.081	0.094	0.120	0.136	0.124	0.122	0.117	0.092

N/A represents data not reported in either the Form46** File or the Expense** File.

Calendar Year Dividend Ratios By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990
4534	0.337	0.364	0.303	0.180	0.191	0.165	0.141	0.166
1334	0.094	0.140	0.113	N/A	0.078	0.092	0.092	0.088
684	0.109	0.125	0.158	0.131	0.089	0.076	0.151	0.148
1424	0.390	N/A	0.323	0.213	0.201	0.249	0.324	0.316
524	0.185	0.136	0.164	0.088	0.093	0.071	0.093	0.122
529	0.162	0.235	0.186	0.138	0.167	-0.006	0.108	0.104
1209	0.029	0.039	0.049	0.033	0.022	0.038	0.031	0.020
794	0.161	0.261	0.197	0.196	0.169	0.161	0.153	N/A
949	0.116	0.088	0.047	N/A	0.049	0.039	0.049	0.076
829	0.146	0.160	0.146	N/A	0.075	0.026	0.126	0.143
954	0.269	0.175	0.133	0.116	0.098	0.110	0.126	0.112
519	0.156	N/A	N/A	N/A	0.132	0.117	0.102	0.097
674	0.231	0.175	0.269	0.234	0.175	0.063	0.089	N/A
539	0.133	0.120	0.148	0.099	0.141	0.108	0.151	0.160
729	0.187	0.200	0.178	0.151	0.123	0.135	0.148	0.127
554	0.196	0.155	0.077	0.121	0.144	0.098	0.157	0.060
1574	0.206	0.173	0.119	0.129	0.169	0.123	0.116	0.111
1874	0.526	0.353	0.220	0.202	0.128	0.116	0.308	0.284
629	0.102	0.131	0.061	0.061	0.052	0.044	0.059	0.119
1379	0.140	N/A	N/A	0.089	0.104	0.065	0.072	0.117
549	0.195	0.143	0.225	0.186	0.084	0.044	0.059	0.026
899	0.069	0.079	0.039	N/A	0.060	0.023	0.028	0.039
1644	0.030	N/A	N/A	0.124	0.105	0.095	0.140	0.158
894	0.220	0.173	0.170	0.191	0.148	0.114	0.220	0.174
579	0.200	0.182	0.176	0.099	0.181	0.037	0.010	0.025
1594	N/A	N/A	0.240	0.118	0.077	0.011	-0.000	0.086
3269	0.196	0.126	0.120	0.081	0.064	0.129	0.117	0.126
1359	N/A	N/A	N/A	0.206	0.176	0.124	0.202	0.232
3564	N/A	0.081	0.050	0.047	0.025	0.047	0.139	0.101
849	0.237	0.136	0.205	0.129	0.178	0.133	0.226	0.222
2924	0.210	0.174	N/A	0.189	0.106	0.109	0.092	0.086
1029	0.000	0.000	0.033	0.031	0.000	0.001	0.000	0.000
2859	0.181	0.105	0.097	0.064	0.033	0.061	0.080	0.115

N/A represents data not reported in either the Form46** File or the Expense** File.

Calendar Year Premium Plus Other Tax Ratios By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990
4534	0.022	0.022	0.023	0.026	0.026	0.027	0.027	0.028
1334	0.028	0.027	0.028	N/A	0.029	0.028	0.029	0.029
684	0.028	0.027	0.027	0.027	0.028	0.029	0.027	0.028
1424	0.021	N/A	0.023	0.026	0.026	0.025	0.023	0.024
524	0.026	0.027	0.026	0.028	0.028	0.029	0.028	0.029
529	0.027	0.025	0.026	0.027	0.027	0.031	0.028	0.029
1209	0.030	0.029	0.029	0.030	0.030	0.030	0.030	0.031
794	0.027	0.024	0.026	0.026	0.027	0.027	0.027	N/A
949	0.028	0.028	0.029	N/A	0.029	0.030	0.030	0.030
829	0.027	0.027	0.027	N/A	0.029	0.030	0.028	0.028
954	0.024	0.026	0.027	0.028	0.028	0.028	0.028	0.029
519	0.027	N/A	N/A	N/A	0.027	0.028	0.028	0.029
674	0.025	0.026	0.024	0.025	0.026	0.029	0.029	N/A
539	0.027	0.027	0.027	0.028	0.027	0.028	0.027	0.028
729	0.026	0.026	0.026	0.027	0.028	0.027	0.027	0.028
554	0.026	0.027	0.029	0.028	0.027	0.028	0.027	0.030
1574	0.025	0.026	0.028	0.027	0.027	0.028	0.028	0.029
1874	0.018	0.022	0.025	0.026	0.027	0.028	0.023	0.025
629	0.028	0.027	0.029	0.029	0.029	0.029	0.029	0.029
1379	0.027	N/A	N/A	0.028	0.028	0.029	0.029	0.029
549	0.026	0.027	0.025	0.026	0.029	0.029	0.029	0.031
899	0.029	0.028	0.029	N/A	0.029	0.030	0.030	0.031
1644	0.030	N/A	N/A	0.028	0.028	0.028	0.027	0.028
894	0.025	0.026	0.026	0.026	0.027	0.028	0.025	0.027
579	0.026	0.026	0.026	0.028	0.026	0.030	0.030	0.031
1594	N/A	N/A	0.025	0.028	0.029	0.030	0.031	0.029
3269	0.026	0.027	0.027	0.029	0.029	0.027	0.028	0.028
1359	N/A	N/A	N/A	0.026	0.026	0.028	0.026	0.026
3564	N/A	0.028	0.029	0.029	0.030	0.029	0.027	0.029
849	0.025	0.027	0.026	0.027	0.026	0.027	0.025	0.026
2924	0.025	0.026	N/A	0.026	0.028	0.028	0.029	0.029
1029	0.030	0.030	0.030	0.030	0.030	0.030	0.031	0.032
2859	0.026	0.028	0.028	0.029	0.030	0.029	0.029	0.029

Notes:

Tax Ratio = (.0233 * (100 - Dividend Ratio) + .7)/100 for 83-85

Tax Ratio = (.0235 * (100 - Dividend Ratio) + .7)/100 for 86-88

Tax Ratio = (.0237 * (100 - Dividend Ratio) + .7)/100 for 89

Tax Ratio = (.0246 * (100 - Dividend Ratio) + .7)/100 for 90

Profitability Regression Analysis

Direct vs. Agency, Domestic vs. Foreign, Stock vs. Non-Stock

Results of Regression Analysis

Regression Output	
Constant	0.966127402
Std Err of Y Est	0.076959092
R Squared	0.024842274
No. of Observations	32
Degrees of Freedom	28

	X1	X2	X3
X Coefficient(s)	-0.0033	0.0221	-0.0083
Std Err of Coef.	0.0380	0.0278	0.0508
T-Statistic	-0.088	0.795	-0.163

Overall Profitability Ratios by Grouping

Indicator	X1 Direct=0 Agent=1	X2 Domestic=0 Foreign=1	X3 Stock=1 Non-Stock=0
0	0.974	0.953	0.978
1	0.963	0.974	0.962

Premium Distribution by Grouping

Indicator	X1 Direct=0 Agent=1	X2 Domestic=0 Foreign=1	X3 Stock=1 Non-Stock=0
0	6.9%	35.0%	10.1%
1	68.2%	40.1%	65.0%
State Fund	24.9%	24.9%	24.9%

Exhibit AIS-2.1

Profitability Regression Analysis

Direct vs. Agency, Domestic vs. Foreign, Stock vs. Non-Stock

Definition of Data Elements

Company Group	Profit Ratio Weighted Average	X1 Direct=0 Agent=1	X2 Domestic=0 Foreign=1	X3 Stock=1 Non-Stock=0	'83 to '90 Relative Premium Weights
4534	0.950				24.9%
1334	0.959	1	0	1	6.6%
684	0.915	1	0	1	6.7%
1424	0.976	1	1	0	5.8%
524	1.032	1	1	1	5.1%
529	1.024	1	0	1	4.4%
1209	0.925	1	1	1	4.2%
794	0.895	1	0	1	3.4%
949	1.009	1	0	1	3.2%
829	0.992	1	1	1	3.1%
954	0.958	1	0	1	3.4%
519	1.025	1	1	1	1.8%
674	0.929	1	1	1	2.8%
539	0.968	1	1	1	2.8%
729	0.974	0	1	0	2.7%
554	0.921	1	1	1	2.7%
1574	0.862	1	0	1	2.1%
1874	0.988	0	0	0	1.6%
629	1.027	1	1	1	1.6%
1379	1.061	1	1	1	1.1%
549	0.950	1	1	1	1.3%
899	0.740	1	1	1	1.1%
1644	0.899	0	1	1	0.9%
894	1.055	1	1	1	1.0%
579	0.975	1	0	1	1.0%
1594	1.086	1	1	1	0.7%
3269	0.874	1	0	1	0.8%
1359	1.105	0	1	1	0.6%
3564	0.941	1	0	1	0.6%
849	1.021	1	1	1	0.6%
2924	1.037	1	0	1	0.6%
1029	0.900	0	1	1	0.6%
2859	0.985	0	0	1	0.6%
Total		26	19	29	100%

Profitability Regression Analysis

Profitability vs. Losses, Expense, Investment Income and Dividends

Results of Regression Analysis

Loss Ratio Regression Output:		
Constant	0.6558	
Std Err of Y Est	0.0660	
R Squared	0.2075	
No. of Observations	33	
Degrees of Freedom	31	
X Coefficient(s)	0.46544	
Std Err of Coef.	0.16335	
T-Statistic	2.849	*

Expense Ratio Regression Output:		
Constant	0.8823	
Std Err of Y Est	0.0717	
R Squared	0.0649	
No. of Observations	33	
Degrees of Freedom	31	
X Coefficient(s)	0.31206	
Std Err of Coef.	0.21274	
T-Statistic	1.467	**

Investment Income Ratio Regression Output:		
Constant	1.0087	
Std Err of Y Est	0.0722	
R Squared	0.0504	
No. of Observations	33	
Degrees of Freedom	31	
X Coefficient(s)	-0.29504	
Std Err of Coef.	0.22999	
T-Statistic	-1.283	***

Dividend Ratio Regression Output:		
Constant	0.9330	
Std Err of Y Est	0.0723	
R Squared	0.0490	
No. of Observations	33	
Degrees of Freedom	31	
X Coefficient(s)	0.27355	
Std Err of Coef.	0.21636	
T-Statistic	1.264	***

* Significant at 0.5% level
** Significant at 10% level
*** Significant at 15% level

Profitability Regression Analysis

Profitability vs. Losses, Expense, Investment Income and Dividends

Definition of Data Elements

Company Group	Profitability Ratio Weighted Average	Loss Ratio Weighted Average	Expense Ratio Weighted Average	Investment Income Weighted Average	Dividend Ratio Weighted Average
4534	0.950	0.790	0.141	0.224	0.217
1334	0.959	0.648	0.298	0.117	0.102
684	0.915	0.679	0.252	0.166	0.123
1424	0.976	0.648	0.144	0.120	0.280
524	1.032	0.735	0.290	0.144	0.123
529	1.024	0.752	0.291	0.194	0.148
1209	0.925	0.768	0.188	0.092	0.031
794	0.895	0.549	0.254	0.115	0.182
949	1.009	0.683	0.323	0.088	0.062
829	0.992	0.735	0.219	0.111	0.120
954	0.958	0.540	0.305	0.063	0.149
519	1.025	0.756	0.287	0.170	0.125
674	0.929	0.632	0.207	0.123	0.187
539	0.968	0.741	0.220	0.155	0.134
729	0.974	0.692	0.230	0.131	0.157
554	0.921	0.641	0.221	0.090	0.121
1574	0.862	0.710	0.345	0.366	0.147
1874	0.988	0.575	0.293	0.162	0.258
629	1.027	0.789	0.298	0.164	0.076
1379	1.061	0.720	0.346	0.131	0.098
549	0.950	0.671	0.293	0.167	0.125
899	0.740	0.610	0.219	0.166	0.048
1644	0.899	0.567	0.308	0.122	0.118
894	1.055	0.744	0.293	0.184	0.177
579	0.975	0.636	0.310	0.089	0.090
1594	1.086	0.717	0.351	0.096	0.085
3269	0.874	0.592	0.262	0.125	0.117
1359	1.105	0.733	0.279	0.119	0.185
3564	0.941	0.609	0.309	0.074	0.069
849	1.021	0.631	0.268	0.085	0.180
2924	1.037	0.601	0.365	0.097	0.141
1029	0.900	0.594	0.407	0.141	0.009
2859	0.985	0.678	0.293	0.110	0.096

Calendar Year Earned Premium Distributions By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990	Average
4534	15.0%	15.7%	17.9%	21.8%	24.1%	24.7%	23.2%	21.9%	20.5%
1334	6.8%	7.1%	8.0%	3.2%	6.4%	5.3%	5.4%	4.6%	5.9%
684	5.8%	6.0%	6.1%	6.2%	5.5%	5.3%	4.7%	4.7%	5.5%
1424	4.3%	4.7%	5.4%	6.1%	6.6%	6.1%	5.2%	4.8%	5.4%
524	5.2%	5.0%	4.4%	4.0%	3.8%	3.9%	3.6%	3.3%	4.2%
529	5.1%	4.8%	4.0%	3.4%	3.1%	2.8%	2.8%	2.8%	3.6%
1209	2.0%	1.8%	2.1%	4.2%	4.3%	3.8%	4.4%	4.9%	3.4%
794	2.1%	2.1%	3.0%	3.8%	3.9%	3.6%	3.8%	4.1%	3.3%
949	2.0%	2.0%	2.2%	3.3%	3.7%	3.5%	4.1%	3.9%	3.1%
829	3.3%	3.1%	3.8%	3.4%	2.9%	2.6%	2.5%	2.3%	3.0%
954	3.6%	3.3%	3.3%	2.6%	2.4%	2.5%	2.4%	2.5%	2.8%
519	3.1%	3.0%	3.2%	3.0%	2.4%	2.4%	2.0%	1.8%	2.6%
674	3.0%	3.0%	3.1%	2.7%	2.2%	2.1%	2.0%	1.9%	2.5%
539	1.3%	1.6%	1.9%	2.3%	2.2%	2.9%	2.9%	3.2%	2.3%
729	2.2%	2.2%	2.5%	2.3%	2.1%	2.1%	2.2%	2.0%	2.2%
554	1.8%	1.7%	2.3%	2.0%	2.1%	2.5%	2.5%	2.7%	2.2%
1574	2.3%	2.2%	2.4%	1.4%	1.1%	1.1%	1.7%	1.4%	1.7%
1874	1.3%	1.3%	1.4%	1.7%	1.6%	1.4%	1.1%	1.0%	1.3%
629	1.2%	0.7%	1.2%	1.4%	1.2%	1.5%	1.6%	1.6%	1.3%
654	1.8%	1.8%	1.9%	1.7%	1.2%	0.9%	0.4%	0.2%	1.2%
1379	1.5%	1.7%	0.0%	1.2%	1.2%	1.3%	1.3%	0.7%	1.1%
1139	4.6%	4.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%
549	1.2%	1.3%	1.1%	1.1%	0.8%	1.0%	1.2%	1.0%	1.1%
899	0.9%	1.2%	1.1%	1.0%	0.8%	1.1%	0.9%	1.2%	1.0%
1009	0.9%	0.8%	0.9%	1.0%	1.1%	1.0%	0.8%	0.9%	0.9%
1644	0.3%	0.7%	0.9%	1.0%	1.2%	1.2%	1.1%	0.9%	0.9%
894	1.0%	1.1%	1.3%	1.1%	0.8%	0.6%	0.4%	0.3%	0.8%
579	0.5%	0.6%	0.7%	0.7%	0.5%	0.4%	0.7%	2.2%	0.8%
774	0.7%	0.9%	1.1%	1.0%	0.7%	0.6%	0.5%	0.5%	0.7%
1594	0.6%	0.8%	0.7%	0.7%	0.6%	0.6%	0.9%	1.0%	0.7%
1904	1.5%	1.5%	1.7%	0.9%	0.0%	0.0%	0.0%	0.0%	0.7%
3269	0.5%	0.5%	0.6%	0.7%	0.7%	0.7%	0.8%	1.1%	0.7%
3159	1.4%	1.3%	1.2%	0.4%	0.0%	0.0%	0.1%	0.2%	0.6%
1359	0.3%	0.3%	0.4%	0.7%	0.7%	0.8%	0.8%	0.7%	0.6%
589	0.0%	0.0%	0.2%	0.0%	0.6%	1.0%	1.2%	1.4%	0.5%
759	0.4%	0.5%	0.6%	0.7%	0.6%	0.5%	0.5%	0.5%	0.5%
3564	0.1%	0.2%	0.6%	0.7%	0.7%	0.7%	0.7%	0.6%	0.5%
849	0.5%	0.5%	0.5%	0.6%	0.5%	0.6%	0.5%	0.4%	0.5%
2924	0.6%	0.7%	0.0%	0.5%	0.5%	0.5%	0.5%	0.6%	0.5%
1029	0.4%	0.5%	0.5%	0.6%	0.5%	0.5%	0.4%	0.5%	0.5%

Calendar Year Earned Premium Distributions By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990	Average
2859	0.6%	0.5%	0.5%	0.5%	0.4%	0.4%	0.4%	0.4%	0.5%
3614	0.0%	0.1%	0.3%	0.4%	0.5%	0.6%	0.7%	0.8%	0.4%
764	0.9%	0.7%	0.7%	0.1%	0.1%	0.2%	0.3%	0.2%	0.4%
1599	0.7%	0.6%	0.5%	0.4%	0.3%	0.3%	0.2%	0.1%	0.4%
3259	1.4%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%
3214	0.0%	0.0%	0.0%	0.3%	0.0%	0.7%	0.9%	1.1%	0.4%
1149	0.0%	0.0%	0.1%	0.5%	0.8%	0.4%	0.5%	0.3%	0.3%
1629	0.1%	0.1%	0.2%	0.3%	0.4%	0.4%	0.5%	0.7%	0.3%
1799	0.6%	0.4%	0.4%	0.3%	0.3%	0.2%	0.2%	0.1%	0.3%
3994	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.8%	1.0%	0.2%
1164	0.3%	0.4%	0.3%	0.2%	0.1%	0.1%	0.1%	0.3%	0.2%
544	0.7%	0.6%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.2%
3959	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.5%	0.9%	0.2%
2724	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
3264	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
1419	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%	0.2%
3874	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.7%	0.2%
534	0.2%	0.2%	0.2%	0.3%	0.2%	0.1%	0.1%	0.0%	0.2%
1439	0.3%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%
1454	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
1794	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.1%
914	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%	0.3%	0.1%
639	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	0.1%
1819	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
3774	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.3%	0.5%	0.1%
1069	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.2%	0.3%	0.1%
3864	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.2%	0.1%
1839	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
3154	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
1469	0.1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%
3699	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.2%	0.0%
1459	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1554	0.2%	0.1%	0.0%	0.0%	-0.0%	0.0%	0.0%	0.0%	0.0%
2849	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%
1309	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%	-0.0%	0.0%	0.0%
2854	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1854	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1349	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
824	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1179	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Calendar Year Earned Premium Distributions By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990	Average
1784	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
2669	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2899	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2584	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3569	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
1894	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3974	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1449	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1979	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3604	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1934	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4029	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
3939	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
4089	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
1174	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1899	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1964	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3839	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3074	0.0%	-0.0%	0.0%	0.0%	0.0%	-0.0%	0.0%	-0.0%	0.0%
1889	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3789	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.0%	0.0%	0.0%
3759	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3129	0.0%	0.0%	0.0%	0.0%	0.0%	-0.0%	0.0%	0.0%	0.0%
3624	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2529	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3304	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1869	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1759	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1734	0.0%	0.0%	0.0%	0.0%	-0.0%	0.0%	0.0%	0.0%	0.0%
3439	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1479	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1404	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3609	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3539	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1994	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3964	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3399	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1389	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1804	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3004	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Calendar Year Earned Premium Distributions By Company Group

Company Group	1983	1984	1985	1986	1987	1988	1989	1990	Average
3364	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3854	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2594	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
864	0.0%	0.0%	-0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3424	0.0%	0.0%	-0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3709	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1624	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1679	0.0%	0.0%	0.0%	0.0%	0.0%	-0.0%	0.0%	0.0%	0.0%
3814	0.0%	-0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1219	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2844	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1814	-0.0%	0.0%	-0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.0%

Database Omissions for Companies Reporting 1983-1990

The following company groups did not report on either the Expense file or the Form46 file for the years set forth below.

Company Group	Years	Computer File
1334	1986	Expense File
1424	1984	Form46 File
794	1990	Form46 File
949	1986	Form46 File
829	1986	Form46 File
519	1984,85,86	Form46 File
674	1990	Form46 File
654 * #	1985,88,90	Form46 File
1379	1984	Form46 File
1379	1985	Expense File
1139 *	1986,87,88,89,90	Expense File
899	1986	Form46 File
1009 *	1986,87,88,89,90	Form46 File
1644	1984,85	Form46 File
774 *	1987,88,89,90	Form46 File
1594	1983,84	Form46 File
1904 *	1987,88,89,90	Expense File
3159 *	1987,88,89,90	Expense File
1359	1983,84,85	Form46 File
589 *	1983,84,85,86	Expense File
759 *	1983,84,85,86,87,88	Form46 File
3564	1983	Form46 File

* These company groups were not used in the analysis.

654 also had a decrease in market share from 1.8% in 1983 to 0.2% in 1990.

Premium Percentage of Selected Companies

Year	(1) Calendar Year Earned Premium	(2) Percentage of Companies with At Least 0.5% Premium	(3) Percentage of Companies with At Least 0.5% Premium Omitted	(4) Percentage of Companies Used in Analysis
1983	3,277,279,155	91.7%	11.4%	80.3%
1984	3,826,038,150	92.5%	10.8%	81.8%
1985	4,048,432,421	95.0%	7.9%	87.1%
1986	4,755,551,659	95.5%	5.7%	89.8%
1987	6,017,002,271	95.8%	4.2%	91.6%
1988	7,184,442,063	94.2%	3.9%	90.3%
1989	7,766,338,235	92.2%	3.6%	88.6%
1990	8,329,828,192	90.4%	3.5%	86.8%
Total	45,204,912,146	93.4%	6.4%	87.0%

Notes:

Column (1) was obtained from Expense** Files.

Column (2) is the sum of those companies in Exhibit 3.1 with at least 0.5% share.

Column (3) is the sum of the "*" companies from Exhibit 3.2.

Column (4) = Column (3) - Column (2).

SECTION 2.0

ACTUARIAL REPORT REGARDING THE REVIEW PROCESS FOR WORKERS' COMPENSATION RATE FILINGS

SUMMARY I-1

SYNOPSIS OF ISSUES INVOLVED IN THE REVIEW OF WORKERS' COMPENSATION RATE FILINGS II-1

EXHIBITS AIS-1

ACTUARIAL REPORT REGARDING THE REVIEW PROCESS FOR WORKERS' COMPENSATION RATE FILINGS

JANUARY 24, 1992

Prepared by
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ACTUARIAL REPORT REGARDING THE REVIEW PROCESS FOR WORKERS' COMPENSATION RATE FILINGS

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Memorandum

Item	Section	Pages
Summary	I	1
Synopsis of Issues Involved in the Review of Workers' Compensation Rate Filings	II	1-10

ACTUARIAL REPORT REGARDING THE REVIEW PROCESS FOR WORKERS' COMPENSATION RATE FILINGS

Exhibits

Item	Exhibit Number
Responses to Survey Sent to State Insurance Departments	AIS-1, Sheets 1-8
Differences between Rate Level Requested and Approved	AIS-2
Aggregate Return on Net Worth 1985-1990 - by State	AIS-3, Sheets 1-2
Residual Market Share by State	AIS-4, Sheets 1-2
Return on Net Worth - Graph Comparing California to Countrywide	AIS-5
Countrywide Residual Market Share 1982-1990	AIS-6

ACTUARIAL REPORT REGARDING THE REVIEW PROCESS FOR WORKERS' COMPENSATION RATE FILINGS

I Summary

AIS Risk Consultants was retained by the California Workers' Compensation Rate Study Commission (WCRSC) to examine the review process for workers' compensation rate filings. In our review we have relied upon data and information supplied by the WCRSC, various regulatory agencies, workers' compensation rating bureaus and other generally accepted sources. While we used our overall knowledge and experience to assess the reasonableness of the information provided, we have not performed an independent audit of the information supplied. The information for this project was supposed to be obtained primarily from survey forms sent out to regulatory agencies and rating bureaus. The response to those surveys has, to date, been limited. We have therefore also relied upon other sources of information.

A total of nine State Insurance Departments have, to date, completed the survey form that was sent out. The responses received are summarized on a sample survey form, and are shown in Exhibit AIS-1.

Statistical measures which could be related to the degree of scrutiny workers' compensation rate filings receive were also examined. The items reviewed were: (1) difference between rate level requested and approved, (2) insurance company profitability and (3) residual market share. These data are shown in Exhibits AIS-2, AIS-3 and AIS-4, respectively. There is a significant variation between states for all three parameters.

For profitability and residual market share, the countrywide results during recent years are displayed in Exhibits AIS-5 and AIS-6, respectively.

Set forth below is a synopsis of the responses we received from the survey. We have also included comments based upon our experience in reviewing workers' compensation rate filings. This would include filings in the following states: Arkansas, Delaware, Florida, Maine, Massachusetts, New Jersey, North Carolina, Oklahoma, Rhode Island, South Carolina, Texas and Virginia.

II Synopsis of Issues Involved in the Review of Workers' Compensation Rate Filings

Does your Insurance Department analyze the following items in reviewing overall premium / loss cost changes proposed in Workers' Compensation filings?

(1) Loss and/or Premium Development

All nine of the Insurance Departments which responded indicated that this item was examined.

Loss development can be an issue since there are many different ways to project losses to an ultimate basis. The dominant methods used are development based upon: (a) paid losses, (b) case incurred losses, (c) total incurred losses excluding incurred but not reported (IBNR) and (d) total incurred losses including IBNR. In addition, there can be disagreements about (i) how many years of historical development should be used, (ii) whether to use an average or trended development factor and (iii) other considerations. Loss development methods are discussed in more detail in our report on ratemaking methodologies.

For premium development, the issues are more limited, as there is just one basic method that is employed. The only source of disagreement would be how the historical data is projected into the future.

Disagreements regarding loss development probably occur in somewhat less than 50% of reviewed filings. Premium development would be an issue in less than 10% of filings.

(2) Loss and/or Premium Trend

All nine of the Insurance Departments which responded indicated that this item was examined.

Each of the items regarding development could also be an issue for trend. This is because developed experience is used in the trend calculation. Other issues regarding trend are: (a) how much credibility to assign to a particular state's experience, (b) what alternate trend value to use if a state's trend data is less than 100% credible, (c) what standard to use for full credibility, (d) whether to use a linear or exponential projection and (e) other considerations.

Disagreements regarding trend can occur in somewhat more than 50% of filings.

(3) Underwriting Profit / Investment Income

Seven of the nine Insurance Departments which responded indicated that this item was examined.

The profit provision is almost always an issue for reviewed filings in states that allow rating bureaus to publish final rates (i.e., rates which include a provision

for losses, expenses and profit). In states where the rating bureau only determines a pure premium (i.e., no expense or profit provision), this may or may not be an issue depending upon how closely the Insurance Department analyzes individual insurance company rates.

The issues involved in analyzing the profit factor can be many. They would include the (a) cash flow patterns, (b) investment return on assets, (c) required cost of capital, (d) accounting system used, (e) treatment of dividends and deviations and (f) other considerations.

There is not usually a large disagreement regarding the first two issues.

For the third issue, the insurance industry usually recommends a cost of capital around 15% to 17% after tax. Regulatory agency recommendations have tended to be in the 12% to 14% after tax range.

Two possible accounting systems can be used. They are generally accepted accounting principles (GAAP) and statutory accounting principles (SAP). GAAP is used by most industries. SAP is used only for insurance companies. This accounting system is supposed to present a conservative view of an insurance company's net worth, by tending to undervalue assets and overstate liabilities. However, in reality, published SAP net worth figures are typically excessive when viewed in hindsight. The difference between using GAAP and SAP can mean a couple of points in rate level.

The major area of contention in the underwriting profit calculation has been the treatment of policyholder dividends and rate deviations. Insurance companies want to have these discounts built back into the manual rate level, so that all insureds pay for the cost of these programs (this is the manner in which policyholder dividends are treated in California). A number of Insurance Departments have not allowed this. They consider dividends and deviations to be competitive pricing devices, which should not impact the manual rate level. The difference between including and excluding dividends plus deviation in the manual rate level calculation can have up to a 10% to 15% influence on the manual rate level.

(4) Loss Adjustment Expenses

Eight of the nine Insurance Departments which responded indicated that this item was examined.

Three main issues arise in connection with the analysis of loss adjustment expenses. They are whether to use: (a) state specific vs. countrywide data, (b) accident year vs.

calendar year data, and (c) experience before or after reinsurance.

Depending upon how these issues are resolved, the difference in rate level can be in the range of 1% to 3%.

Disagreements regarding the treatment of loss adjustment expenses can occur in somewhat less than 50% of filings.

(5) Non-Tax Underwriting Expenses (e.g., Commissions & Brokerage, Other Acquisition Expenses, General Expenses and Premium Discount)

Eight of the nine Insurance Departments which responded indicated that this item was examined.

Three main issues arise in connection with the analysis of underwriting expenses. They are whether to use: (a) state specific vs. countrywide data, (b) the experience of all companies vs. the experience of a limited sub-group of companies (usually stock companies), and (c) an experience based or "budgetary" provision.

The NCCI prefers the use of countrywide data, a limited sub-group of companies and a "budgetary" provision. Many Insurance Departments take the exact opposite position on these issues.

The outcome of how underwriting expenses are handled can make a 2% to 4% difference in the rate level.

Disagreements regarding the treatment of underwriting expenses will occur in the vast majority of filings that are carefully analyzed.

(6) Miscellaneous Premium Tax Provisions

Eight of the nine Insurance Departments which responded indicated that this item was examined.

This provision covers social security and other payroll taxes, along with regulatory examination fees. The magnitude of the item is fairly small (usually 0.8% of premium). This is almost never an issue in a filing.

(7) Other Premium Tax Provisions

Seven of the nine Insurance Departments which responded indicated that this item was examined.

The level of state premium taxes is set by the legislature. This issue occasionally arises when insurers are allowed an offset to the premium tax payable contingent upon some other action, usually purchasing state securities. The area of contention is whether the statutory or actual tax rate should be used. This issue comes up in less than 10% of filings. It would usually have an impact of less than 1% of premium.

(8) Assessment Provisions

Seven of the nine Insurance Departments which responded indicated that this item was examined.

Assessments can be levied to provide for operations such as a second injury fund. The issue occasionally comes up as to whether these state mandated programs should be funded on an accrual or cash basis. This issue may arise in 10% to 20% of filings. Depending upon the size of the assessment, the treatment of this item can result in up to a 3% to 4% difference in rate level.

(9) Years and Types (e.g., policy vs. accident vs. calendar year, financial vs. unit statistical, etc.) of Experience Used

All nine of the Insurance Departments which responded indicated that this item was examined.

This is almost never an issue. When it does arise, depending upon the position taken, it can have a significant (e.g., 5%) impact on the rate level.

(10) Benefit Evaluation Factors

Eight of the nine Insurance Departments which responded indicated that this item was examined.

The methodology for evaluating "standard" benefit level issues such as changes in the rate of compensation, maximum / minimum weekly benefits, length of benefits, etc. are fairly well established, and only rarely does a disagreement arise involving the pricing.

In recent years, as various states have dealt with rapidly increasing workers' compensation costs, more complex benefit level changes have been enacted. These deal with items such as (a) limiting employee choice of physician, (b) state mandated safety programs, (c) benefit duration connected to maximum medical improvement, (d) changes in the administration of the workers' compensation system, (e)

medical cost containment, (f) limits on rehabilitation (g) compensability of given injuries and (h) compensation based on wage loss vs. degree of impairment. These types of changes are much more difficult to price. As a result, during recent years, in jurisdictions which have passed intricate workers' compensation law reforms, it is not unusual to see a 10% or more difference in the evaluation of the benefit change.

(11) Statistical Data Sources (e.g., Financial, Unit Statistical, Detailed Claim Information, Special Studies, etc.) Used

Seven of the nine Insurance Departments which responded indicated that this item was examined.

This is almost never an issue. When it does arise, depending upon the position taken, it can have a significant (e.g., 5%) impact on the rate level.

(12) How experience of State Fund, if any, is considered.

Arizona indicated that the experience of the state fund is treated the same as any other insurer.

In New York, state fund experience is excluded from the overall rate change (this has been the practice since at least the 1950's). It is, however, included in the analysis of classification relativities.

(13) Other items

Responses to this were that the prior year's filing was examined (Arizona) and the experience of the assigned risk program was considered (Virginia).

(14) Which role(s) does the Department of Insurance have regarding Workers' Compensation filings?

The Department of Insurance was (i) a Party To Case in 1 of 9 responses, (ii) the Decision Maker in 6 of 9 responses and (iii) Both Party To Case And Decision Maker in 2 of 9 responses.

A reason that Insurance Departments did not appear to be a party to the case more often, is that in many states rate filings are settled without a hearing. In those instances, there are no parties to the case.

(15) Please indicate the types of personnel used by the Department of Insurance in evaluating Workers' Compensation filings.

The most common type of personnel used are actuaries [9 responses], followed by underwriters [6], economists [3], statisticians [2] and accountants [1], rate analysts [1] and certified financial examiner [1].

Of the actuaries used, 3 were Fellows of the Casualty Actuarial Society (CAS) and 5 were Associates of the CAS. These responses could give the impression that Insurance Departments are generally well staffed with regard to actuarial skills. However, this conclusion would be somewhat incorrect. As of April 1991, only nineteen Insurance Departments had a member of the CAS as an employee. Of these, only four Insurance Departments had more than one CAS member on staff.

This raises the possibility that the responses received do not represent a random sample, but instead came from Insurance Departments with more highly skilled personnel in the field of casualty actuarial science. This possible bias could also mean that the answers given to the other questions are not representative of Insurance Departments in general. Instead, they could reflect the practices and views of Insurance Departments that are able to scrutinize rate filings more carefully.

(16) Does the Department of Insurance use employees or consultants to examine these filings?

Employees were used in 4 of 9 responses, both employees and consultants in 5 of 9 responses.

This is somewhat dissimilar to our experience, where consultants alone are often used to analyze filings. This may again reflect a bias in the responses towards more well staffed Insurance Departments. It could also represent ambiguity in the question regarding the type of employee who participated in the review.

(17) Have parties other than the filer and Department of Insurance been involved in the analysis of Workers' Compensation insurance filings?

Four responses indicated involvement by a party other than the Insurance Department or filer. The responses indicated the following entities were involved (with the number of responses in brackets): attorney general [3], public / consumer advocate [2], employer groups [3], employee groups [2] and individual insurance companies [4].

Our experience in various states indicates the following regarding participation in the rate review process.

State	Entities other than DOI and Filer That Have Participated in Review of Filing
Florida	State Consumer Advocate, Governor's Office
Maine	State Public Advocate, Maine AFL-CIO, Maine Chamber Commerce & Industry
Massachusetts	Associated Industries of Massachusetts
Oklahoma	Attorney General
Rhode Island	Attorney General
South Carolina	State Consumer Advocate
Texas	State Public Insurance Counsel
Virginia	Attorney General, Virginia Manufactures Association

(18) Do specific statutory and/or administrative time frames apply to the following steps taken in the processing of Workers' Compensation filings?
(A) Notice of hearing
(B) Submission of pre-filed testimony
(C) Start of hearing
(D) Length of hearing
(E) Regulator's decision on filing
(F) Other

Most states have some type of time frames which govern the processing of insurance rate filings. A totally indefinite time period in which to review filings could be construed to violate an insurer's due process rights and might be alleged to confiscate insurance company assets. However, the beginning of the time period in which to review a filing could be contingent upon some other event, such as the filing being considered complete. The Insurance Department could therefore have some control over the triggering event.

For a workers' compensation rate filing that is subjected to review, it can take about 3 to 6 months from the date of filing until the regulatory decision.

(19) Can rates / loss costs other than those approved by the regulator be implemented?

We know of only one state where a rate higher than that approved by the regulator can be implemented by insurers. In North Carolina, companies can charge a rate higher than that approved by the Insurance Commissioner. The difference is place in an escrow account while the regulatory decision is appealed to the courts. In North Carolina, almost every workers' compensation rate decision in at least the last 10 years has been appealed.

(20) Are there specific data and information which must be included in Workers' Compensation filings, either as a result of statutes, regulations, rules or other circumstances?

Both Maine and North Carolina have detailed requirements regarding the information which must be submitted with a rate filing. Having this information supplied with the filing assists in the review process, and also helps to eliminate some discovery disputes. Copies of the Maine statute and North Carolina regulation were included in our report on ratemaking data.

(21) Are there specific data and information which must be provided by the filer during the review process for Workers' Compensation filings, either as a result of statutes, regulations, rules or other circumstances?

Insurance Departments will normally have the authority to obtain all information necessary to analyze the filing. However, sometimes disputes arise regarding what information is needed. With statutory time frames running, Insurance Departments on occasion do not receive all the information requested. In order to limit disputes regarding data requests, it would be useful to have a statute or regulation setting forth the minimum information needed to review a filing.

(22) Are there any specific analytic procedures which must be followed regarding the calculations included with the filing (e.g., standard treatment of investment income)?

Most Insurance Departments have developed preferred procedures over time. For example, in Maine, a standard practice was adopted regarding how to treat the impact of the 1987 law change on loss development. Another illustration would be from Virginia, where a standard method is used to determine the loss adjustment expense provision. Virginia also uses a standard model to analyze investment income and

the underwriting profit. However, the value of the inputs into that model are subject to dispute.

An Insurance Department, however, cannot typically prevent a filer from proposing an alternate methodology.

(23) *Are there specific types of data (e.g., financial, unit statistical, detailed claim information, special studies, etc.) which the Department of Insurance has found useful in analyzing Workers' Compensation filings?*

Different types of information can be put to various uses. Financial data are used to examine the overall rate level. These data, however, do not provide much information regarding the underlying reasons for a particular rate indication. Unit statistical plan (USP) data are used to determine class relativities. Also, since USP information is broken down by (a) injury type, (b) medical vs. indemnity and (c) dollars of loss vs. number of claims, it can provide some indication as to why the rate level is changing (e.g., a large jump in permanent partial claims). Detailed claim information and special studies will provide more information as to why a particular rate level is indicated. They will also be useful in formulating proposals to change the workers' compensation benefit and administrative system.

CALIFORNIA WORKERS' COMPENSATION RATE STUDY COMMISSION

Questionnaire for State Insurance Departments

Insurance Departments Responding : Arizona, Georgia, Louisiana, Montana, Nebraska, South Carolina, Utah, Virginia and Wisconsin

Does your Insurance Department analyze the following items in reviewing overall premium / loss cost changes proposed in Workers' Compensation filings? For each issue that is reviewed, please explain in detail what type of review is made and provide a copy of the Department's most recent analysis of each such issue.

(1)	**Loss and/or Premium Development**	**Yes** 9	**No**
(2)	**Loss and/or Premium Trend**	**Yes** 9	**No**
(3)	**Underwriting Profit / Investment Income**	**Yes** 7	**No** 2
(4)	**Loss Adjustment Expenses**	**Yes** 8	**No** 1
(5)	**Non-Tax Underwriting Expenses (e.g., Commissions & Brokerage, Other Acquisition Expenses, General Expenses and Premium Discount)**	**Yes** 8	**No** 1
(6)	**Miscellaneous Premium Tax Provisions**	**Yes** 8	**No** 1
(7)	**Other Premium Tax Provisions**	**Yes** 7	**No** 2
(8)	**Assessment Provisions**	**Yes** 7	**No** 2
(9)	**Years and Types (e.g., policy vs. accident vs. calendar year, financial vs. unit statistical, etc.) of Experience Used**	**Yes** 9	**No**
(10)	**Benefit Evaluation Factors**	**Yes** 8	**No** 1
(11)	**Statistical Data Sources (e.g., Financial, Unit Statistical, Detailed Claim Information, Special Studies, etc.) Used**	**Yes** 7	**No** 2
(12)	**How experience of State Fund, if any, is considered.**	**Yes** 3	**No**
(13)	**Other items**	**Yes** 2	**No**

Arizona - State Fund's experience considered as any other insurer's would be considered.
Previous year's filing is used to compare.

Montana - NCCI filing components and independent filings reviewed for accuracy, reasonableness and compliance with Title 33, Chapter 16, MCA.

Virginia - Experience of assigned risk program.

(14) Which role(s) does the Department of Insurance have regarding Workers' Compensation filings?

(A) Party to case (i.e., presents testimony)	**1**
(B) Decision maker	**6**
(C) Both party to case and decision maker	**2**
(D) Other	

Arizona - ADOI may disapprove rate filing via a hearing, but it may also present testimony, etc.

Montana - Department reviews filings for compliance; identify areas of non-compliance (if any). Historically, questions have been resolved without formal hearings.

Nebraska - We decide yes or no on NCCI rate filing, no other parties are involved.

Utah - Utah law gives the Insurance Commissioner prior approval authority over NCCI work comp filings.

Virginia - The Bureau of Insurance makes its recommendation to a three-judge tribunal.

(15) Please indicate the types of personnel used by the Department of Insurance in evaluating Workers' Compensation filings.

(A) Actuaries	**9**
Fellows of Casualty Actuarial Society (FCAS)	**3**
Associates of Casualty Actuarial Society (ACAS)	**5**
Students in Casualty Actuarial Society	**2**
Fellows of Society of Actuaries (FSA)	**1**
Associates of Society of Actuaries (ASA)	
Students in Society of Actuaries	
Member of the American Academy of Actuaries (MAAA)	**2**

Other 2

Montana - On staff actuary since 4/90 (ACAS since 10/91).

South Carolina - Fellow of Conference of Actuaries

Utah - In recent years, hired a consulting actuary to review the filing (not the same actuary).

Wisconsin - Actuary in training, with several exams.

(B) Economists 3

South Carolina - Actuary handles

(C) Chartered Property Casualty Underwriters (CPCU) 6

(D) Accountants 1

(E) Statisticians 2

(F) Other 2

Arizona - All rate analysts have a background in math, economics, statistics, and in insurance ratemaking and rating policies.

Utah - CFE

(16) Does the Department of Insurance use employees or consultants to examine these filings?

(A) Employees 4

(B) Consultants _____

(C) Both 5

Arizona - At times the ADOI has used independent actuarial firms.

(17) Have parties other than the filer and Department of Insurance been involved in the analysis of Workers' Compensation insurance filings? **Yes** 4 **No** 4

If yes, please indicate which of the following entities have been involved.

(A) Attorney General's office 3

Arizona - Attorney General's office involved if we go to a hearing.

(B) Public / Consumer Advocate's office __2__

(C) Employer groups (e.g., manufacturing association) __3__

Louisiana - LA Assoc. of Business & Ind., Assoc. Gen. Contractors.

(D) Employee groups (e.g., AFL-CIO) __2__

Louisiana - AFL-CIO

(E) Individual insurance companies __4__

(F) Other _____

(G) Have these groups presented expert testimony concerning the technical aspects of the filing? Yes __4__ No __1__

(H) Has the participation of these groups been of assistance in evaluating filings? Yes __5__ No _____

Louisiana - Enables LIRC to hear from all parties.

Utah - All of these participate in the rate filing hearing

(18) Do specific statutory and/or administrative time frames apply to the following steps taken in the processing of Workers' Compensation filings?

(A) Notice of hearing Yes __5__ No __4__

Arizona - The ADOI has 15 days to disapprove filing. Notice and hearing must be conducted within that time frame.

Montana - Typically no hearing held.

South Carolina - Deemer provision.

Virginia - At least 30 days notice must be given

(B) Submission of pre-filed testimony Yes __2__ No __6__

Virginia - Set by order.

Wisconsin - Not testimony - actuarial indications / documentation.

(C) Start of hearing **Yes 3 No 4**

Louisiana - 10 day public notice.

Virginia - Set by order.

(D) Length of hearing **Yes ____ No 7**

(E) Regulator's decision on filing **Yes 6 No 2**

Louisiana - 30 days

Nebraska - 30 days after receipt, subject to 30 day extension, begins once all material requested has been received.

South Carolina - Set time following hearing.

Utah - Within a total of 30 days before the filing is effective.

Wisconsin - If Commissioner contests part or all of the request, informal negotiations are held to resolve issues. Informal negotiations are held to resolve issues. Rating bureau has never contested Commissioner's decision.

(F) Other **Yes 1 No 1**

Arizona - Grounds for disapproval must be in evidence. Grounds include that the rate is inadequate, excessive or unfairly discriminatory.

(19) Can rates / loss costs other than those approved by the regulator be implemented? **Yes 1 No 8**

Louisiana - If actuarially justified rates may be lowered & filing party has 14 days in which to accept amended filing or withdraw same.

Montana - All rates must be filed, with supporting data 33-16-203, MCA.

(20) Are there specific data and information which must be included in Workers' Compensation filings, either as a result of statutes, regulations, rules or other circumstances?

Yes __2__ **No** __7__

Montana - General considerations identified in 33-16-1004, MCA.

South Carolina - Loss costs must be justified with experience. Insurers with > 3% market share are required to have public hearing. Expenses & profit factors must be justified.

Utah - 31A-19-403 Utah Code

Virginia - Administrative letter 1991-4

(21) Are there specific data and information which must be provided by the filer during the review process for Workers' Compensation filings, either as a result of statutes, regulations, rules or other circumstances?

Yes __5__ **No** __3__

Arizona - The ADOI will require the filer to submit any information it believes is needed to justify and support the rate filing.

Montana - General: Supporting data sufficient to substantiate the filing. 33-16-203, MCA.

Utah - 31A-19-403 Utah Code

Virginia - Must respond to interrogatories.

Wisconsin - We have asked for greater documentation of investment income and internal rate of return analysis used by NCCI and applied to Wisconsin filing.

(22) Are there any specific analytic procedures which must be followed regarding the calculations included with the filing (e.g., standard treatment of investment income)?

Yes __3__ **No** __5__

Virginia - A computer based rate of return model is used

Wisconsin - As of this year we will be using an "agreed method" to develop and trend losses. This method will be reviewed annually and modified if on the basis of a consensus of experts on review committee.

(23) Are there specific types of data (e.g., financial, unit statistical, detailed claim information, special studies, etc.) which the Department of Insurance has found useful in analyzing Workers' Compensation filings?

Yes __5__ No __2__

Arizona - Additionally, we have used what other states may have required if, for example, the NCCI made a filing like that filed in Arizona in the other state.

Montana - NCCI pure premium exhibits, et al.

South Carolina - Varies with each analysis. NCCI requested to supply additional information on loss development, trend, reserves, investments, etc.

Virginia - Any and all of this information can be used as needed by our actuary.

(24) Which statutes govern the technical and procedural aspects for the review of Workers' Compensation rate filings?

Arizona - A.R.S. 20-341 through 20-374 and 20-400 through 20-400.09

Montana - None. Review methods are at the discretion of the Department.

Nebraska - Past - Chapter 44, Article 14, New - Chapter 44, Article 50

South Carolina - Casualty insurer rate filing approvals.

Utah - 31A -19 Part 4 Utah Code

Virginia - Chapter 20 of Title 38.2 and "Rules of Practice and Procedure" adopted by the State Corporation Commission.

(25) Which regulations govern the technical and procedural aspects for the review of Workers' Compensation rate filings?

Arizona - No regulations

Montana - None. Review methods are at the discretion of the Department.

Utah - No regulations

Wisconsin - None - Commissioner / staff discretion.

(26) Please fill out the enclosed table for each Workers' Compensation filing made in your jurisdiction from 1980 to the present.

(27) Is there any other information you can provide which would be useful in understanding how your jurisdiction evaluates Workers' Compensation filings - from both technical and procedural aspects?

Montana - Our rating laws our quite permissive.

(28) Are there rating plans and procedures available in your state which are used to encourage safety, especially on the part of small and medium sized insureds? If yes, please describe and provide a copy of these plans and procedures.

Arizona - Schedule and experience rating plans - standard NCCI plans.

Virginia - Yes - experience rating plans and the assigned risk adjustment program - standard NCCI plans.

WORKERS' COMPENSATION RATE CHANGES

State	Actual Effective Date		Cumulative Rate Change		Annual Rate Change		
	First	Last	Filed	Approved	Filed	Approved	Difference
Alabama	07/01/80	04/01/91	3.830	2.364	12.1%	7.6%	4.5%
Alaska	01/01/82	01/01/91	1.262	1.262	2.4%	2.4%	0.0%
Arizona	09/01/81	10/01/90	1.260	1.260	2.3%	2.3%	0.0%
Arkansas	04/01/81	03/01/91	2.228	1.351	7.6%	2.8%	4.8%
Colorado	07/01/81	06/01/90	3.068	3.068	12.0%	12.0%	0.0%
Connecticut	10/01/82	01/01/89	1.590	1.402	6.6%	4.8%	1.8%
CT (Voluntary)	01/01/90	01/01/91	1.004	0.920	0.2%	-4.1%	4.3%
CT (Assigned Risk)	01/01/90	01/01/91	1.583	1.210	25.8%	10.0%	15.8%
D.C.	12/01/79	01/01/87	1.039	0.811	0.5%	-2.6%	3.0%
D.C. (Voluntary)	01/01/88	04/01/91	1.078	0.986	1.8%	-0.3%	2.1%
D.C. (Assigned Risk)	01/01/88	04/01/91	1.483	1.105	9.7%	2.4%	7.3%
Florida	01/01/81	09/01/90	8.863	2.171	22.7%	7.5%	15.2%
GA (Voluntary)	01/01/82	07/01/90	2.389	2.349	9.6%	9.4%	0.2%
GA (Assigned Risk)	07/01/81	07/01/90	3.096	2.654	12.0%	10.2%	1.7%
Hawaii	01/01/79	10/01/89	4.673	1.586	14.0%	4.0%	10.0%
Idaho	01/01/81	01/01/91	1.723	1.561	5.1%	4.1%	0.9%
IL (Advisory)	01/01/83	01/01/91	1.825	1.825	6.9%	6.9%	0.0%
IL (Assigned Risk)	01/01/83	01/01/91	5.276	2.320	20.3%	9.8%	10.5%
IN (Voluntary)	08/01/81	01/01/91	2.275	2.257	8.2%	8.1%	0.1%
IN (Assigned Risk)	08/01/81	01/01/91	2.784	2.763	10.3%	10.2%	0.1%
Iowa	11/01/82	04/01/91	2.214	1.505	8.8%	4.4%	4.4%
Kansas	09/01/80	06/01/91	3.239	2.064	10.5%	6.4%	4.2%
Kentucky	07/15/80	07/01/89	1.652	1.398	5.2%	3.4%	1.7%
Louisiana	11/01/80	02/01/88	4.363	1.268	19.5%	2.9%	16.6%
Maine	03/02/81	08/01/85	2.383	1.250	17.4%	4.2%	13.2%
ME (Voluntary)	04/27/88	04/17/90	3.918	1.593	58.3%	16.9%	41.4%
ME (Assigned Risk)	06/26/87	04/17/90	5.604	2.080	57.2%	21.2%	36.0%
Maryland	01/01/79	01/01/87	2.718	1.816	11.7%	6.9%	4.9%
MI (OC-Placement Facility)	01/01/83	01/01/91	1.367	1.284	3.5%	2.8%	0.7%
MI (OC-Data Collection)	01/01/83	01/01/91	1.255	1.211	2.6%	2.1%	0.4%
Mississippi	01/01/80	06/01/90	3.231	2.205	10.8%	7.2%	3.6%
Missouri	10/01/80	09/01/91	3.676	2.783	11.5%	9.0%	2.6%
Montana	07/01/81	07/01/90	3.239	3.239	12.5%	12.5%	0.0%
Nebraska	09/01/80	11/01/88	2.065	1.676	8.2%	5.8%	2.4%
NE (Voluntary)	09/01/89	07/01/91	1.892	1.554	25.3%	16.8%	8.4%
NE (Assigned Risk)	09/01/89	07/01/91	1.892	1.554	25.3%	16.8%	8.4%
New Hampshire	04/01/82	09/01/91	3.374	1.949	12.4%	6.6%	5.8%
New Jersey	01/01/80	01/01/90	0.844	0.809	-1.5%	-1.9%	0.4%
New Mexico	01/01/80	10/01/87	2.723	1.932	12.1%	7.8%	4.3%
NM (Voluntary)	04/01/89	02/15/91	1.342	1.252	10.8%	8.1%	2.6%
NM (Assigned Risk)	06/01/89	01/01/91	2.017	1.347	31.2%	12.2%	19.0%
New York	07/01/80	07/01/91	2.913	1.518	9.3%	3.5%	5.8%
North Carolina	01/01/82	01/01/91	2.209	1.569	8.2%	4.6%	3.6%
Oklahoma	01/01/81	07/01/91	4.652	1.617	14.3%	4.3%	10.0%
OR (Assigned Risk)	07/01/82	01/01/91	2.891	2.306	11.8%	9.2%	2.6%
OR*	01/01/80	01/01/91	2.001	1.344	5.9%	2.5%	3.5%
RI (Voluntary)	05/01/80	06/22/89	6.769	2.006	20.7%	7.1%	13.6%
RI (Assigned Risk)	05/01/80	06/22/89	8.932	2.647	24.1%	10.1%	14.0%
RI (Advisory Loss Cost)	12/16/85	06/22/89	2.661	2.149	24.2%	18.4%	5.7%
South Carolina	02/01/80	02/06/88	3.648	1.822	15.4%	6.9%	8.6%
SC (Voluntary)	01/01/91	01/01/91	1.062	1.009	6.2%	0.9%	5.3%
SC (Assigned Risk)	07/01/90	07/01/90	1.214	1.122	21.4%	12.2%	9.2%
South Dakota	07/01/79	05/01/91	2.961	2.366	8.8%	6.9%	1.9%
SD (Assigned Risk)	02/01/89	05/01/91	2.115	1.519	26.0%	13.8%	12.2%
Tennessee	07/01/81	07/01/91	3.154	2.103	11.0%	7.0%	4.0%
Texas	02/01/81	01/01/91	10.090	3.720	23.6%	12.8%	10.8%
Utah	01/01/80	01/01/91	2.161	1.798	6.6%	5.0%	1.6%
Vermont	02/01/81	07/01/90	2.301	1.892	8.3%	6.3%	2.0%
Virginia	08/01/81	11/01/90	2.768	1.083	10.4%	0.8%	9.7%
Wisconsin	07/01/80	07/01/89	2.885	2.117	11.2%	7.8%	3.4%

* Voluntary until 6/30/82 with Open Competitive Rating Bill effective 7/01/82.

OC = Open Competition

WORKERS' COMPENSATION

Aggregate Return on Net Worth 1985-1990

State	1990 Earned Premiums (in 000's)	1985-1990 Workers' Compensation Return on Net Worth
Alabama	$425,342	-0.8%
Alaska	$191,809	18.5%
Arizona	$474,841	11.4%
Arkansas	$251,702	7.1%
California	$8,419,062	12.3%
Colorado	$637,707	-15.9%
Connecticut	$829,512	11.6%
Delaware	$106,682	21.1%
D.C.	$148,924	31.7%
Florida	$1,794,518	-6.5%
Georgia	$989,986	0.4%
Hawaii	$273,935	25.7%
Idaho	$158,533	9.1%
Illinois	$2,090,232	15.5%
Indiana	$515,146	7.5%
Iowa	$349,854	11.6%
Kansas	$293,635	5.9%
Kentucky	$386,323	14.6%
Louisiana	$551,562	-6.1%
Maine	$297,612	-18.6%
Maryland	$507,748	22.1%
Massachusetts	$1,353,091	-4.5%
Michigan	$1,094,351	14.2%
Minnesota	$716,322	13.5%
Mississippi	$262,144	2.6%
Missouri	$579,488	5.4%
Montana	$38,207	-4.1%
Nebraska	$169,853	6.9%
Nevada	$7,450	89.3%
New Hampshire	$212,333	7.8%
New Jersey	$1,033,386	14.1%
New Mexico	$212,805	-5.7%
New York	$1,564,907	18.7%
North Carolina	$557,950	1.4%
North Dakota	$3,140	95.9%
Ohio	$42,442	37.7%
Oklahoma	$246,089	7.7%
Oregon	$734,978	10.2%
Pennsylvania	$2,381,430	10.1%
Rhode Island	$220,672	-14.2%
South Carolina	$399,203	9.5%
South Dakota	$77,878	5.0%
Tennessee	$619,000	-0.4%
Texas	$4,073,819	-13.2%
Utah	$68,685	14.3%
Vermont	$88,819	8.0%
Virginia	$601,807	10.4%
Washington	$67,898	44.6%
West Virginia	$4,368	21.4%
Wisconsin	$874,756	14.3%
Wyoming	$2,914	58.0%
Countrywide	$38,008,871	7.3%

Source: Report on Profitability by Line by State 1990, NAIC, November 1991

Workers' Compensation
Aggregate Return on Net Worth 1985-1990

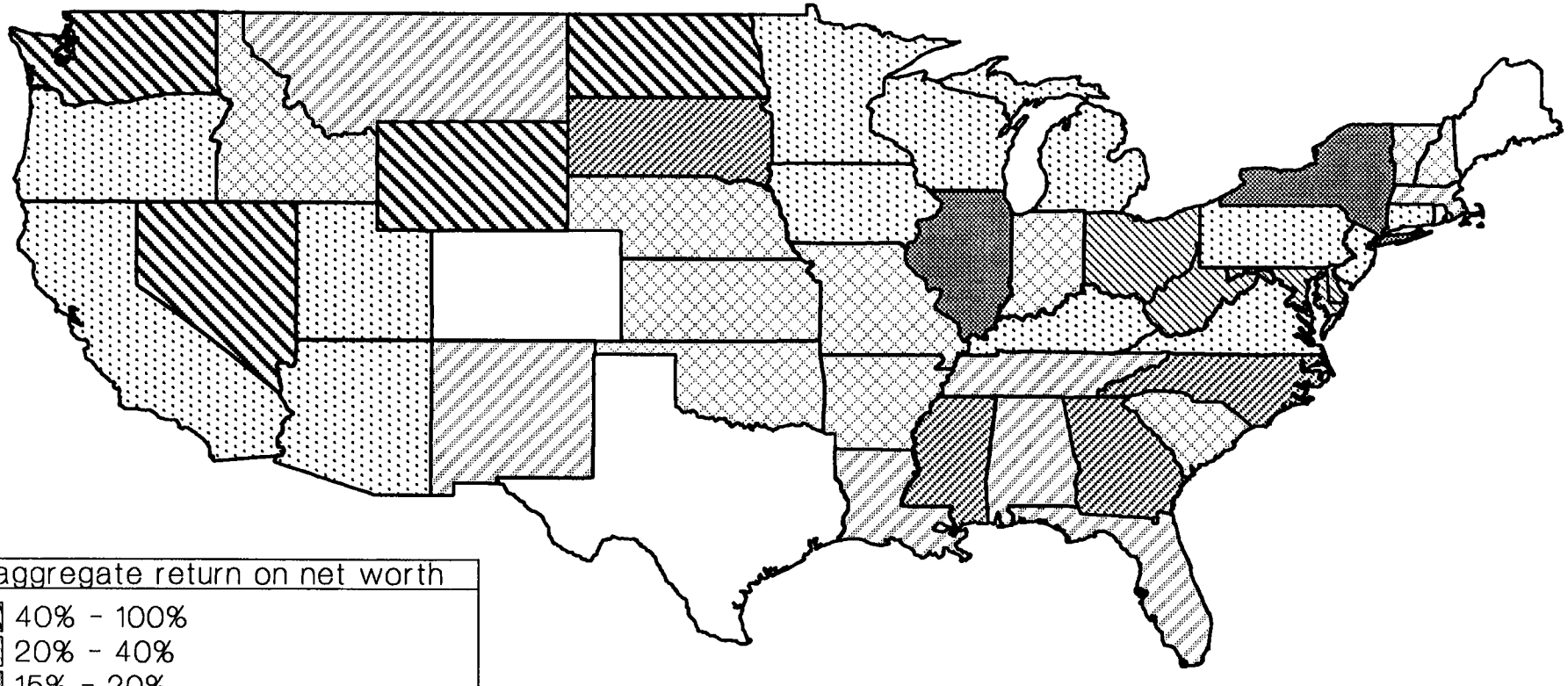
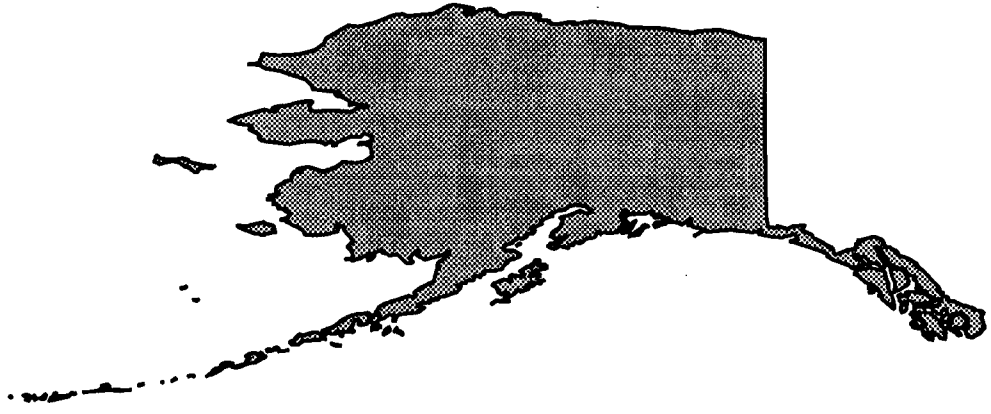


Exhibit AIS-3, Sheet 2a

Workers' Compensation AK & HI
Aggregate Return on Net Worth 1985-1990



aggregate return on net worth
40% - 100%
20% - 40%
15% - 20%
10% - 15%
5% - 10%
0% - 5%
-10% - 0%
-19% - -10%

Exhibit AIS-3, Sheet 2b

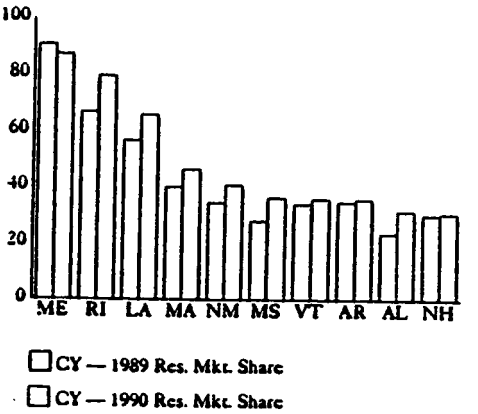
PERCENTAGE OF POOLS' REINSURED PREMIUMS TO NCCI-REPORTED DIRECT WORKERS COMPENSATION PREMIUMS WRITTEN RESIDUAL ARKET SHARE

State	1990	1989	1988	1987	1986
Alabama	31.6%	23.5%	22.5%	21.6%	18.4%
Alaska	15.0%	13.3%	15.1%	13.9%	15.9%
Arizona	3.1%	2.2%	1.7%	2.4%	2.2%
Arkansas	35.7%	34.7%	27.9%	26.5%	24.4%
*California	—	—	—	—	—
*Colorado	—	—	—	—	—
Connecticut	12.0%	12.7%	11.1%	12.0%	9.8%
Delaware	9.6%	7.3%	6.7%	6.7%	5.5%
District of Columbia	13.2%	10.3%	9.7%	10.1%	9.8%
Florida	23.4%	22.9%	21.0%	22.2%	17.7%
Georgia	19.5%	18.7%	16.2%	19.5%	16.7%
Hawaii	10.1%	10.4%	9.5%	8.9%	7.8%
**Idaho	—	—	—	—	—
Illinois	14.9%	15.1%	15.2%	17.8%	17.4%
Indiana	20.5%	20.0%	20.3%	22.6%	20.0%
Iowa	17.0%	17.2%	17.2%	16.5%	14.5%
Kansas	27.7%	24.1%	21.7%	24.5%	21.7%
Kentucky	25.3%	23.7%	21.1%	20.9%	15.4%
Louisiana	65.8%	56.7%	43.9%	36.5%	33.2%
Maine	87.1%	90.6%	82.3%	67.2%	54.6%
*Maryland	—	—	—	—	—
Massachusetts	46.3%	40.1%	29.5%	25.0%	20.4%
Michigan	10.7%	10.1%	10.6%	11.7%	10.5%
Mississippi	36.2%	28.0%	28.2%	25.7%	18.3%
Missouri	28.8%	26.5%	25.2%	25.1%	23.9%
*Montana	—	—	—	—	—
Nebraska	23.3%	23.4%	17.9%	17.2%	16.0%
New Hampshire	30.8%	30.3%	26.4%	30.3%	24.6%
New Jersey	10.0%	7.9%	9.6%	9.2%	8.1%
New Mexico	40.7%	34.4%	31.3%	30.2%	20.1%
North Carolina	19.4%	18.2%	16.2%	15.4%	12.6%
*Oklahoma	—	—	—	—	—
Oregon	9.8%	4.2%	3.3%	3.4%	3.6%
*Pennsylvania	—	—	—	—	—
Rhode Island	79.5%	66.8%	51.5%	44.4%	36.8%
South Carolina	25.6%	23.6%	20.9%	19.2%	16.5%
South Dakota	23.4%	30.2%	27.4%	25.2%	28.0%
Tennessee	27.2%	22.3%	23.3%	22.2%	19.2%
*Utah	—	—	—	—	—
Vermont	35.8%	34.0%	27.2%	29.8%	26.8%
Virginia	17.8%	14.3%	12.4%	11.6%	9.6%
*Washington	—	—	—	—	—
*Wyoming	—	—	—	—	—
Totals	**24.1%**	**22.0%**	**19.6%**	**19.0%**	**16.3%**

* In these states, pool reinsurance is available only for specific coverages not applicable under state assigned risk plans.
** Effective August 20, 1990, the state of Idaho developed a full, formal workers compensation insurance plan, reinsurable under the National Pool.

HIGHEST RESIDUAL MARKET SHARE STATES

(as % of Total Direct Written)



RESIDUAL MARKET SHARE — CALENDAR YEAR

(Percent)

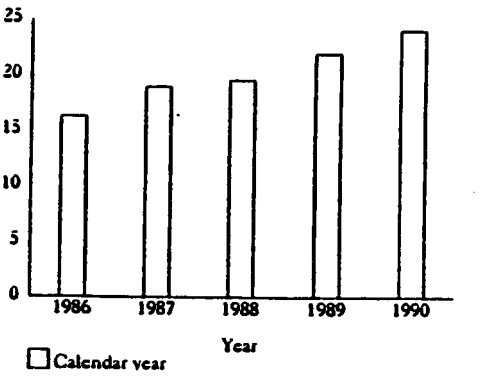
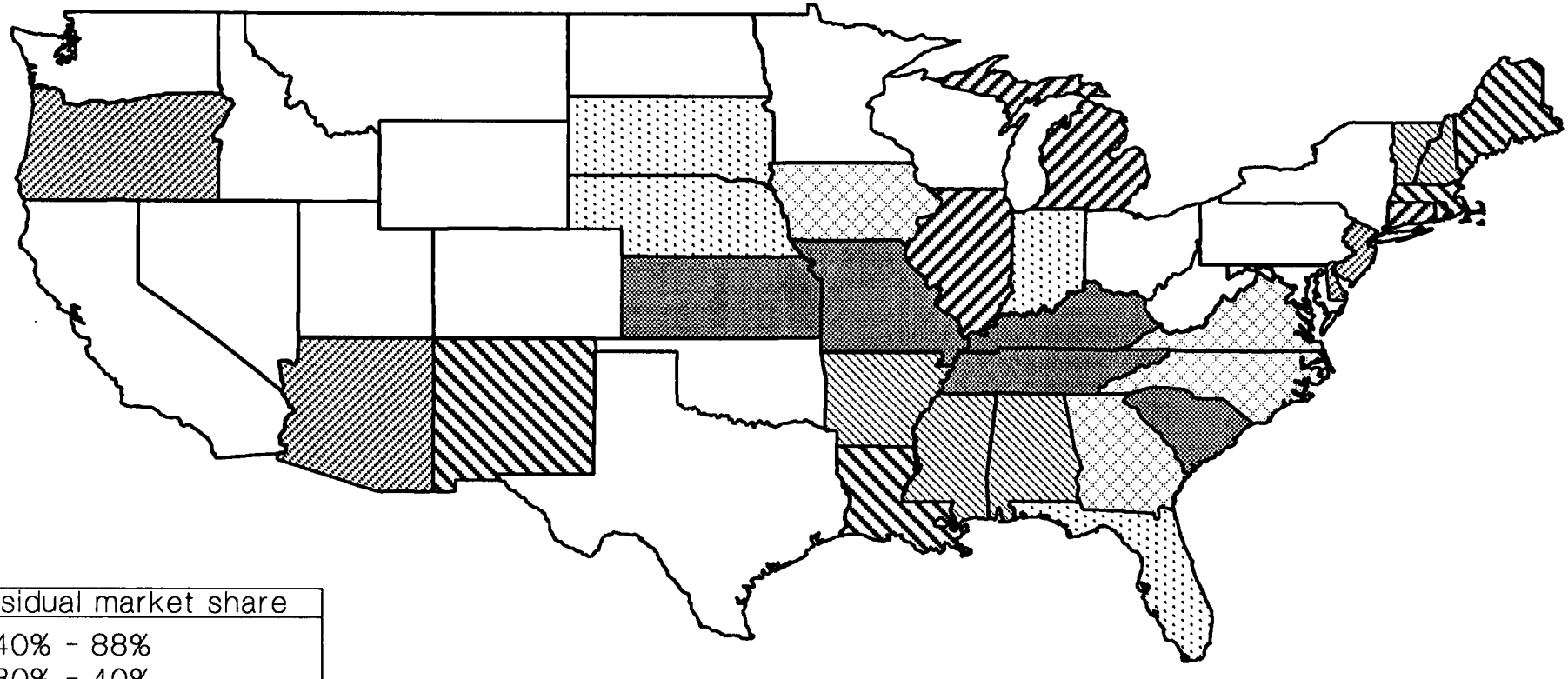


Exhibit AIS-4, Sheet 1

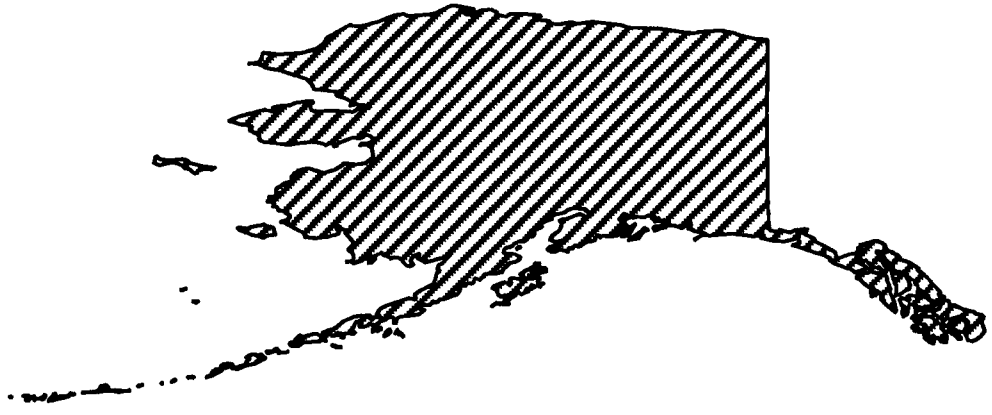
Workers' Compensation
1990 Residual Market Share



residual market share
- 40% - 88%
- 30% - 40%
- 25% - 30%
- 20% - 25%
- 15% - 20%
- 10% - 15%
- 3% - 10%
- Not Available

Exhibit AIS-4, Sheet 2a

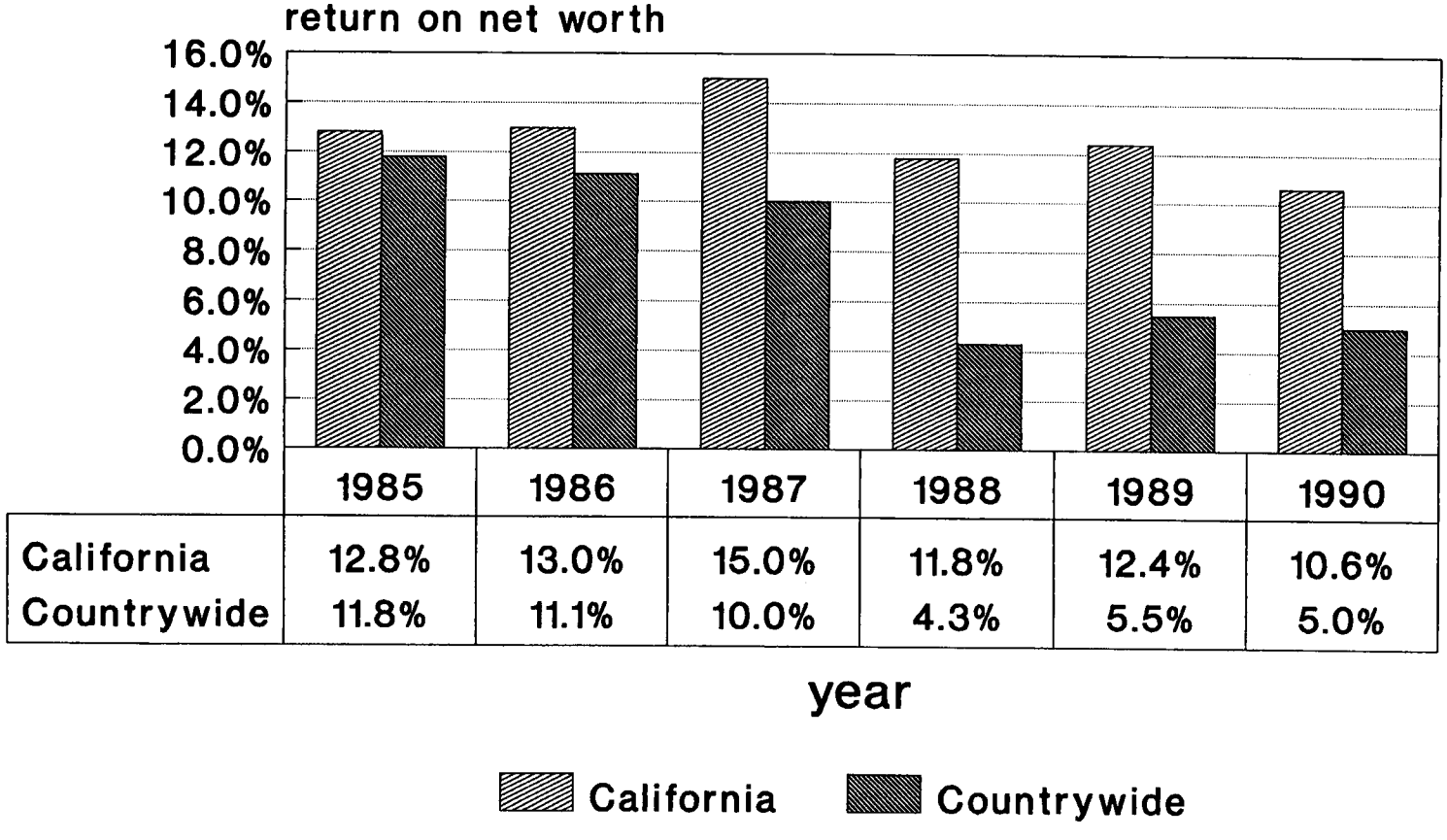
Workers' Compensation AK & HI
1990 Residual Market Share



residual market share
40% - 88%
30% - 40%
25% - 30%
20% - 25%
15% - 20%
10% - 15%
3% - 10%
Not Available

Exhibit AIS-4, Sheet 2b

Workers' Compensation
Return on Net Worth



	1985	1986	1987	1988	1989	1990
California	12.8%	13.0%	15.0%	11.8%	12.4%	10.6%
Countrywide	11.8%	11.1%	10.0%	4.3%	5.5%	5.0%

Source: Report on Profitability By Line By State 1990, NAIC, November 1991

EXHIBIT AIS-5

Countrywide Workers' Compensation
Residual Market Share

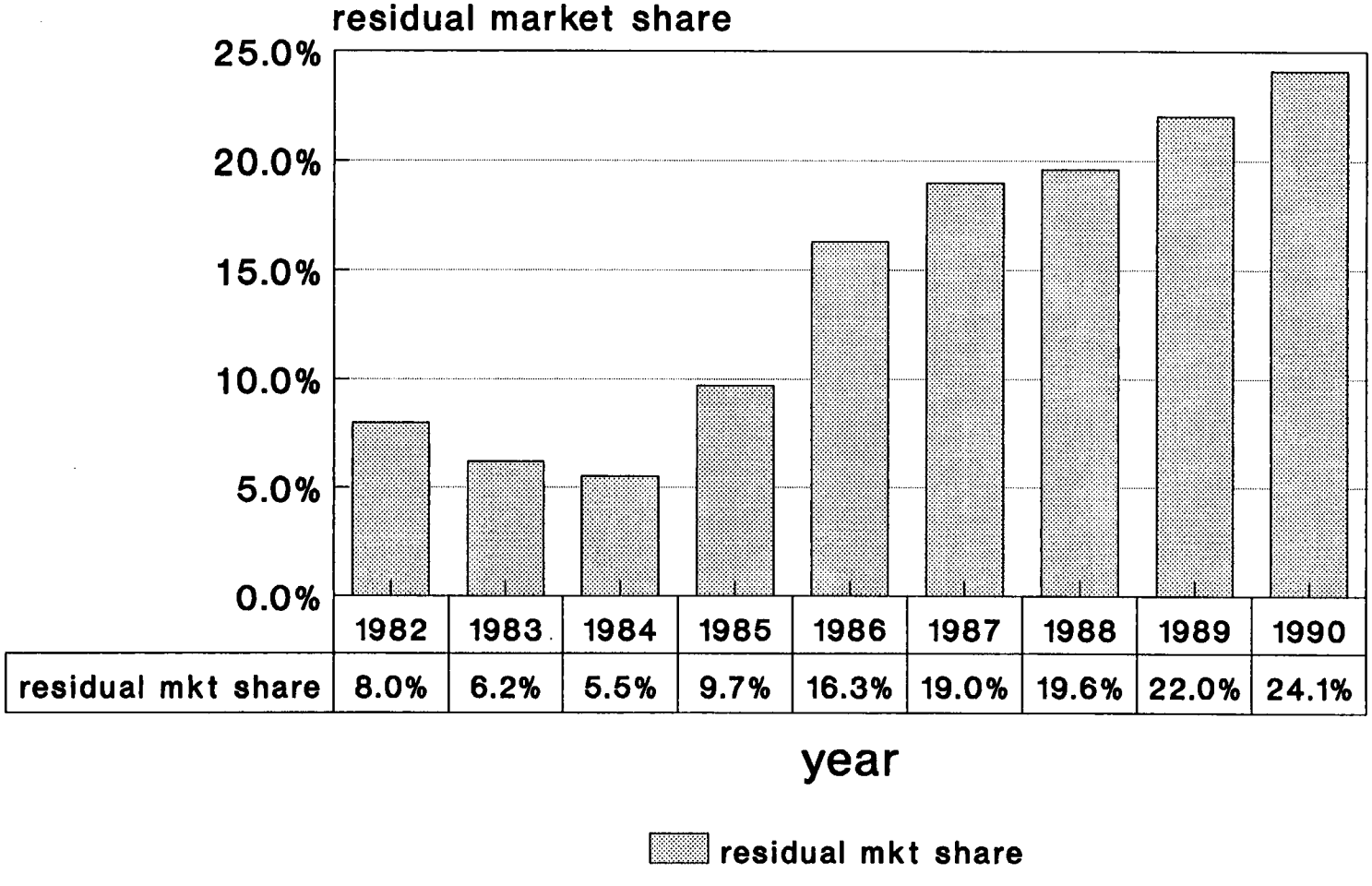


Exhibit AIS-6

SECTION 3.0

ACTUARIAL REPORT ON THE RATEMAKING DATA USED BY THE WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA

SUMMARY I-1

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
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MODEL REGULATION ..... Appendix B

ACTUARIAL REPORT ON THE RATEMAKING DATA USED BY THE WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA

January 14, 1992

Prepared by
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ACTUARIAL REPORT ON THE RATEMAKING DATA USED BY THE WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA

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Memorandum

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National Association of Insurance Commissioners Workers' Compensation Insurance Data Reporting Model Regulation	Appendix B

ACTUARIAL REPORT ON THE RATEMAKING DATA USED BY THE WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA

I Summary

AIS Risk Consultants was retained by the California Workers' Compensation Rate Study Commission (WCRSC) to review the ratemaking data used by the Workers' Compensation Insurance Rating Bureau of California (WCIRBC). Our review consisted of an examination of the data used (and collected) by the WCIRBC, including a comparison to the data used (and collected) in other jurisdictions. We have not evaluated the actual mechanics by which the WCIRBC obtains these data from member insurers and elsewhere. In our analysis we have relied upon data and information supplied by the WCIRBC, the WCRSC and other generally accepted sources. While we used our overall knowledge and experience to assess the reasonableness of the information provided, we have not performed an independent audit of the information supplied.

There are three main purposes for which data are used in workers' compensation ratemaking. These are (1) setting the overall rate level, (2) distributing the overall rate level to classifications and insureds, and (3) analyzing the reasons why costs are at a certain level.

Based upon our review, we have the following conclusions regarding the data collected by the WCIRBC.

(1) In the data calls for both accident and policy year information, the losses for indemnity and medical should be broken down between paid losses, case reserves, bulk reserves and IBNR reserves.

(2) In the data calls for both accident and policy year information, claim count as well as loss information should be collected. At a minimum, incurred indemnity claim count information should be obtained. If possible, the incurred claim count information should also be split between open and closed claims.

(3) The calendar experience call should be revised, or a new call developed, to deal with the issue of prior policy period audit premiums booked during the calendar year. This additional information is needed to properly match the premiums and losses used in the accident year experience analysis.

(4) Policy year development information should start to be collected on a quarterly basis. This will match the current procedure used for accident year data.

(5) In the data calls for both accident and policy year information, the WCIRBC should continue the past practice of collecting development data out to further maturities with each call.

(6) The WCIRBC collects detailed claim information through the use of individual claim reports (ICR). This is a somewhat different process than that used by the National Council on Compensation Insurance (NCCI) or the National Association of Insurance Commissioners (NAIC). The WCIRBC has attempted to tailor the ICR call to the particular situation in California. One area where consideration should be given to having the ICR call match the other calls is to collect information for additional time periods if the claim remains open.

II Data Used in Overall Rate Level Analysis

The premium, loss and expense information used to determine the overall rate level is referred to as financial data. These data provide the most recent information as to the revenues and costs for workers' compensation insurance. The tradeoff for obtaining the information as quickly as possible is that the data are in a highly aggregated form. Financial data are not broken down by classification, insured, benefit type or any other level of detail. Therefore, these data can not be used to determine the rate level needs for particular classes or insureds. However, another type of information (i.e., unit statistical data) is available for that purpose.

The financial data calls used by the WCIRBC are:[1]

1. Accident Year Call - This Call is issued quarterly and requires the reporting of accident year paid and incurred losses segregated between medical and indemnity. Loss information is valued as of the most recent quarter end. Updated information is requested beginning for accident year 1970. This information, which forms the basis of the loss data reflected in the Bureau's Rate Filing, is attested to annually by the independent auditor of each insurer who writes more than $3 million of annual premium in California.

2. Calendar Quarter Information - The Bureau issues a quarterly call for calendar quarter experience, which requires the filing of written and earned premium and paid, outstanding and incurred losses segregated between medical and indemnity. This data also is attested to annually by each insurer's independent

auditor and the premium amounts are reflected in the Bureau's Rate Filing.

3. Policy Year Call - A Policy Year Call is issued by the Bureau annually which requires the submission of policy year premiums and paid and incurred loss information. This data is used in certain special studies and in the reconciliation and testing of data from other Bureau calls.

4. Annual Expense Call - Annually, the Bureau issues a call for expenses incurred by calendar year for California workers' compensation insurance. This expense data, which is segregated into several categories, is the basis of the expense information that has historically been reflected in Bureau rate filings or, more recently, in Bureau Bulletins on historic California profitability.

With regard to the Accident Year Call, the information collected by the WCIRBC is in some ways more complete, and in other ways less complete, than the data collected by the NCCI in its accident year call.

The WCIRBC Accident Year Call is more complete in that it collects development information on a quarterly basis, whereas the NCCI call only collects annual development. In addition, the WCIRBC collects information much further out than the NCCI. In the WCIRBC filing for rates effective 1/1/92, loss development was available out to 246 months beyond the beginning of the accident year. In recent NCCI filings, accident year development went out only to 132 months beyond the beginning of the accident year.[2]

The WCIRBC Accident Year Call is less complete in that loss reserves excluding IBNR are not broken down into case reserve and bulk reserve components.[3] In addition, the IBNR reserve is not split between indemnity and medical. Also, no information regarding incurred indemnity claim counts are collected. All of these data elements are obtained by the NCCI.

We recommend that all the additional information collected by the NCCI accident year call be made a standard part of the WCIRBC Accident Year Call. The split of loss reserves between case and bulk is needed to perform alternative loss development projections. The same is true for the split of IBNR between indemnity and medical. Collecting claim count information will allow for the use of other loss development procedures and the testing of the different loss projection methods.

In addition, we believe an attempt should be made to go

beyond the current NCCI claim count information. Along with collecting incurred indemnity claim count information, the data should be split, if possible, between closed and open claim counts.[4]

The Calendar Quarter Call is used in the ratemaking process to obtain premium information to go along with the accident year losses. The NCCI collects calendar year premiums both in its accident year call and calendar year call. There is no need to obtain the same information from two separate calls. As long as the WCIRBC has controls to properly compile the calendar quarter premiums into a calendar year basis, there is no need to collect additional premium information.

As mentioned in the report on ratemaking procedures, in the accident year experience analysis preformed by the WCIRBC, the premiums do not match up exactly with the losses. This is the result of a portion of the current calendar year premiums being attributable to audits from prior policy periods. Hence, the premiums used do not match those actually charged by insurance companies to cover accidents during a particular year.

The calendar quarter call should be revised, or a new call developed, to deal with the issue of prior policy period audit premiums booked during the calendar year. This additional information is needed to properly match the premiums and losses used in the accident year experience analysis.

As part of our review of the WCIRBC ratemaking procedures, we recommended that policy year, as well as accident year data be used in examining the overall rate level. Therefore, the additional loss data recommended for the accident year call should be collected for the policy year call. This would include (i) a split of loss reserves between case and bulk, (ii) a split of IBNR reserves between indemnity and medical, and (iii) the collection of incurred indemnity claim count information, split between closed and open claims. In addition, policy year development should be obtained on a quarterly basis, as is currently the situation with accident year data.

It is important that loss development be available for as many individual maturities as possible. The WCIRBC is ahead of the NCCI in collecting data at the latter development maturities. We recommend that for both the accident and policy year calls, the WCIRBC continue to collect development data at latter development maturities. These data are important in performing projections of past experience to an ultimate basis.

III Data Used in Distributing the Overall Rate Level

The overall rate level is distributed down to individual insureds in a two step process. First, the overall rate level is distributed to the employer classification codes for California workers' compensation.[5] Second, the classification manual rates are modified for particular employers based upon that insured's own experience.[6] Unit statistical data are used in both of these calculations.

The analysis of rates for individual classifications is based upon between 2 and 5 years of unit statistical data. The larger the experience base of the classification, the less years of experience are used.[7] The analysis of individual classification experience is contained within the WCIRBC rate filing in the Pure Premium Review Sheets.[8]

For eligible policyholders, the classification rates can be further adjusted depending upon the insured's own experience. The rules and procedures for accomplishing this adjustment are contained in the California Experience Rating Plan Manual. An analysis of the experience rating plan is being performed by Milliman and Robertson.

IV Analyzing Underlying Reasons for a Given Cost Level

Financial aggregate and unit statistical data are aimed at answering the question of what the workers' compensation rate level should be in order to fund the system and produce equitable rates. These data cannot answer the question of why the losses are at a given level or how changing statutory benefits, eligibility, system administration, etc. will change the level of losses. In order to address these latter questions, more detailed information at the individual claim level is needed.

The WCIRBC collects these more detailed information in a number of different fashions. Three such sources used by the WCIRBC are (1) individual case reports, (2) call for vocational rehabilitation losses and (3) special claims studies.[9]

The most complete and comprehensive individual claim information collected by the WCIRBC is through individual case reports (ICR).[10]

Other than the WCIRBC individual case reports, two main alternative data collection mechanisms exist for obtaining individual claim information. These are the Detailed Claim Information (DCI) call used by the NCCI and the Workers' Compensation Insurance Data Reporting Model Regulation of the NAIC. As with the WCIRBC, the NCCI has recently expanded its

call for information at the individual claim level.[11]

The difference between the WCIRBC, NCCI and NAIC calls can be split down into a number of different categories.

First, the WCIRBC, NCCI and NAIC calls all collect somewhat different information. Although there is a great deal of overlap, the three calls do not collect all the same information.[12]

Second, the volume of claim reports is different for the three calls. The WCIRBC collects detailed claim information on all serious claims.[13] Both the NCCI and NAIC calls rely upon a sample of indemnity claims. A sample can be more cost effective than examining data for all claims. However, sampling limits the number of ways in which the data can be sub-divided. For example, to examine data by classification would require a much larger data base than examining data for all classes combined.[14]

Third, the length of time for which the data are collected differs. The WCIRBC will be collecting information up to 5.5 years after policy inception. The NCCI collects information until the claim is closed, up to nine years. The NAIC form calls for a claim information to be reported until closed or for eight years, whichever is longer. The WCIRBC may want to consider collecting information for a longer period of time than is currently required. Especially on serious claims, the status of the claim can change after many years.

Fourth is whom the data is collected from. The WCIRBC and NCCI collect information from insurance companies. The NAIC call also obtains information from self-insurers. If the purpose of the call is to obtain ratemaking information, then it makes sense to limit the call to insurance companies. However, if wider purposes such as evaluating the cost of the overall workers' compensation system, including self-insurers, or comparing the experience of insurance companies to self-insurers are intended, then also collecting data from self-insurers would be required. If data is to be collected from self-insurers, then a random sample survey form such as that used by the NCCI or NAIC would probably be preferable to the WCIRBC procedure of collecting information on every eligible claim.

The call for Vocational Rehabilitation Benefits by Accident Year collects financial aggregate information breaking the cost of benefits down between (1) vocational rehabilitation benefits, (2) other incurred indemnity and (3) incurred medical plus total IBNR. Given the size of, and concern with, vocational rehabilitation benefits, it makes sense to have a call like this which tracks on a recent basis

the fraction of all losses going towards vocational rehabilitation benefits.

The standard calls developed by the WCIRBC cannot anticipate every need for information that may arise. Because of this, special calls for information will be needed from time to time. Such calls have been issued when a special need has arisen.

The WCIRBC collects detailed claim information through a process somewhat different than the other two main alternatives. The WCIRBC has attempted to tailor the ICR call to the particular situation in California. One area where consideration should be given to having the ICR call match the other calls is to collect information for additional time periods if the claim remains open.

Footnotes

[1] Descriptions provided by the WCIRBC.

[2] In both WCIRBC and NCCI rate filings, a collective factor is used for development to ultimate beyond the latest available individual accident year information.

[3] In recent years, the WCIRBC has obtained a split between case and bulk reserves through a "Supplemental Call for California Workers' Compensation Experience by Accident Year".

[4] The NAIC examination of the NCCI recommended, "The collection of additional claims count data for use in diagnostic tests of loss development." The NCCI's response was, "NCCI agrees that this data would be useful as an additional diagnostic tool."

[5] Rates were given for 437 employer class codes in the January 1, 1991 California Workers' Compensation Insurance Manual.

[6] Not all policyholders are eligible for experience rating. A risk qualifies for the experience rating plan if it develops not less than $23,900 in premium by applying manual rates to the total renumeration that would be used in the rating calculation.

[7] This is an example of balancing stability and responsiveness in the rate level calculation. No more than 5 years of data are used in the rate calculation in order that the experience by responsive. No less than two years are used to add stability to the data. Within that range, more years are used for smaller classifications (to promote stability) and less years are used for larger classifications (to promote responsiveness).

[8] The detailed calculations used by the WCIRBC in deriving classification rates were not analyzed. This was not one of the projects for which we were retained.

[9] One example of a special claim study is a call for information on about 8,500 permanent disability claims per year from 1989 to 1993 in order to monitor the cost effect of the 1989 Reform Act. Another is a psychiatric claim survey.

[10] These are collected as part of the unit statistical plan.

[11] Beginning with January 1991 reported accidents on a voluntary basis and January 1992 reported accidents on a mandatory basis, the DCI will contain some 85 fields of information and will be collected in all NCCI jurisdictions.

Prior to this change, 54 fields of information were collected in 13 jurisdiction. At least part of the impetus for this change on the part of the NCCI was the NAIC model regulation.

[12] As part of its proposed revisions in the unit statistical plan proposed effective 1/1/93, the WCIRBC considered the data elements collected by the NCCI and NAIC. Each such element was considered and either accepted or rejected by the WCIRBC for use in the individual claim reports.

[13] These constitute all death and permanent disability claims, and all temporary disability claims with total incurred losses greater than $5,000.

[14] In the past, the WCIRBC has examined the information from the ICR on a class basis. Hence, for the purposes for which it is being used, collection of data on all claims makes sense.

NATIONAL COUNCIL ON COMPENSATION INSURANCE

CALL FOR DETAILED CLAIM INFORMATION

ADM. NO.

COMMON INFORMATION

INSURER NAME	1. CARRIER CODE	2. POLICY NUMBER

3. POLICY EFFECTIVE DATE	4. CLAIM NUMBER	5. REPORT TYPE	6. TRANSACTION CODE
– –			1 - Original Report 2 - Revised Report

7. STATE OF JURSIDICTION	8. STATE OF ACCIDENT	9. DATE REPORTED TO INSURER	10. EMPLOYEE SOCIAL SECURITY NUMBER
		– –	– –

CLAIMANT AND EMPLOYER INFORMATION

11. EMPLOYER FEDERAL TAX NUMBER	12. EMPLOYER SIC CODE	13. EMPLOYER PAYROLL 1 - $0 2 - $1 – $100,000 3 - $100,001 – $1,000,000 4 - $1,000,001 – $10,000,000 5 - OVER $10,000,000	14. ZIP CODE OF INJURY SITE	15. EMPLOYEE NAME LAST FIRST

16. SEX 1 - Male 2 - Female 3 - Unknown	17. MARITAL STATUS 1 - Single 3 - Separated 2 - Married 4 - Unknown	18. DATE OF BIRTH	19. DATE OF HIRE	20. OCC. CODE	21. EMPLOYMENT STATUS 1 - Regular Employee 2 - Part Time Employee 3 - Unemployed 4 - On Strike 5 - Disabled 6 - Retired 7 - Other
		– –	– –		

22. DATE OF INJURY	23. CLASS CODE	24. PART OF BODY	25. NATURE OF INJURY	26. CAUSE OF INJURY	27. LOSS COVERAGE CODE	28. NO. OF DEPENDENTS
– –						

29. PRE-INJURY WEEKLY WAGE	30. METHOD OF DETERMINING PRE-INJURY WAGE 1 - Actual 3 - Min. Wkly. Ben. 2 - Estimated 4 - Max. Wkly. Ben.	31. OTHER WEEKLY PAYMENTS	32. DATE REPORTED TO EMPLOYER	33. SURGERY 1 - YES 2 - NO	34. CLAIM STATUS 1 - Open 2 - Open (Med. Only) 3 - Reopened 4 - Closed 5 - Became Med. Only 6 - Reopened, Closed
			– –		

35. DATE OF CLOSING	36. DATE OF FIRST PAYMENT	37. DATE DISABILITY BEGAN	38. DATE OF RETURN TO WORK
– –	– –	– –	– –

BENEFITS AND PAYMENTS

INDEMNITY BENEFITS

39. TOTAL INCURRED (INCL. VOC. REH.)

40. BENEFIT TYPE	41. BENEFITS PAID TO DATE	42. WEEKLY BENEFIT
43. BENEFIT TYPE	44. BENEFITS PAID TO DATE	45. WEEKLY BENEFIT
46. BENEFIT TYPE	47. BENEFITS PAID TO DATE	48. WEEKLY BENEFIT
49. BENEFIT TYPE	50. BENEFITS PAID TO DATE	51. WEEKLY BENEFIT
52. BENEFIT TYPE	53. BENEFITS PAID TO DATE	54. WEEKLY BENEFIT

VOCATIONAL REHABILITATION

55. TOTAL INCURRED VOC. REH.
56. VOC. REH. EVALUATION EXPENSE PAID TO DATE
57. VOC. REH. MAINTENANCE BENEFIT PAID TO DATE
58. VOC. REH. EDUCATION EXPENSE PAID TO DATE
59. OTHER VOC. REH. EXPENSES PAID TO DATE

MEDICAL BENEFITS

60. TOTAL INCURRED MEDICAL
61. HOSPITAL COSTS PAID TO DATE
62. TOTAL PAYMENTS TO PHYSICIANS
63. OTHER MEDICAL PAID TO DATE

MISCELLANEOUS INFORMATION

64. POST INJURY WEEKLY WAGE	65. PERCENTAGE IMPAIRMENT	66. DATE OF MAXIMUM MEDICAL IMPROVEMENT
		– –

OTHER BENEFITS AND PAYMENTS

67. FUNERAL EXPENSES PAID TO DATE	68. LUMP SUM SETTLEMENT AMOUNT	69. EMPLOYERS LIABILITY PAID TO DATE

CLAIM ADMINISTRATION DETAILS

70. ATTORNEY OR AUTHOR. REP. 1 - YES 2 - NO	71. CONTROVERTED CASE 1 - YES 2 - NO	72. DEDUCTIBLE 1 - YES 2 - NO

SUBROGATION

73. PRODUCT LIABILITY	74. AUTO LIABILITY	75. OTHER

OTHER AMOUNTS PAID TO DATE

76. EMPLOYER LEGAL EXPENSE PAID TO DATE	77. CLAIMANT LEGAL EXPENSE PAID TO DATE	78. EXPERT WITNESS FEES PAID TO DATE	79. PENALTIES PAID TO DATE	80. ALLOCATED LOSS ADJUST. EXPENSE PAID TO DATE

BENEFIT OFFSETS

81. SOCIAL SECURITY 1 - YES 2 - NO	82. UNEMPLOYMENT 1 - YES 2 - NO	83. PENSION PLAN 1 - YES 2 - NO	84. SPECIAL FUND 1 - YES 2 - NO	85. OTHER 1 - YES 2 - NO

NC2590(0032g)

Appendix A

WORKERS' COMPENSATION INSURANCE DATA REPORTING MODEL REGULATION

Table of Contents

Section 1. Authority
Section 2. Purpose
Section 3. Definitions
Section 4. Powers and Duties
Section 5. Statistical Reporting
Section 6. Reporting Thresholds
Section 7. Exemption

Section 1. Authority

This regulation is promulgated pursuant to Sections [insert reference to sections authorizing the adoption of rules and regulations and the section in the statutes relating to financial and statistical reporting] regarding the reporting of financial and statistical data by insurance companies.

Section 2. Purpose

The purpose of this regulation is to enhance the ability of the Commissioner to determine the nature and sources of costs of the provision of workers' compensation benefits, insurance, and self insurance in this state by the establishment of standards relating to the manner of reporting and the kinds of data that are to be included in the statistical reports required to be gathered by workers' compensation insurers and self insurers. This regulation shall not be interpreted to limit the powers granted to the Commissioner by any laws or part of laws of this state.

Section 3. Definitions

For purposes of this regulation the following words shall have the following meanings:

A. "Basic Claim Survey" means an annual survey of randomly selected claims to provide detailed information on selected claims. Claim data is reported until closed or for eight years, whichever period is shorter.

B. "Statistical Agent" means an organization designated by the Commissioner to gather and compile insurance statistical experience.

C. "Statistical Plan" means a system for collecting and recording claim information.

Section 4. Powers and Duties

The Commissioner may enter into agreements with any qualified data collection service corporations, associations or other entities to undertake the compilation and analysis of data collected pursuant to this regulation.

Section 5. Statistical Reporting

Every insurance company, state fund and self insurer licensed to transact the business of workers' compensation insurance in this state shall report its statistical experience to at least one of the statistical agents designated by the Commissioner.

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A. Annual Data Reporting. At least annually, insurers, state funds and self insurers shall submit to surveys by a statistical agent. Upon inclusion in a survey, a particular claim shall be surveyed until closed or for eight years, whichever period is shorter. In order to prevent duplication of effort, any existing sources of data may be utilized provided that the source (e.g., statistical agents or the Workers' Compensation Commission) can attest to the validity and accuracy of the data it submits.

B. Basic Claim Survey. In accordance with statistical plans adopted by the Commissioner, the annual survey data shall include the following elements on each claim:

(1) Accident Information

(a) Employee Information

(i) Name
(ii) Social Security number
(iii) Date of birth
(iv) Sex
(v) Marital status
(vi) Occupation at time of injury (employee class code)
(vii) Employment status at time of report
(viii) Number of dependents*
(ix) Date of hire*

(b) Employer Information

(i) Federal tax identification number
(ii) SIC code*
(iii) Payroll

(c) Claims Administration Information (third party administrator, insurer, state fund, self-administered, other)

(i) Name of carrier
(ii) Insurer identification code number
(iii) Policy number
(iv) Policy effective date
(v) Deductible (yes/no)**

(d) Accident Severity

(i) Date of injury (accident date for traumatic injury, for all others last date of injurious exposure but if not determinable then last effective day of policy if there is one or date of first report if there is no policy)
(ii) Nature of injury***
(iii) Part of body affected***
(iv) Cause of injury or illness***
(v) Date disability began (date eligible for benefits)
(vi) Zip code of injury site
(vii) Source (this is a standard ANSI category but would not be included if NCCI codes are used)

(e) General Information

(i) Date reported to the employer
(ii) Date reported to insurer, third party administrator, or other
(iii) Date reported to the Compensation Commission
(iv) Jurisdiction (state or federal acts)
(v) Carrier claim number
(vi) Report type
(vii) Compensation Commission file number
(viii) Status at time of report (open, reopen, final, or refinal)

(2) Benefit Information

(a) Payment Information

(i) Weekly wage at time of injury
(ii) Other amounts (weekly) included in computing the compensation rate
(iii) Date of first indemnity payment
(iv) Date of closing
(v) Date employee returns to work

(b) Indemnity Payment Information

(i) Benefits paid to date by type
- Temporary total
- Temporary partial
- Permanent partial
- Scheduled
  - Non-scheduled
  - Disfigurement
- Permanent total
- Fatal benefits

(ii) Compensation rate by type (weekly compensation payment for each indemnity type at the time the report is completed, to be completed only where a specific type indemnity payment has been made)
(iii) Incurred indemnity benefits (paid plus reserves excluding vocational rehabilitation)
(iv) Funeral expense (burial benefit)
(v) Method of payment (lump sum, structured settlement)
(vi) Percentage of permanent impairment (where useful and authoritatively determined using American Medical Association standard)
(vii) Date of maximum medical improvement (where useful and authoritatively determined)

(c) Medical Benefit Information****

(i) Payments to physicians with description of services and identification
(ii) Payments to hospitals with description of services and identification
(iii) Other medical
- Drugs
- Prosthetic devices
- Custodial care

(iv) Incurred medical
(v) Days hospitalized
(vi) Doctor visits to date

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(d) Vocational Rehabilitation

(i) Vocational rehabilitation paid to date
- Evaluation expense
- Education/retraining expense
- Job placement expense
- All other expenses

(ii) Incurred vocational rehabilitation

(iii) Post rehabilitation weekly wage

(e) Other Benefit Information (paid amounts in dollars)

(i) Employers liability payments

(ii) Employers legal expense

(iii) Employees legal expense in addition to award

(iv) Expert witness fees

(v) Penalties

(f) Benefit Offsets (yes/no)

(i) - Social Security
- Disability
- Old age and retirement benefits

(ii) Unemployment compensation

(iii) Employer-provided pension benefits

(g) Benefit Recoveries (dollar amounts)*****

(i) Third party recoveries (subrogation)
- Product liability
- Automobile liability
- Other

(ii) Special fund recoveries
- Second injury
- Apportionment between carriers
- Apportionment for preexisting injury

(3) Attorney Involvement and Litigation*

(a) Involvement of Claimant's Attorney

(i) Attorney name

(ii) Attorney identification number

(iii) Date of attorney retention

(iv) Financial arrangement regarding fees

(b) Controverted Case Information (for each level of litigation including informal proceedings, formal proceedings, administrative and judicial review)

(i) Reason for controversy

(ii) Date notice of controversy filed

(iii) Date of award

(iv) Resolution

Notes:

* Include these elements if they are collected by the International Association of Industrial Accident Boards and Commissions (IAIABC) through the Basic Administrative Information System (BAIS).

** Deductible information should be provided simply as a yes/no. If amounts are required, a special survey can be done on those cases. Companies should convert to a system that provides reports including both gross and net of deductible.

*** If the IAIABC is to provide this information, ANSI codes should be used. If the information will come from National Council on Compensation Insurance (NCCI), then unistate codes should be used.

**** In order for this survey to provide the necessary data, standardized forms would have to be adopted. The most common forms in use today are the HCFA 1500 for physicians, the HCFA 1450 for hospitals, and the J510 for dentists.

***** Since payment reports are generally net, recoveries must be added to determine gross payments.

C. All paid data should be reported on a calendar year basis, tabulated annually from the date of injury.

D. All incurred values shall be valued annually with the first valuation occurring eighteen (18) months after the date of injury and annually thereafter unless another valuation schedule is approved by the Commissioner.

Section 6. Reporting Thresholds

The Commissioner may establish reporting thresholds for which reporting requirements of this regulation may apply.

Section 7. Exemption

Upon application by a statistical agent or an individual insurer or self insurer, the Commissioner may allow the submission of a report or statistical data at a specified later date if the submission of the report or data on the date required by this regulation would create substantial hardship on the statistical agent or insurer.

Section 8. Confidentiality

Any report of information relating to a particular claim shall be confidential and shall not be revealed by the Commissioner, except that the Commissioner may make compilations including this experience.

Section 9. Penalty

Failure to file the information required under this regulation and in accordance with a statistical plan adopted by the Commissioner shall result in a penalty of [insert amount].

Section 10. Effective Date

This regulation shall be effective [state effective date].

Legislative History (all references are to the Proceedings of the NAIC).

1990 Proc. I (adopted).

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SECTION 4.0

ACTUARIAL REPORT ON THE OVERALL RATEMAKING METHODOLOGY USED BY THE WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA

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ACTUARIAL REPORT ON THE OVERALL RATEMAKING METHODOLOGY USED BY THE WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA

January 14, 1992

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ACTUARIAL REPORT ON THE OVERALL RATEMAKING METHODOLOGY USED BY THE WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA

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ACTUARIAL REPORT ON THE OVERALL
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ACTUARIAL REPORT ON THE OVERALL RATEMAKING METHODOLOGY USED BY THE WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA

I Summary

AIS Risk Consultants was retained by the California Workers' Compensation Rate Study Commission (WCRSC) to review the overall rate level procedures used by the Workers' Compensation Insurance Rating Bureau of California (WCIRBC). Our review consisted of an examination of the overall procedures used by the WCIRBC, including a comparison to the methodologies used in other jurisdictions. We have not made an analysis as to whether or not the application of these overall methods in any particular California workers' compensation rate filing has led to appropriate rate level indications. In our analysis, we have relied upon data and information supplied by the WCRSC, the WCIRBC and other generally accepted sources. While we used our overall knowledge and experience to assess the reasonableness of the information provided, we have not performed an independent audit of the information supplied.

The overall conceptual basis for insurance ratemaking is very simple. The basic equation, which is set forth in Exhibit AIS-1, is that the income and outgo from the insurance operations should be equal. Both the income and the outgo need to be adjusted to the prospective basis that is expected to exist during the future rate period. Sources of income and outgo for the property/casualty insurance industry are set forth in Exhibits AIS-2 and AIS-3, respectively. Keeping this overall goal in mind assists in retaining a complete perspective on the ratemaking process while examining various details.

The ratemaking process of forecasting the prospective outgo can be conceptually broken down into a number of steps. These are (1) analyzing historical experience to determine the final cost of past losses, (2) projecting the cost of past experience losses to the prospective rate level period, (3) adjusting the losses for any benefit level changes, (4) adding a provision for expenses, (5) adding a provision for profit (net of investment income) and (6) giving consideration to dividends. Prospective income is forecasted by (a) analyzing historical experience to determine the final value of prior premiums and (b) projecting the value of past premiums to the current rate level.

A simple comparison of the projected costs for the rate period with the income expected at the current rate level will determine whether rates need to increase (cost > revenue), stay the same (cost = revenue), or decrease (cost <

revenue).

Based upon our review of these items, which is set forth in more detail in the following sections, we have the following recommendations:

Analysis of Historical Loss Experience

(1) Future rate filings should include an analysis of policy year as well as accident year experience. The current procedure only uses accident year data.

(2) Future rate filings should include an analysis of historical loss development based upon paid losses, case incurred losses, incurred losses excluding IBNR and total incurred losses. The current procedure uses only incurred losses excluding IBNR.

(3) Future rate filings should more fully explain the basis for the selection of loss development factors by period.

(4) Consideration should be given to selecting loss development factors based upon a simple rule (e.g., average of the last two indications). This would serve as a check against the loss development factors selected by the WCIRBC on a judgmental basis.

(5) The current procedure of not giving full weight to the State Fund experience is appropriate.

(6) Consideration should also be given to lowering the State Fund's loss ratio as well as its market share in the rate level calculation. By using the overall State Fund loss ratio, the "residual market type" business within the State Fund is still being taken into account to some degree.

(7) An attempt should be made to more carefully split the business of the State Fund into its "competitive" and "assigned risk" components. This will allow for a more precise way of handling the higher loss ratios developed by the State Fund.

Projecting Experience Period Losses to Rate Level Period

(8) In the double exponential smoothing model used for trending, the parameters employed should be based upon optimizing the fitted values to the actual historical data. The current procedure is to

pre-select the smoothing parameter.

(9) The trend projection period should take into account the fact that polices are not issued uniformly throughout the year. The current procedure assumes a uniform distribution, and this can lead to a higher than needed rate level.

(10) The WCIRBC should examine the possibility of using an exponential trend model for future filings. Even if such a model is not used for the rate level indication, the results may want to be presented to compare them to the current linear model being used.

(11) Future rate filings should show the results of applying the NCCI trend model. This will serve as a check of the results from the WCIRBC model.

(12) The WCIRBC should work on developing models which explain changes in costs over time. The current trend model used is a time series analysis.

Benefit Level Changes

(13) The details of the benefit level analysis in past rate filings were not well documented and many intermediate calculations were not presented. Future filings should include a more detailed explanation of the benefit level analysis.

(14) Some of the statistics and parameters used in the analysis appeared to be quite old. An attempt should be made to keep the underlying statistics as current as possible.

Expenses

(15) Loss adjustment expenses should be analyzed based upon a fraction of losses. Currently, loss adjustment expenses are based upon a percentage of premium. The change should be made because loss adjustment expenses are more closely related to losses than to premiums.

(16) The provision for other underwriting expenses (i.e., commissions & brokerage, other acquisition expenses and general expenses) should be set on the basis of stock and non-stock company experience combined. The current procedure is to rely only upon stock company experience. Stock company other

underwriting expenses are about 5% to 7% higher than those for non-stock companies. This may, depending upon legal interpretation, require a change in Article 2 (State Rate Supervision), Section 11732.

(17) A mandatory premium discount schedule should be adopted to reflect expense differences by size of risk. The current procedure is that insurers may return these expense savings to policyholders in the form of dividends. However, there is no guarantee that the expense savings will be returned, or that there will not be unfair discrimination in the way policyholders with different insurers are treated. This will require a modification of Article 2 (State Rate Supervision), Section 11732.4

Investment Income

(18) Future rate filings by the WCIRBC should give greater attention to the impact of investment income. While the WCIRBC filing does appear to take investment income into account, their model is so basic, simple and undocumented that we believe it is inadequate for the purpose of setting a rate level. In the context of this report, we are not recommending any specific model. Several generally accepted models exist. The choice of the parameters for implementing a model are typically more important than the particular model used.

Policyholder Dividends

(19) Policyholder dividends should not automatically be treated as a direct pass through in the manual ratemaking process.

(20) Any safety incentives and equity considerations from a voluntary policyholder dividend program may be improved upon by a mandatory one-way retrospective rating plan.

Analysis of Premium Income

(21) Future rate filings should adjust for the mismatch between accident year premiums and losses caused by the accounting treatment of audit premiums.

(22) The rate filings prepared by the WCIRBC, as presented to the California Department of Insurance, are not well documented. Either through legislation or regulation, more detailed filing requirements should be implemented. This will allow parties other than the WCIRBC to more fully understand the basis for any rate change.

II **Analysis of Historical Loss Experience**

There are numerous subitems regarding the issue of historical loss experience. These are (1) how experience is to be grouped, (2) which loss categories to include, (3) how to determine the ultimate cost for historical periods, (4) how many years of prior experience to use and (5) which companies to use.

Experience Grouping

Insurance loss data are typically organized into four different possible combinations for ratemaking, depending upon the characteristics of the lines of insurance being examined. A description of these data groupings is given in Exhibit AIS-4, Sheets 1 and 2. For workers' compensation, the two types of data organization normally used are accident year and policy year data.

Accident year data tracks the loss experience which results from the accidents that occur in a particular year. The premium for an accident year is an accounting entry, which tries to match income with outgo. For workers' compensation, the correspondence between premiums and losses is not exact. This mismatch can cause distortions in the rate level indications (this will be discussed in more detail later in this report). These loss data provide the most recent experience for a particular group of claims, and are considered to be the most responsive experience for the liability lines of coverage.[1] Tied to containing the most responsive data, accident year experience also contains the highest level of reserves and the smallest level of actual payments. As a result of this, the rate level indications from accident year data are the most variable.[2]

Policy year data tracks the loss experience which results from the accidents that are covered by insurance policies which are issued during a particular year. Policy year premiums are those charged to the same group of policies. As such, there is an exact match between the premiums and losses for a policy year. Policy year 'X' data take longer to report than accident year 'X' data.[3] Hence,

the experience is less responsiveness to the most recent conditions.[4] Of course, this means that a greater portion of the losses are actually paid, less is in reserves, and the rate level indications will be subject to less variability.[5]

At various points in the ratemaking process, actuaries attempt to balance the two conflicting objectives of responsiveness and stability. It is desirable to have the historical experience be as representative as possible to the conditions expected to prevail during the rating period (i.e. responsiveness). On the other hand, sufficient experience needs to be used such that the indications are not subject to excessive random fluctuations (i.e., stability).

For workers' compensation ratemaking, the most common[6] historical data used are one policy year and one accident year. There is a general belief that this provides a reasonable balance between responsiveness and stability.

The WCIRBC uses only accident year data in its ratemaking analysis.[7] It cannot definitely be said that it is improper to rely only upon accident year data.[8] However, this method is contrary to the procedures used in most other jurisdictions.[9]

We recommend that the WCIRBC include in future rate level analyses a projection based upon policy year experience. This would at the very least provide a check of the reasonableness of the accident year analysis.

Loss Categories to Include in Historical Experience

The losses reported by insurance companies for workers' compensation fall into four categories. These are (1) paid losses, (2) case reserves, (3) bulk reserves and (4) incurred but not reported (IBNR) reserves.

Paid losses consist of the actual payments made by insurers. These amounts are known with exact certainty. Case reserves are established on an individual claim-by-claim basis. They represent claim adjusters' valuation of the future payments to be made on individual claims. Bulk reserves constitute an aggregate adjustment made to a group of particular claims. This can include a provision for the difference between the sum of claim adjusters' case reserve estimates and the value of the total case reserves established on an aggregate financial basis. IBNR reserves are set up to cover the cost of claims that have not yet been reported to the insurance company, but for which the insurer believes it will be responsible. These reserves are established based upon statistical analyses.

An illustration of this breakdown of total losses into

these four categories is presented in Exhibit AIS-5. As each layer of loss is added, the size of the data base increases. However, each additional stratum of losses carries with it the possibility for decreasing reliability. Paid losses are known exactly. Case reserves are based upon information for particular claims. Bulk reserves are based upon information regarding claims that have already been reported to the insurer. IBNR reserves are provision for claims which the insurer does not yet know of, and are projected using statistical methods.

Case reserve adequacy is subject to cycles based upon economic and other conditions. This is also true of bulk and IBNR reserves. However, the later two types of reserves are financial accounting entries. As such, they are subject to insurance company management discretion for reasons other than setting an appropriate reserve level.[10]

The combination of paid losses plus case reserves is referred to as case incurred losses. Adding bulk reserves gives incurred losses excluding IBNR. Increasing this for IBNR gives total incurred losses. These equations are:

Case Incurred = Paid + Case Reserves

Incurred Excluding IBNR = Case Incurred + Bulk Reserves

Total Incurred = Incurred Excluding IBNR + IBNR Reserves

A distribution of losses by paid, case incurred, incurred excluding IBNR (case & bulk) and total incurred is set forth in Exhibit AIS-6, Sheets 1 to 4. This shows the information by policy year, indemnity vs. medical and by development maturity for workers' compensation.[11]

For ratemaking purposes, the WCIRBC uses incurred losses excluding IBNR. The regular accident year ratemaking call for accident year experience provides information on paid losses, loss reserves excluding IBNR (= case & bulk reserves) and IBNR.[12] Bulk reserves are collected through a supplemental call.

The NCCI has at various times used paid losses, case incurred losses, incurred losses excluding IBNR and total incurred losses in the historical data base. The NCCI's decision regarding which method to use in a particular rate filing is based upon an analysis of the circumstances in that particular case. At one time, the NCCI relied mainly upon total incurred development. The more recent practice has been to use paid development in the majority of instances, with the other three data bases being used about equally.

The proper data base to use may vary from filing to

filing based upon the particular circumstances that exist. The rate indications can vary substantially depending upon the loss data base used. An illustration of this is set forth in Exhibit AIS-7. This shows a range of rate level indications based upon the data base used of about 15%. This range, and even larger ones, are not uncommon.

We recommend that the WCIRBC include in future rate level analyses a projection of historical experience using each of these four data bases. By using different data sources, the various indications can be checked against one another and any anomalies could be explored in further detail. By using only one data base, there is no readily apparent way of determining if there is anything abnormal or unusual in the data being relied upon.

Determining the Ultimate Losses for Historical Periods

Once a data base is selected, that experience needs to be projected to an ultimate basis.[13] This is accomplished through a process called development. Conceptually, development is a very simple process. Set forth below is the formulation of the development method of analyzing experience.

Let:

L = Losses (either paid, case incurred, incurred excluding IBNR or total incurred) that are reported at the evaluation date

P = Percent of ultimate cost anticipated to have been reported at a given evaluation date

D = Development factor to ultimate = 1 / P

U_{DM} = Ultimate cost derived from the development method

Then:

$U_{DM} = L / P = L * D$

The key item in the development method is estimating the development factor.

Let:

L_J = Losses at evaluation date (J)

D_J = Development factor from evaluation date (J) to evaluation date (J+1)

Then:

$$D_J = L_{J+1} / L_J$$

$$D = \prod_{J}^{\infty} D_J$$

The D_J are estimated based upon an examination of the historical development factors. In the WCIRBC's most recent filing, historical development is displayed in Exhibit 4 for private carriers and Exhibit 13 for the State Fund.[14]

The NCCI typically uses the average of the latest two historical development factors at each evaluation date.

The WCIRBC uses different procedures for various evaluation dates. In the most recent filing, the following procedures were employed for private carrier indemnity losses. For the 18 to 30 month development factor, a double exponential smoothing model was used. For the 30 to 42 month factor, a selection was made, "... to reflect the upturn in the loss development cycle". For the 42 to 54 month factor, the latest historical observation was used. For each period from 54 months until 246 months, the average of the last three historical development factors was used. From 246 months to ultimate, the indicated development factor was reduced by 58%, "To adjust for non-repeating asbestosis claim pattern in old accident years..." For private carrier medical development, essentially the same procedure was used. For the State Fund, a somewhat different combination of procedures was selected. The most current State Fund experience was in general given more weight than was the case for private carriers. This was presumably done to reflect recent changes in the State Fund's operations.

The historical loss development from the most recent WCIRBC filing is set forth in Exhibit AIS-8, Sheets 1 to 4. This shows development for both private carriers and the State Fund, split between indemnity and medical losses. Also shown are the averages of the historical development factors taken in different ways, and the loss development factors selected by the WCIRBC. The selected factors fall within the range of the various historical average factors.

This mix of different procedures used by the WCIRBC may give the most accurate indication. However, it can also give the impression of selecting development factors in a way to influence the final rate level indication.

We believe that it would be useful to develop a standard method for selecting loss development factors. This could be

the use of the most recent two historical indications, as is done by the NCCI. Then, any variations from this standard method could be quantified. In addition, it would be useful for the WCIRBC to perform a retrospective analysis of the procedures it has employed. This would help in determining if the various development selection rules used by the WCIRBC have made for better predictions of future loss development. If not, it may be preferable to use a simple selection rule. Of course, we would not want to imply that loss development analysis can be boiled down into a simple mechanical process. There will always be the need to use some degree of judgment.

Years of Prior Experience

The filing by the WCIRBC for rates effective January 1, 1992 used 21 years of historic experience, covering the time period from accident year 1970 to 1990. This is used as both an experience and a trend period. Through the use of exponential smoothing, the more recent years receive a larger weight than the earlier years.

The NCCI uses two years of historical data for an experience period[15], and five years of historic trend data. Hence, the NCCI procedure would at first appear to be more responsive to current conditions than the WCIRBC procedure.

However, the WCIRBC relies only upon accident year data, whereas the NCCI relies more heavily on policy year data. In addition, the NCCI procedure weights each year of experience equally. By contrast, the WCIRBC, through the use of exponential smoothing, gives more weight to the more recent experience. In addition, the WCIRBC collects accident year data at quarterly developments, whereas the NCCI collects development only on an annual basis. Hence, the WCIRBC development data is more recent.[16]

It cannot be said that either the WCIRBC or NCCI procedure with regard to the number of year of experience to use is inherently better. The predictions from each model will depend upon the parameters selected, as well as other components of the ratemaking formula.

Companies to use in Experience Base

In recent years, one of the key issues in the WCIRBC rate filing has been how to treat the experience of the State Fund. The loss experience of the State Fund has generally been worse than that of private insurance carriers. In recent years, the disparity has been growing. This is seen in Exhibit AIS-9.

In addition, the market share of the State Fund has been increasing. During the early to mid 1980's, the State Fund

market share was around 15% to 17%. In more recent years, this has grown to about 20% to 24%. A history of the State Fund market share from 1970 to 1990 is set forth in Exhibit AIS-10.[17]

In the most recent filing by the WCIRBC, the State Fund loss experience was given a weight of 11%, or about half its market share.

The reasons that the loss experience for the State Fund is worse than that of private insurance carriers could be numerous. One obvious cause is that private carriers can underwrite their business, whereas the State Fund cannot. That is, insurance companies can choose to write, or not to write, particular businesses. The State Fund does not have that option. The State Fund polices can be split, at least theoretically, into two groups. The first group are those insureds where the State Fund has effectively competed with private insurers to write particular business. The other is to provide insurance to policyholders who could not obtain coverage elsewhere. This latter group is equivalent to assigned risk or residual market business in states that do not have a state fund to write these types of insureds.

There is little doubt that it is appropriate to include in the rate level analysis the business where the State Fund competes with private insurers. This is business that under some circumstances could be written by private insurers, and therefore the experience should be reflected in the overall rate level. The question then becomes how to handle the "assigned risk" business.

In states where assigned risk business is handled outside of a state fund, that experience is used in setting the overall rate level. Therefore, insurers receive the benefit of the worse assigned risk business in the form of higher manual rates. However, any deficit which accrues to the assigned risk plan is charged back against insurance companies. Hence, the existence of the assigned risk plan also operates to the detriment of insurers, in the form of assessments to fund deficits in the residual market.

If the full California State Fund experience was included in the rate level analysis, private insurers would receive the benefit of higher rates. However, since there is no assessment on private insurers for State Fund experience, they would not receive a detriment. Hence, this procedure would cause an imbalance.

The next issue to consider is how much of the State Fund business is competitive and how much is assigned risk. This is a question that is difficult to answer with precision.

During recent years, the countrywide percentage of business in assigned risk pools has been in the range of 20%. By this measure, almost all of the business in the State Fund could be considered residual market business. However, this is an over-projection of residual market type business for California. Workers' compensation in California is more profitable than workers' compensation on a countrywide basis. Hence, the percentage of assigned risk business in California should be less than countrywide. The minimum amount of assigned risk business, even in profitable periods, is in the range of 5%. By this measure, about a quarter of the State Fund writing's constitute residual market business.

Based upon the above considerations, an estimate that half the State Fund's policyholders are residual market type insureds is not unreasonable.

The procedure used in the rate filing, however, does not consider the fact that the competitive business written in the State Fund should have a lower loss ratio than the overall book of business. A rough estimate is that assigned risk business is 40% worse than voluntary market business.[18]

The State Fund overall projected rate period loss ratio from the 1/1/92 filing was .9530. Let us assume that the State Fund's business is split 50%:50% between competitive and assigned risk insureds, and that the latter has a 40% higher loss ratio. Then the State Fund competitive business loss ratio is .7942 and the assigned risk loss ratio is 1.1118.[19]

Combining the competitive State Fund loss ratio of .7624 with the private carrier loss ratio of .7127 yields a combined loss ratio of .7228.[20] The loss ratio actually used in the filing was .7391. This is a difference of 2.3% (= .7391 / .7228). Hence, by not considering the fact that the overall loss ratio for the State Fund is higher than that of the business written on a competitive basis, the rate level indication is somewhat overstated.[21]

In summary, we believe that giving the State Fund's experience 50% of the weight indicated by its market share probably does not understate the rate level indication. In fact, it could overstate the rate level indication because no consideration is given to the difference between the State Fund's overall loss ratio, and that produced by its competitive and assigned risk sub-markets.

It would be useful if the State Fund's business could be more precisely separated into its competitive and assigned risk components. This could be done in one of two ways. One option would be for the State Fund to internally split the business. Another choice would be to actually split the

assigned risk business from the State Fund's regular business. Within this latter option, the State Fund could either continue to handle the residual market business and be responsible for the operating results, or the residual business could be handled through a separate assigned risk market.[22]

III Projecting Experience Period Losses to Rate Level Period

Manual rates for any line of insurance consist of losses plus expenses[23] per exposure. Losses per exposure[24] can be split into various components. This is shown below:

$$\frac{\text{Losses}}{\text{Exposure}} = \frac{\text{Cost of Claims}}{\text{Number of Claims}} \times \frac{\text{Number of Claims}}{\text{Number of Exposures}}$$

or

$$\text{Pure Premium} = \text{Claim Severity} \times \text{Claim Frequency}$$

This can be further broken down as follows:

$$\frac{\text{Cost of Claims}}{\text{Number of Claims}} = \frac{\text{Cost of Claims}}{\text{Period of Benefits}} \times \frac{\text{Period of Benefits}}{\text{Number of Claims}}$$

or

$$\text{Claim Severity} = \text{Cost Per Period} \times \text{Claim Duration}$$

and

$$\frac{\text{Number of Claims}}{\text{Number of Exposure}} = \frac{\text{Number of Claims}}{\text{Number of Workers}} \times \frac{\text{Number of Workers}}{\text{Number of Exposures}}$$

or

$$\text{Claim Frequency (per exposure)} = \text{Claim Frequency per Worker} / \text{Number of Exposures per Worker}$$

Each one of these components (i.e., cost per period, claim duration, claim frequency per worker and number of exposures per worker) can change over time. The purpose of a projection or trend factor is to bridge the gap in these values between the historical experience period and the future rate period.

The most recent experience period included in the 1/1/92 rate filing was accident year 1990. This has an average

accident date of 7/1/90.[25] The rate period is for polices issued during 1992. This has an average accident date of 1/1/93.[26] The relationship between the most recent experience period in the filing, the prospective rate period and the trend projection period is displayed in Exhibit AIS-11.

The WCIRBC measures the changes in these components on a combined basis. This is accomplished by examining the movement in the loss ratio, after adjusting losses to a common cost level and premiums to a common rate level.[27] This general procedure of trending all cost components together is the same one used by the NCCI. The difference between the WCIRBC and the NCCI is in the specific formulas used.[28]

The WCIRBC makes a projection using double exponential smoothing. The trend experience period used in the last filing was 21 years, covering accident years 1970 to 1990. Full credibility is given to the projected loss ratio, and only California experience is used.

The NCCI makes a projection using a least-squares fit to the latest five policy years of experience. State specific data usually receives less than 100% credibility. To the extent that the state specific trend is not credible, experience from other jurisdictions is used.

This is another area where it cannot be said that either the WCIRBC or NCCI is intrinsically superior. Some of the difficulty in making a trend projection can be seen from examining the historical private carrier loss ratio experience shown in Exhibit AIS-12. Indemnity loss ratios are shown in Sheet 1. Medical loss ratios are given in Sheet 2.

During this period, the annual change for indemnity loss ratios has varied from -1.2% to +16.9%. For medical, the range has been from -2.3% to 18.7%. Over the entire period, there does not appear to be any long-range pattern in the trend. The annual trend in the percent loss ratio changes are very small (-0.1% for indemnity and -0.2% for medical) and are not statistically significant. Since there is no long-term pattern in the trends, it would seem that a procedure such as that used by the WCIRBC which relies upon a long time period would be better than the one used by the NCCI, which relies upon a shorter time period.

However, even though there is no long-term movement in the annual trend, there can be shorter-term cycles. For example, during each year from 1986 to 1990, the annual trend increased from one year to the next for both indemnity and medical. This acceleration in the trend caused the WCIRBC to

project a lower loss ratio in accident year 1991 than the one which actually occurred for accident year 1990. In such a case, it may be better to rely on a procedure such as that used by the NCCI, which is more responsive to current conditions.

The conclusion is that neither the WCIRBC or NCCI method can be employed mechanically. Under either method, informed judgment must be used.

A problem with both the WCIRBC and NCCI methods are that they are simple time series analyses. They do not try to explain why changes in losses occur over time. They both simply look at past experience and project it into the future based upon certain mathematical formulas. We believe it would be useful for the WCIRBC to look into the possibility of developing econometric formulas to explain changes in the loss ratios over time. Even if those formulas do not become the basis for determining the trend factor, they should help in the application of the time series models.[29]

With regard to the specific time series formula used by the WCIRBC, we have three suggestions.

First, the double exponential smoothing formula uses an alpha value of 0.3. It would be preferable to use a value which optimizes the fit of the double exponential curve to the historical data.

Second, the projection period used assumes that policies are issued uniformly through the year. This assumption is usually not correct. January typically has the highest percentage of policies issued throughout the year. July is normally the next highest month. By employing an assumed uniform distribution of policies through the year instead of the actual distribution which is weighted more heavily towards the beginning of the year, the WCIRBC lengthens the trend period beyond what is actually needed. This, in turn, increases the trend factor and results in a higher projected loss ratio and rate level.[30]

Third, the WCIRBC model assumes that the loss ratios change over time on a linear basis. This is the assumption that has been used for many years for workers' compensation. However, the trend in workers' compensation loss ratios in recent years has become much more material. This has led to the suggestion that an exponential curve may be more appropriate than a linear projection.[31] The WCIRBC should look into this issue for future filings.

We also believe it would be useful for the WCIRBC to include in future rate filings a trend projection based upon the NCCI method. While we are not suggesting that the NCCI

model should replace the one currently being used in California, we believe that having this alternate projection will provide a check on the reasonableness of the value derived from the WCIRBC model.

IV Benefit Level Changes

The workers' compensation benefits paid injured workers are set by the legislature. Changes in benefits can alter either of the three costs components discussed in relation to trend. These were cost of benefits per period, the duration of benefits and the frequency of claims.[32] The cost impact of benefit level changes instituted in California during the period from 1981 to 1990 are given in the following table

Year	Benefit Level Cost Impact[33]
1981	+ 8.9%
1982	+ 0.5%
1983	+23.6%
1984	+ 6.4%
1985	+ 0.8%
1987	+ 0.8%
1990	+ 2.5%

As can be seen, benefit changes are not enacted every year. In addition, particular benefit level changes can have widely varying cost impacts. Although not shown in this table, benefit changes can reduce costs, sometimes significantly.[34]

The traditional method of analyzing benefit costs is to examine the cost impact on different types of injuries. The cost impact by injury type is then weighted by that injury type's percent of the total costs to obtain an overall benefit level impact. The different benefit types are fatal, permanent total, major permanent partial, minor permanent partial, temporary total and medical. The WCIRBC follows this standard method of analyzing the benefit impact by type of injury.

The benefit level change which we examined to review the procedures followed by the WCIRBC was the Margolin-Bill Greene Workers' Compensation Reform Act of 1989 (Assembly Bill 276 and Senate Bill 47). The overall procedures used by the WCIRBC followed normal actuarial procedures.

We do, however, have two suggestions regarding the procedures used by the WCIRBC.

First, the details of the benefit level analysis were not well documented in the rate filing and many intermediate

calculations were not presented. This makes it difficult to follow the details of the procedures used in the analysis.

Second, some of the statistics and parameters used in the analysis appeared to be quite old. An attempt should be made to keep the underlying statistics as current as possible.

V Expenses

The expenses of an insurance company fall into the following categories:

(1) Commission & Brokerage

(2) Other Acquisition Expenses

(3) General Expenses

(4) Premium Taxes, Licenses and Fees

(5) Loss Adjustment Expenses

The definition of these expenses are set forth in Appendix A.[35]

For rates effective to January 1, 1988 and January 1, 1989, a 35 percent expense loading[36] was used. This was based upon an analysis of expenses performed by the WCIRBC. For rates effective January 1, 1990, January 1, 1991 and January 1, 1992, the expense provision has been 34 percent, 33 percent and 32.8 percent of premium, respectively. These amounts were based upon a statutory provision.[37] The statutory expense provisions remain operative only until January 1, 1993.

Other Underwriting Expenses

The WCIRBC's analysis of other underwriting expenses (i.e., commissions & brokerage, other acquisition expenses and general expenses combined) has in the past been based upon the experience of stock companies only.[38] At one time, this was a common procedure to use. However, in more recent years, there is a greater tendency to examine the expenses of all types of insurance companies.[39]

The underwriting expenses of stock companies have been about 5% to 7% higher than those of non-stock companies. This is seen from Exhibit AIS-13. By ignoring the experience of non-stock companies, the indicated manual rates are forced up to a higher than average level.

The usual argument given for using stock company expense experience alone is that these insurers write a majority of business, and rates should be set high enough to allow them to operate at a reasonable profit. However, using an average expense provision in the manual rates does not prevent American Agency System companies from having the opportunity to earn a reasonable profit. If these companies believe their expenses cause them to need a higher rate level, there are at least two options available to them. One is to charge rates higher than the minimum allowed under California law. The other is to operate more efficiently and thereby lower expenses. Furthermore, American Agency System companies do not constitute one uniform group of companies. The expense ratio for American Agency System companies are mixed in with those of direct writers. Some have higher expenses, while others have lower expenses. This is seen in Exhibit AIS-14.

Furthermore, the current procedure whereby the manual rate expense provision is based upon stock company expense only forces all policyholders in California to subsidize the cost of the American Agency System, whether they want to or not. By setting an expense provision based upon average expenses, insureds who want to buy insurance through agency companies will still have that option, although perhaps at a higher than manual premium. Setting a manual rate based upon stock company expense alone obscures the fact that the expenses for those companies are higher, on average, than for non-stock companies.

We believe that when the various considerations are taken into account in total, there is no compelling reason to set the rates for the voluntary market based only upon the sub-set of companies which have higher than average expenses.

Manual rates should represent an average of all the experience for companies writing in the voluntary market. Therefore, the provision for underwriting expenses in the manual rate level should be set based upon the average underwriting expenses of stock and non-stock companies. This may, depending upon legal interpretation, require a change in Article 2 (State Rate Supervision), Section 11732.

Loss Adjustment Expenses

The provision for loss adjustment expenses (LAE) is determined by the WCIRBC based upon the ratio of LAE to premium. LAE is generally considered more closely related to losses than to premiums. The NCCI bases the provision for LAE as a percentage of losses[40], rather than the WCIRBC procedure where LAE is set as a percentage of premium.[41]

Since LAE is more closely associated with losses than with premiums, we believe that it would be appropriate to

follow the NCCI procedure of basing LAE as a fraction of losses instead of the WCIRBC procedure where LAE is set as a percentage of premium.

Expense Provisions by Size of Policy

The underwriting expenses incurred by an insurer in writing particular workers' compensation insurance policies do not vary in direct proportion with the premium for those policies. For example, the commission paid to an agent on a $100,000 is not 10 times the commission paid on a $10,000 policy. Also, a $100,000 policy will not consume 10 times as much office space, employees' time, postage, etc. than a $10,000. However, the calculation of standard premium, which is simply the manual rate times the payroll (in hundreds), assumes that all underwriting expenses vary in direct proportion to premium. This causes large insureds to pay higher than their "fair share" of insurance company expenses.

One way that this inequity may be rectified is through the use of policyholders dividends.[42] However, there is no guarantee that the excessive expense payments will be returned to policyholders. In addition, it is possible that insureds with different insurers will be treated in unequal fashions.

A different procedure exists for returning the excessive expense provisions to insureds. This is accomplished through the use of a premium discount table. Premium discounts are used by both the NCCI and other rating bureaus. An example of the premium discount tables in use are shown in Exhibit AIS-15. Two different tables are shown. The (Y) table is based upon actual studies of expense savings by size of risk. The (X) table values are selected values based upon actual expense savings and other considerations.[43]

The use of premium discount tables instead of policyholder dividends to return excessive expense payments has several advantages. First, insureds are guaranteed that the premium they pay will reflect expense savings to companies. Second, insureds will have a better idea at the start of the policy period as to how much their final cost for coverage will be. Third, insureds with different insurance companies will be treated on an equal basis. Fourth, the reliance on subjective policyholder dividends to determine the final cost of insurance will be decreased.

We would recommend that premium discounts tables, which reflect up front the savings in expenses by size of policy, be implemented. Implementing this will require a modification of Article 2 (State Rate Supervision), Section 11732.4.

VI Investment Gain on Reserves and Surplus

An insurance company has two main sources of revenue. These are premiums and investment gains. Investment gains can be further broken down into revenue derived from policyholder supplied funds and owner supplied funds.[44] Investment gain can also be split between pure investment income (i.e., dividends, interest, rents, etc.) and capital gains/losses.

It is generally acknowledged that all sources of income should be considered in the ratemaking process to make a determination of the proper rate level. Many different models exist to consider investment income in insurance ratemaking.[45]

The model used by the WCIRBC is very simple and naive. We have not seen it used anywhere else. The method used by the WCIRBC to project investment income on reserves is not well documented. Investment income on capital and surplus does not appear to be taken into account. No analysis is made of the total income needs for writing workers' compensation. We do not believe in using unnecessarily complex models for ratemaking. However, we believe that the WCIRBC model is so basic that it fails to meet even minimum requirements for representing a sufficient analysis.

We recommend that future rate filings by the WCIRBC give greater attention to the impact of investment income on premiums. In the context of this report, we are not recommending any specific model. Several generally accepted models exist. The choice of the parameters for implementing a model are generally more important that the particular model used.

VII Policyholder Dividends

The issue of how to handle policyholder dividends in ratemaking probably represents the biggest theoretical / philosophical difference in the viewpoints of the insurance industry and insurance regulators. The NCCI, as well as other workers' compensation insurance rating bureaus, believe that policyholder dividends should be a direct pass through into the manual rates. Insurance departments that we have dealt with, however, tend to believe that insurance manual rates should not be increased because of the payment of policyholder dividends.

There are many reasons given by Insurance Departments as to why a specific numeric provision for policyholder dividends should not be included in the manual rates. The one most often given is summed up in the following quote,

"As voluntary payments, policyholder dividends need not be considered in prospective ratemaking."[46]

The WCIRBC belief that a provision for policyholder dividends should be included in the manual rates is based, at least in part, upon the following reasoning.

> The adjustment of an employer's premium charges based upon actual loss experience incurring under a policy adds both substantial safety incentives and increased employer equity to the pricing mechanism. Additionally, dividends reflect expense savings realized on policies covering larger employers.[47]

The goals of safety incentives and increased employer equity are certainly laudable. However, these goals are already accomplished for California workers' compensation, at least to a certain extent, by the experience rating plan and retrospective rating plan. In addition, these are important goals for other lines of insurance. However, as Exhibit AIS-16 shows, policyholder dividends are negligible for other lines of commercial insurance compared to workers' compensation in general, and especially compared to California workers' compensation. This raises the question as to why dividends are so much higher in workers' compensation than in other lines of business, especially when workers' compensation is considered to have one of the more refined classification systems and experience rating plans.

With respect to the purpose of returning expense savings on policies for larger employers, this can be accomplished in a more efficient and equitable manner through the use of the premium discount tables discussed in the previous section on expenses.

The question of whether or not policyholder dividends encourage safety and increase rating equity is an open one. However, if providing a premium refund to employers at the end of the policy does accomplish these goals, there may be a way to implement this other than through a system of voluntary discretionary policyholder dividends.

The current procedure regarding dividends is to increase manual rates substantially[48], and then possibly provide a refund at the end of the year. This process could also be carried out by the use of a one-way retrospective rating plan. Such a retrospective rating plan would have well defined procedures at the start of the year, as opposed policyholder dividends which are voluntary discretionary payments by insurance company management at the end of the year.

In a one-way retrospective rating plan, insureds can only receive a credit. They cannot be charged more than the standard premium. This is different than the regular retrospective rating plan used for larger insureds.[49] Under that plan, debits as well as credits from the standard premium are possible.

Such a mandatory pre-determined plan would likely have a bigger impact on safety and equity than policyholder dividends. Insureds would know in advance that they will receive a refund, and the amount of the refund, contingent upon their own experience. Since there would be no uncertainty that good experience would be rewarded, there should be a larger incentive to improve safety than under a voluntary plan where good experience may not be rewarded.[50]

In summary, we have two recommendations with regard to policyholder dividends. First, they should not automatically be a direct pass through in the manual ratemaking process. Second, any safety incentives and equity considerations from a voluntary policyholder dividend program may be improved upon by a mandatory one-way retrospective rating plan.

VIII **Premium Development**

The premium base for workers' compensation is payroll (in hundreds). At the time a policy is written for a particular insured, the payroll for the coverage period is estimated. After the policy expires, a policyholders' records are examined in order to accurately determine the payroll by classification which will be used in determining the premium for the insureds. The general tendency is for the final premiums to exceed the estimate premium. That is, the insurance companies will charge more, on average, for coverage than the amounts recorded when the policy was first written.[51] This additional premium is referred to as audit premium.

The premiums used in an accident year loss ratio calculation do not take this additional audit premium properly into account. The audit premium is based upon the operations from prior years of insurance coverage, not the current year. In a situation where overall premium are growing,[52] this will understate the premiums attributable to the accident coverage provided in a given year. This, in turn, will cause the loss ratio to be inflated and lead to a higher than necessary rate level.

We would recommend that future rate filings made by the WCIRBC adjust for this mismatch between accident year premiums and losses caused by the accounting treatment of audit premiums.[53]

IX Documentation of Rate Filing

A rate filing for workers' compensation insurance, by its very nature and purpose, will most likely be a lengthy and complex document. We were surprised at how thin the rate filings submitted by the WCIRBC to the California Department of Insurance have been.

Using just the information contained in the rate filings, it is difficult to follow the steps, logic, reasoning and calculations employed by the WCIRBC. Based upon the review of actuarial committee agenda and minutes, we believe that the WCIRBC did spend a good deal of time analyzing various issues. Unfortunately, however, these analyses are not part of the filing itself.

We believe that the rate filing should be more complete and thorough. The filing should explain what the WCIRBC did, why they did it and how they did it. Alternate analyses prepared and examined by the WCIRBC should be included. In addition, various other standard actuarial methodologies should be included in the filing, as a check on the procedures adopted by the WCIRBC (see, for example, Sections II and III above).

We recommend that California adopt, either through a statute and/or a regulation, standard rate filing requirements for workers' compensation. These would be considered the minimum data necessary in order to analyze the rate filing. Of course, the regulator would retain the right to obtain additional information when necessary. Enclosed, as examples of standard rate filing requirements, is a Maine statute and a North Carolina regulation. These are set forth in Appendices B and C, respectively.

Footnotes:

[1] Examples of liability lines of insurance are workers' compensation, medical malpractice, general liability, automobile liability, etc. These coverages are characterized by a delay in both the time from the occurrence to the reporting of a claim, and from the reporting of the claim to its final disposition. For other lines of coverage, such as fire and automobile physical damage insurance, where claims are closed quickly, calendar year experience provides more recent data than an accident year. However, because of possible loss reserve distortions, it is usually not appropriate to use calendar year information for liability lines of coverage.

[2] Various steps can be taken in other parts of the ratemaking formula to offset this variability. These include the use of additional years of historical experience and the trending methodology used.

[3] This can be seen from Exhibit AIS-4, Sheet 2. Accident year 'X' is first evaluated at 12/31/X. Policy year 'X' does not reach a first evaluation until 12/31/X+1, or one year later.

[4] A policy year spans two calendar years, whereas an accident year spans only one calendar year. Therefore, when policy year (X) information is available, accident year (X+1) information will also be available. The average claim for accident year (X+1) is six months more recent than for policy year (X).

[5] This discussion of variability only takes into account the projection of historical losses to an ultimate basis. The further back in time the historical experience is, the less projection needs to be made to determine the ultimate cost for that particular year. This will result in a smaller variability for this component of the ratemaking process. However, a larger trend period will be needed, which causes additional variability in a different part of the rate analysis.

[6] When citing common procedures used for workers' compensation ratemaking, it will be a reference to the methodology employed by the National Council on Compensation Insurance (NCCI). The NCCI is the insurance industry ratemaking, statistical and/or advisory organization for workers' compensation in about 38 jurisdictions.

[7] The WCIRBC collects policy year and accident year information. However,the former is not used in developing rates. According to the WCIRBC, "This data [policy year information] is used in certain special studies and in the

reconciliation and testing of data from other Bureau calls."

[8] This is especially true in that different portions of the ratemaking formula interact with each other. For example, the use of additional years of historical information would tend to add more stability and less responsiveness to the accident year analysis.

[9] In addition to the NCCI, the Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIBM) also uses one accident year and one policy year in its ratemaking analysis. The Pennsylvania Compensation Rating Bureau (PCRB) also uses policy year data (but not accident year data).

[10] Consideration that may be taken into account are smoothing out earnings and tax considerations. We are not suggesting that insurance company management would set an inappropriate rate level in order to accomplish other objectives. However, within the range of reasonableness for the reserve level, other factors can be taken into account.

[11] These data are not California specific. The qualitative indications would be the same for California, but the specific quantitative breakdown would likely be somewhat different.

[12] The paid losses and loss reserves excluding IBNR are collected separately for indemnity and medical. IBNR reserves are only collected on a combined basis.

[13] The ultimate basis is the final value when all claims under consideration (i.e., accident year or policy year experience) have been reported and closed. In the case of workers' compensation, most claims will have reached there final value in at most ten years. However, for certain types of claims such as those with lifetime benefits (i.e., permanent total) and occupational disease claims, the final value may not be settled for 50 years or longer.

[14] This is contained in Section A, Development of Indicated Rate Level Change Due to Loss Experience, of the WCIRBC's filing dated September 20, 1991.

[15] The experience period consists of one accident year and one policy year. Since there is some degree of overlap between these two periods, only about 1.5 years of independent experience is used. The trend experience data consists of the five most recent policy years.

[16] The accident year data used by the WCIRBC is evaluated at 18 months. The accident year data used by the NCCI is evaluated at 12 months. Hence, the WCIRBC accident year data is evaluated 6 months more recently than that used by the

NCCI.

[17] This is the State Fund market share by premium. Since loss ratios are higher for the State Fund than for private carriers, the market share based upon losses would be higher. For example, during 1990 the State Fund market share based upon premiums was 22%. Based upon losses, the State Fund market share was 27%

[18] Recent rate filings in Florida, South Carolina and Virginia have shown residual market loss ratios higher than those in the voluntary market by 53%, 41% and 35%, respectively.

[19] .9530 = .5 X .7942 + .5 X 1.1118 and .7942 X 1.4 = 1.1118

[20] .7228 = [.7942 X .11 + .7127 X .78] / .89, .11 is State Fund competitive market share and .78 is private carrier market share.

[21] The procedure followed in the rate filing of giving the State Fund experience only 50% of the weight indicated from its market share lowers the rate level by 3.5% compared to the result if the State Fund experience was given its full market share weight.

[22] Several states with competitive state funds have separate assigned risk plans to handle business. For example, in 1989, the assigned risk market percentages in Arizona, Michigan and Oregon were 2.2%, 10.1% and 4.2%, respectively.

[23] Expenses include profit, and depending upon the particular jurisdiction, may included policyholder dividends.

[24] This is sometimes referred to as the pure premium or loss cost.

[25] This assumes that accidents occur uniformly throughout the year.

[26] This assumes that policies are issued uniformly throughout the year and accidents are evenly spaced on each policy. The first of these assumptions is not totally accurate.

[27] By adjusting losses to a common cost level, the other changes which can not be quantified through cost indices are accounted for in the trend factor. By adjusting premiums to a common rate level, the loss ratio is made proportional to the pure premium. This is because premiums = exposures x rate. By adjusting the rates for all years to a common basis, a proportionality exists between exposures and premiums.

[28] This procedure of trending all components together is also followed by the PCRB. However, the WCRIBM trends claim severity, claim frequency and exposures separately.

[29] The NAIC examination of the NCCI states, "That NCCI perform extensive analysis of econometric models." NCCI's response is that, "NCCI is in favor of the use of economic analysis in ratemaking and, in 1991, has reinstituted an economic research unit that will concentrating [sic] on econometric modeling."

[30] The NAIC examination of the NCCI states, "That adjustments be made to the lengths of the trend periods to reflect distributions of premiums writings by month." NCCI's response is that, "NCCI agrees that this represents an improvement over the present procedure and will implement beginning early next year with rate level calculations using 12/91 data."

[31] From the mid-1970's through to 1990, the NCCI has used a linear trend model. During the last year, the NCCI has used an exponential trend model. The WCRIBM, in their filing for rates effective 1/1/92, still used a linear trend model.

[32] Statutory benefit level changes should not normally change the frequency of accidents occurring (although they may through changes in safety and related programs). However, by altering eligibility standards (for example, presumptions regarding the compensability of stress claims), they can change the frequency of compensable injuries.

[33] Values taken from page 20 of the NCCI 1991 Statistical Bulletin. These are the anticipated effect of the benefit level change. The actual impact on cost may have turned out to be different.

[34] For example, a November 20, 1987 benefit level change in Maine was projected to reduce costs by -41.9%. A July 1, 1987 benefit change in Montana was projected to reduce costs by -25.0%

[35] These pages are taken from the National Association of Insurance Commissioners (NAIC) Accounting Practices and Procedures Manual for Fire and Casualty Insurance Companies.

[36] This includes a provision for policyholders dividends and profits as well as expenses.

[37] Article 2 (State Rate Supervision), Section 11732.5.

[38] According to the WCIRBC, previous bureau filings, Department of Insurance Decisions and an Attorney General's

Opinion have interpreted the Insurance Code requirement that rates be adequate for all insurers to mean that the rates should be adequate for insurers doing business under the American Agency System. Stock companies are sometimes taken as a close substitute for insurance companies doing business through the American Agency System.

[39] Among the Insurance Departments that have examined the underwriting expenses of all types of insurers combined are Maine, Massachusetts, North Carolina and South Carolina. In addition, the NAIC examination of the NCCI recommends that expense provision be based upon the combined experience of stock and mutual companies.

[40] The WCRIBM and the PCRB also determine LAE as a fraction of losses.

[41] The ratio of LAE to losses and LAE to premium can be converted from one to another based upon the ratio of losses to premium. The real issue is not how the ratio is expressed, but the basis upon which it is derived.

[42] This is one reason that policyholder dividends in California increase with the size of premium. The increasing dividends by policy premium size can represent, at least partially, a return of the excessive expense provisions included in the standard premium. The other main reason that dividends increase by policy size is that the loss experience is more statistically credible.

[43] The proportion of insurers using the (Y) and (X) tables varies by state, and statistics regarding the exact split between the two are difficult to come by. However, it is generally believed that in most states the overwhelming majority of business is written using the (Y) table.

[44] Policyholder supplied funds are considered as the loss, loss adjustment expense and unearned premium reserves (with various adjustments applied) of the insurance company. These reserves are generally considered to be funded from the premiums that policyholders pay. Owner supplied funds are the capital and surplus.

[45] See for example, N.A.I.C. Study of Investment Income, Supplement to the Proceeding, 1984, Vol. II, pages 46 to 77 for "Examples Of Ratemaking Methodologies Which Give Explicit Consideration To Investment Income".

[46] N.A.I.C. Study of Investment Income, Supplement to the Proceeding, 1984, Vol. II, page 7.

[47] WCIRBC - January 1989 Rev. Section B, Permissible Loss Ratio, Dividends, page 7.

[48] The procedure used by the WCIRBC to include policyholder dividends into the ratemaking process raises manual rates by about 15% to 23%.

[49] Eligibility for the regular retrospective rating plan is an estimated annual premium of $25,000.

[50] For example, if other insureds covered by the insurance company have bad experience, a policyholder may not receive a dividend (or may receive a reduced dividend) even though it had very good experience. A system of loading up manual rates for policyholder dividends transfers some risk from insurance companies to policyholders. It does this by adding in a large risk margin into the manual rates (policyholder dividends) which may not be returned to policyholders.

[51] The final premium for a policy year will exceed the initially estimated value by about 4% to 5%. In different states, the range is from about 1% to 8%.

[52] California workers' compensation standard premium grew by about 16% per year between 1985 and 1990.

[53] Such an adjustment was recently upheld in a workers' compensation rate case in Maine. This has also been proposed by the staff of the North Carolina Department of Insurance. The NAIC examination of the NCCI states, "The adjustment of calendar year earned premium to current rate level does not take into account the contributions to calendar year premium arising from audit adjustments to older policy years." NCCI response is that, "NCCI agrees that this is an idea worth pursuing and is already investigating what modification to make to the present procedure."

BASIC EQUATION FOR INSURANCE RATEMAKING

Income = Outgo

(Both adjusted to a prospective basis)

Exhibit AIS-1

SOURCES OF INCOME

1. Premiums
2. Investment Income on Reserves
3. Investment Income on Surplus
4. Capital Gains / Losses
5. Other (e.g., Premium Finance Charges)

Exhibit AIS-2

SOURCES OF OUTGO

1. Losses

2. Loss Adjustment Expenses
   - *Allocated*
   - *Unallocated*

3. Other Expenses
   - *Commissions & Brokerage*
   - *Other Acquisition Expenses*
   - *General Expenses*
   - *Premium Taxes*
   - *Policyholder Dividends??*

4. Profit

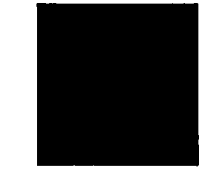
Exhibit AIS-3

TYPES OF DATA ORGANIZATION

Ratemaking Issue	Calendar Year	Accident Year	Policy Year	Report Year
Type of Loss Data	Financial Accounting Model = Paid + Change in Reserves	Tracks Accidents Occurring Within Time Period	Tracks Accidents Arising From Policies Issued	Tracks Claims Reported Within Time Period
Development Factors	None	Largest	Moderate	Moderate
Trend Factors	Smallest	Moderate	Largest	Moderate
Matching of Losses to Premiums	Worst	Moderate	Best	Moderate
Types of Coverages Most Useful For	Short Tail Lines (e.g., Auto Physical Damage, Fire, etc.)	Liability Lines (e.g., Auto Liability, Commercial Multi-Peril, etc.)	Lines With Premium Development (e.g., Workers' Compensation, Auto Garage Liability, etc.)	Lines Issued Under Claims-Made Policies (e.g., Medical & Legal Malpractice, etc.)

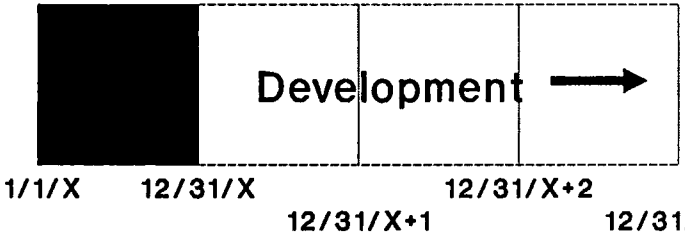
TYPES OF DATA ORGANIZATION

Calendar Year 'X'



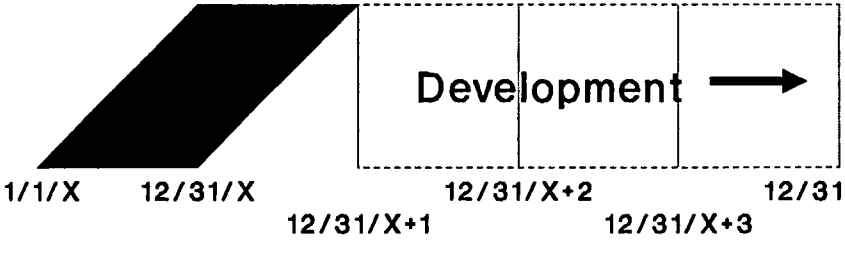
- Financial Data
- Most Responsive
- Least Variable
- Least Consistent

Accident / Report Year 'X'



- Tracks Incidents
- Middle Responsiveness
- Most Variable
- Middle Consistency

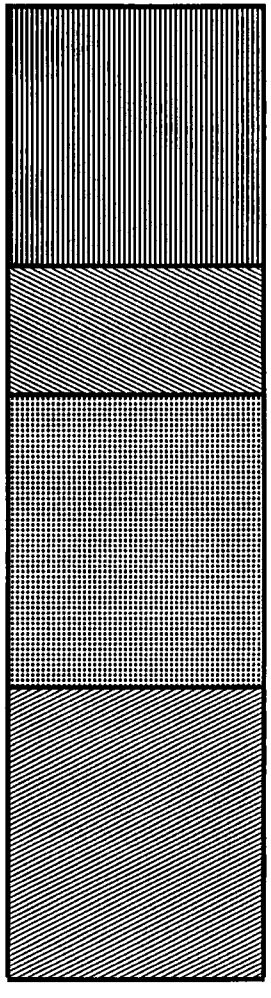
Policy Year 'X'



- Tracks Policies
- Least Responsive
- Middle Variability
- Most Consistent

Exhibit AIS-4, Sheet 2

TYPES OF LOSS DATA



IBNR Reserves

Bulk Reserves

Case Reserves

Paid Losses

Increasing Reliability of Data Base

Increasing Size of Data Base

Exhibit AIS-5

Accident Year Loss Development
Workers' Compensation - Indemnity

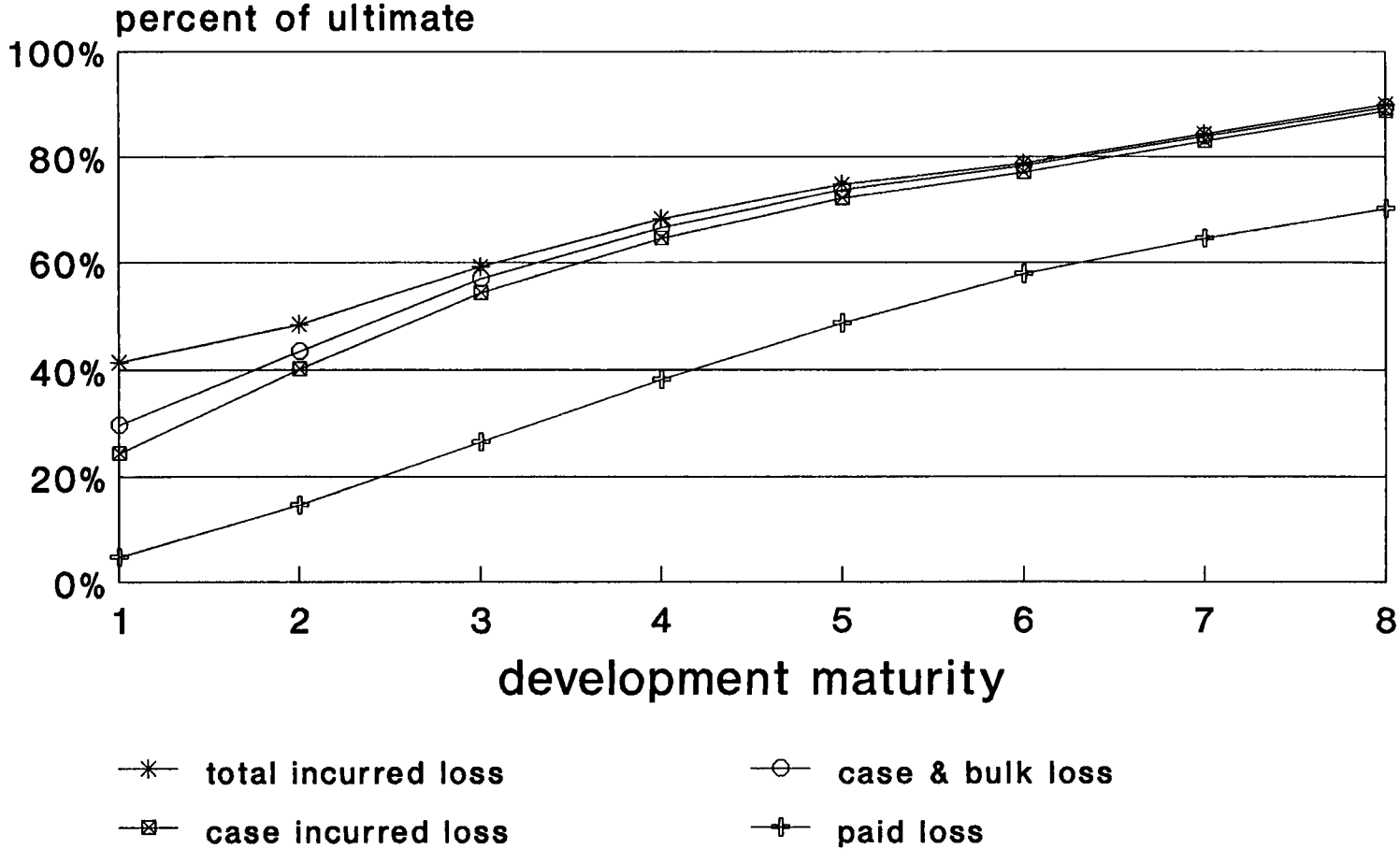


Exhibit AIS-6, Sheet 1

Accident Year Loss Development
Workers' Compensation - Medical

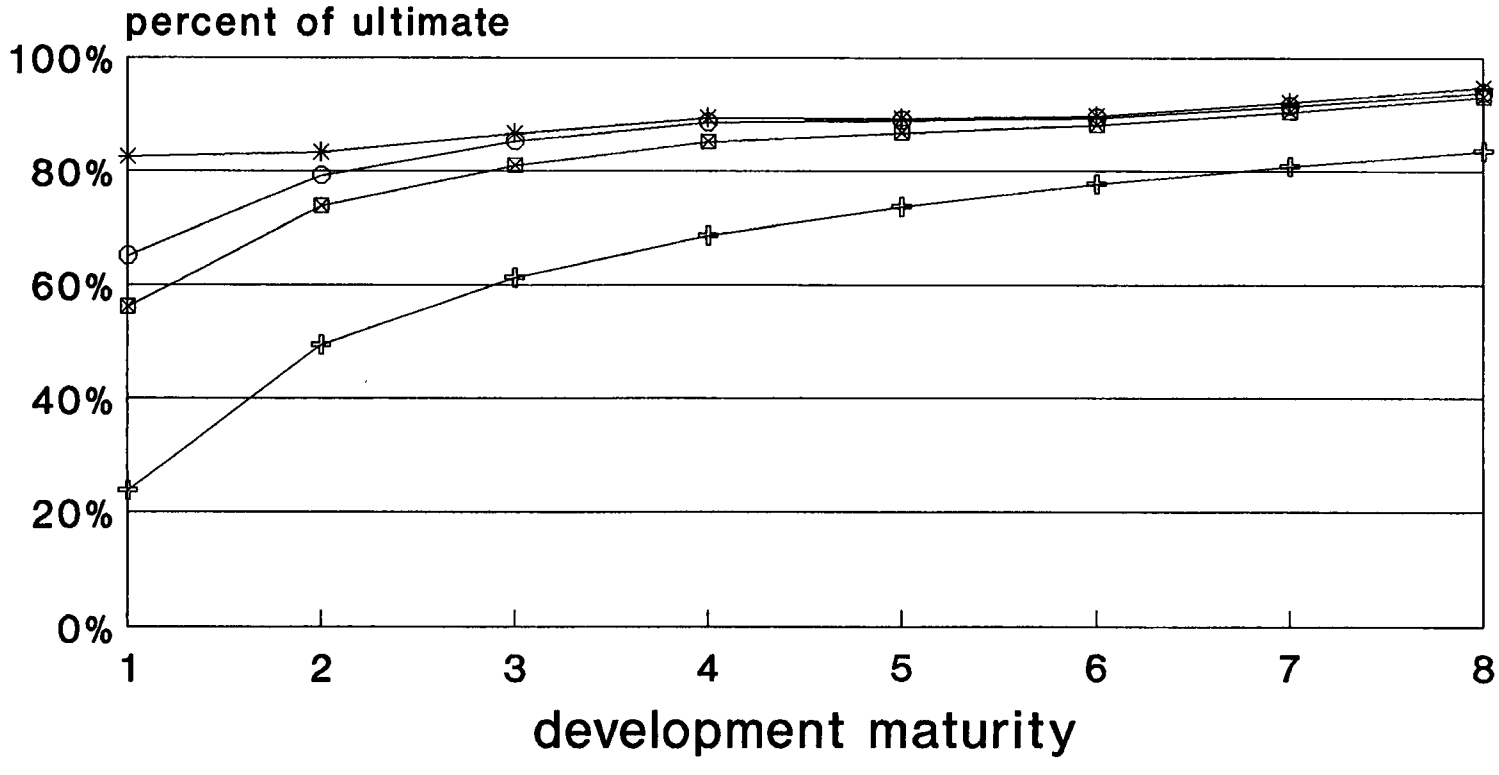


Exhibit AIS-6, Sheet 2

Policy Year Loss Development
Workers' Compensation - Indemnity

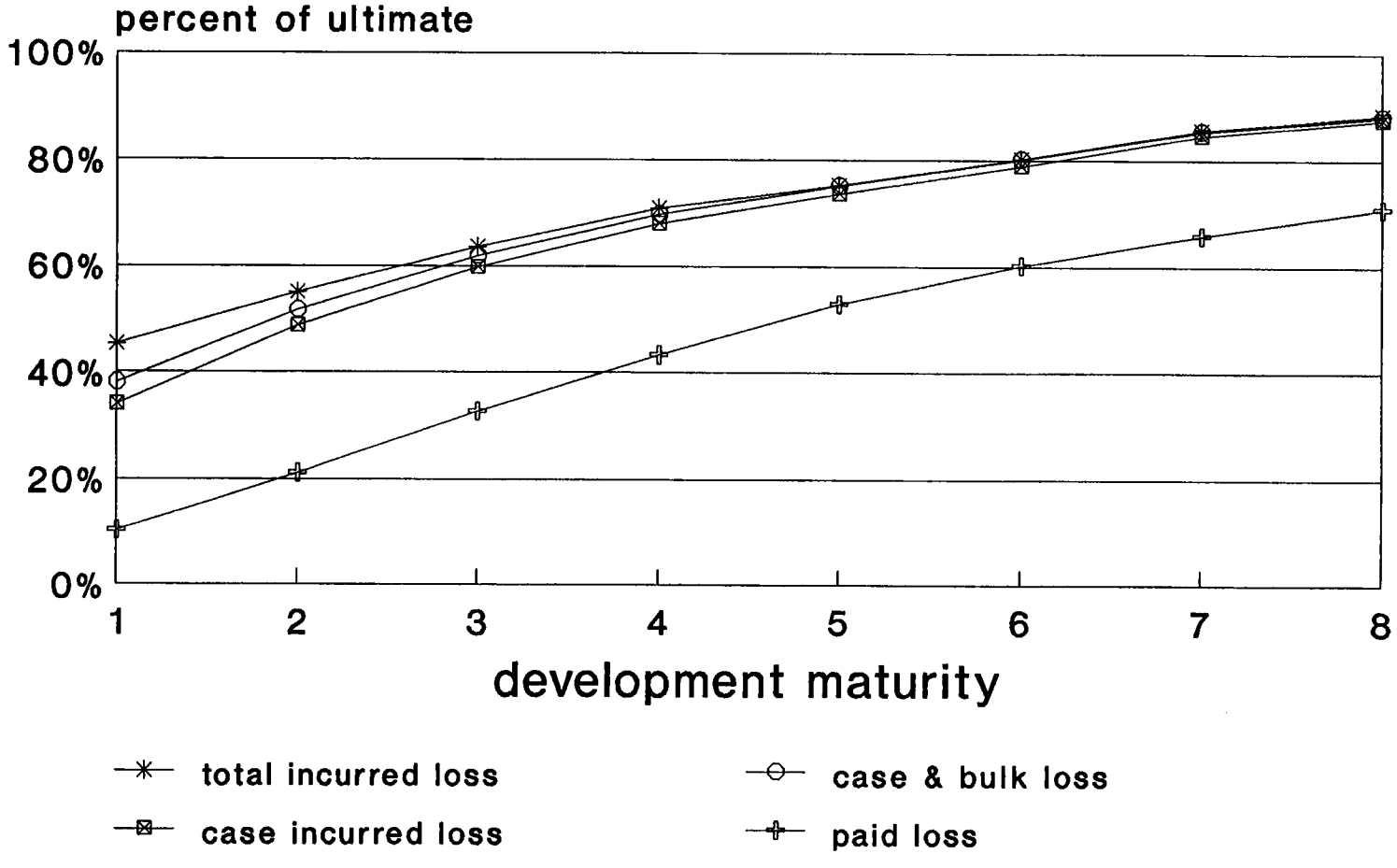


Exhibit AIS-6, Sheet 3

Policy Year Loss Development
Workers' Compensation - Medical

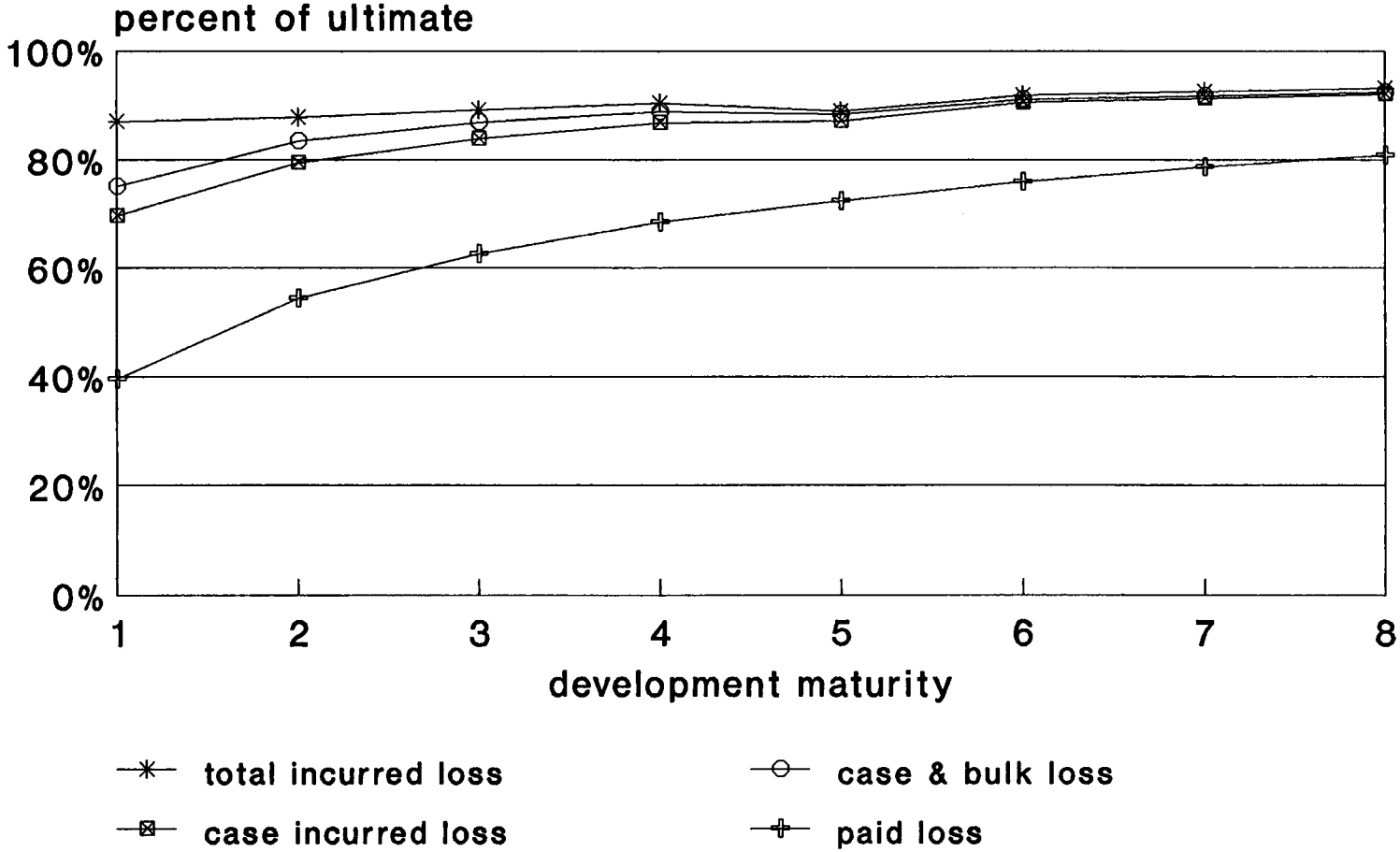


Exhibit AIS-6, Sheet 4

SOUTH CAROLINA

LOSS COST INDICATIONS

	INCURRED	EX-IBNR	EX-BULK	PAID TO A 4TH	PAID TO AN 8TH
Experience	14.1%	8.9%	5.8%	2.9%	2.5%
Change in Trend*	1.1%	0.7%	0.2%	-1.3%	-1.5%
Change in Loss Loss AdjustExpenses	0.1%	0.1%	0.1%	0.1%	0.1%
Benefit Change (1/1/90)	0.9%	0.9%	0.9%	0.9%	0.9%
Change in Assessment	4.1%	4.1%	4.1%	4.1%	4.1%
OVERALL PREMIUM LEVEL CHANGE	21.3%	15.3%	11.5%	6.8%	6.2%

* Includes the adjustment for anticipated Voluntary Loss Cost Differential from Statewide.

California Workers' Compensation

Private Carriers - Indemnity Loss Development Factors

Age in Months	Reported as of 6/85	6/86	6/87	6/88	6/89	6/90	6/91	Average	Avg x Hi/Low	5 Yr Avg	3 Yr Avg	Maximum	Minimum	Selected
30/18	1.2176	1.2664	1.2161	1.1869	1.2003	1.1549	1.1836	1.2037	1.2009	1.1884	1.1796	1.2664	1.1549	1.1991
42/30	1.0477	1.0835	1.0779	1.0652	1.0530	1.0303	1.0346	1.0560	1.0557	1.0522	1.0393	1.0835	1.0303	1.0500
54/42	1.0124	1.0394	1.0328	1.0236	1.0099	1.0027	1.0030	1.0177	1.0163	1.0144	1.0052	1.0394	1.0027	1.0030
66/54	1.0037	1.0108	1.0185	1.0138	1.0112	1.0004	1.0009	1.0085	1.0081	1.0090	1.0042	1.0185	1.0004	1.0042
78/66	1.0001	1.0062	1.0075	1.0126	1.0002	0.9941	0.9970	1.0025	1.0022	1.0023	0.9971	1.0126	0.9941	0.9971
90/78	0.9969	0.9990	1.0072	1.0083	1.0023	0.9999	1.0041	1.0025	1.0025	1.0044	1.0021	1.0083	0.9969	1.0021
102/90	0.9986	0.9972	0.9993	1.0046	1.0041	0.9977	0.9990	1.0001	0.9997	1.0009	1.0003	1.0046	0.9972	1.0003
114/102	1.0061	0.9976	1.0065	1.0006	1.0056	0.9985	1.0030	1.0026	1.0028	1.0028	1.0024	1.0065	0.9976	1.0024
126/114	0.9974	0.9990	1.0028	1.0036	1.0009	0.9999	1.0051	1.0012	1.0012	1.0025	1.0020	1.0051	0.9974	1.0020
138/126	0.9973	1.0025	1.0035	1.0035	0.9990	1.0019	1.0014	1.0013	1.0017	1.0019	1.0008	1.0035	0.9973	1.0008
150/138	0.9981	1.0008	1.0015	1.0007	1.0036	1.0009	1.0003	1.0008	1.0008	1.0014	1.0016	1.0036	0.9981	1.0016
162/150	1.0020	1.0013	1.0037	1.0025	1.0037	1.0010	1.0006	1.0021	1.0021	1.0023	1.0018	1.0037	1.0006	1.0018
174/162	1.0004	1.0016	1.0020	0.9984	1.0035	1.0028	1.0014	1.0014	1.0016	1.0016	1.0026	1.0035	0.9984	1.0026
186/174	1.0018	1.0021	1.0016	1.0043	1.0041	1.0022	1.0010	1.0024	1.0024	1.0026	1.0024	1.0043	1.0010	1.0024
198/186		0.9993	1.0016	1.0026	1.0021	0.9987	1.0019	1.0010	1.0012	1.0014	1.0009	1.0026	0.9987	1.0009
210/198			1.0056	1.0052	1.0077	1.0014	1.0009	1.0042	1.0041	1.0042	1.0033	1.0077	1.0009	1.0033
222/210				1.0024	1.0049	0.9995	1.0055	1.0031	1.0037	1.0031	1.0033	1.0055	0.9995	1.0033
234/222					1.0052	1.0021	1.0046	1.0040	1.0046	1.0040	1.0040	1.0052	1.0021	1.0040
246/234						1.0044	1.0042	1.0043	1.0043	1.0043	1.0043	1.0044	1.0042	1.0043
Ult/246					1.0180	1.0058	1.0189	1.0142	1.0180	1.0142	1.0142	1.0189	1.0058	1.0042

California Workers' Compensation

Private Carriers - Medical Loss Development Factors

Age in Months	Reported as of 6/85	6/86	6/87	6/88	6/89	6/90	6/91	Average	Avg x Hi/Low	5 Yr Avg	3 Yr Avg	Maximum	Minimum	Selected
30/18	1.0879	1.1185	1.1279	1.1069	1.1156	1.1059	1.1104	1.1104	1.1115	1.1133	1.1106	1.1279	1.0879	1.1125
42/30	1.0074	1.0246	1.0212	1.0164	1.0124	1.0113	1.0127	1.0151	1.0148	1.0148	1.0121	1.0246	1.0074	1.0135
54/42	0.9919	1.0097	1.0050	1.0105	0.9955	1.0036	1.0008	1.0024	1.0029	1.0031	1.0000	1.0105	0.9919	1.0008
66/54	0.9992	0.9957	1.0129	0.9944	1.0032	1.0041	0.9931	1.0004	0.9993	1.0015	1.0001	1.0129	0.9931	1.0001
78/66	1.0038	0.9973	1.0047	1.0067	1.0013	0.9991	1.0047	1.0025	1.0027	1.0033	1.0017	1.0067	0.9973	1.0017
90/78	0.9972	0.9982	1.0074	1.0014	1.0068	0.9980	1.0029	1.0017	1.0015	1.0033	1.0026	1.0074	0.9972	1.0026
102/90	1.0146	0.9940	1.0194	0.9997	1.0104	1.0049	1.0027	1.0065	1.0065	1.0074	1.0060	1.0194	0.9940	1.0060
114/102	1.0290	1.0062	1.0046	1.0018	1.0028	1.0071	1.0016	1.0076	1.0045	1.0036	1.0038	1.0290	1.0016	1.0038
126/114	1.0071	1.0034	1.0063	1.0071	1.0092	1.0064	1.0079	1.0068	1.0070	1.0074	1.0078	1.0092	1.0034	1.0078
138/126	1.0121	1.0129	1.0095	1.0042	1.0038	1.0055	1.0108	1.0084	1.0084	1.0068	1.0067	1.0129	1.0038	1.0067
150/138	0.9952	1.0116	1.0064	1.0047	1.0071	1.0092	1.0043	1.0055	1.0063	1.0063	1.0069	1.0116	0.9952	1.0069
162/150	1.0111	1.0128	1.0126	1.0106	1.0096	1.0003	1.0062	1.0090	1.0100	1.0079	1.0054	1.0128	1.0003	1.0054
174/162	1.0070	1.0088	0.9984	1.0061	1.0167	1.0083	1.0082	1.0076	1.0077	1.0075	1.0111	1.0167	0.9984	1.0111
186/174	1.0042	1.0082	1.0021	1.0116	1.0021	1.0188	1.0059	1.0076	1.0064	1.0081	1.0089	1.0188	1.0021	1.0089
198/186		1.0089	1.0124	1.0113	1.0096	1.0084	1.0075	1.0097	1.0096	1.0098	1.0085	1.0124	1.0075	1.0085
210/198			1.0048	1.0108	1.0121	1.0029	1.0071	1.0075	1.0076	1.0075	1.0074	1.0121	1.0029	1.0074
222/210				1.0023	1.0084	1.0146	1.0040	1.0073	1.0062	1.0073	1.0090	1.0146	1.0023	1.0090
234/222					1.0067	1.0062	1.0035	1.0055	1.0062	1.0055	1.0055	1.0067	1.0035	1.0055
246/234						1.0065	1.0054	1.0060	1.0060	1.0060	1.0060	1.0065	1.0054	1.0060
Ult/246					1.0462	1.0183	1.0554	1.0400	1.0462	1.0400	1.0400	1.0554	1.0183	1.0400

California Workers' Compensation

State Fund - Indemnity Loss Development Factors

Age in Months	Reported as of 6/85	6/86	6/87	6/88	6/89	6/90	6/91	Average	Avg x Hi/Low	5 Yr Avg	3 Yr Avg	Maximum	Minimum	Selected
30/18	1.2270	1.2444	1.2465	1.2723	1.1879	1.1656	1.1099	1.2077	1.2143	1.1964	1.1545	1.2723	1.1099	1.1500
42/30	1.0491	1.0946	1.0924	1.0639	1.0272	1.0146	0.9761	1.0454	1.0494	1.0348	1.0060	1.0946	0.9761	0.9761
54/42	1.0228	1.0347	1.0424	1.0288	0.9938	1.0039	0.9856	1.0160	1.0168	1.0109	0.9944	1.0424	0.9856	0.9856
66/54	1.0102	1.0336	1.0333	1.0177	1.0026	0.9971	0.9789	1.0105	1.0122	1.0059	0.9929	1.0336	0.9789	0.9789
78/66	1.0006	1.0104	1.0247	1.0096	0.9951	0.9913	0.9847	1.0023	1.0014	1.0011	0.9904	1.0247	0.9847	0.9847
90/78	0.9995	0.9990	1.0083	0.9989	1.0044	0.9971	0.9937	1.0001	0.9998	1.0005	0.9984	1.0083	0.9937	0.9937
102/90	0.9982	0.9905	0.9970	1.0009	1.0088	0.9965	0.9975	0.9985	0.9980	1.0001	1.0009	1.0088	0.9905	0.9975
114/102	0.9957	0.9949	0.9968	1.0096	1.0053	1.0010	0.9868	0.9986	0.9987	0.9999	0.9977	1.0096	0.9868	0.9868
126/114	0.9990	0.9973	1.0003	1.0029	1.0040	0.9977	0.9955	0.9995	0.9994	1.0001	0.9991	1.0040	0.9955	0.9955
138/126	0.9959	0.9984	1.0049	1.0015	1.0173	1.0028	0.9948	1.0022	1.0007	1.0043	1.0050	1.0173	0.9948	0.9948
150/138	0.9959	1.0050	1.0005	1.0091	1.0276	1.0092	1.0017	1.0070	1.0051	1.0096	1.0128	1.0276	0.9959	1.0017
162/150	0.9972	0.9989	1.0027	1.0052	1.0602	1.0010	0.9991	1.0092	1.0014	1.0136	1.0201	1.0602	0.9972	0.9991
174/162	0.9975	0.9975	1.0011	0.9977	1.0360	1.0028	1.0037	1.0052	1.0006	1.0083	1.0142	1.0360	0.9975	1.0037
186/174	0.9987	1.0092	0.9982	1.0046	1.0213	1.0020	0.9974	1.0045	1.0025	1.0047	1.0069	1.0213	0.9974	0.9974
198/186		1.0018	1.0229	1.0047	1.0058	1.0025	0.9975	1.0059	1.0037	1.0067	1.0019	1.0229	0.9975	0.9975
210/198			1.0019	0.9770	1.0062	1.0012	1.0004	0.9973	1.0012	0.9973	1.0026	1.0062	0.9770	1.0004
222/210				1.0084	1.0037	1.0004	1.0009	1.0034	1.0023	1.0034	1.0017	1.0084	1.0004	1.0009
234/222					1.0085	1.0051	1.0040	1.0059	1.0051	1.0059	1.0059	1.0085	1.0040	1.0040
246/234						1.0032	1.0034	1.0033	1.0033	1.0033	1.0033	1.0034	1.0032	1.0034
Ult/246					1.0180	1.0058	1.0189	1.0142	1.0180	1.0142	1.0142	1.0189	1.0058	1.0142

California Workers' Compensation

State Fund - Medical Loss Development Factors

Age in Months	Reported as of 6/85	6/86	6/87	6/88	6/89	6/90	6/91	Average	Avg x Hi/Low	5 Yr Avg	3 Yr Avg	Maximum	Minimum	Selected
30/18	1.0983	1.0721	1.0859	1.1163	1.1256	1.1249	1.0951	1.1026	1.1041	1.1096	1.1152	1.1256	1.0721	1.0951
42/30	1.0067	1.0163	1.0312	1.0118	1.0128	0.9976	0.9807	1.0082	1.0090	1.0068	0.9970	1.0312	0.9807	0.9807
54/42	0.9947	1.0083	1.0262	0.9945	0.9949	1.0151	0.9650	0.9998	1.0015	0.9991	0.9917	1.0262	0.9650	0.9650
66/54	1.0049	0.9849	0.9976	1.0151	1.0194	1.0041	0.9865	1.0018	1.0016	1.0045	1.0033	1.0194	0.9849	0.9865
78/66	0.9858	1.0077	1.0152	1.0110	1.0071	0.9999	0.9932	1.0028	1.0038	1.0053	1.0001	1.0152	0.9858	0.9932
90/78	0.9999	1.0188	0.9999	1.0095	1.0164	1.0017	0.9976	1.0063	1.0055	1.0050	1.0052	1.0188	0.9976	0.9976
102/90	0.9875	1.0140	1.0044	1.0074	1.0296	1.0374	1.0150	1.0136	1.0141	1.0188	1.0273	1.0374	0.9875	1.0273
114/102	1.0115	1.0016	1.0161	1.0141	1.0014	1.0077	0.9612	1.0019	1.0073	1.0001	0.9901	1.0161	0.9612	0.9901
126/114	1.0068	0.9987	1.0023	1.0226	1.0116	1.0078	1.0114	1.0087	1.0080	1.0111	1.0103	1.0226	0.9987	1.0103
138/126	1.0017	0.9941	1.0170	1.0215	1.0085	1.0181	1.0162	1.0110	1.0123	1.0163	1.0143	1.0215	0.9941	1.0143
150/138	1.0016	0.9941	1.0030	1.0185	1.0030	1.0138	1.0025	1.0052	1.0048	1.0082	1.0064	1.0185	0.9941	1.0064
162/150	1.0298	0.9820	1.0182	1.0356	1.0373	1.0148	1.0073	1.0179	1.0211	1.0226	1.0198	1.0373	0.9820	1.0198
174/162	1.0037	1.0064	1.0461	1.0409	0.9960	1.0167	1.0084	1.0169	1.0152	1.0216	1.0070	1.0461	0.9960	1.0070
186/174	1.0119	1.0041	1.0089	1.0244	1.0123	1.0147	1.0337	1.0157	1.0144	1.0188	1.0202	1.0337	1.0041	1.0202
198/186		1.0182	1.0090	1.0526	1.0176	1.0088	1.0512	1.0262	1.0240	1.0278	1.0259	1.0526	1.0088	1.0259
210/198			0.9938	1.0198	1.0135	1.0106	1.0087	1.0093	1.0109	1.0093	1.0109	1.0198	0.9938	1.0109
222/210				1.0133	1.0143	1.0159	1.0271	1.0177	1.0151	1.0177	1.0191	1.0271	1.0133	1.0191
234/222					1.0384	1.0063	1.1186	1.0544	1.0384	1.0544	1.0544	1.1186	1.0063	1.0384
246/234						1.0212	1.0136	1.0174	1.0174	1.0174	1.0174	1.0212	1.0136	1.0174
Ult/246					1.0462	1.0183	1.0554	1.0400	1.0462	1.0400	1.0400	1.0554	1.0183	1.0400

California Workers' Compensation

Loss Ratios

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Private Carrier Loss Ratio			State Fund Loss Ratio			SF- PC Loss Ratio Difference
Year	Indemnity	Medical	Total	Indemnity	Medical	Total	(7) - (4)
1970	0.0963	0.1093	0.2056	0.1061	0.1451	0.2512	0.0456
1971	0.1076	0.1297	0.2373	0.1123	0.1446	0.2569	0.0196
1972	0.1167	0.1444	0.2611	0.1270	0.2195	0.3465	0.0854
1973	0.1242	0.1482	0.2724	0.1259	0.2035	0.3294	0.0570
1974	0.1377	0.1647	0.3024	0.1263	0.1871	0.3134	0.0110
1975	0.1466	0.1694	0.3160	0.1251	0.1672	0.2923	-0.0237
1976	0.1515	0.1705	0.3220	0.1621	0.2182	0.3803	0.0583
1977	0.1558	0.1753	0.3311	0.1514	0.1988	0.3502	0.0191
1978	0.1543	0.1720	0.3263	0.1496	0.2132	0.3628	0.0365
1979	0.1804	0.1972	0.3776	0.1775	0.2428	0.4203	0.0427
1980	0.1969	0.1991	0.3960	0.1903	0.2492	0.4395	0.0435
1981	0.2069	0.2039	0.4108	0.2119	0.2711	0.4830	0.0722
1982	0.2308	0.1992	0.4300	0.2374	0.2778	0.5152	0.0852
1983	0.2442	0.2213	0.4655	0.2573	0.3240	0.5813	0.1158
1984	0.2581	0.2244	0.4825	0.2695	0.3290	0.5985	0.1160
1985	0.2749	0.2383	0.5132	0.2928	0.3386	0.6314	0.1182
1986	0.2715	0.2414	0.5129	0.2854	0.3541	0.6395	0.1266
1987	0.2813	0.2510	0.5323	0.2848	0.3579	0.6427	0.1104
1988	0.2964	0.2627	0.5591	0.3020	0.3699	0.6719	0.1128
1989	0.3137	0.2816	0.5953	0.3262	0.4094	0.7356	0.1403
1990	0.3649	0.3126	0.6775	0.4283	0.5030	0.9313	0.2538

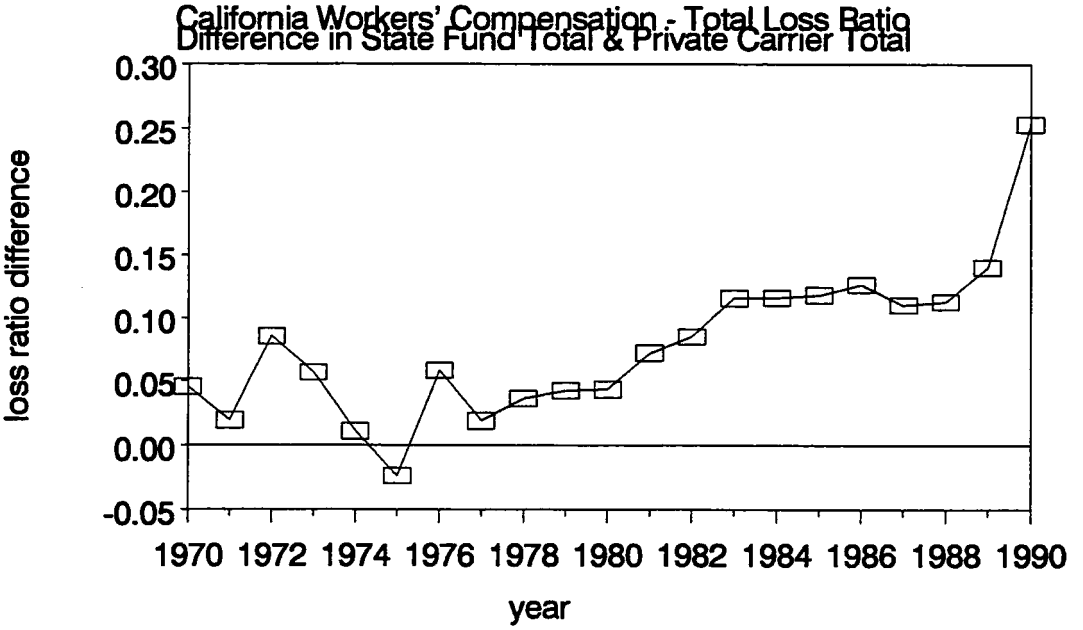


Exhibit AIS-9

California Workers' Compensation

Market Share

Year	Premium			Market Share	
	Private Carriers	State Fund	Total	Private Carriers	State Fund
1970	$425,067,278	$89,184,836	$514,252,114	82.7%	17.3%
1971	$401,017,412	$97,230,003	$498,247,415	80.5%	19.5%
1972	$460,046,145	$109,142,756	$569,188,901	80.8%	19.2%
1973	$569,332,932	$126,497,043	$695,829,975	81.8%	18.2%
1974	$647,431,333	$146,272,768	$793,704,101	81.6%	18.4%
1975	$748,432,963	$175,735,476	$924,168,439	81.0%	19.0%
1976	$962,500,006	$184,403,872	$1,146,903,878	83.9%	16.1%
1977	$1,368,201,818	$273,983,682	$1,642,185,500	83.3%	16.7%
1978	$1,650,687,734	$360,833,972	$2,011,521,706	82.1%	17.9%
1979	$1,896,240,392	$371,908,771	$2,268,149,163	83.6%	16.4%
1980	$2,092,213,119	$395,675,738	$2,487,888,857	84.1%	15.9%
1981	$2,203,137,742	$398,120,412	$2,601,258,154	84.7%	15.3%
1982	$2,158,580,278	$377,946,170	$2,536,526,448	85.1%	14.9%
1983	$2,472,501,980	$448,644,202	$2,921,146,182	84.6%	15.4%
1984	$2,920,555,351	$556,345,450	$3,476,900,801	84.0%	16.0%
1985	$3,318,263,644	$683,779,865	$4,002,043,509	82.9%	17.1%
1986	$3,893,449,351	$986,205,568	$4,879,654,919	79.8%	20.2%
1987	$4,608,111,489	$1,401,585,695	$6,009,697,184	76.7%	23.3%
1988	$5,371,031,206	$1,721,375,249	$7,092,406,455	75.7%	24.3%
1989	$5,954,706,816	$1,754,063,476	$7,708,770,292	77.2%	22.8%
1990	$6,489,118,449	$1,777,717,871	$8,266,836,320	78.5%	21.5%

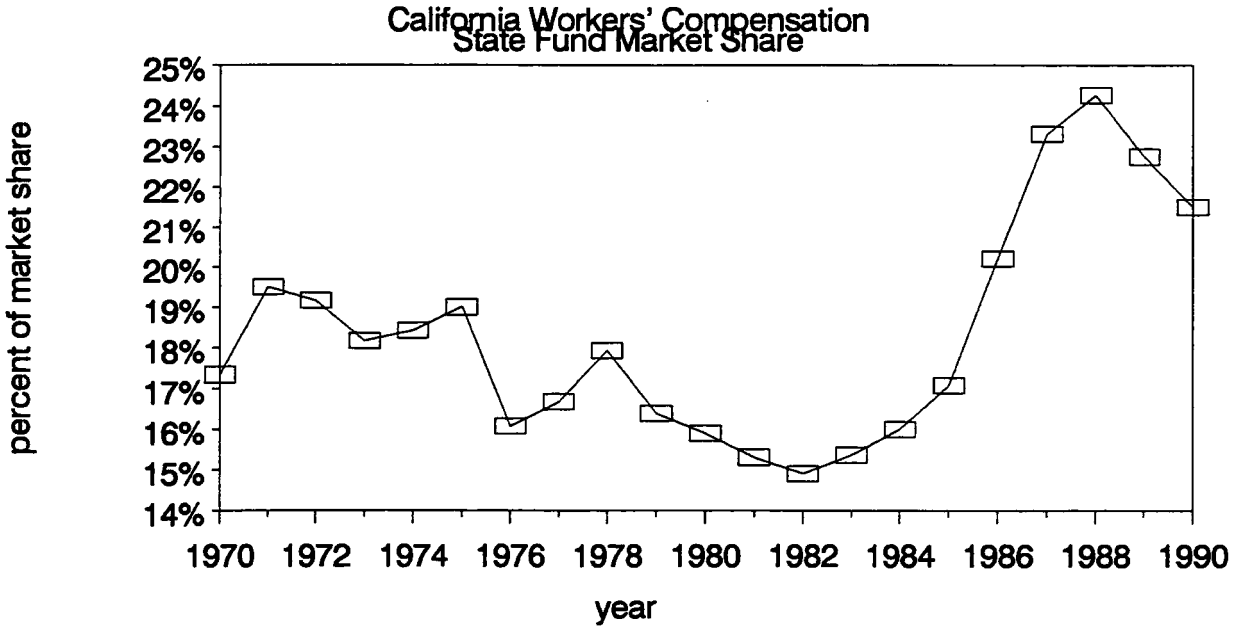


Exhibit AIS-10

DERIVATION OF LOSS TREND PERIOD

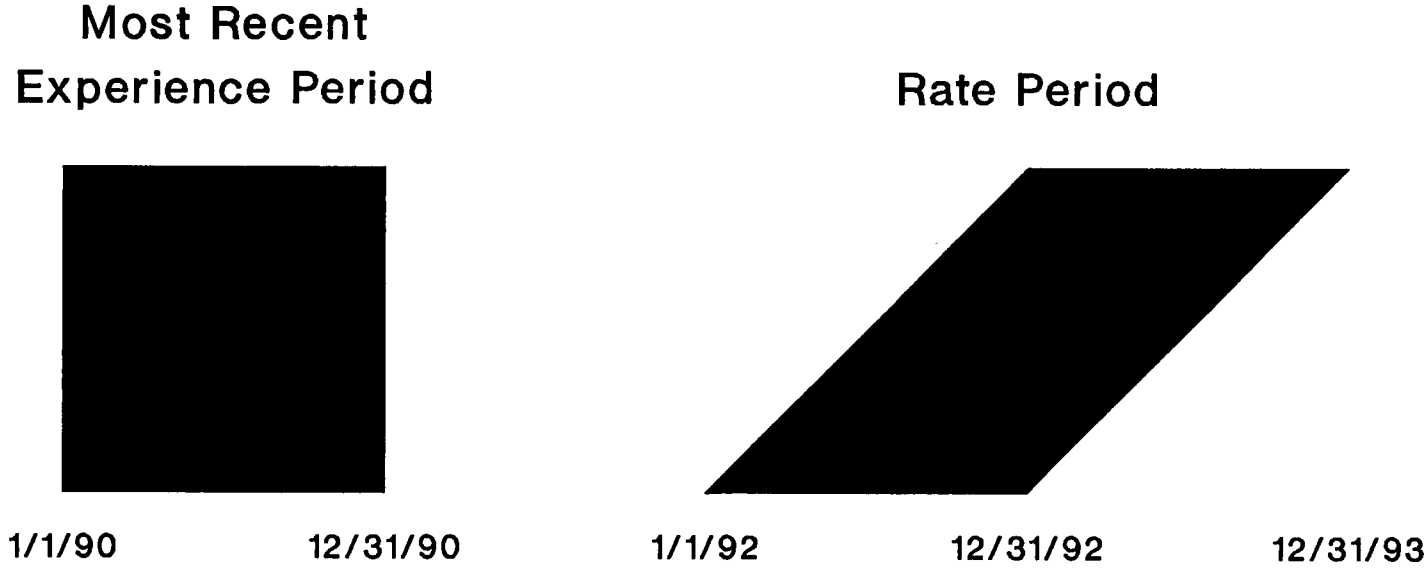


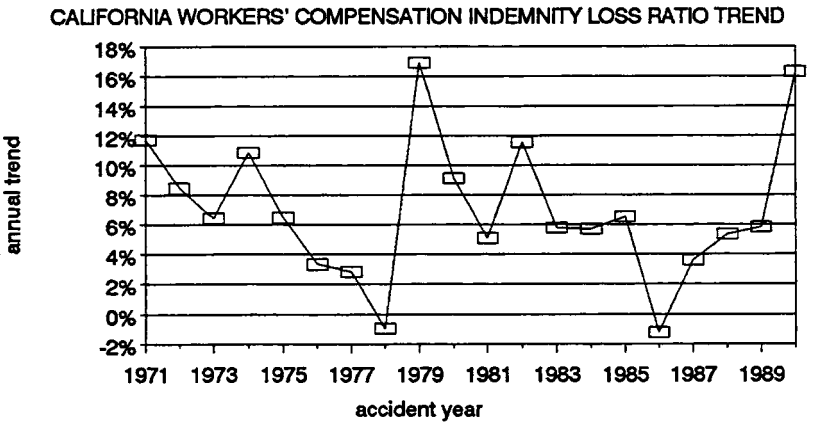
Exhibit AIS-11

CALIFORNIA WORKERS' COMPENSATION INDEMNITY LOSS RATIO TREND

Accident Year	Loss Ratio	Percent Change	Least Squared Fitted Value Linear	Least Squared Fitted Value Exponential	Residual Linear	Residual Exponential
1970	0.096		0.083	0.103	-0.013	0.007
1971	0.108	11.7%	0.095	0.110	-0.012	0.002
1972	0.117	8.5%	0.108	0.117	-0.009	-0.000
1973	0.124	6.4%	0.120	0.124	-0.004	-0.000
1974	0.138	10.9%	0.132	0.132	-0.006	-0.006
1975	0.147	6.5%	0.144	0.140	-0.002	-0.006
1976	0.152	3.3%	0.156	0.149	0.005	-0.002
1977	0.156	2.8%	0.169	0.159	0.013	0.003
1978	0.154	-1.0%	0.181	0.169	0.027	0.015
1979	0.180	16.9%	0.193	0.180	0.013	-0.000
1980	0.197	9.1%	0.205	0.191	0.008	-0.005
1981	0.207	5.1%	0.217	0.204	0.011	-0.003
1982	0.231	11.6%	0.230	0.217	-0.001	-0.014
1983	0.244	5.8%	0.242	0.231	-0.002	-0.014
1984	0.258	5.7%	0.254	0.245	-0.004	-0.013
1985	0.275	6.5%	0.266	0.261	-0.009	-0.014
1986	0.272	-1.2%	0.278	0.278	0.007	0.006
1987	0.281	3.6%	0.291	0.296	0.009	0.014
1988	0.296	5.4%	0.303	0.315	0.006	0.018
1989	0.314	5.8%	0.315	0.335	0.001	0.021
1990	0.365	16.3%	0.327	0.356	-0.038	-0.009
Average		7.0%			0.000	0.000
Avg Ex Hi/Low		6.9%				
Standard Deviation		4.7%				
Maximum		16.9%				
Minimum		-1.2%				
Annual Trend		-0.1%	(R squared =	0.007)		

Linear Regression Output:	
Constant	-23.9497
Std Err of Y Est	0.0133505
R Squared	0.9712968
No. of Observations	21
Degrees of Freedom	19
X Coefficient(s)	0.0121994
Std Err of Coef.	0.0004811
T-Statistic	25.356411

Exponential Regression Output:	
Constant	-124.4892
Std Err of Y Est	0.0471304
R Squared	0.9859588
No. of Observations	21
Degrees of Freedom	19
X Coefficient(s)	0.0620385
Std Err of Coef.	0.0016984
T-Statistic	36.526272

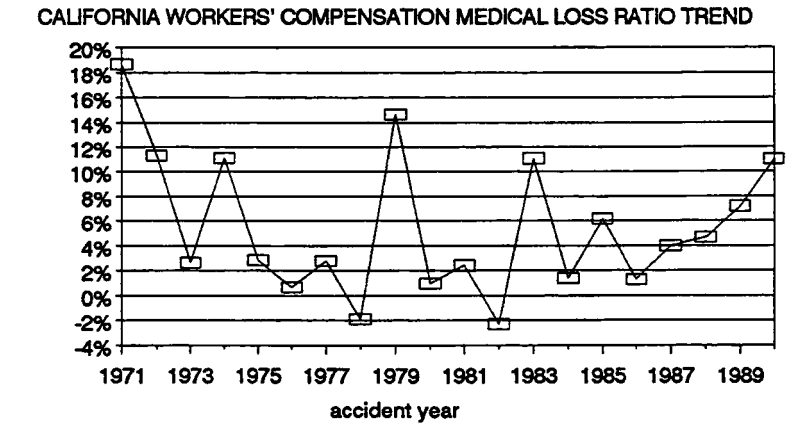


CALIFORNIA WORKERS' COMPENSATION MEDICAL LOSS RATIO TREND

Accident Year	Loss Ratio	Percent Change	Least Squared Fitted Value Linear	Least Squared Fitted Value Exponential	Residual Linear	Residual Exponential
1970	0.109		0.119	0.128	0.010	0.019
1971	0.130	18.7%	0.127	0.134	-0.002	0.004
1972	0.144	11.3%	0.135	0.139	-0.009	-0.005
1973	0.148	2.6%	0.144	0.145	-0.005	-0.003
1974	0.165	11.1%	0.152	0.151	-0.013	-0.013
1975	0.169	2.9%	0.160	0.158	-0.009	-0.012
1976	0.171	0.6%	0.168	0.165	-0.002	-0.006
1977	0.175	2.8%	0.176	0.172	0.001	-0.004
1978	0.172	-1.9%	0.184	0.179	0.012	0.007
1979	0.197	14.7%	0.193	0.186	-0.005	-0.011
1980	0.199	1.0%	0.201	0.194	0.002	-0.005
1981	0.204	2.4%	0.209	0.203	0.005	-0.001
1982	0.199	-2.3%	0.217	0.211	0.018	0.012
1983	0.221	11.1%	0.225	0.220	0.004	-0.001
1984	0.224	1.4%	0.233	0.230	0.009	0.005
1985	0.238	6.2%	0.242	0.239	0.003	0.001
1986	0.241	1.3%	0.250	0.250	0.008	0.008
1987	0.251	4.0%	0.258	0.260	0.007	0.009
1988	0.263	4.7%	0.266	0.271	0.003	0.009
1989	0.282	7.2%	0.274	0.283	-0.007	0.001
1990	0.313	11.0%	0.282	0.295	-0.030	-0.018
Average		5.5%			-0.000	-0.000
Avg Ex Hi/Low		5.2%				
Standard Deviation		5.6%				
Maximum		18.7%				
Minimum		-2.3%				
Annual Trend		-0.2%	(R squared =	0.035)		

Linear Regression Output:	
Constant	-15.96194
Std Err of Y Est	0.0107434
R Squared	0.9590099
No. of Observations	21
Degrees of Freedom	19
X Coefficient(s)	0.0081629
Std Err of Coef.	0.0003871
T-Statistic	21.083814

Exponential Regression Output:	
Constant	-84.14612
Std Err of Y Est	0.0552221
R Squared	0.9584660
No. of Observations	21
Degrees of Freedom	19
X Coefficient(s)	0.0416707
Std Err of Coef.	0.0019900
T-Statistic	20.939357



California Workers' Compensation Expense Ratios

	1983	1984	1985	1986	1987
			All Companies		
Loss Adjustment Expense	8.93%	9.12%	9.29%	9.72%	10.19%
Commission	6.96%	6.06%	5.69%	5.53%	5.16%
Other Acquisition Expense	3.76%	3.82%	3.47%	2.96%	2.76%
General Expense	7.22%	6.18%	5.65%	5.05%	4.92%
State and Other Tax	2.58%	2.59%	2.62%	2.75%	2.74%
Total	29.45%	27.77%	26.72%	26.01%	25.77%
Underwriting Expenses	17.94%	16.06%	14.81%	13.54%	12.84%
			Stock Companies		
Loss Adjustment Expense	9.20%	9.38%	9.62%	10.03%	10.80%
Commission	8.64%	8.06%	7.36%	7.67%	7.38%
Other Acquisition Expense	3.77%	3.96%	3.62%	3.04%	3.00%
General Expense	8.03%	6.90%	6.43%	5.96%	6.37%
State and Other Tax	2.58%	2.59%	2.62%	2.75%	2.74%
Total	32.22%	30.89%	29.65%	29.45%	30.29%
Underwriting Expenses	20.44%	18.92%	17.41%	16.67%	16.75%
			Non-Stock Companies (Excluding State Fund)		
Loss Adjustment Expense	8.32%	8.53%	8.80%	9.68%	9.69%
Commission	4.03%	2.56%	3.94%	3.07%	3.89%
Other Acquisition Expense	4.89%	4.60%	3.73%	3.57%	2.71%
General Expense	6.16%	6.02%	4.54%	4.49%	2.76%
State and Other Tax	2.58%	2.59%	2.62%	2.75%	2.74%
Total	25.98%	24.30%	23.63%	23.56%	21.79%
Underwriting Expenses	15.08%	13.18%	12.21%	11.13%	9.36%
			State Fund		
Loss Adjustment Expense	7.92%	8.44%	8.27%	8.76%	8.87%
Commission	—	—	—	—	—
Other Acquisition Expense	3.03%	2.87%	2.74%	2.42%	2.14%
General Expense	3.64%	3.45%	3.18%	2.47%	2.24%
State and Other Tax	2.58%	2.59%	2.62%	2.75%	2.74%
Total	17.17%	17.35%	16.81%	16.40%	15.99%
Underwriting Expenses	6.67%	6.32%	5.92%	4.89%	4.38%

Note: All ratios based on California Workers' Compensation Expense Call, except State and Other Tax, which is assumed to be 2.35% of premium after dividends +.7%.

EXPENSE COMPARISON BY MARKET TYPE OF INSURER

(Net of Reinsurance - Countrywide)

(1)	(2)	1989 Workers' Compensation Countrywide Expense Ratios (3)	(4)	(5)	(6)	(7)
Group	1989 Net WC Written Premium (000)	Commission & Brokerage	Other Acquisition	General Expenses	Total Non-Tax Expenses	Direct / Agency
Nationwide	$912,549	-12.1%	6.8%	6.0%	0.7%	D
New Jersey Mfrs	$190,510	0.7%	1.1%	2.3%	4.1%	D
Employers Of Texas	$249,269	-7.1%	3.8%	7.6%	4.3%	A
CIGNA	$1,207,791	-2.5%	3.0%	4.1%	4.6%	A
Liberty Mutual	$3,118,741	-1.8%	2.5%	3.9%	4.6%	D
Travelers	$1,089,155	2.5%	4.2%	-2.0%	4.7%	A
Electric Mutual Group	$103,075	5.4%	0.2%	2.3%	7.9%	D
American International	$1,522,013	1.5%	2.7%	3.7%	7.9%	A
Aetna Life & Casualty	$1,256,037	5.2%	5.0%	-0.5%	9.7%	A
Old Republic	$214,956	-0.8%	1.0%	9.6%	9.8%	A
CNA Insurance	$1,638,428	5.9%	1.9%	2.8%	10.6%	A
Kemper	$1,226,752	4.3%	2.5%	3.9%	10.7%	A
Allstate Insurance	$341,669	3.1%	1.9%	5.7%	10.7%	D
PMA	$547,242	5.7%	2.2%	3.9%	11.8%	A
SAIF	$252,615	0.4%	8.2%	3.8%	12.4%	D
Republic American	$293,242	9.1%	2.0%	2.3%	13.4%	A
Commercial Union	$140,487	11.4%	-7.4%	9.7%	13.7%	A
Home Insurance	$577,204	7.4%	0.8%	6.1%	14.3%	A
Hartford Insurance	$1,097,229	10.5%	1.0%	3.5%	15.0%	A
Argonaut Insurance	$309,910	7.6%	6.2%	1.8%	15.6%	A
Fireman's Fund	$560,446	1.6%	3.5%	10.6%	15.7%	A
Continental Insurance	$890,449	2.6%	4.1%	9.1%	15.8%	A
Highlands Insurance	$171,837	3.5%	3.3%	9.0%	15.8%	A
Orion	$353,211	6.9%	4.0%	5.7%	16.6%	A
Ohio Casualty	$204,771	12.0%	1.7%	3.0%	16.7%	A
St Paul	$291,515	1.7%	5.3%	10.4%	17.4%	A
Cincinnati Financial	$91,671	12.2%	2.2%	3.1%	17.5%	A
United States F & G	$633,691	12.5%	2.1%	3.3%	17.9%	A
Zurich	$824,263	9.7%	3.0%	5.4%	18.1%	A
Amerisure Ins Cos	$138,524	9.9%	2.8%	5.6%	18.3%	A
General Accident	$151,042	10.0%	3.5%	4.8%	18.3%	A
Reliance	$305,686	3.9%	4.4%	10.1%	18.4%	A
Harleysville Insurance	$96,784	11.5%	6.5%	0.6%	18.6%	A
Sentry	$211,225	12.6%	3.3%	3.2%	19.1%	D
Farmers Insurance	$103,993	18.6%	-	0.8%	19.4%	D
Safeco	$137,893	10.1%	5.0%	4.4%	19.5%	A
Utica National	$107,974	10.1%	1.8%	7.6%	19.5%	A
Crum & Forster	$749,124	8.4%	2.8%	8.4%	19.6%	A
State Farm	$218,976	12.4%	4.8%	3.5%	20.7%	D
Auto-Owners Group	$94,759	14.7%	3.9%	2.7%	21.3%	A
American Financial	$172,846	12.2%	2.5%	7.5%	22.2%	A
Royal Insurance	$331,387	7.7%	2.7%	11.9%	22.3%	A
Fremont General	$341,353	9.5%	4.2%	8.7%	22.4%	A
Atlantic Mutual	$136,467	10.2%	9.2%	4.1%	23.5%	A
Zenith National	$186,113	9.5%	5.1%	9.3%	23.9%	A
Transamerica	$387,957	10.6%	6.3%	7.0%	23.9%	A
Hanover Insurance	$197,159	14.0%	3.7%	6.4%	24.1%	A
Lincoln National	$273,953	15.0%	3.0%	6.2%	24.2%	A
Chubb	$223,715	5.3%	7.2%	12.9%	25.4%	A
Lumbermen's	$93,368	13.1%	0.5%	13.9%	27.5%	D
Sub-Total	$24,971,026	4.2%	3.2%	4.7%	12.1%	
Industry Total	$28,241,380	4.6%	3.4%	4.9%	12.9%	

Source: Best's Aggregates & Averages

Other Underwriting Expenses
(Net of Reinsurance - Countrywide)
By Market Type of Company

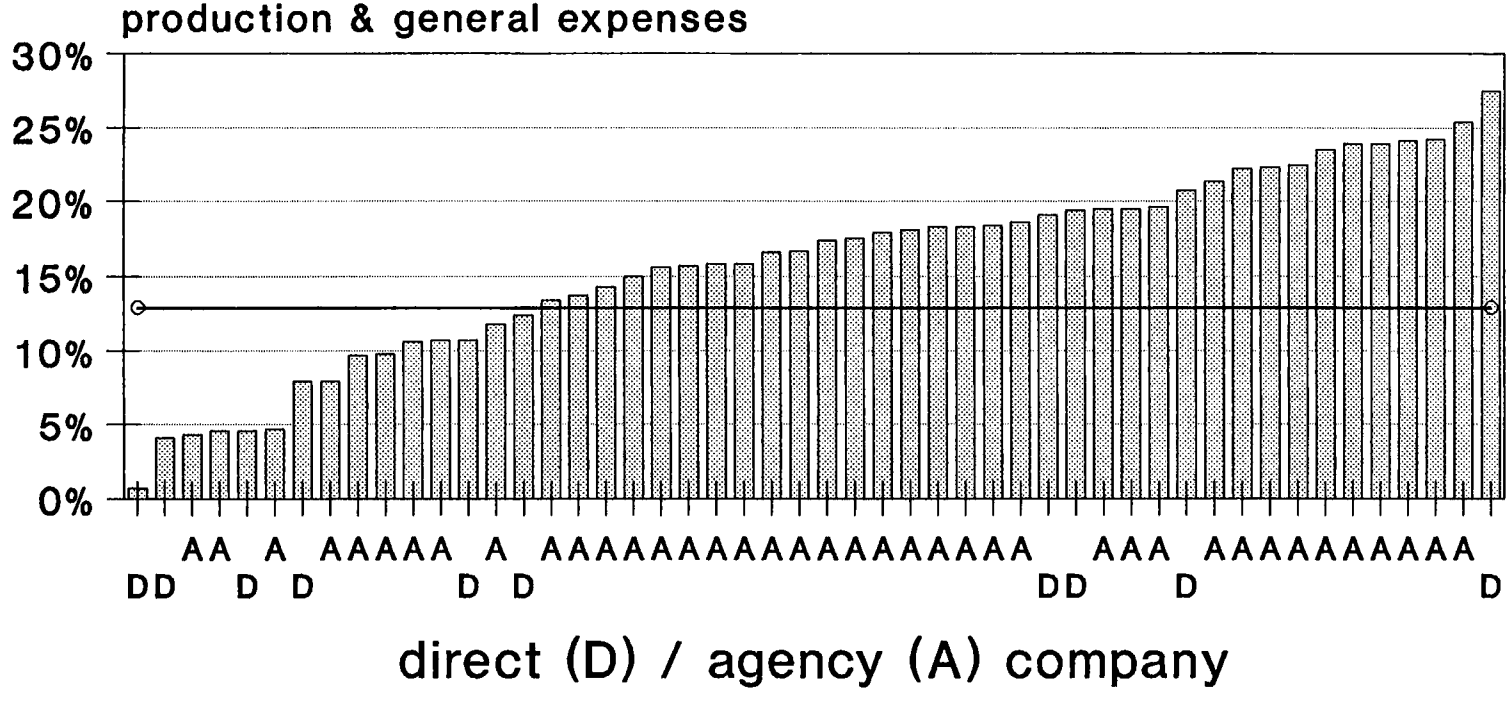


Exhibit AIS-14, Sheet 2

VIRGINIA

EXHIBIT II

Exhibit II-F - Table of Premium Discounts

Division of Standard Premium		Schedule (Y)+ *	Schedule (X)+
First	$5,000	---	---
Next	$95,000	10.9%	3.5%
Next	$400,000	12.6%	5.0%
Over	$500,000	14.4%	7.0%

\+ Note - Each company shall use the schedule of discounts approved for its use by the State Corporation Commission.

* To be used by all carriers for policies issued under an assigned risk plan.

Application of the appropriate discount schedule to the standard premium produces a dollar discount that is subtracted from the standard premium.

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POLICYHOLDER DIVIDEND RATIOS
Average from 1981 - 1990

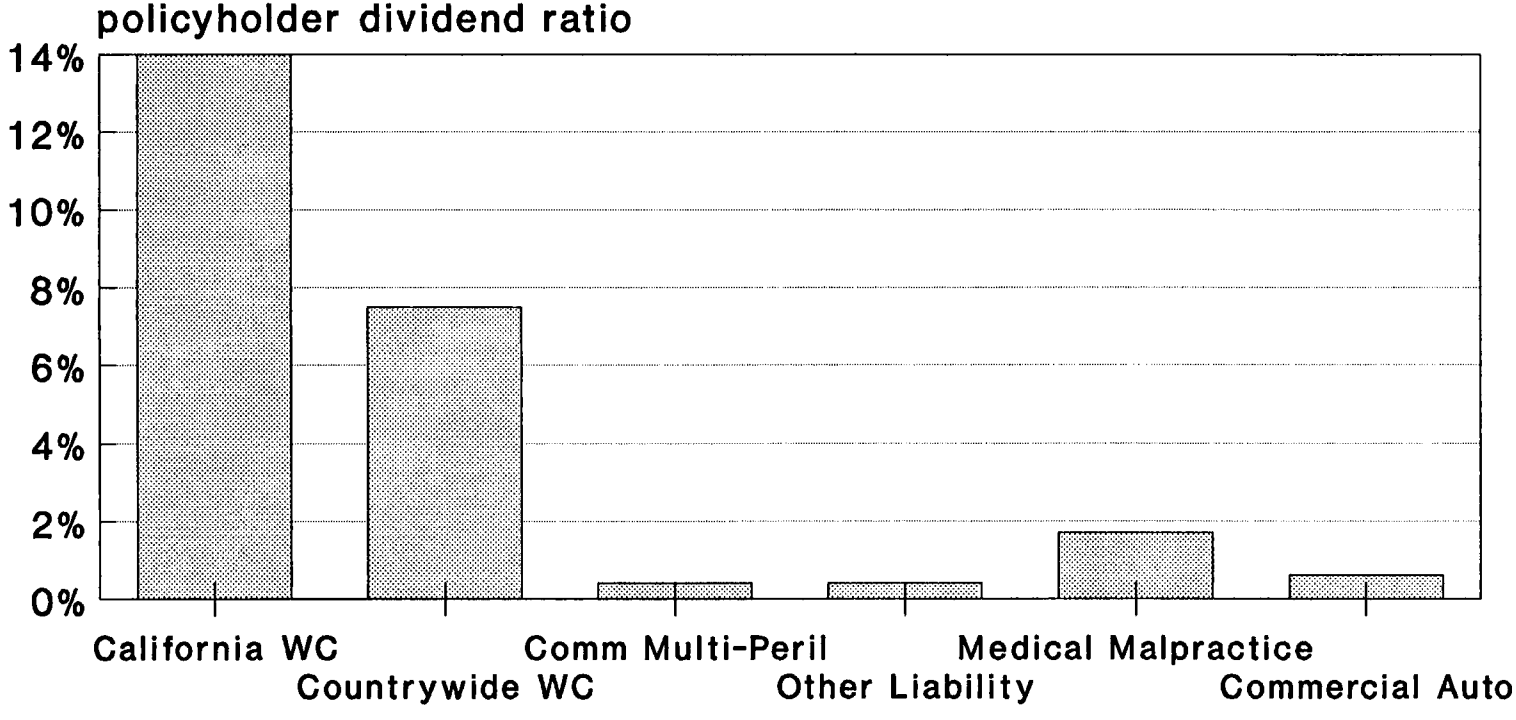

Exhibit AIS-16

CHAPTER 17

LOSS AND LOSS ADJUSTMENT EXPENSES INCURRED

Losses Incurred

Losses incurred are reported in the Underwriting and Investment exhibits of the annual statement. Losses incurred are shown in a separate exhibit in the annual statement by adding the current year change in unpaid losses to the paid loss amount for the current year. The paid figure is direct paid losses, plus assumed paid losses, less ceded paid losses. Unpaid loss changes are also calculated on a basis net of reinsurance.

Loss Adjustment Expenses Incurred

Loss adjustment expenses incurred as presented in the annual statement comprise all expenses incurred in connection with the adjustment and recording of policy claims.

They include the total of the expense classification "Claim Adjustment Services" and the types of expenses incurred by company employees in connection with the adjustment and recording of claims. Examples of expenses incurred in these activities are estimating the amounts of claims, disbursing claims, maintaining records, general clerical, secretarial, office maintenance, supervisory and executive duties, supplies, and postage.

Loss adjustment expenses are either "allocated" or "unallocated." Allocated expenses are those that can usually be related to specific claims; typically they are "claim adjustment services" for which specific invoices are rendered. They are adjusted for reinsurance assumed and ceded.

Unallocated expenses are those for which no identification can be made to specific claims. These include a portion of the expenses charged to the other operating expense classifications such as salaries. These expenses should be allocated to the expense group "Loss Adjustment Expense."

For further information on allocation of expenses, see Chapter 19-Expenses.

Uninsured Accident and Health Plans

See Chapter 14-Premiums for the discussion of uninsured accident and health plans and partially insured accident and health plans.

Losses paid by the insurer under uninsured accident and health plans should not be reported in the underwriting and investment exhibits. Loss payments under the insured portion of partially insured plans are reported as accident and health losses.

CHAPTER 18

COMMISSIONS

Commissions represent a significant portion of "Other Underwriting" expenses for most insurance companies. Statutory insurance accounting requires that the total commissions allowed on the policy be immediately charged as an expense. Commissions must be recorded when premium entries are recorded.

The method used to pay commissions depends on the contractual relationship between the agent and the company. If a company uses direct billings for premium collections, agents' commissions are usually paid by the company to the agent on a scheduled timing basis. If premiums are billed by the company using the agency billing method, the agent usually deducts commissions from premium collections and remits the net amount of premium to the company. Under both payment methods, commissions are recorded when premium entries are made. (See Chapter 7-Agents' Balances or Uncollected Premiums.)

Under agency billing or direct billing, the commission payable can be netted against a corresponding receivable or reflected as a liability.

Some companies allow specified agents an additional compensation that is based either upon attainment of certain production levels, within a stated period, or upon the occurrence of some other event or condition (except for commission rates contingent upon loss experience). Such amounts, which neither have been paid nor credited to the respective agents' accounts, also should be included as an offset to "Agents' Balances or Uncollected Premiums."

Financial statements should not reflect paid or incurred commissions on an earned premium basis, except for commissions based on loss experience. If commissions by contract are paid on an earned premium basis, but are not dependent on the loss experience of the insurance written, a reserve should be established for unpaid commissions. This reserve shall also be offset against "Agents' Balances or Uncollected Premiums."

Commissions payable on reinsurance assumed business should be included as an offset to "Agents' Balances or Uncollected Premiums." Commissions receivable on reinsurance ceded business should be included as an offset to "Ceded Reinsurance Balances Payable," which are included in "Agents' Balances or Uncollected Premiums."

Contingent Commission

Some insurance companies, to encourage quantity and quality of production, or to penetrate a line of business or geographical area, will enter into special commission arrangements with some of their agents. The incentive for the selection of good risks is that the agent is allowed to share in the profitability of the insurance he produces. The terms of the arrangement usually will be set forth in a "contingency commission agreement," which is either incorporated as part of the agency contract or as a separate contract. The agreement will provide for the dates upon which accountings are to be rendered to determine the contingent commissions, items to be included in the calculation, and a provision for the calculation, if any, in the event the contract is cancelled.

The determination of the contingent commission liability is based upon the terms of the commission agreement. If the contract specifies that commissions will be determined on the basis of a formula that relates to loss experience, a commission liability must be established for the earned portion. The unpaid liability for commissions that are based upon loss experience should be included in a separate liability heading—"Contingent Commissions and Other Similar Charges."

Some agency contracts provide for vesting of the agents' commissions for renewals or policy adjustments. The contract also may specify that the company will pay the agent for the commutation of commissions payable on future premium collections. Such payments must be included as a commission expense. If the company has incurred a liability to commutate an agent's commission at the balance sheet date, the liability should be included as an offset to "Agents' Balances or Uncollected Premiums."

Agents' Commission Rates

Commission rates are usually not determined by statute, but are subject to negotiation between the insurance company and its agents or brokers. Such negotiated commission rates are set forth in the agency or broker contracts.

CHAPTER 19

EXPENSES

In the insurance industry, there are expenses involved in acquiring and underwriting policies and servicing the policyholders and third party claimants. These expenses will be discussed in this chapter. (Commissions are discussed in Chapter 18.)

Regulation Number 30, called the "Uniform Classification of Expenses of Fire and Marine and Casualty and Surety Insurer," was effective January 1, 1949, for licensed New York companies. The NAIC prescribed similar uniform accounting instructions for expense reporting effective January 1, 1949. These acts brought uniformity to the industry.

This uniformity is helpful since expenses are important elements of the company's operations and accurate statistics are needed for comparisons and control. The instructions for uniform classification of expenses are a part of the NAIC *Financial Condition Examiners Handbook.*

Expense Group Classifications

Expenses for fire and casualty insurance companies are allocated to expense groups as follows:

A. Loss Adjustment Expenses

Loss adjustment expenses constitute expenses incurred in connection with the adjusting, recording, and paying of claims. (See Chapter 17-Loss and Loss Adjustment Expenses Incurred.)

B. Other Underwriting Expenses

Other underwriting expenses are classified into three categories as follows:

1. Acquisition, Field Supervision, and Collection Expenses

Acquisition costs consist of all expenses incurred in relation to the production of new and renewal insurance business. Also included are specifically identifiable and allocated expenses relating to the following activities: commissions, bonuses, allowances, and other compensation paid to agents and brokers; operating costs for agencies or branch offices; training agents and brokers; underwriting new risks; issuing new policies; receiving and paying of premiums and commissions; maintaining general and detailed records; data processing; advertising and publicity; clerical, secretarial, office maintenance, supervisory, and executive duties; postage and supplies; and all other functions reasonably associated with the production of new and renewal insurance business, such as premium collection.

2. General Expenses

This category includes all expenses not assignable to other expense groups.

3. Taxes, Licenses, and Fees

These are state and local insurance taxes, insurance department licenses and fees, allocable payroll taxes, and all other taxes excluding federal and foreign income and real estate taxes.

All other taxes might include: (1) qualifying bond premiums; (2) statement publication fees; (3) advertising required by law; (4) personal property taxes; (5) state income taxes; (6) capital stock taxes; (7) business or corporation licenses or fees; (8) marine profits taxes; (9) documentary stamps on reinsurance; (10) guaranty association assessments; and (11) any other taxes.

Real estate taxes on investment properties are generally included with investment expenses, and capital stock taxes and apportioned payroll taxes may be reported as investment expenses.

C. Investment Expenses

These comprise expenses incurred in the investing of funds and the pursuit of investment income, including specifically identifiable and allocated expenses related to such activities as: initiating or handling orders and recommendations for investments; research; pricing; appraising and valuing; disbursing funds and collecting income; safekeeping of securities and valuable papers; maintaining general and detailed records; data processing; general clerical, secretarial, office maintenance, supervisory, and executive duties; supplies, postage, and the like; and all other functions reasonably attributable to the investment of funds.

Allocation of Expenses to Expense Groups

Some general guidelines for allocating to expense groups are shown in the following table. The expenses shown are those in the annual statement.

TABLE 19

General Guidelines for Classifying Expenses

Expenses to be Allocated to Expense Groups	Principal Basis for Allocation
Claim adjustment services	Direct charge to loss adjustment expense
Commission and brokerage	Direct charge to other underwriting acquisition
Advertising	Direct charge to other underwriting acquisition
Boards, bureaus, associations	Direct charge to other underwriting - general
Surveys and underwriting reports	Direct charge to other underwriting - general
Audit of insureds' records	Direct charge to other underwriting - general
Salaries	Studies of employee activities
Employee relations and welfare	Pro rate on salary ratios
Insurance	Pro rate on salary ratios
Directors' fees	Pro rate on salary ratios
Travel and travel items	Special studies
Rent and rent items	Pro rate on salary ratios
Equipment	Pro rate on salary ratios
Printing and stationery	Pro rate on salary ratios
Postage, telephone and telegraph, exchange and express	Pro rate on salary ratios
Legal and auditing	Special studies

Taxes, licenses, and fees (Except payroll taxes)	Special studies
Real estate expenses	Investment expenses
Real estate taxes	Investment expenses
Miscellaneous	Special studies

Any other basis of allocation which yields a more accurate result may be used for those expenses being allocated on the basis of salaries. Any basis of allocation which is found to be inappropriate should be discounted.

Apportionment of Joint Expenses

Many insurance companies operate on a group basis, sharing personnel and facilities in conducting business. When this occurs, the expenses involved must be properly apportioned to the company incurring the expenses, and included in the same expense classifications as if originally paid by that company.

Some examples of specifically identifiable expenses that may be incurred solely on behalf of one company, and charged directly to the applicable company are:

1. Advertising;
2. Claims adjustment services;
3. Commissions and brokerages;
4. Taxes and real estate expenses;
5. Employees' salaries;
6. Any other expenses that can be attributed directly in whole or in part to a specific company.

The following table contains some general guidelines for apportioning joint expenses among companies.

TABLE 19-B

General Guidelines for Apportioning Joint Expenses

Expense Item	Basis for Apportionment
Advertising	Percentage of premiums
Boards, bureaus, associations	Special studies
Surveys and underwriting reports	Special studies
Audit of insured's records	Special studies
Salaries	Studies of employee activities
Employee relations and welfare	Salaries
Insurance	Salaries
Travel and travel items	Special studies

Rent and rent items	Salaries
Equipment	Salaries
Printing and Stationery	Salaries
Postage, telephone and telegraph, exchange and express	Salaries
Legal and auditing	Special studies
Payroll taxes	Salaries
Miscellaneous	Special studies

Any other basis of allocation should be used if it yields more precise results than expenses allocated on the salaries or premium basis. If clearly inappropriate, allocation based on salaries or premium should not be employed.

A company that pays joint expenses, which are ultimately apportioned and charged to other companies in the group, should credit the apportioned expenses to the same expense items charged when the payment was made. Apportionment expenses generally should not be reported as income nor be accumulated in a separate account used to reduce total expenses for the company.

Uninsured Accident and Health Plans

Uninsured accident and health plans have been discussed in prior chapters of this manual. Commissions, expenses, and taxes incurred by the insurers are to be reported on a gross basis by type of expense; however, administration fees and expense reimbursements relating to uninsured business are deducted in the operations statements net of such fees and reimbursements.

4. Contents of filing. A rate filing shall include:

A. Maine premium, loss and loss adjustment experience. Maine premium, loss and loss adjustment experience shall show:

(1) Data from all companies writing workers' compensation insurance in this State. If a company is excluded from the rate level, trend, loss development, expense determination, classification differentials or investment income calculations, that company and its market share shall be identified and an explanation provided for its exclusion;

(2) Premiums calculated at current rate level. Whenever on-level factors are used, their derivation shall be shown. The derivation of the percentages of total premium written and earned at various rate levels shall also be shown;

(3) The amount of premium collected from the expense constant. This premium shall be provided in dollars and as a percentage of the standard earned premium and as a percentage of net earned premium. If the percentage of premium collected in this manner is expected to change, the extent of the change shall be estimated and the details of this estimation provided;

(4) The amount of premium collected by the minimum premium. This premium shall be provided in dollars and as a percentage of standard earned premium and as a percentage of earned premium. If the percentage of premium collected in this manner is expected to change, the extent of the change shall be estimated and the details of this estimation provided;

(5) Earned premiums which shall include premium collected from the specific disease loading. If disease loadings have been excluded, a justification shall be provided;

(6) The latest earned premiums and market shares for the 10 largest workers' compensation insurers, by group, in this State;

(7) The following information on companies deviating from bureau workers' compensation rates for each of the last 3 years:

(a) A list of all deviating companies;

(b) The total standard premium written at deviated rates;

(c) The percentage of the entire statewide standard premium written at deviated rates;

(d) The total amount of deviations in dollars;

(e) The average percentage deviation for deviating companies; and

(f) The average percentage deviation for all companies;

(8) The following information on company workers' compensation dividend practices for each of the last 3 years:

(a) A list of all companies issuing dividends;

(b) The total amount of dividends in dollars;

(c) The average percentage dividend issued by companies issuing dividends; and

(d) The average percentage dividend issued by all companies;

(9) All policy year and accident year incurred loss data used in the filing, provided in the aggregate and also separated into paid losses, case-incurred and incurred but not reported losses; and

(10) The related incurred losses for all incurred loss adjustment expense data contained in the filing;

B. Credibility factor development and application. All information relating to the selection of the credibility factors contained in the filing shall be provided, which shall include:

(1) A complete description of the methodology used to derive the factors;

(2) A description of the criteria used to select the methodology for inclusion in the filing;

(3) Details on the application of the methodology to this filing; and

(4) A listing of alternative methodologies used in other states in filings made during the last 2 years;

C. Loss development factor development and application.

(1) The following loss data at successive evaluation dates shall be provided:

(a) At least the latest available 12 years of data for matching companies for all pairs of successive evaluation dates, except that for a rate filing made in 1989 and 1990 the data periods shall be 10 and 11 years, respectively;

(b) Data on both a policy year and an accident year basis;

(c) Data separated into indemnity and medical losses as well as combined data;

(d) Data separated into paid, case-incurred, including incurred but not reported losses and case-incurred excluding incurred but not reported portions as well as total losses;

(e) Reported indemnity, medical, and total claims for all years and evaluation dates for which loss information is provided;

(f) The latest available 5-unit statistical policy years of loss data for matching companies for all pairs of successive evaluation dates;

(g) Case-incurred losses, number of claims, standard earned premium and earned exposures;

(h) Losses separated into indemnity and medical losses;

(i) Compensable claim experience separated into deaths, permanent totals, major permanent partials, minor permanent partials and temporary totals;

(j) Current on-level benefit factors for each injury type split between indemnity and medical; and

(k) For each policy year, the actual average wage and the average wage after the application of any payroll limitation.

(2) All information relating to the selection of the loss development factors contained in the filing shall be provided. This information shall consist of:

(a) A complete description of the methodology used to arrive at the selected factors;

(b) A description of alternative methodologies used or considered for use by the rating bureau in other states during the last 2 years; and

(c) Specific details regarding the application of the criteria used in the selection of a methodology for this filing;

D. Trending factor development and application, which shall include:

(1) The following trend information:

(a) Indemnity and medical trend factor calculations based upon both policy year data and accident year data from this State;

(b) Indemnity and medical trend factor calculations based upon countrywide policy year data;

(c) For the medical trend, separate compilations for fee schedule and nonfee schedule states on both a policy year and an accident year basis; and

(d) Any econometric projections done of claim severity, claim frequency and average weekly wages based on models used by or in the possession of the rating bureau; and

(2) All information relating to the selection of the trend factors contained in the filings. This information shall include:

(a) A complete description of the methodology used to derive the selected factors;

(b) A description of alternative methodologies used or considered for use by the rating bureau in other states; and

(c) Specific details regarding the application of the criteria used in the selection of a methodology of this filing;

E. Changes in premium base and exposures. The following information shall be provided with any filing proposing a change in premium discounts, expense constants or minimum premiums:

(1) Information on the distribution by size of policy shall be provided so that the effects of premium discount, the expense constant and the minimum premium rule can be calculated. This information shall include the number of policies and the dollar amount of premium in this State for the latest available 3 years separately for stock and nonstock companies, and combined using the following premium size distribution: $0-$199; $200-$299; $300-$499; $500-$999; $1,000-$2,999; $3,000-$4,999; $5,000-$9,999; $10,000-$24,999; $25,000-$49,999; $50,000-$99;999; $100,000-$249,999; and over $249,999. Information shall be provided for the premium bands affected by the proposed changes; and

(2) Any countrywide distributions of number of policies or premium by layer that is used in the filing shall be described. Details shall be provided concerning how these distributions have been used in the rate filing, the sources and dates of the information used to produce the distributions and a description of any adjustments that have been made to the distributions;

F. Limiting factor development and application, which shall include the following information:

(1) Limitations on losses included in the statistical data used in the filing;

(2) Limitations on the extent of the rate level change;

(3) Limitations on the extent of classification rate changes; and

(4) Any other limitations applied;

G. Overhead expenses. The part of the filing pertaining to overhead expenses shall include the following:

(1) The expense provisions used in the filing and an explanation of the derivation of the expense provisions which shall include the following information:

(a) A complete description of the methodology used to derive the selected provisions;

(b) A description of alternative methodologies used or considered for use by the rating bureau in other states; and

(c) Specific details regarding the application of the criteria used in the selection of a methodology for this filing;

(2) Support for all the expense, tax and profit provisions for the proposed rates, under both the current and proposed expense provisions. An explanation shall be provided concerning why these provisions are appropriate for stock and nonstock insurance companies;

(3) Expense experience allocable to the coverage of risks in this State, including acquisition and field supervision expenses; taxes, licenses and fees; general expenses; and loss adjustment expenses. Safety engineering expense and loss control services expense shall be stated separately under general expense;

(4) A description of any adjustments of countrywide data to reflect conditions within this State and the details of the underlying calculations. If the proposed expense provisions differ from those indicated by the data, an explanation shall be provided;

(5) A description of how proposed allowances for expenses are reviewed each year by committees of the rating bureau;

(6) The dollar amount, if any, of taxes and assessments included in the collected loss data;

(7) The details of the derivations of the tax multiplier;

(8) Expense data required by this subsection, reported in the aggregate for all insurers. The expense data shall be reported separately for each of the 10 largest insurers, based on written premium in the prior calendar year;

(9) For each of the 10 largest writers of workers' compensation insurance in this State, a statement regarding any expense reduction activities undertaken in the last 3 years; and

(10) The changes and improvements instituted in loss control and employee safety engineering for the 10 largest carriers, based on written premium in the prior calendar year.

If the superintendent finds that state expense data is not fully credible, the superintendent may consider expense data from outside this State;

H. Law amendment valuation. For any law changes becoming effective during that period in which rates will be in effect, or in effect but not evaluated in prior rate filings, the following information shall be provided:

(1) A complete description of the methodology used to evaluate the law change;

(2) Identification of assumptions made and supporting information for those assumptions, both as to information before and after the law change; and

(3) Identification of the source and timeliness of data, including identification of data from experience within this State and data from countrywide or other states;

I. A showing of the overall statewide rate change as well as the amount of the change attributable to each of the following: Loss experience; a modification of the trend factor; a change in expense provisions; law amendments; a change in the tax provision; a change in the assessment provision; and any other factors. The rate changes for each industry group and each classification shall also be shown;

J. The proposed rates for each classification;

K. Investment earnings. The following information related to anticipated investment income shall be provided:

(1) Information on the amount of investment income earned on loss, loss expense and unearned premium reserves in relation to both net and standard earned premium for workers' compensation in this State calculated for the latest 5 years, and the total amount of investment income expected to be earned on loss, loss expense and unearned premium reserves in relation to both net and standard premium reserves for workers' compensation policies sold in this State during the years in which the proposed rates will be in effect. The derivation of these calculations shall be provided in detail, including the amount of the composite reserves of each type at the beginning and end of the specified years.

(8) Rule .1109 applies to all licensed rating organizations participating in a filing made by the North Carolina Rate Bureau or the North Carolina Reinsurance Facility.
(9) Rate filings are not required for the following lines of insurance:
(a) Aviation physical damage;
(b) Fidelity and surety;
(c) Mortgage guaranty;
(d) Ocean marine.
(10) Rate filings are not required for the following types of policies:
(a) Those written pursuant to the Surplus Lines Act;
(b) Those written under the Fair Access to Insurance Requirements (FAIR) Plan;
(c) Those written by the North Carolina Insurance Underwriting Association (the Beach Plan) that include coverages other than only windstorm and hail;
(d) Those written in North Carolina covering multistate insureds except in respect to coverages applicable to North Carolina locations;
(e) Those written by a town or county farmers mutual fire insurance association restricting its operations to not more than six adjacent counties in this State;
(f) Those that contain assessment provisions and that are written by domestic insurance companies, associations, orders or fraternal benefit societies that are not reciprocals.
(11) All inland marine manual rates and rating plans must be filed.
(a) This Subparagraph applies to the manual rates and rating plans of both companies and rating organizations.
(b) Rates and rating plans that are not contained in or derived from a manual need not be filed.
(12) Rate filings are required for all rates whether advisory, suggested, or manual, except for those lines, policies, and rates specifically excluded in Subparagraphs (9), (10), and (11) of this Rule.
(a) Rates applicable to only one particular risk must be filed.
(b) Rates may be filed either as manual rates or as ranges of rates from which the rates for individual insureds are determined.
(c) Rates based on loss cost filings must be filed in accordance with all the requirements of Rules .1107 and .1108 including the one that requires a comparison of current and proposed rates.
(13) Rules .1107 and .1108 also apply to loss cost filings. In cases where a rating organization files prospective loss costs, the same requirements as for rate filings apply, with the exception of those dealing with expense and profit provisions.
(14) The rates contained in all filings approved prior to January 1, 1990, other than those made by the North Carolina Rate Bureau or the North Carolina Reinsurance Facility, shall have an expiration date of January 1, 1992. Such rates may, subject to the Department's approval, be automatically renewed by a letter to the Department, specifying the Department's file number and the original approval date. Thereafter, they remain in effect until superseded, withdrawn, or modified by a subsequent filing.

History Note: Statutory Authority G.S. 58-2-40; 58-36-15; 58-36-30;
Eff. January 1, 1989;
Amended Eff. July 1, 1990; January 1, 1990; June 1, 1989.

.1103 WORKERS' COMPENSATION

The information required by N.C.G.S. 58-36-15(h) shall be presented as follows:

Note: If data required by this Rule are not currently being collected or reported, or are not currently readily available to insurers, insurers shall commence prospectively collecting or reporting such data beginning January 1, 1992. If certain data are not regularly collected through the statistical plan, a special call for such data to companies whose aggregate workers' compensation written premium is at least three-fourths of the North Carolina premium may be substituted. Thereafter, such required data that have accrued shall be included in each filing until enough data are available to fully satisfy this Rule. If in addition to the full years of data specified in this Rule, more recent data of less than a full year are available, such data shall also be provided. If updates to the information specified in this Rule become available before the close of evidence relating to the filing, they shall also be provided.

(1) North Carolina earned premiums at the actual and current rate level; losses and loss adjustment expenses, each on paid and incurred bases without trending or other modification for the experience period, including the loss ratio anticipated at the time the rates were promulgated for the experience period:

(a) Include premium, loss, and loss adjustment expense data from all companies writing North Carolina workers' compensation insurance. In addition, if exposures are used in the calculation of premiums at present rates, provide all available exposure data from these companies. If the experience of any company that writes more than one percent of the North Carolina workers' compensation written premium has been excluded from any rate level, trend, loss development, or investment income calculations, identify the company and its market share and provide an explanation for its exclusion. Also estimate the aggregate market share of other companies whose experience is excluded from such calculations.

(b) Include expense data from all companies writing North Carolina workers' compensation insurance. If the experience of any of the 50 largest (based on written premium) countrywide writers of workers' compensation insurance is excluded from any expense level calculation, identify the company and its market share and provide an explanation for its exclusion. Also estimate the aggregate market share of other companies whose experience is excluded from such calculations.

(c) If any identifiable group of policies is excluded from the calculation of classification differentials, describe those policies, indicate their market share, and provide an explanation for their exclusion.

(d) Clearly describe all adjustments to premiums, losses, loss adjustment expenses, expenses, and exposures included in the filing. Show the unadjusted amounts to which adjustments were made, identify the specific adjustments, provide details on the derivation and application of the adjustment factors, and describe all intermediate calculations. Where identical adjustments are applied to a set of similar data, an example of one of these adjustments is sufficient.

(e) Include actual earned premiums and calculate earned premiums at present rates. Also indicate how such calculations were produced, supply supporting documentation for a sample of such calculations, and justify any aggregate factors used.

(f) Estimate the amount of premium collected from expense constants. Provide this premium in dollars, as a percentage of the standard earned premium, and as a percentage of net earned premium. If the percentage of premium collected in this manner is expected to change, estimate the extent of the change and provide the details of this calculation.

(g) Estimate the amount of additional premium collected because of the minimum premium rule. Provide this premium in dollars, as a percentage of standard earned premium, and as a percentage of net earned premium. If the percentage of premium collected in this manner is expected to change, estimate the extent of the change and provide the details of this calculation.

(h) Provide the latest available written and earned premiums and market shares for the ten largest writers of North Carolina workers' compensation insurance.

(i) Provide composite loss and premium information from each of the latest two Annual Statements for which aggregate data are available for the 50 largest writers of North Carolina workers' compensation insurance, including the following:
  (i) Underwriting and Investment Exhibit, Part 2, Line 16;
  (ii) Underwriting and Investment Exhibit, Part 3, Line 16;
  (iii) North Carolina Page 14, Line 16.

(j) Provide to the extent possible the following information on companies deviating from the workers' compensation rates of the North Carolina Rate Bureau for each of the latest five available calendar years:
  (i) A list of all deviating companies;
  (ii) The estimated total standard premium written at deviated rates;
  (iii) The estimated percentage of the entire statewide standard premium written at deviated rates;
  (iv) The total amount of deviations in dollars;
  (v) The average percentage deviation for deviating companies;
  (vi) The average percentage deviation for all companies.

(k) Provide to the extent possible the following information on companies issuing dividends on North Carolina workers' compensation policies for each of the latest five calendar years:
  (i) A list of all companies issuing dividends;
  (ii) The estimated total premium of companies issuing dividends;
  (iii) The estimated percentage of the entire statewide premium of companies issuing dividends;
  (iv) The total amount of dividends in dollars;
  (v) The average percentage dividend issued by companies issuing dividends;
  (vi) The average percentage dividend issued by all companies.

(l) Provide the following information on losses and loss adjustment expenses:

(i) For each of the latest three available accident and calendar years, undeveloped and untrended losses and loss adjustment expenses;
(ii) For each rate level implemented in the latest three calendar years, the expected loss ratios that were anticipated in the implemented rates;
(iii) For each accident and policy year included in the filing, paid losses, case basis reserves, loss development, incurred allocated loss adjustment expenses (if collected separately from losses), incurred unallocated (or combined allocated and unallocated) loss adjustment expenses, applied trend factors, and trended incurred losses and loss adjustment expenses.

(2) Credibility factor development and application. Provide all information related to the derivation of all credibility factors contained in the filing, including the following:
(a) A description of all data reviewed and all worksheets used;
(b) A complete description of the methodology used to derive these factors;
(c) A description of alternative methodologies used or considered for use in the last three years;
(d) A description of the criteria used to select a methodology;
(e) Specific details on the application of these criteria in the selection of a methodology for this filing;
(f) Details on the application of the methodology to this filing.

(3) Loss development factor development and application on both paid and incurred bases and in both numbers and dollars of claims:
(a) Provide all information related to the derivation of all loss development factors contained in the filing, including the following:
(i) A description of all data reviewed and all worksheets used;
(ii) A complete description of the methodology used to derive these factors;
(iii) A description of alternative methodologies used or considered for use in the last three years;
(iv) A description of the criteria used to select a methodology;
(v) Specific details on the application of these criteria in the selection of a methodology for this filing;
(vi) Details on the application of the methodology to this filing.
(b) Provide at least the latest five available years of the aggregate loss data described in Subparagraphs (3)(b)(i) through (iii) of this Rule for matching companies for all pairs of successive evaluation dates. Also provide the corresponding loss development factors and five-year average factors derivable from these data.
(i) Data on both a policy year and an accident year basis;
(ii) Data separated into indemnity and medical portions, as well as combined data;
(iii) Data separated into paid, case incurred, and incurred but not reported portions, as well as combined data;
(c) Provide for each of the loss amounts in Subparagraph (3)(b) of this Rule, the corresponding earned premiums, paid claim counts, incurred claim counts, and outstanding claim counts.
(d) Provide at least the latest ten available policy years of the incurred loss data described in Subparagraphs (3)(d)(i) through (ii) of this Rule from the Unit Statistical Plan for matching policies for all pairs of successive evaluation dates. Also provide the corresponding loss development factors and five-year average factors derivable from the data.
(i) Losses separated into indemnity and medical portions, as well as combined data;
(ii) Losses separated into deaths, permanent totals, major permanent partials, minor permanent partials, temporary totals, and noncompensable medicals.
(e) Provide for each of the loss amounts in Subparagraph (3)(d) of this Rule the corresponding incurred claim counts and for each of the policy years in Subparagraph (3)(d) of this Rule the aggregate earned exposures and standard earned premium. Where small claims are reported in bulk, provide such information as accurately as possible, given the imprecision inherent in such aggregate data.
(f) Provide for each of the policy periods in Subparagraphs (3)(b) and (3)(d) of this Rule the law amendment factors for adjusting past losses to current benefit levels.
(g) Include a description of the reasons for the differences between the policy year data provided in response to Subparagraphs (3)(b) and (3)(c) of this Rule and those provided in response to Subparagraphs (3)(d) and (3)(e) of this Rule.
(h) Provide the information in Subparagraphs (3)(b) and (3)(c) of this Rule for each of the 15 largest writers of North Carolina workers' compensation insurance.

(4) Trending factor development and application:

(a) Provide all information related to the derivation of all trend factors contained in the filing including the following:
(i) A description of all data reviewed and all worksheets used;
(ii) A complete description of the methodology used to derive these factors;
(iii) A description of alternative methodologies used or considered for use in the last three years;
(iv) A description of the criteria used to select a methodology;
(v) Specific details on the application of these criteria in the selection of a methodology for this filing;
(vi) Details on the application of the methodology to this filing.
(b) Calculate the following trend factors:
(i) Indemnity and medical trend factors based on the latest five available policy years of North Carolina paid and incurred data;
(ii) Indemnity and medical trend factors based on the latest five available accident years of North Carolina paid and incurred data;
(iii) Indemnity and medical trend factors based on the latest five available policy years of countrywide paid and incurred data;
(iv) Indemnity trend factors for individual states based on policy year data and their reconciliations with the countrywide factor;
(v) Medical trend factors for individual states and for groups of fee schedule and non-fee schedule states based on incurred policy year data and their reconciliation with the countrywide factor;
(vi) The factors in Subparagraphs (4)(b)(iii), (4)(b)(iv), and (4)(b)(v) of this Rule based on accident year data, if available.
(5) Changes in premium base and exposures.
(a) For the intervals listed in this Subparagraph, provide the number of North Carolina workers' compensation policies and their aggregate premium for the latest available five policy years. Provide this information separately for stock and nonstock companies and for all companies combined: $1 - $99, $100 - $199, $200 - $299, $300 - $499, $500 - $999, $1,000 - $2,999, $3,000 - $4,999, $5,000 - $9,999, $10,000 - $24,999, $25,000 - $49,999, $50,000 - $99,999, $100,000 - $249,999, $250,000 - $499,999, and over $499,999.
(b) Describe any countrywide distributions of number of policies or premium by layer that are used in the filing. Also provide details of how such distributions have been used in the rate filing and a description of any adjustments that have been made to them.
(c) Provide the following estimates of the average premium discount for each of the latest five available policy years:
(i) That using the North Carolina distribution of policies contained in Subparagraph (5)(a) of this Rule;
(ii) That using a countrywide distribution of policies;
(iii) That using the North Carolina distribution of policies contained in Subparagraph (5)(a) of this Rule adjusted for its exclusion of the portions of interstate policies not located in North Carolina. In estimating this adjustment factor calculate and take into the account the aggregate intrastate portions of those policies making up the countrywide distribution in Subparagraph (5)(c)(ii) of this Rule.
(d) Provide or estimate the following information on exposure trends:
(i) The statewide average weekly wage for the latest five available calendar years;
(ii) The statewide average weekly wage for the latest ten available policy years without the application of a payroll limitation;
(iii) The statewide average weekly wage for the latest ten available policy years after the application of a payroll limitation;
(iv) The estimated statewide average weekly wage for the calendar and policy years during which the rates will be in effect.
(6) Limiting factor development and application. Provide information on the following items:
(a) Limitations on losses included in the statistical data used in the filing.
(b) Limitations on the extent of the rate level change.
(c) Limitations on the extent of classification rate changes.
(d) Any other limitations applied.
(7) Overhead expense development and the application of commission and brokerage, other acquisition expenses, general expenses, taxes, licenses, and fees:

(a) Provide all information related to the derivation of all expense provisions contained in the filing including the following:
(i) A description of all data reviewed and all worksheets used;
(ii) A complete description of the methodology used to derive these factors;
(iii) A description of alternative methodologies used or considered for use in the last three years;
(iv) A description of the criteria used to select a methodology;
(v) Specific details on the application of these criteria in the selection of a methodology for this filing;
(vi) Details on the application of the methodology to this filing.
(b) Provide a comparison of the proposed expense provisions with those composite provisions for the 50 largest writers of North Carolina workers' compensation insurance included in the latest available Insurance Expense Exhibit, with those same composite provisions included in the preliminary data underlying the next such Exhibit (if available), and with those provisions in the latest available Call for 19xx Calendar Year Data by State for North Carolina.
(c) For each of the ten largest writers of North Carolina workers' compensation insurance, provide a statement regarding any activities affecting expense or service levels undertaken in the last three years.
(8) The percent rate change:
(a) Provide the overall statewide rate change, as well as the amount of the change attributable to each of the following: loss experience, a modification of the trend factor, a change in expense provisions, law amendments, a change in the tax provision, a change in the assessment provision, and any other factors.
(b) Provide the rate changes for each industry group and for each classification.
(c) If the rate changes eventually implemented differ from those provided in the filing, submit a supplement to the filing that describes the implemented changes and the modifications made to the filing to produce them. This supplement shall be submitted as soon as possible after a decision is reached to implement rates other than those that were originally filed and in any case no later than the first implementation date of the rates.
(9) Final proposed rates:
(a) Provide the proposed rates for each classification.
(b) If the rates eventually implemented differ from those provided in the filing, submit a supplement to the filing that describes the implemented rates for each classification. This supplement shall be submitted as soon as possible after a decision is reached to implement rates other than those that were originally filed and in any case no later than the first implementation date of the rates.
(10) Investment earnings, consisting of investment income and realized plus unrealized capital gains, from loss, loss expense, and unearned premium reserves:
(a) Calculate the amount of investment income earned on loss, loss expense and unearned premium reserves from North Carolina workers' compensation policies (as a ratio to both net and standard earned premium) for each of the latest five available calendar years and estimate that income for the current year and for all years during which the proposed rates are expected to be in effect. Provide the details of all calculations, including the amount of the composite reserves of each type at the beginning and end of each of the latest five available calendar years. Also describe and justify all assumptions used in such calculations.
(b) Provide information on the estimated average length of time that elapses between the occurrence of a compensable accident in North Carolina and the payment of a claim on that accident. The average shall be a weighted average based on size of claim payments. Estimate how the length has changed over the latest ten available calendar years.
(c) Provide composite asset, liability, and income information from each of the latest two Annual Statements for which aggregate data are available for the 50 largest writers of North Carolina workers' compensation insurance, including the following (in the same format and detail as the exhibits in individual company statements):
(i) Page 2 (Assets);
(ii) Page 3 (Liabilities, Surplus and Other Funds);
(iii) Page 4 (Underwriting and Investment Exhibit);
(iv) Insurance Expense Exhibit Part II, Column 16.
(11) Identification of applicable statistical plans and programs and a certification of compliance with them:

(a) Identify all statistical plans used or consulted in preparing this filing and describe the data compiled by each plan.
(b) Provide a certification that there is no evidence known to the Bureau or to the statistical agencies involved that the data that were collected in accordance with such statistical plans and were used in the rate filing are not true and accurate representations of each company's experience to the best of that company's knowledge.
(c) Provide general descriptions of the editing procedures used to verify that the data were collected in accordance with the statistical plans, and concise summaries of the adjustments and corrections made to the consolidated ratemaking data.

(12) Investment earnings on capital and surplus: Given the selected underwriting profit and contingencies provision contained in the filing, indicate the resulting rates of return (including consideration of investment income) on equity capital, on statutory surplus, and on total assets. Show the derivation of all factors used in producing these calculations and justify the fairness and reasonableness of these rates of return.

(13) Level of capital surplus needed to support premium writings without endangering the solvency of member companies:
(a) Provide aggregate premium to surplus ratios for the latest ten available calendar years for those companies writing North Carolina workers' compensation insurance during that entire period;
(b) Provide estimates of the comparable ratios for all companies writing North Carolina workers' compensation insurance for all years during which the proposed rates are expected to be in effect.
(c) Provide information on the amount of surplus needed to support the writing of North Carolina workers' compensation insurance, taking into account the riskiness of the line. Describe the assumptions used in the derivation of that amount.
(d) Provide all information relating to any explicit or implicit allocation of surplus by state and by line undertaken in the filing, including the following:
(i) A description of all data reviewed and all worksheets used;
(ii) A complete description of the methodology used to produce this allocation;
(iii) A description of alternative methodologies used or considered for use in the last three years;
(iv) A description of the criteria used to select a methodology;
(v) Specific details on the application of these criteria in the selection of a methodology for this filing;
(vi) Details on the application of the methodology to this filing.

(14) Such other information that may be required by any rule adopted by the Commissioner:
(a) Provide information on the following aspects of workers' compensation individual risk rating plans, including an explanation of their purpose and a detailed description of their derivation:
(i) Expected loss rate;
(ii) D-Ratio;
(iii) Excess loss factors;
(iv) Excess loss adjustment amounts;
(v) Table of weighting and ballast values.
(b) Provide all information relating to the profit and contingencies provision contained in the filing, including the following:
(i) A description of all data reviewed and all worksheets used;
(ii) A complete description of the methodology used to derive this provision;
(iii) A description of alternative methodologies used or considered for use in the last three years;
(iv) A description of the criteria used to select a methodology;
(v) Specific details on the application of these criteria in the selection of a methodology for this filing;
(vi) Details on the application of the methodology to this filing.
(c) Include copies of all agendas and minutes of meetings of the North Carolina Rate Bureau affecting the filing, as well as a list of all attendees at these meetings, their titles, and their affiliations.
(d) Describe all payments made to all consultants (including lawyers, actuaries, and economists) related to this filing and the previous one on workers' compensation insurance. If payments cannot be specifically identified as related to particular filings, estimate them. "
(e) Identify and describe all changes in methodologies from the previous North Carolina workers' compensation rate filing. If any collected or reported data required by this Rule are provided within 30 days after the initial submittal of a filing, that data shall be made a part of the filing,

provided the initial submittal acknowledges that it is incomplete and identifies specifically what further data are to be submitted within the time permitted. No filing otherwise complete shall be deemed to be proper until such time that all data required by this Rule have been submitted.

History Note: Statutory Authority G.S. 58-2-40; 58-36-15(h);
Eff. January 1, 1989;
Amended Eff. October 1, 1990.

.1104 NONFLEET PRIVATE PASSENGER AUTOMOBILE

The information required by N.C.G.S. 58-36-15(h) for nonfleet private passenger automobile rate filings shall be presented as follows:

Note: If data required by this Rule, other than that specified in Subparagraph (3)(c), are not being collected or reported, or are not readily available to insurers prior to January 1, 1991, then insurers shall commence as of that date prospectively collecting and reporting such data. The date for commencing prospectively collecting and reporting the data specified in Subparagraph (3)(c) is January 1, 1992. Thereafter, such required data as have accrued shall be included in each filing until enough data are available to fully satisfy this Rule. If in addition to the full years of data specified in any of the Subparagraphs below, more recent data of less than a full year are available, such data shall also be provided. If updates to the information specified in any of the Subparagraphs in this Rule become available before the close of evidence relating to the filing, they shall also be provided.

(1) North Carolina earned premiums at the actual and current rate level; losses and loss adjustment expenses, each on paid and incurred bases without trending or other modification for the experience period, including the loss ratio anticipated at the times the rates were promulgated for the experience period:

(a) Include premium, loss, loss adjustment expense, expense, and exposure data from all companies writing North Carolina nonfleet private passenger automobile insurance. If the experience of any company that writes more than one percent of the North Carolina nonfleet private passenger automobile written premium has been excluded from any rate level, trend, loss development, or investment income calculation for any coverage, identify the coverage, the company and its market share and provide an explanation for its exclusion. Also estimate the aggregate market share of other companies whose experience is excluded from such calculations.

(b) Include data relating to increased limits factors and deductible credits if such factors have not been reviewed in the last two filings or reviews. Provide justification that the factors and credits contained in the filing are neither excessive, inadequate, nor unfairly discriminatory. Also provide all information related to their derivation, including the following:

(i) A description of all data reviewed and all worksheets used;
(ii) A complete description of the methodology used to derive these factors and credits;
(iii) A description of alternative methodologies used or considered for use in the last three years;
(iv) A description of the criteria used to select a methodology;
(v) Specific details on the application of these criteria in the selection of a methodology for this filing;
(vi) Details on the application of the methodology to this filing.

(c) Clearly describe all adjustments to premiums, losses, loss adjustment expenses, and exposures included in the filing. Show the unadjusted amounts to which adjustments were made, identify the specific adjustments, provide details on the derivation and application of the adjustment factors, and describe all intermediate calculations. Where identical adjustments are applied to a set of similar data, an example of one of these adjustments is similar.

(d) For each coverage, include actual earned premiums and calculate earned premiums at present rates. Also indicate how such calculations were produced, supply supporting documentation for a sample of such calculations, and justify any aggregate factors used.

(e) Provide the latest written and earned premiums and market shares for the ten largest writers of North Carolina nonfleet private passenger automobile insurance.

(f) Provide composite loss and premium information from each of the latest two Annual Statements for the 50 largest writers of North Carolina nonfleet private passenger insurance, including the following:

(i) Underwriting and Investment Exhibit, Part 2, Lines 19 and 21;
(ii) Underwriting and Investment Exhibit, Part 3, Lines 19 and 21;
(iii) North Carolina Page 14, Lines 19.1, 19.2, and 21.1.

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APPENDIX A-II

SECTION A - CALCULATION OF POLICY YEAR DEVELOPMENT FACTORS (1st TO 4th REPORT)

	(1)	(2)	(3)	(4)	(5)
Premium and Indemnity & Medical Excluding IBNR Losses for Matching Companies as Per:	1st Report	2nd Report	3rd Report	4th Report	Development Factor
1985 Std.Prem.	xxx	xxx	405,564,044	406,551,068	1.002
Ind.Losses	xxx	xxx	149,518,540	159,137,382	1.064
Med.Losses	xxx	xxx	120,920,110	122,917,443	1.017
1986 Std.Prem.	xxx	xxx	476,509,658	476,680,112	1.000
Ind.Losses	xxx	xxx	167,868,237	174,381,478	1.039
Med.Losses	xxx	xxx	140,315,108	139,852,894	.997
1986 Std.Prem.	xxx	478,970,139	479,634,265	xxx	1.001
Ind.Losses	xxx	153,770,694	166,907,612	xxx	1.085
Med.Losses	xxx	137,740,969	140,399,199	xxx	1.019
1987 Std.Prem.	xxx	525,940,177	525,719,317	xxx	1.000
Ind.Losses	xxx	176,265,864	189,215,592	xxx	1.073
Med.Losses	xxx	156,224,173	160,757,798	xxx	1.029
1987 Std.Prem.	505,980,054	526,916,703	xxx	xxx	1.041
Ind.Losses	147,151,787	174,927,634	xxx	xxx	1.189
Med.Losses	146,209,489	156,055,690	xxx	xxx	1.067
1988 Std.Prem.	558,938,334	575,009,514	xxx	xxx	1.029
Ind.Losses	166,989,387	198,540,609	xxx	xxx	1.189
Med.Losses	173,978,741	186,768,459	xxx	xxx	1.074

UNWEIGHTED AVERAGE DEVELOPMENT FACTORS

	1st/2nd	2nd/3rd	3rd/4th
Std.Prem.	1.035	1.001	1.001
Ind.Losses	1.189	1.079	1.052
Med.Losses	1.071	1.024	1.007

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APPENDIX A-II

SECTION B - CALCULATION OF POLICY YEAR DEVELOPMENT FACTORS (4th TO 8th REPORT)

	(1)	(2)	(3)	(4)	(5)	(6)
Premium and Indemnity & Medical Excluding IBNR Losses for Matching Companies as Per:	4th Report	5th Report	6th Report	7th Report	8th Report	Development Factor
1981 Ind.Losses	xxx	xxx	xxx	90,759,688	92,473,149	1.019
Med.Losses	xxx	xxx	xxx	66,281,429	66,585,445	1.005
1982 Ind.Losses	xxx	xxx	xxx	103,760,826	104,200,806	1.004
Med.Losses	xxx	xxx	xxx	76,795,794	78,549,100	1.023
1982 Ind.Losses	xxx	xxx	99,623,030	98,714,465	xxx	.991
Med.Losses	xxx	xxx	73,032,549	72,751,547	xxx	.996
1983 Ind.Losses	xxx	xxx	114,344,987	115,862,579	xxx	1.013
Med.Losses	xxx	xxx	90,284,524	90,969,812	xxx	1.008
1983 Ind.Losses	xxx	109,336,573	109,825,424	xxx	xxx	1.004
Med.Losses	xxx	85,940,710	86,673,246	xxx	xxx	1.009
1984 Ind.Losses	xxx	137,971,730	139,855,093	xxx	xxx	1.014
Med.Losses	xxx	109,212,150	113,509,703	xxx	xxx	1.039
1984 Std.Prem.	347,293,405	347,071,940	xxx	xxx	xxx	.999
Ind.Losses	134,341,025	135,739,494	xxx	xxx	xxx	1.010
Med.Losses	107,665,753	107,357,545	xxx	xxx	xxx	.997
1985 Std.Prem.	404,966,334	404,833,016	xxx	xxx	xxx	1.000
Ind.Losses	158,647,616	160,489,719	xxx	xxx	xxx	1.012
Med.Losses	122,228,433	124,896,323	xxx	xxx	xxx	1.022

UNWEIGHTED AVERAGE DEVELOPMENT FACTORS

	4th/5th	5th/6th	6th/7th	7th/8th
Std.Prem.	1.000	xxx	xxx	xxx
Ind.Losses	1.011	1.009	1.002	1.012
Med.Losses	1.010	1.024	1.002	1.014

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APPENDIX A-II

SECTION C - CALCULATION OF POLICY YEAR DEVELOPMENT FACTORS (8th TO 10th REPORT)

		(1) 8th Report	(2) 9th Report	(3) 10th Report	(4) 11th Report	(5) 12th Report	(6) Development Factor
Indemnity & Medical Excluding IBNR Losses for Matching Companies as Per:							
	Ind.Losses	xxx	xxx	xxx	xxx	xxx	xxx
	Med.Losses	xxx	xxx	xxx	xxx	xxx	xxx
	Ind.Losses	xxx	xxx	xxx	xxx	xxx	xxx
	Med.Losses	xxx	xxx	xxx	xxx	xxx	xxx
	Ind.Losses	xxx	xxx	xxx	xxx	xxx	xxx
	Med.Losses	xxx	xxx	xxx	xxx	xxx	xxx
	Ind.Losses	xxx	xxx	xxx	xxx	xxx	xxx
	Med.Losses	xxx	xxx	xxx	xxx	xxx	xxx
1979	Ind.Losses	xxx	87,015,079	86,765,059	xxx	xxx	.997
	Med.Losses	xxx	50,481,761	50,498,823	xxx	xxx	1.000
1980	Ind.Losses	xxx	95,335,271	94,741,259	xxx	xxx	.994
	Med.Losses	xxx	64,073,360	64,196,452	xxx	xxx	1.002
1980	Ind.Losses	84,313,983	84,794,691	xxx	xxx	xxx	1.006
	Med.Losses	54,729,483	55,116,997	xxx	xxx	xxx	1.007
1981	Ind.Losses	93,082,414	93,164,932	xxx	xxx	xxx	1.001
	Med.Losses	68,839,309	70,947,543	xxx	xxx	xxx	1.031

UNWEIGHTED AVERAGE DEVELOPMENT FACTORS

	8TH/9TH	9TH/10TH	10TH/11TH	11TH/12TH
Ind.Losses	1.004	.996	xxx	xxx
Med.Losses	1.019	1.001	xxx	xxx

POLICY YEAR EXCLUDING IBNR TO INCLUDING IBNR RATIOS AT A TENTH REPORT

Policy Year	Excluding IBNR Losses Indemnity	Excluding IBNR Losses Medical	Including IBNR Losses Indemnity	Including IBNR Losses Medical	Excluding IBNR to Including IBNR Ratios Indemnity	Excluding IBNR to Including IBNR Ratios Medical
1979	106,577,991	62,726,859	106,914,613	63,551,124	.997	.987
1980	94,741,259	64,196,452	95,319,605	64,872,179	.994	.990
Unweighted Average					.996	.989

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APPENDIX A-II

SECTION D - CALCULATION OF POLICY YEAR DEVELOPMENT FACTORS (10th TO ULTIMATE REPORT)

		INDEMNITY	MEDICAL
(1)	Losses for policy year 1976 valued as of 12-31-84	55,323,078	31,537,856
(2)	Losses for policy year 1977 valued as of 12-31-85	63,212,060	37,726,977
(3)	Losses for policy year 1978 valued as of 12-31-86	78,152,038	45,661,546
(4)	Average ((1)+(2)+(3))/3	65,562,392	38,308,793
(5)	Ratio (4)/(3)	.839	.839
(6)	Losses for policy year 1978 valued as of 12-31-88	69,832,578	42,058,714
(7)	Losses for all policy years prior to 1978 valued as of 12-31-88	353,536,276	228,941,933
(8)	Losses for all policy years prior to 1979 valued as of 12-31-89	424,871,960	272,748,204
(9)	Loss development factor from 10th to ultimate report for all years prior to 1979 (1 + ((8)-(7)-(6))/((6)x(5)))	1.026	1.050

(1), (2) and (3) include only data for matching companies for 12/31/84, 12/31/85 and 12/31/86 valuations.

(6), (7) and (8) include only data for matching companies for 12/31/88 and 12/31/89 valuations.

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APPENDIX A-II

SECTION D - CALCULATION OF POLICY YEAR DEVELOPMENT FACTORS (10th TO ULTIMATE REPORT) - CONTD.

		INDEMNITY	MEDICAL
(10)	Losses for policy year 1977 valued as of 12-31-85	69,607,931	42,474,867
(11)	Losses for policy year 1978 valued as of 12-31-86	86,465,313	50,235,283
(12)	Losses for policy year 1979 valued as of 12-31-87	102,558,842	58,069,269
(13)	Average ((10)+(11)+(12))/3	86,210,695	50,259,806
(14)	Ratio (13)/(12)	.841	.866
(15)	Losses for policy year 1979 valued as of 12-31-89	100,921,482	59,562,516
(16)	Losses for all policy years prior to 1979 valued as of 12-31-89	489,291,795	317,522,466
(17)	Losses for all policy years prior to 1980 valued as of 12-31-90	588,373,275	380,495,714
(18)	Loss development factor from 10th to ultimate report for all years prior to 1980 (1 + ((17)-(16)-(15))/((15)x(14)))	.978	1.066
(19)	Unweighted average 10th to ultimate loss development factor ((9)+(18))/2	1.002	1.058

(10), (11) and (12) include only data for matching companies for 12/31/85, 12/31/86 and 12/31/87 valuations.

(15), (16) and (17) include only data for matching companies for 12/31/89 and 12/31/90 valuations.

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APPENDIX A-II

SECTION E - SUMMARY OF POLICY YEAR DEVELOPMENT FACTORS

	(1) 1st/2nd	(2) 2nd/3rd	(3) 3rd/4th	(4) 4th/5th	(5) 3rd/5th (3)x(4)	(6) 2nd/5th (2)x(5)	(7) 1st/5th (1)x(6)
Std.Prem.	1.035	1.001	1.001	1.000	1.001	1.002	1.037
Ind.Losses	1.189	1.079	1.052	1.011	xxx	xxx	xxx
Med.Losses	1.071	1.024	1.007	1.010	xxx	xxx	xxx

	(8) 5th/6th	(9) 6th/7th	(10) 7th/8th	(11) 8th/9th	(12) 9th/10th
Ind.Losses	1.009	1.002	1.012	1.004	.996
Med.Losses	1.024	1.002	1.014	1.019	1.001

	(13) 5th/10th (8)x((9)x((10)x((11)x(12))))	(14) Excl. IBNR to Incl. IBNR Ratio at a 10th Report	(15) 10th/Ult.
Ind.Losses	1.023	.996	1.002
Med.Losses	1.061	.989	1.058

	(16) 5th/Ult. ((13)/(14))x(15)	(17) 4th/Ult. (4)x(16)	(18) 3rd/Ult. (3)x(17)	(19) 2nd/Ult. (2)x(18)	(20) 1st/Ult. (1)x(19)
Ind.Losses	1.029	1.040	1.094	1.180	1.403
Med.Losses	1.135	1.146	1.154	1.182	1.266

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APPENDIX A-IV

SECTION A - CALCULATION OF CALENDAR-ACCIDENT YEAR DEVELOPMENT FACTORS (1st TO 4th REPORT)

	(1)	(2)	(3)	(4)	(5)
Indemnity & Medical Excluding IBNR Losses for Matching Companies as Per:	1st Report	2nd Report	3rd Report	4th Report	Development Factor
1986 Ind.Losses	xxx	xxx	157,535,688	166,991,713	1.060
Med.Losses	xxx	xxx	126,307,771	128,669,278	1.019
1987 Ind.Losses	xxx	xxx	174,461,123	183,005,435	1.049
Med.Losses	xxx	xxx	158,066,449	158,705,724	1.004
1987 Ind.Losses	xxx	153,019,699	173,532,789	xxx	1.134
Med.Losses	xxx	153,084,849	158,169,862	xxx	1.033
1988 Ind.Losses	xxx	165,473,810	190,637,607	xxx	1.152
Med.Losses	xxx	162,444,206	170,040,797	xxx	1.047
1988 Ind.Losses	131,600,604	163,296,754	xxx	xxx	1.241
Med.Losses	134,850,055	161,598,282	xxx	xxx	1.198
1989 Ind.Losses	151,957,542	188,157,535	xxx	xxx	1.238
Med.Losses	158,930,780	191,495,820	xxx	xxx	1.205

UNWEIGHTED AVERAGE DEVELOPMENT FACTORS

	1st/2nd	2nd/3rd	3rd/4th
Ind.Losses	1.240	1.143	1.055
Med.Losses	1.202	1.040	1.012

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APPENDIX A-IV

SECTION B - CALCULATION OF CALENDAR-ACCIDENT YEAR DEVELOPMENT FACTORS (4th TO 8th REPORT)

	(1)	(2)	(3)	(4)	(5)	(6)
Indemnity & Medical Excluding IBNR Losses for Matching Companies as Per:	4th Report	5th Report	6th Report	7th Report	8th Report	Development Factor
1982 Ind.Losses	xxx	xxx	xxx	94,987,360	93,367,645	.983
Med.Losses	xxx	xxx	xxx	65,439,743	66,407,897	1.015
1983 Ind.Losses	xxx	xxx	xxx	108,242,582	109,148,547	1.008
Med.Losses	xxx	xxx	xxx	83,259,726	84,207,704	1.011
1983 Ind.Losses	xxx	xxx	102,949,962	104,087,543	xxx	1.011
Med.Losses	xxx	xxx	79,769,755	79,699,694	xxx	.999
1984 Ind.Losses	xxx	xxx	133,043,304	135,025,524	xxx	1.015
Med.Losses	xxx	xxx	104,413,427	106,595,139	xxx	1.021
1984 Ind.Losses	xxx	126,775,419	129,586,690	xxx	xxx	1.022
Med.Losses	xxx	100,597,966	102,042,367	xxx	xxx	1.014
1985 Ind.Losses	xxx	145,929,887	146,551,645	xxx	xxx	1.004
Med.Losses	xxx	115,846,939	118,862,850	xxx	xxx	1.026
1985 Ind.Losses	136,270,789	145,595,880	xxx	xxx	xxx	1.068
Med.Losses	113,329,266	115,556,457	xxx	xxx	xxx	1.020
1986 Ind.Losses	165,783,560	170,011,685	xxx	xxx	xxx	1.026
Med.Losses	127,753,465	129,397,352	xxx	xxx	xxx	1.013

UNWEIGHTED AVERAGE DEVELOPMENT FACTORS

	4th/5th	5th/6th	6th/7th	7th/8th
Ind.Losses	1.047	1.013	1.013	.996
Med.Losses	1.017	1.020	1.010	1.013

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APPENDIX A-IV

ECTION C - CALCULATION OF CALENDAR-ACCIDENT YEAR DEVELOPMENT FACTORS (8th TO 10th REPORT)

	(1)	(2)	(3)	(4)	(5)	(6)
ndemnity & Medical Excluding IBNR Losses for Matching Companies as Per:	8th Report	9th Report	10th Report	11th Report	12th Report	Development Factor
Ind.Losses	xxx	xxx	xxx	xxx	xxx	xxx
Med.Losses	xxx	xxx	xxx	xxx	xxx	xxx
Ind.Losses	xxx	xxx	xxx	xxx	xxx	xxx
Med.Losses	xxx	xxx	xxx	xxx	xxx	xxx
Ind.Losses	xxx	xxx	xxx	xxx	xxx	xxx
Med.Losses	xxx	xxx	xxx	xxx	xxx	xxx
Ind.Losses	xxx	xxx	xxx	xxx	xxx	xxx
Med.Losses	xxx	xxx	xxx	xxx	xxx	xxx
)80 Ind.Losses	xxx	88,783,670	88,529,048	xxx	xxx	.997
Med.Losses	xxx	54,802,078	55,254,248	xxx	xxx	1.008
)81 Ind.Losses	xxx	94,297,032	93,971,497	xxx	xxx	.997
Med.Losses	xxx	67,976,711	69,814,552	xxx	xxx	1.027
)81 Ind.Losses	80,982,459	81,917,650	xxx	xxx	xxx	1.012
Med.Losses	56,914,821	57,330,183	xxx	xxx	xxx	1.007
)82 Ind.Losses	94,871,187	94,932,312	xxx	xxx	xxx	1.001
Med.Losses	68,560,783	69,651,857	xxx	xxx	xxx	1.016

UNWEIGHTED AVERAGE DEVELOPMENT FACTORS

	8th/9th	9th/10th	10th/11th	11th/12th
Ind.Losses	1.007	.997	xxx	xxx
Med.Losses	1.012	1.018	xxx	xxx

CALENDAR-ACCIDENT YEAR EXCLUDING IBNR TO INCLUDING IBNR RATIOS AT A TENTH REPORT

Calendar-Accident Year	Excluding IBNR Losses Indemnity	Excluding IBNR Losses Medical	Including IBNR Losses Indemnity	Including IBNR Losses Medical	Excluding IBNR to Including IBNR Ratios Indemnity	Excluding IBNR to Including IBNR Ratios Medical
1980	106,081,919	65,416,582	106,481,890	66,067,627	.996	.990
1981	93,971,497	69,814,552	94,964,922	71,066,643	.990	.982
Unweighted Average					.993	.986

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APPENDIX A-IV

SECTION D - CALCULATION OF CALENDAR-ACCIDENT YEAR DEVELOPMENT FACTORS (10th TO ULTIMATE REPORT)

		INDEMNITY	MEDICAL
(1)	Losses for accident year 1977 valued as of 12-31-84	59,102,058	34,188,323
(2)	Losses for accident year 1978 valued as of 12-31-85	72,215,613	41,233,150
(3)	Losses for accident year 1979 valued as of 12-31-86	87,605,942	51,339,074
(4)	Average ((1)+(2)+(3))/3	72,974,538	42,253,516
(5)	Ratio (4)/(3)	.833	.823
(6)	Losses for accident year 1979 valued as of 12-31-88	81,209,142	48,255,625
(7)	Losses for all accident years prior to 1979 valued as of 12-31-88	369,454,264	239,088,126
(8)	Losses for all accident years prior to 1980 valued as of 12-31-89	451,630,188	288,575,775
(9)	Loss development factor from 10th to ultimate report for all years prior to 1980 (1 + ((8)-(7)-(6))/((6)x(5)))	1.014	1.031

(1), (2) and (3) include only data for matching companies for 12/31/84, 12/31/85 and 12/31/86 valuations.

(6), (7) and (8) include only data for matching companies for 12/31/88 and 12/31/89 valuations.

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APPENDIX A-IV

SECTION D - CALCULATION OF CALENDAR-ACCIDENT YEAR DEVELOPMENT FACTORS (10th TO ULTIMATE REPORT) - CONTD.

		INDEMNITY	MEDICAL
(10)	Losses for accident year 1978 valued as of 12-31-85	80,029,658	45,285,580
(11)	Losses for accident year 1979 valued as of 12-31-86	97,741,343	56,854,118
(12)	Losses for accident year 1980 valued as of 12-31-87	102,849,579	61,661,034
(13)	Average ((10)+(11)+(12))/3	93,540,193	54,600,244
(14)	Ratio (13)/(12)	.909	.885
(15)	Losses for accident year 1980 valued as of 12-31-89	98,758,747	61,629,448
(16)	Losses for all accident years prior to 1980 valued as of 12-31-89	529,426,606	342,900,609
(17)	Losses for all accident years prior to 1981 valued as of 12-31-90	626,307,936	408,348,789
(18)	Loss development factor from 10th to ultimate report for all years prior to 1981 (1 + ((17)-(16)-(15))/((15)x(14)))	.979	1.070
(19)	Unweighted average 10th to ultimate loss development factor ((9)+(18))/2	.997	1.051

(10), (11) and (12) include only data for matching companies for 12/31/85, 12/31/86 and 12/31/87 valuations.

(15), (16) and (17) include only data for matching companies for 12/31/89 and 12/31/90 valuations.

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APPENDIX A-IV

SECTION E - SUMMARY OF CALENDAR-ACCIDENT YEAR DEVELOPMENT FACTORS

	(1) 1st/2nd	(2) 2nd/3rd	(3) 3rd/4th	(4) 4th/5th
Ind.Losses	1.240	1.143	1.055	1.047
Med.Losses	1.202	1.040	1.012	1.017

	(5) 5th/6th	(6) 6th/7th	(7) 7th/8th	(8) 8th/9th	(9) 9th/10th
Ind.Losses	1.013	1.013	.996	1.007	.997
Med.Losses	1.020	1.010	1.013	1.012	1.018

	(13) 5th/10th (5)x((6)x((7)x((8)x(9))))	(14) Excl. IBNR to Incl. IBNR Ratio at a 10th Report	(15) 10th/Ult.
Ind.Losses	1.026	.993	.997
Med.Losses	1.074	.986	1.051

	(16) 5th/Ult. ((13)/(14))x(15)	(17) 4th/Ult. (4)x(16)	(18) 3rd/Ult. (3)x(17)	(19) 2nd/Ult. (2)x(18)	(20) 1st/Ult. (1)x(19)
Ind.Losses	1.030	1.078	1.137	1.300	1.612
Med.Losses	1.145	1.164	1.178	1.225	1.472

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APPENDIX A-V

CALCULATION OF FIVE POLICY YEAR EXPONENTIAL TREND FACTOR

SECTION A - STANDARD EARNED PREMIUM

Policy Year	(1) Standard Earned Premium	(2) Development Factor to Fifth Report	(3) On Level Factor	(4) Premium On Level (1)x((2)x(3))
1985	404,833,016	1.000	1.091	441,672,820
1986	476,680,112	1.000	.971	462,856,389
1987	525,719,317	1.001	.990	520,987,843
1988	575,083,807	1.002	.976	562,431,963
1989	605,271,752	1.037	.933	585,903,056

SECTION B - INDEMNITY LOSSES

Policy Year	(1) Indemnity Losses	(2) Development Factor to Ultimate Report	(3) On Level Factor	(4) Ind. Losses On Level (1)x((2)x(3))
1985	160,489,719	1.029	1.041	171,884,489
1986	174,381,478	1.040	1.031	186,936,944
1987	189,215,592	1.094	1.023	211,732,247
1988	198,541,793	1.180	1.014	237,654,526
1989	177,829,813	1.403	1.005	250,740,036

SECTION C - MEDICAL LOSSES

Policy Year	(1) Medical Losses	(2) Development Factor to Ultimate Report	(3) On Level Factor	(4) Med. Losses On Level (1)x((2)x(3))
1985	124,896,323	1.135	1.000	141,757,327
1986	139,852,894	1.146	1.000	160,271,417
1987	160,757,798	1.154	1.000	185,514,499
1988	186,775,149	1.182	1.000	220,768,226
1989	184,411,123	1.266	1.000	233,464,482

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APPENDIX A-V

CALCULATION OF FIVE POLICY YEAR EXPONENTIAL TREND FACTOR (CONTD.)

SECTION D - DATA FOR INDEMNITY TREND FACTOR

(1) Policy Year	(2) Time Index	(3) Premium On Level (See App. A-V Sect.A)	(4) Ind. Losses On Level (See App. A-V Sect.B)	(5) Ind. Loss Ratio (4)/(3)	(6) Ln(5)	(7) (2)x(6)	(8) (Ax(2))+B	(9) Fitted Indemnity Loss Ratio Exp((Ax(2))+B)
1985	1	441,672,820	171,884,489	.389	-.944	-.944	-.940	.391
1986	2	462,856,389	186,936,944	.404	-.906	-1.812	-.916	.400
1987	3	520,987,843	211,732,247	.406	-.901	-2.703	-.892	.410
1988	4	562,431,963	237,654,526	.423	-.860	-3.440	-.868	.420
1989	5	585,903,056	250,740,036	.428	-.849	-4.245	-.844	.430
Total	15	xxx	xxx	2.050	-4.460	-13.144	xxx	xxx

SECTION E - DATA FOR MEDICAL TREND FACTOR

(1) Policy Year	(2) Time Index	(3) Premium On Level (See App. A-V Sect.A)	(4) Med. Losses On Level (See App. A-V Sect.C)	(5) Med. Loss Ratio (4)/(3)	(6) Ln(5)	(7) (2)x(6)	(8) (Ax(2))+B	(9) Fitted Medical Loss Ratio Exp((Ax(2))+B)
1985	1	441,672,820	141,757,327	.321	-1.136	-1.136	-1.129	.323
1986	2	462,856,389	160,271,417	.346	-1.061	-2.122	-1.073	.342
1987	3	520,987,843	185,514,499	.356	-1.033	-3.099	-1.017	.362
1988	4	562,431,963	220,768,226	.393	-.934	-3.736	-.961	.383
1989	5	585,903,056	233,464,482	.398	-.921	-4.605	-.905	.405
Total	15	xxx	xxx	1.814	-5.085	-14.698	xxx	xxx

SECTIONS D AND E, CONTD. - CALCULATION OF INDEMNITY AND MEDICAL TREND FACTORS

	INDEMNITY (See Section D)	MEDICAL (See Section E)
(10) A: (NxSum(7)-Sum(2)xSum(6)) / (NxSum((2)**2) - Sum(2)xSum(2))	.024	.056
(11) B: (Sum(6)-(10)xSum(2)) / N	-.964	-1.185
(12) Midpoint of Experience in Filing is 4-1-90. Time Index for 4-1-90 is:	5.250	5.250
(13) Midpoint of Period during which Proposed Rates are Effective is 12-1-92. Time Index for 12-1-92 is:	7.917	7.917
(14) Trend Factor prior to Credibility: (Exp((Ax(13))+B)) / (Exp((Ax(12))+B))	1.065	1.161
(15) E = Sum of Squares of ((6)-(8))	.000286	.001434
(16) Credibility (Limited to 100%): (.0011 / (15))**.5	100%	88%
(17) Annual Expected Trend	.050	.105
(18) Credibility Weighted Trend Factor: (1.000-(16)) x ((1.000 + (17))**((13)-(12))) + ((14)x(16))	1.065	1.179

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APPENDIX A-V

CALCULATION OF FIVE POLICY YEAR EXPONENTIAL TREND FACTOR (CONTD.)

SECTION F - DETERMINATION OF OVERALL TREND FACTOR

(1)	Adjusted Indemnity Losses for Policy Year 1989 valued as of 12-31-90 (See Appendix A-V - Section B)	250,740,036
(2)	Adjusted Medical Losses for Policy Year 1989 valued as of 12-31-90 (See Appendix A-V - Section C)	233,464,482
(3)	Indemnity Trend Factor	1.065
(4)	Medical Trend Factor	1.179
(5)	Indicated Overall Trend Factor $\frac{((1)x(3)) + ((2)x(4))}{(1) + (2)}$	1.120

SECTION G - DERIVATION OF EFFECT OF TREND FACTOR

Policy year 1989 with an average accident date of January 1, 1990 (Exhibit I-A) and calendar-accident year 1990 with an average accident date of July 1, 1990 (Exhibit I-B) are used in the determination of the indicated change based upon experience (Exhibit I-D). This experience reflects, on average, conditions as of April 1, 1990. The midpoint of the time period for which the revised rates are being proposed is December 1, 1992. The premium level must therefore reflect experience levels which will exist 32 months later than the midpoint of the experience on which the current indication has been derived. The indicated trend factor is 1.120. Since the present rates include a factor of 1.105, the appropriate factor to incorporate the effect of trend into the overall change in premium level is the ratio of these two trend factors: 1.014 (1.014 = 1.120 / 1.105).

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SECTION 5.0

ACTUARIAL REPORT REGARDING WORKER'S COMPENSATION RATING SYSTEM THAT ENCOURAGE SAFETY AND HEALTH

SUMMARY I-1

MERIT RATING PLANS II-2

COST SHARING PROGRAMS III-3

LOSS CONTROL PROGRAMS IV-5

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ACTUARIAL REPORT REGARDING WORKERS' COMPENSATION RATING SYSTEMS THAT ENCOURAGE SAFETY AND HEALTH

JANUARY 24, 1992

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ACTUARIAL REPORT REGARDING WORKERS' COMPENSATION RATING SYSTEMS THAT ENCOURAGE SAFETY AND HEALTH

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ACTUARIAL REPORT REGARDING WORKERS' COMPENSATION RATING SYSTEMS THAT ENCOURAGE SAFETY AND HEALTH

Exhibits

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Examples of Schedule Rating Plans	AIS-1, Sheets 1-3
Mandatory Safety Program - Maine	AIS-2, Sheets 1-3
Mandatory Safety Program - Texas	AIS-3, Sheets 1-14
The Delaware Workplace Safety Program	AIS-4, Sheets 1-14
Qualified Loss Management Program - Massachusetts	AIS-5, Sheets 1-35
Safety Health Achievement Recognition Program - Oklahoma	AIS-6, Sheets 1-17
California Workers' Compensation Retrospective Rating Plan Manual	AIS-7, Sheets 1-2
New York Workers' Compensation Retrospective Rating Plan Manual	AIS-8, Sheets 1-2
Incurred Dividends as a Percentage of Premium	AIS-9, Sheet 1
Incurred Dividend Ratios	AIS-9, Sheet 2

ACTUARIAL REPORT REGARDING WORKERS' COMPENSATION RATING SYSTEMS THAT ENCOURAGE SAFETY AND HEALTH

I Summary

AIS Risk Consultants was retained by the California Workers' Compensation Rate Study Commission (WCRSC) to review workers' compensation rating systems that encourage safety and health. In our analysis we have relied upon data and information supplied by the WCRSC, various regulatory agencies and other generally accepted sources. While we used our overall knowledge and experience to assess the reasonableness of the information provided, we have not performed an independent audit of the information supplied. The information for this project was supposed to be obtained primarily from survey forms sent out to regulatory agencies and rating bureaus. The response to those surveys has, to date, been limited. We have therefore relied principally upon other sources of information.

Based upon our review, we found three main groupings of rating plans that can encourage safety for small to medium sized insureds[1]. These groupings are:

(1) Merit Rating Plans - These plans have lower eligibility requirements than experience rating plans. In addition, they take into account only the number of claims, whereas experience rating plans also take into account the size of the claims.

(2) Cost Sharing Programs - In these plans, the employer shares in the cost of claims, either through a deductible or co-payment.

(3) Loss Control Programs - These programs encourage safety by giving premium credits to insureds who meet certain safety standards. Within this group, three different types of plans exist. They are: (1) schedule rating, (2) state mandated programs and (3) safety inspections / risk management.

Each of these programs are discussed in more detail in the following sections.

With regard to the current rating plans in California that could encourage safety and health for small to medium sized employers, we found the following:

(A) The eligibility requirement for retrospective rating makes it of limited applicability to small and medium sized risks. An expected annual premium of $25,000 is needed to apply the plan. Furthermore, even at that limit, the high maximum premium

limitation will likely discourage its use. California has only one retro plan. Many other states have five plans. These additional plans, which provide for more flexibility, could enable additional insureds to use retrospective rating.

(B) Policyholder dividends are relatively minor for small to medium sized insureds. For policy year 1987, insureds with a premium less than $1,000 received an average dividend of 0% of premium. For insureds with premiums between $1,000 and $9,999, the dividend averaged 6% of premium. For larger policies, the dividend averaged between 16% and 20% of premium. In addition, the non-guaranteed discretionary nature of dividends may make them less effective than a predetermined mandatory program.

(C) Premium surcharges are applied to a small percentage of insureds. The premium received from these surcharges are less than 1% of the overall statewide standard premium. This program only provides for premium debits, not for credits. In addition, the revenue insurers receive from these surcharges are not reflected in the manual rate level calculation.

II Merit Rating Plans

Most experience rating plans have moderately high eligibility requirements.[2] As such, these plans cannot be used with small premium insureds.

There are alternate loss based rating plans, referred to as merit rating or claim rating programs. These plans have much lower eligibility requirements. The typical merit rating plan has an eligibility requirement of $500 or less in annual premium. The rate modification from such a plan is based upon the number of indemnity claims which occur during the experience period.[3]

We found four examples of these plans in the materials that were reviewed. The rating values for these plans are shown in the following table.

Illustrative Rating Impact of Merit Rating Plans

Number of Indemnity Claims	Massachusetts	Michigan State Fund	Oregon State Fund	Oregon Assigned Risk
0	-5%	-10%	-5%	-10%
1	0%	- 5%	0%	0%
2 or more	+5%	0%	Non-renew	+10%
3 or more		+ 5%		

Most insureds which qualify for these plans would be expected not to have any indemnity claims during the experience period. The Oregon State Fund indicated that about 75% of their non-experience rated risks do not have any claims in a given three year rating period. Because of this, the application of a merit rating plan will reduce the overall premiums charged to the group of risks to which it is applied.[4] The Massachusetts Workers' Compensation and Inspection Rating Bureau estimated that for the insureds covered under their merit rating plan, an average credit of 3.6% would result. They also projected that these risks would constitute 3.2% of the overall statewide premium. Therefore, manual rates would need to be increased by 0.1% (= 3.6% average credit X 3.2% market share) to offset the revenue loss resulting from the merit rating plan.

III Cost Sharing Programs

In these programs, the insured shares in the cost of the workers' compensation claims which occur. This is done either through a deductible or co-payment on each claim. These programs represent, in a general sense, the same type of cost sharing plans used for health insurance.[5]

Within this basic overall framework, many variations are possible. Some of these options are:

(a) The deductible can be applied to only indemnity losses, only medical losses, or to both types of losses.

(b) The plan can have the insurer make the payment, to be later reimbursed by the insured, or the insured can be made directly responsible for the payment.

(c) The plan can be mandatory or optional with regard to the insured.

(d) An aggregate limit can be placed on the total amount the insured has to pay for cost sharing.

A number of states have implemented this type of program. Those states include Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Maine, Montana, Nebraska, New Hampshire, New Mexico, New York, Oregon, Rhode Island, South Dakota and Texas.

Having the insurer primarily responsible for paying the claim, to be later reimbursed by the employer, provides the maximum assurance that the injured worker will receive the benefits which should be provided. However, under this type of mechanism, insurers could face collection problems from

some insureds. Therefore, under this arrangement, the credit given in the rate structure will typically be lower than if the insured is directly responsible for payments within the deductible or co-payment.

Making the deductible plan optional on the part of the insured provides more freedom than a mandatory plan. However, this raises the possibility of adverse selection against the insurer. That is, insureds with poor experience will likely not choose a deductible because the premium credit will not cover the losses expected to be retained. On the other hand, insureds with good experience will choose the deductible, since the premium credit will be larger than the expected losses retained. Because of the possibility of adverse selection, the premium credit offered by insurers will be smaller with an optional plan than with a mandatory plan.

An aggregate limit on the losses retained by the insured can be used. With such a plan, once the insured has paid the aggregate limit amount, the insured will make no further loss payments, even for claims within the deductible. This plan has the advantage of putting an upper limit on an insured's financial responsibility. Without this limit, the employer's payments could reach a substantial amount if numerous claims occur. This potentially high liability could be a problem for small policyholders. The disadvantage of an aggregate limit plan is that the pricing is significantly more complex than for a plan without such a limit.[6]

An illustration of the deductible amounts and rate credits implemented in various states is given in the table below.

Illustration of Deductible Amounts and Rate Credits[7]

Deductible Amount	Colorado	Connecticut	Hawaii˜	Montana˜	New Mexico
$ 100			1.0%		
150			1.5%		
200			2.0%		
300			2.8%		
400			3.5%		
500	3.6%		3.9%	2.6%	2% to 5%*
1,000	5.3%	3% to 6%*	5.8%	3.7%	4% to 8%*
1,500	6.6%		7.1%	4.6%	5% to 10%*
2,000			8.1%	5.3%	6% to 12%*
2,500			9.1%	5.9%	7% to 13%*
5,000		10% to 17%*			10% to 18%*
10,000		16% to 25%*			16% to 27%*

* Credit depends upon hazard group of insured.
˜ Medical only deductible.

The only state we found that has a co-payment provision is Florida. Up to specified limits, the insured will pay for 20% of the loss, with the insurer paying 80%. The co-payment limits range from $5,000 to $21,000, with rate credits ranging from 3.2% to 6.5%. Florida also has a deductible plan and a mixed deductible / co-payment plan.

IV Loss Control Programs

We found three different types of loss control programs that could be used to provide a safety incentive for small to medium insureds. They were : (1) schedule rating, (2) state mandated programs and (3) safety inspections / risk management. These are explained further below.

Schedule Rating

A description of schedule rating is as follows:

> Schedule rating is the only individual risk rating system that does not directly reflect an entity's claim experience; in theory, it recognizes characteristics that are expected to have a material effect on an entity's experience but that are not actually reflected in that experience. These characteristics could result from recent changes in exposure (such as the addition of a swimming pool in an apartment complex) or risk control programs (such as the recent implementation of a new program). Schedule rating is also used for entities that are too small to qualify for experience rating or composite rating.
>
> Schedule rating systems usually take the form of percentage credits and debits. These credits and debits are sometimes applied before and sometimes after experience rating. There may be a limit to the total debit or credit that an entity can receive.
>
> Note that schedule credits and debits apply only to those characteristics which should affect an entity's loss and ALAE experience. If a characteristic is listed which should not affect a particular entity's loss and ALAE experience, there should be no adjustment to the manual rates for that characteristic for that entity.
>
> Also note that the application of schedule credits and debits may take considerable underwriting judgment. A schedule rating system that is based on objective criteria will result

in more consistent treatment of affected entities than a system that relies on subjective evaluation.[8]

The criteria a schedule rating plan might take into account are: (a) location - exposure inside and outside premises; (b) premises - condition, care; (c) equipment - type, condition, care; (d) classification peculiarities; (e) employees - selection, training, supervision, experience and (f) cooperation - medical facilities, safety program. Each item will allow for credits and debits within a certain range, usually no more than +/- 10%. In addition, there can be a limit on the total schedule adjustment from all factors combined. A common limit is +/- 25%. Examples of schedule rating plans are given in Exhibit AIS-1.

Schedule rating can result in more equitable rating for insureds of all sizes, not just small and medium insureds. By reflecting the unique characteristics of a particular insured, an incentive is given to improve experience. The premium credits (or debits) are immediate. An insured does not have to wait 2 to 4 years for the improved experience to show up in an experience or merit rating plan.

The main problem with schedule rating plans are that they can be highly subjective. This can result in a schedule rating plan deteriorating from its intended purposes (i.e., helping in the equity of rating and providing an incentive for safety) into a pricing device used by insurers to undercut competitors. It can also lead to different insureds with the same characteristics being treated in an unequal manner.

If a schedule rating plan were to be used, the criteria in it should be made as objective as possible. In addition, insurers should be required to maintain adequate documentation in their files as to why a particular credit (or debit) was applied.

Schedule rating has been used in numerous states in recent years.[9] The application of schedule rating has led in some instances to substantial reductions in premiums.[10]

State Mandated Programs

Some states have implemented mandatory safety programs for employers with poor loss experience. Two states we know of that have this type of program are Maine and Texas. The statutory provisions which established these programs are set forth in Exhibits AIS-2 and AIS-3, respectively.

Maine's program was adopted as Section A-22 of H.P. 1397. A brief outline of Maine's program is as follows:

(a) Employers with an experience modification of 2 or more are required to undertake a workplace health and safety program.[10.5]

(b) The Department of Labor administers the details of the safety program.

(c) If the employer fails to complete the workplace health and safety program, a 5% surcharge is imposed on that employer's workers' compensation premium.

(d) The surcharge amounts go into various state programs used to improve workplace safety.

The Texas program was adopted in Article 7 of SB 1. A brief outline of the Texas program is as follows:[11]

(a) "Extra-hazardous employers" are defined as those with injury frequencies that substantially exceed those that may be expected in that employer's business or industry (Section 7.04).

(b) Those identified employers are required to implement an accident prevention plan.

(c) An employer who fails or refuses to implement the accident prevention plan or other suitable hazard abatement measures are subject to various penalties.

Safety Inspection / Risk Management Programs

We found three programs that provide credits for workers' compensation premiums if the insured takes part in a safety inspection / risk management program. The three states where these programs exist are (a) Delaware, (b) Massachusetts and Oklahoma. The details of these programs are given in Exhibits AIS-4, AIS-5 and AIS-6, respectively. A brief outline of these programs is given below.

The Delaware Workplace Safety Program is administered by the Insurance Department. This program provides for up to a 20% discount on workers' compensation insurance premiums to employers who pass two safety inspections - one announced, the other not announced. The independent inspections are performed by safety engineers who are retained by the Insurance Department.

The Massachusetts program is called the Qualified Loss Management Program. At the present, it only applies to insureds in the assigned risk plan. However, there is nothing inherent in this program which would prevent it from being applied to the voluntary market. An insured who retains an approved loss control management firm receives a

credit on their workers' compensation premium. The size of the credit is determined based upon the past record of the loss control firm in reducing losses. As of August 1991, twenty-three loss control firms were approved to offer a credit. The credit is applied over a three year period. The credit is limited to a maximum of 10% in the first two years, and 5% in the third year. No further credit is applied after that, as any improved loss experience should show up in the experience modification.

The Oklahoma program is referred to as SHARP (Safety Health Achievement Recognition Program). The program is administered through the Department of Labor. Currently, 121 employers are participating in the plan, which takes about a year to complete. The program is relatively new and no credits have yet been issued under the plan.

V Current California Rating Programs

Four programs presently exist in California which could encourage safety and health. They are (1) experience rating,[12] (2) retrospective rating, (3) policyholder dividends[13] and (4) surcharges. All of these programs can encourage safety and health in the workplace by having the employer's final cost for workers' compensation depend upon actual loss experience.

Retrospective Rating

The rules governing retrospective rating are set forth in the California Workers' Compensation Retrospective Rating Plan Manual, published by the WCIRBC. The basic concept underlying retrospective rating is very simple. The final premium an insured will pay for coverage for a given policy period will depend upon the losses that occur during the period. The premium is limited to no more than a given maximum, nor less than a specific minimum. A basic premium charge is applied irrespective of the actual losses. This amount covers the insurance company's expenses, profit and risk charge for the maximum premium. The rating formula, basic premium, minimum premium and maximum premium are set forth in Exhibit AIS-7.

The minimum eligibility for retrospective rating is an expected annual premium of $25,000. As such, the plan's applicability to small and medium sized insureds is very limited. Even at a premium of $25,000 the program may have only marginal use, since the maximum premium is a relatively high 179.4% of the standard premium. California's retrospective rating program allows only one set of basic, minimum and maximum premiums. Most other states have five different retrospective rating programs. A description of

these is given in Exhibit AIS-8. The first of these programs allows for a maximum premium equal to the standard premium.[14] Consideration could be given to allowing California to have more than one retrospective rating plan.

Policyholder Dividends

Policyholder dividend plans can return funds to insureds after the expiration of the policy period for which coverage was provided. The amount of the dividend returned to a specific insured will typically reflect two items. They are: (1) expense savings for larger policyholders resulting from the excessive expense provisions built into the manual rate level and (2) favorable loss experience. Dividends returned to small policyholders will typically be a much lower percentage of premium than those returned to large policyholders. This is seen from Exhibit AIS-9, which is an excerpt from the WCIRBC's policy year 1987 dividend study. This lower percentage can reflect three possible factors. They are that smaller insureds had: (1) higher expenses in relation to premium, (2) higher losses in relation to premium and (3) less credible loss experience.

One concern regarding policyholder dividends are that they cannot be guaranteed at the start of the year. Hence, an insured has no assurance that improved safety, which results in lower losses, will end up being rewarded with a dividend. The amount of the dividend given to a particular insured depends not only upon the experience of that insured, but of all the employers covered by the insurance company. Therefore, if an insurer has a bad year financially, insureds with good loss experience may receive a lower, or possibly no dividend.

Another concern with policyholder dividends are that they can result in disparate results for similarly situated policyholders in different insurance companies. A given insurance company cannot institute an unfairly discriminatory dividend plan for its own policyholders. However, there is nothing that prevents unequal treatment for policyholders in two different insurance companies.

Both of these concerns might be alleviated by implementing a mandatory rating program which would supplement policyholder dividends. In such a program, the manual rate would be increased by a certain amount to allow for the payment of refunds after the end of the policy period based upon favorable experience. However, instead of leaving the size and distribution of the refunds to the discretion of insurance companies, it could be set in advance. Since this plan would assure that favorable experience is rewarded with a refund, it could have a more beneficial impact than discretionary policyholder dividends. Such a plan would not

supplant policyholder dividends, but would be used in conjunction with it.

Surcharges

"Surcharges are used when an employer has a demonstrably and consistently poor loss history or presents an unusual hazard for its industry classification and is therefore likely to develop losses beyond those contemplated at basic rates. Surcharges are intended as an inducement to provide a safe workplace."[15] The application of surcharges is limited in scope. The State Fund estimates that 2% of its policyholders receive surcharges. From 1981 to 1990, the amount of premium resulting from surcharges was less than 1% of the overall premium. Two other concerns with this program are that (1) the plan only provides for premium surcharges, not for premium credits and (2) the revenue insurers receive from these surcharges are not reflected in the manual rates.

Footnotes:

[1] In some cases these plans may be more applicable to small insureds than medium insureds and vice versa. In addition, some of these plans might also be applicable to large insureds.

[2] Some State Funds' experience rating plans have fairly low eligibility requirements. Such experience rating plans could encourage safety on the part of small employers. An examination of experience rating plans was beyond the scope of our assignment.

[3] In this way, the merit rating plans are different than experience rating plans. The latter also takes into account the dollar value of the claims which occurred during the experience rating period.

[4] This would occur since many more insureds would receive credits than debits.

[5] One difference with health insurance is that in those plans, the employee shares in the cost of the claim. In workers compensation plans, it is the employer, not the employee, that shares in the cost of the claim.

[6] Texas is the only state we know of that uses an aggregate limit.

[7] The specific deductible amounts and rate credits should be taken as illustrative, as particular states can change these over time.

[8] Foundations of Casualty Actuarial Science, Casualty Actuarial Society, 1990, pages 102 - 103

[9] Schedule rating has been used in about 20 jurisdictions in recent years.

[10] In various states during the early to mid 1980's, it was not uncommon for the overall statewide premium to be reduced by 5% to 10%, or on rare occasion even more, as a result of the application of schedule rating. We have not analyzed whether the schedule credits were given to reflect improved safety conditions, or because of competition.

[10.5]These employers make up about 11% of the insured losses in the Maine workers' compensation system.

[11] In addition to required safety plans for extra-hazardous employers, other safety measures in SB 1 were: (1) the requirement that insurance companies provide accident prevention facilities [Section 7.05], (2) a back injury prevention training program [Section 7.07], (3) employee

reports of safety violations [Section 7.08] and (4) policies for elimination of drugs in the workplace [Section 7.10]. All of these sections are included in Exhibit AIS-3.

[12] A discussion of the impact of experience rating was outside the scope of our assignment.

[13] Policyholder dividend plans are not usually considered rating plans, in part because Insurance Departments typically have very little control over how the dividend plans are implemented.

[14] In these other states, a mandatory premium discount plan is applied to recognize the expense savings on large insureds. Therefore, under the plan where the maximum premium equals the standard premium, the insured trades the possibility of a lower premium for the chance that the premium discount will be lost. In California, mandatory premium discounts to reflect expense savings do not exist. This would need to be changed to implement a retrospective rating plan where the maximum premium was equal to the standard premium.

[15] State Compensation Insurance Fund's report to the Workers' Compensation Rate Study Commission, page 7

SCHEDULE RATING

1. The premium for a risk may be modified in accordance with the table below to reflect such characteristics of the risk that are not reflected in its experience.
2. The amount of schedule credit or debit shall be applied to an experience rated risk in a multiplicative manner, after application of the experience modification, and before the application of premium discounts and expense constant.
3. There shall be an annual report to the National Council on Compensation Insurance illustrating the total dollar amount of schedule debits and the total dollar amount of schedule credits.
4. Standard earned premium figures reported to the National Council on the aggregate calls for experience (e.g., policy year, calendar year, etc.) must exclude (i.e., be prior to) the effects of schedule rating premium adjustments. Net earned premium reported on these calls must include (i.e., be after) the effects of schedule rating premium adjustments.

   Schedule rating premium adjustments must be reported under unique classification codes on unit statistical reports submitted to the National Council.
5. This program is not applicable to residual market policyholders covered under the Workers Compensation Insurance Plan.
6. All schedule debits and all schedule credits shall be based on evidence that is contained in the file of the carrier at the time the schedule debit or credit is applied.
7. The effective date of any schedule debit or credit shall not be any date prior to the receipt in the insurer's office of the evidence supporting the debit or credit.
8. The derivation of the schedule factor must be made available to the insured upon request. To the degree that the insured can correct the reason for any schedule debit to the satisfaction of the insurer, the debit may be removed effective the date documentation for the correction is received in the insurer's office.
9. The Schedule Rating Program can be used only on risks which are rated in compliance with the National Council on Compensation Insurance's filed and approved rates without deviation.

SCHEDULE RATING TABLE

State	Effective Date (New & Renewal Policies)	Maximum Modification	Eligibility (Minimum Annual Premium At Manual Rates)	RANGE OF MODIFICATION (Credit to Debit)						
				Premises	Classification Peculiarities	Medical Facilities	Safety Devices	Employees-Selection, Training, Supervision	Management-Cooperation Withinsurance Carrier	Management-Safety Organization
Alabama	6-1-83	15%	$1,000	6%-6%	6%-6%	3%-3%	3%-3%	6%-6%	3%-3%	3%-3%
Arizona	7-1-82	25%	$2,500	10%-10%	10%-10%	5%-5%	5%-5%	10%-10%	5%-5%	5%-5%
Colorado	7-1-83	25%	$2,500	10%-10%	10%-10%	5%-5%	5%-5%	10%-10%	5%-5%	5%-5%
District of Columbia	2-1-83	25%	$2,500	10%-10%	10%-10%	5%-5%	5%-5%	10%-10%	5%-5%	5%-5%
Mississippi	11-1-83	25%	$2,500	10%-10%	10%-10%	5%-5%	5%-5%	10%-10%	5%-5%	5%-5%
New Mexico	5-1-82	15%	$1,500	6%-6%	6%-6%	3%-3%	3%-3%	6%-6%	3%-3%	3%-3%
Rhode Island	3-1-83	25%	$2,500	10%-10%	10%-10%	5%-5%	5%-5%	10%-10%	5%-5%	5%-5%
South Carolina	4-1-83	25%	$2,500	10%-10%	10%-10%	5%-5%	5%-5%	10%-10%	5%-5%	5%-5%
South Dakota	12-1-82	25%	$750	10%-10%	10%-10%	5%-5%	5%-5%	10%-10%	5%-5%	5%-5%
Tennessee	5-1-83	25%	$2,500	10%-10%	10%-10%	5%-5%	5%-5%	10%-10%	5%-5%	5%-5%
Utah	1-1-83	25%	$2,500	10%-10%	10%-10%	5%-5%	5%-5%	10%-10%	5%-5%	5%-5%

Note: Refer to state special rules on page A-8.

SCHEDULE RATING

STATE SPECIAL RULES

ARIZONA

Add to 3:

These dollar amounts shall be derived by policy level insurer records. National Council shall perform an independent audit of insurer records to verify accurate recording at policy level and tabulations of total credits and debits.

Amend Number 4 as follows:

Standard earned premium figures reported to the National Council on the aggregate calls for experience (e.g., policy year, calendar year, etc.) must exclude (i.e., be prior to) the effects of schedule rating premium adjustments. Net earned premium reported on these calls must include (i.e., be after) the effects of schedule rating premium adjustments. NCCI shall verify that the premium reported under such calls reconciles to total premium and credits/debits outlined in (3) above.

Schedule rating premium adjustments must be reported under unique classification codes on unit statistical reports submitted to the National Council.

Amend Number 6 as follows:

★ "Completion of the Schedule Rating Worksheet, attached hereto as Exhibit A and by this reference incorporated herein, and inclusion of the completed Worksheet in each workers compensation policy file shall be deemed to be in compliance with the evidentiary requirements of this Section, provided the total modification applicable to a specific risk does not exceed 25%, and further provided that each modification applicable to a specific risk characteristic falls within the available range of modifications provided for in this Schedule Rating Plan."

Add to 7:

Such evidence shall include, or be supplemented by within 90 days of policy effective date, a loss prevention survey of insured. This survey must be performed by a loss control specialist whose principal duties are loss prevention.

Amend Number 7 as follows:

★ "A copy of a completed Schedule Rating Worksheet, as described in Section 6 hereof, and a copy of a completed loss prevention survey as described herein shall be completed for each risk and included within each workers compensation policy file within the time frames provided for in this Schedule Rating Plan. For the purposes of this Section the term 'each risk' shall be deemed to include each member risk of an association or safety group."

COLORADO

Number 5 does not apply.

DISTRICT OF COLUMBIA

Add to 7:

Such evidence shall include, or be supplemented by, a loss prevention survey of the insured within 90 days of policy effective date. This survey must be performed by a loss control specialist whose principal duties are loss prevention.

NEW MEXICO

Numbers 6, 7, 8 and 9 do not apply.

SOUTH DAKOTA

Amend Number 4 as follows:

All statistical reporting on policies effective November 1, 1982, and thereafter reported to the National Council on Compensation Insurance or other statistical agents shall not include the effect of this schedule rating plan (report at Council rate level). This includes, but is not limited to, premiums reported on the Unit Statistical Plan, Policy-Year Premiums, Calendar-Accident-Year Premiums and Calendar-Year Premiums.

Number 9 does not apply.

UTAH

Number 5 does not apply.

ARIZONA SCHEDULE RATING WORKSHEET

(Risk Name)

(Risk Address)

(Carrier)

(Carrier Code—5 Digit)

(Risk Identification Number)

(Policy Number)

(Policy Effective Date)

(Effective/Expiration Date of Schedule Rating Applicability)

Loss Prevention Survey Completed?
Yes _____ No _____

Are NCCI Rates Being Used Without Deviation? Yes _____ No _____

Does Estimated Standard Premium Equal or Exceed Current Experience Rating Eligibility Level?
Yes _____ No _____

Category	Available Range of Modification (Credit to Debit)	Credit Applied	Debit Applied	Reason/Basis
Premises	10% to 10%			
Classification Peculiarities	10% to 10%			
Medical Facilities	5% to 5%			
Safety Devices	5% to 5%			
Employees—Selection, Training, Supervision	10% to 10%			
Management—Cooperation with Insurance Carrier	5% to 5%			
Management—Safety Organization	5% to 5%			
	Total			Maximum = 25%

(Arizona Estimated Standard Premium)

(Total Schedule Rating Modification)

Exhibit AIS-1, Sheet 3

115th MAINE LEGISLATURE

FIRST SPECIAL SESSION-1991

Legislative Document **No. 1981**

H.P. 1397 House of Representatives, July 17, 1991

Reported by the Majority from the Committee on Labor and the Committee on Banking and Insurance pursuant to H.P. 1382 and printed under Joint Rule 2.

Ed Pert

EDWIN H. PERT, Clerk

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-ONE

An Act to Make Changes in the Workers' Compensation System.

Enacted, As Amended by Amendments

Committee Amendment A
House Amendment A
House Amendment B
House Amendment C
House Amendment G

Printed on recycled paper

then, depending on the final outcome of that subsequent proceeding, either the workers' compensation insurance carrier shall return excess premium collected or the employer shall remit premium subsequently due in order to put the parties in the same position as if the final outcome under the contested claim were predetermined correctly.

3. Predetermination submission. A party may submit, on forms approved by the Department of Labor, a request for predetermination regarding the status of a person or job description as an employee or independent contractor. The status requested by a party is deemed to have been approved if the Department of Labor does not deny or take other appropriate action on the submission within 14 days.

4. Hearing. A hearing, if requested by a party within 10 days of the Department of Labor's decision on a petition, must be conducted under the Maine Administrative Procedure Act.

5. Certificate. The Department of Labor shall provide the petitioning party a certified copy of the decision regarding predetermination that is to be used as evidence at a later hearing on benefits.

6. Rulemaking. The Commissioner of Labor is authorized to adopt reasonable rules pursuant to the Maine Administrative Procedure Act to implement the intent of this section, which is to afford speedy and equitable predetermination of employee and independent contractor status.

Sec. A-22. 39 MRSA §21-A, sub-§4 is enacted to read:

4. Workplace health and safety training programs. The following workplace health and safety plan requirements apply to all employers in the State required to secure payment of compensation in conformity with this Title.

A. The Commissioner of Labor or the commissioner's designee shall adopt rules regarding workplace health and safety programs.

B. The Superintendent of Insurance shall communicate to the Department of Labor the names of employers that receive in any policy year an experience rating of 2 or more. The Department of Labor shall notify each employer on that list that the employer is required to undertake a workplace health and safety program, shall provide a statistical evaluation of the employer's workplace health and safety experience and shall enclose a set of workplace health and

safety options, including on-site consultation, education and training activities and technical assistance.

C. The employer shall submit a workplace health and safety plan to the Department of Labor for review and comment, complete the elements of the plan and notify the Department of Labor of its completion. The plan may include attendance at a Maine technical college or the Department of Labor workplace health and safety training programs.

D. The Department of Labor shall notify the Superintendent of Insurance of any employer that fails to complete the workplace health and safety program as required by this section and the rules. The superintendent shall assess a surcharge of 5% on that employer's workers' compensation insurance premium or the imputed premium for self-insurers, to be paid to the Treasurer of State who shall credit 1/2 of that amount to the Safety Education and Training Fund, as established by Title 26, section 61, and 1/2 to the Occupational Safety Loan Fund, as established by Title 26, section 62.

E. The Commissioner of Labor shall report to the joint standing committee having jurisdiction over banking and insurance matters and the joint standing committee having jurisdiction over labor matters by October 1, 1993 on the rules adopted, performance by employers and any surcharges imposed by the Superintendent of Insurance.

Sec. A-23. 39 MRSA §23, sub-§1-A is enacted to read:

1-A. Pilot projects. Workers' compensation health benefits pilot projects are authorized under the following provisions.

A. The Superintendent of Insurance shall adopt rules to enable employers and employees to enter into agreements to provide the employees with workers' compensation medical payments benefits through comprehensive health insurance that covers workplace injury and illness. The superintendent shall review all pilot project proposals and may approve a proposal only if it confers medical benefits upon injured employees substantially similar to benefits available under this Title. The superintendent shall revoke approval if the pilot project fails to deliver the intended benefits to the injured employees.

B. The comprehensive health insurance may provide for health care by a health maintenance organization or a preferred provider organization. The premium must be paid entirely by the employer. The program may use deductibles,

VOLUME V

INSURANCE RELATED LEGISLATION ENACTED BY THE 71st LEGISLATURE OF TEXAS SECOND CALLED SESSION

PREPARED BY

TEXAS STATE BOARD OF INSURANCE

AUSTIN, TEXAS

PAUL T. WROTENBERY
CHAIRMAN

RICHARD REYNOLDS
MEMBER

JO ANN HOWARD
MEMBER

judicial review shall be conducted in the manner provided for judicial review of a contested case under Section 19, Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes).

(b) Judicial review conducted under this section is governed by the substantial evidence rule.

ARTICLE 7. WORKERS' HEALTH AND SAFETY

CHAPTER A. SAFETY

SECTION 7.01. APPLICABILITY. (a) In this article, "employer" means a person who makes a contract or contracts of hire.

(b) An employer who obtains workers' compensation insurance coverage is subject to this article.

(c) An employer who employs more than four employees and who is not required to and does not obtain workers' compensation insurance coverage is subject to this article as prescribed in Subsection (d) of this section.

(d) An employer described in Subsection (c) of this section is subject to this article as follows:

(1) an employer employing 150 or more employees not exempt from workers' compensation insurance coverage is subject to this article beginning January 1, 1992;

(2) an employer employing 50 or more employees not exempt from workers' compensation insurance coverage is subject to this article beginning January 1, 1993; and

(3) an employer employing more than four employees not

exempt from workers' compensation insurance coverage is subject to this article beginning January 1, 1994.

SECTION 7.02. DIVISION OF WORKERS' HEALTH AND SAFETY. (a) The division of workers' health and safety of the commission shall coordinate and enforce the implementation of state laws and rules relating to workers' health and safety issues.

(b) The division shall collect and serve as a repository for statistical information on workers' health and safety. The division shall analyze and use the information to identify and assign priorities to safety needs and to better coordinate the safety services provided by public or private organizations, including insurance carriers. The division shall promote workers' health and safety through educational programs and other innovative programs developed by the division.

(c) The division shall coordinate or supervise the collection of information relating to job safety by state or federal entities, including information collected for the supplementary data system and the annual survey of the Bureau of Labor Statistics of the United States Department of Labor.

(d) With the approval of the commission, the division may enter contracts with the federal government to perform occupational safety projects and may apply for funds from the federal government through any federal program relating to occupational safety.

(e) The division shall publish or procure and issue educational books, pamphlets, brochures, films, videotapes, and other informational and educational material. Specific educational

material shall be directed to high-risk industries and employments and shall specifically address means and methods of avoiding high frequency, but preventable, workers' injuries. Other educational material shall be directed to business and industry generally and shall specifically address means and methods of avoiding common workers' injuries. Specific decisions as to what issues and problems should be addressed by such information shall be made by the division after assigning appropriate priorities based on frequency of injuries, degree of hazard, severity of injuries, and similar considerations. Such educational materials shall include specific references to the requirements of state and federal laws and regulations, to recommendations and practices of business, industry, and trade associations, and, where needed, to recommended work practices based on recommendations made by the division for the prevention of injury.

(f) The division shall cooperate with business and industry trade associations, labor organizations, and other entities to develop means and methods of educating employees and employers with regard to workplace safety.

(g) The division shall cooperate with other entities in the development and approval of safety courses, safety plans, and safety programs.

(h) The division shall certify safe employers to provide peer review safety programs.

(i) The division shall advise insurance carrier loss control service organizations of hazard classifications, specific

employers, industries, occupations, or geographic regions to which loss control services should be directed or of the identity and types of injuries or occupational diseases and means and methods for prevention of the same to which loss control services should be directed and shall advise insurance carrier loss control service organizations of safety needs and priorities developed by the division.

(j) In accordance with Section 7(c), Occupational Safety and Health Act of 1970 (29 U.S.C. Section 656), the division shall:

(1) consult with employers regarding compliance with the federal occupational safety laws and rules; and

(2) collect information relating to occupational safety as required by federal laws, rules, or agreements.

SECTION 7.03. JOB SAFETY INFORMATION SYSTEM. (a) The division shall establish and maintain a job safety information system. The division is authorized, empowered, and directed to obtain from any state agency, including the State Board of Insurance, the Texas Department of Health, and the Texas Employment Commission, data and statistics, including those compiled for the purpose of rate making. The division shall consult with the State Board of Insurance and the Texas Employment Commission in the design of data information and retrieval systems that will accomplish the mutual purposes of those agencies and of the division.

(b) Employers shall file with the commission a report on each on-the-job injury which results in the employee's absence from

work for more than one day and on each occupational disease of which the employer has knowledge. The commission shall promulgate rules and prescribe the form and manner of such reports.

(c) The job safety information system shall include a comprehensive data base that incorporates all pertinent information relating to each reported injury, including:

(1) age, sex, wage level, occupation, and insurance company payroll classification code of the injured employee;

(2) the nature, source, and severity of the injury;

(3) the reported cause of the injury;

(4) the part of the body affected;

(5) any equipment involved in the injury;

(6) the number of prior workers' compensation claims by the employee;

(7) the prior loss history of the employer;

(8) the standard industrial classification code of the employer;

(9) the classification code of the employer; and

(10) any other information deemed useful for the purpose of statistical analysis.

(d) The identity of the employee is confidential and may not be disclosed as part of the job safety information system.

SECTION 7.04. EXTRA-HAZARDOUS EMPLOYER PROGRAM. (a) The division shall develop a program including injury frequency to identify "extra-hazardous employers." The term "extra-hazardous employer" means an employer's injury frequencies substantially

exceed those that may reasonably be expected in that employer's business or industry. The division shall notify each identified extra-hazardous employer and the insurance carrier for the employer that the employer has been identified as an extra-hazardous employer.

(b) An employer that receives notification under Subsection (a) of this section must obtain a safety consultation within 30 days from the division, the employer's insurance carrier, or another professional source approved by the division for that purpose. The safety consultant shall file a written report with the commission and the employer setting out any hazardous conditions or practices identified by the safety consultation.

(c) The employer and the consultant shall formulate a specific accident prevention plan which addresses the hazards identified by the consultant. The employer shall comply with the accident prevention plan.

(d) The division may investigate accidents occurring at the worksites of an employer for whom a plan has been formulated under Subsection (c) of this section, and the division may otherwise monitor the implementation of the accident prevention plan as it finds necessary.

(e) Six months after the formulation of an accident prevention plan prescribed by Subsection (c) of this section, the division shall conduct a follow-up inspection of the employer's premises. The commission may require the participation of the safety consultant who performed the initial consultation and

formulated the safety plan. If the division determines that the employer has complied with the terms of the accident prevention plan or has implemented other acceptable corrective measures, the division shall so certify. An employer who fails or refuses to implement the accident prevention plan or other suitable hazard abatement measures commits a Class B administrative violation, and each day of noncompliance constitutes a separate violation.

(f) If, at the time of the inspection required under Subsection (e) of this section, the employer continues to exceed the injury frequencies that may reasonably be expected in that employer's business or industry, the division shall continue to monitor the safety conditions at the worksite and may formulate additional safety plans reasonably calculated to abate hazards. The employer shall comply with such plans and is subject to additional penalties for failure to implement the plan or plans.

(g) The commission shall bill the employer for the reasonable cost of services provided under Subsections (c) through (f) of this section. The costs of services shall be at a cost-reimbursement level including a reasonable allocation of the commission's administrative costs.

(h) An employer may request a hearing to contest findings made by the commission under this section. The hearing shall be conducted in the manner provided for a contested case under the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes) and is subject to judicial review as provided in that Act.

(i) The identification as an extra-hazardous employer under this section is not admissible in any judicial proceeding unless the commission has determined that the employer is not in compliance with this section and that determination has not been reversed or superseded at the time of the event giving rise to the judicial proceeding.

SECTION 7.05. ACCIDENT PREVENTION SERVICES. (a) Any insurance company desiring to write workers' compensation insurance in Texas shall maintain or provide accident prevention facilities as a prerequisite for a license to write such insurance. Such facilities shall be adequate to furnish accident prevention services required by the nature of its policyholders' operations and shall include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services to implement the program of accident prevention services. Each field safety representative shall be either a college graduate who shall have a bachelor's degree in science or engineering, a registered professional engineer, a certified safety professional, a certified industrial hygienist, an individual with 10 years' experience in occupational safety and health, or an individual who shall have completed a certified training program in accident prevention services approved by the division. The insurance company may employ qualified personnel, retain qualified independent contractors, contract with the policyholder to provide qualified accident prevention personnel and services, or use a combination of the methods enumerated in this

subsection. Such personnel shall have the qualification required for field safety representatives.

(b) The division shall conduct inspections to determine the adequacy of the accident prevention services required by Subsection (a) of this section at least every two years for each insurance company writing workers' compensation insurance in Texas.

(c) Notice that services are available to the policyholder from the insurance company must appear in no less than 10-point bold type on the front of each workers' compensation insurance policy delivered or issued for delivery in the state.

(d) At least once each year each insurance company writing workers' compensation insurance in Texas must submit to the division detailed information on the type of accident prevention facilities offered to that insurance company's policyholders. The information must include:

(1) the amount of money spent by the insurance company on accident prevention services;

(2) the number and qualifications of field safety representatives employed by the insurance company;

(3) the number of site inspections performed;

(4) any accident prevention services for which the insurance company contracts;

(5) a breakdown of the premium size of the risks to which services were provided;

(6) evidence of the effectiveness of and accomplishments in accident prevention; and

(7) any additional information required by the commission.

(e) If the insurance company does not maintain or provide the accident prevention services required by this section or if the insurance company does not use the services in a reasonable manner to prevent injury to employees of its policyholders, the insurance company commits a Class B administrative violation, and each day of noncompliance is a separate violation.

(f) The commission shall employ the personnel necessary to enforce this section and shall employ at least 10 safety inspectors to perform inspections at the job site and at the insurance company to determine the adequacy of the accident prevention services provided by the insurance company. The safety inspectors must have the qualification required for field safety representatives by Subsection (a) of this section.

SECTION 7.06. IMMUNITY FROM CERTAIN LIABILITY. The insurance company, the agent, servant, or employee of the insurance company, or a safety consultant who performs a safety consultation under Sections 7.04 and 7.05 of this Act shall have no liability with respect to any accident based on the allegation that such accident was caused or could have been prevented by a program, inspection, or other activity or service undertaken by the insurance company for the prevention of accidents in connection with operations of the employer; provided, however, this immunity shall not affect the liability of the insurance carrier for compensation or as otherwise provided in this Act.

SECTION 7.07. BACK INJURY PREVENTION TRAINING PROGRAM. (a) The division shall prepare and administer a back injury prevention training program designed to instruct workers in methods of performing job-related movements and tasks that minimize strain and safeguard against injury or reinjury to the back.

(b) The division shall:

(1) set minimum standards by published rules and regulations for instruction, qualifications for instructors, program content, and supplementary materials and equipment;

(2) contract with other state agencies, political and legal subdivisions of the state, or other suitable public and private agencies to provide approved back injury prevention training programs;

(3) compile information to evaluate the program; and

(4) establish a maximum cost for the training not to exceed $35 per participant to be paid by the insurance carrier.

(c) An employee who receives income benefits for four or more weeks for a back injury shall participate in this program. If the employee refuses to participate, without good cause, the division director may order the insurance carrier to suspend income benefits for the period of noncompliance.

(d) The program created under this section will be a pilot program to be administered in one metropolitan area and in one rural area to be determined by the commission for a period of two years.

SECTION 7.08. EMPLOYEE REPORTS OF SAFETY VIOLATIONS.

(a) The division shall establish and maintain on a 24-hour-a-day basis a toll-free telephone number which a person may use to report a violation of an occupational health or safety law. Each employer shall notify its employees of this service in a manner prescribed by the commission.

(b) An employer may not suspend or terminate the employment of or otherwise discriminate against an employee for reporting an alleged violation of an occupational health or safety law as prescribed in Subsection (a) of this section if the employee report is made in good faith.

(c) An employee whose employment is terminated or suspended is entitled to reinstatement in the employee's former position, compensation for wages lost during the period of the suspension or termination, and reinstatement of any fringe benefits or seniority rights lost because of the suspension or termination. An employee seeking relief under this subsection must file suit not later than the 90th day after the alleged conduct of the employer occurred or was discovered or discoverable by the employee through the use of reasonable diligence. An employee who prevails in a suit under this section may obtain costs of court and reasonable attorney's fees.

SECTION 7.09. EXCLUSIVE REMEDY. Except as specifically provided in Section 7.08 of this Act, this article does not create an independent cause of action at law or in equity. This article provides the sole remedy for violation of this article.

SECTION 7.10. POLICIES FOR ELIMINATION OF DRUGS IN THE

WORKPLACE. (a) Each employer who has 15 or more employees and who maintains workers' compensation insurance coverage shall adopt a policy designed to eliminate drug abuse and its effects in the workplace. The employer shall distribute to each employee a written copy of the policy.

(b) The commission shall enforce this requirement and may adopt rules for that purpose.

[Sections 7.11-7.20 reserved for expansion]

CHAPTER B. DIVISION OF RISK MANAGEMENT

SECTION 7.21. RISK MANAGEMENT FOR CERTAIN STATE AGENCIES. (a) In this section, "state agency" means a board, commission, department, office, or other agency in the executive, judicial, or legislative branch of state government that was created by the constitution or a statute of this state and that has authority that is not limited to a specific geographical portion of the state. The term includes an institution of higher education as defined by Section 61.003, Education Code. The term does not include an entity with fewer than five employees.

(b) This chapter does not apply to those state agencies that had medical malpractice, workers' compensation, or other self-insurance coverage with associated risk management programs prior to January 1, 1989.

(c) The director of the division of risk management shall serve as the state risk manager. In that capacity, the director shall supervise the development and administration of systems to:

(1) identify the property and liability losses,

State of Delaware

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841 SILVER LAKE BLVD.
DOVER, DELAWARE 19901
302/739 - 4251
FACSIMILE 302/739 - 5280

Department of Insurance

MEMORANDUM

TO: Employers Indicating An Interest In Delaware's Workplace Safety Program

FROM: Patricia C. Ament pca
Workplace Safety Administrator

RE: Survey Questionnaire and Procedures To Be Followed To Begin The Review Process

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You have indicated interest in Commissioner David N. Levinson's Workplace Safety Program. Enclosed please find the Delaware Employers' Workplace Health and Safety Incentive Program General Questionnaire. In order to start the process to qualify for the premium discount, you will need to complete this form and return it to:

Patricia C. Ament
Workplace Safety Administrator
Department of Insurance
841 Silver Lake Blvd.
Dover, Delaware 19901

You will need to return a questionnaire for every site to be surveyed. Feel free to duplicate this form.

When you return this questionnaire, it is also necessary to include a check for the appropriate survey costs. This check should be made out to the Delaware Insurance Department. In most cases only two visits will be necessary to determine eligibility. However, an employer with flexible work sites will be visited at his base of operations and at work sites in the field. The following examples will help you determine the cost of the required surveys:

(A) One building:

(1) Announced visit - $150

(2) Unannounced visit - $150
Total $300

(B) Two or more buildings:

(1) Announced visit - $150 per building

(2) Unannounced visit - $150 per building

2 buildings - $600 Total

4 buildings - $1200 Total

6 buildings - $1800 Total

8 buildings - $2400 Total

10 buildings - $3000 Total

(C) Contractor (General, Building, Custodial, etc.) or Artisans

(1) Home base plus 2 sites or less - $500

(2) Home base plus 3 to 5 sites - $750

(3) Home base plus 6 sites to 10 sites - $1000

(4) Home base plus 11 sites to 15 sites - $1500

(5) Home base plus 16 sites or more - $2500

Only Delaware work sites will be eligible for this Workplace Safety Program. Sites out of Delaware that are part of the Delaware experience can be part of the program at a negotiated survey fee. The safety credit applies to only Delaware premiums in multi-state policies.

The safety discount will be given as a result of the first visit. The unannounced visit will occur during the policy year for which the discount has been given. Failure to reaffirm the findings of the first visit will lead to a loss of the discount given for that policy year.

Contractors or artisans will obviously not be able to indicate to us at this point how many work sites that they would have when the unannounced survey is to be done. In order to avoid as much paperwork as possible, contractors or artisans should base the amount of the check for all surveys on the number of work sites at the time the original survey is returned to the Insurance Department. Adjustments will be made after the unannounced visits have been completed.

If you have 11 or more employees, please also send to us a copy of the latest OSHA Log Form 200.

With the return of the questionnaire, the OSHA Form 200, if appropriate, and the check covering the cost of the visits, the Department will assign a field surveyor to arrange the date and time for the first visit. The surveyor will use the questionnaire that you have provided the Department as the basis for both the announced and unannounced visits.

IMPORTANT: You must have the first (announced) inspection completed at least 4 months (120) days prior to your policy renewal date.

Employers who have applied and passed the inspections in previous years, must re-apply each renewal year. Re-certification requires a questionnaire and one safety inspection. With the return of the questionnaire and the check covering the cost of one inspection to the Insurance Department, an inspector will be assigned to conduct one unannounced visit.

If you have any questions, don't hesitate to call me at 1-800-282-8611 or 739-4251.

DELAWARE DEPARTMENT OF INSURANCE
841 SILVER LAKE BOULEVARD
RODNEY BUILDING
DOVER, DELAWARE 19901

REGULATION NO. 65
DELAWARE WORKPLACE SAFETY REGULATION

SECTIONS

1. AUTHORITY
2. PURPOSE
3. SCOPE
4. ELIGIBILITY AND PREMIUM CREDIT
5. NOTICE OF EMPLOYER ELIGIBILITY
6. ELIGIBILITY PERIOD
7. INSPECTIONS AND COST
8. RENEWALS AND ELIGIBILITY
9. PREMIUM SIZE RANGES AND CORRESPONDING CREDITS
10. EFFECT UPON MANUAL RATES AND SCHEDULE RATING CREDITS
11. EFFECTIVE DATE

SECTION 1. AUTHORITY.

This regulation is adopted and promulgated by the Insurance Commissioner pursuant to Title 18 Del. C. Section 314, Section 2533 and promulgated under 29 Del. C. Chapter 101.

SECTION 2. PURPOSE.

The purpose of this regulation is to:

A. Enhance the health and safety of workers in the State of Delaware.

B. Provide lower insurance premiums for qualifying employers who currently pay between $3,161 and $60,000 of annual Delaware Workers' Compensation premiums.

C. Establish both testing and inspection procedures to determine an employer's qualification for a premium credit under the Workplace Safety Program.

SECTION 3. SCOPE.

All employers who comply with the criteria set forth in this regulation are eligible for participation in the Workplace Safety Program. Only Delaware work sites will be eligible for this program and safety credit applies to only Delaware premiums in multi-state policies.

SECTION 4. ELIGIBILITY AND PREMIUM CREDIT.

An employer is eligible for the Safety Program if its annual premium is between $3,161 and $60,000. Workplace Safety credit eligibility is based on the most current unit statistical card filing. The Delaware Compensation Rating Bureau will test each employer by taking the most current unit statistical card payroll times current rates times current experience modification to determine the employer's premium size.

SECTION 5. NOTICE OF EMPLOYER ELIGIBILITY.

A. Employers meeting the premium requirement will be notified by the Delaware Department of Insurance seven months in advance of their policy renewal date. This notification will include a questionnaire to ascertain

whether the employer may qualify for a safe workplace credit, together with the schedule of inspection costs.

B. In a form acceptable by the Delaware Department of Insurance, the Delaware Compensation Rating Bureau will mail to each carrier's home office a list of its policyholders whom have met the premium requirements and who have been notified by the Department.

SECTION 6. ELIGIBILITY PERIOD.

The Department will notify the employer of eligibility, and inform the employer that he must elect at least five (5) months in advance of the date of policy renewal to participate in the Safety Program. Failure to notify the Department within this time period of an intent to renew participation may preclude the employer's participation in the Program for the next year. Election to participate shall commence by contacting the Delaware Department of Insurance.

SECTION 7. INSPECTIONS AND COST.

A. All inspections shall be made by a representative from an independent safety expert company under contract to the Insurance Department. The Insurance Department will notify the inspector of the employer's request. The inspector, in turn, will then contact the employer to set up the first of two inspections. A second <u>unannounced</u>

inspection shall be made no later than the expiration date of the policy to which any workplace safety credit based on the inspection will apply to confirm the initial certifications of safety in the workplace. The Department of Insurance will notify the Bureau when an employer successfully completes both the scheduled and nonscheduled inspection. Failure to pass the first scheduled inspection will result in a denial of an employer's eligibility to participate in the Workplace Safety Program. However, the employer, after failing its first inspection can request another inspection, after successful completion of which will make them eligible for participation in the Workplace Safety Program.

B. The cost of each inspection will be borne by the employer. The minimum charge for safety inspection is $150 per location. Each work location must successfully pass both inspections before an employer is entitled to a premium credit under the program.

SECTION 8. RENEWALS AND ELIGIBILITY.

An employer must apply for the Workplace Safety Program each year. For each year after the initial qualification, the inspection requirement will consist of one unannounced inspection. The Department will maintain a list of inspection charges which will be sent to interested parties upon request.

SECTION 9. PREMIUM SIZE RANGES AND CORRESPONDING CREDITS.

Qualifying employers will receive Workplace Safety credits of from 1% to 20% based on their premium size. Following are the premium-size ranges and corresponding credits to which an employer is eligible if his workplace passes the safety inspection.

PREMIUM RANGE			SAFETY PLAN CREDIT
$3,161	-	$3,197	10%
$3,198	-	$3,234	11%
$3,235	-	$3,272	12%
$3,273	-	$3,309	13%
$3,310	-	$3,346	14%
$3,347	-	$3,383	15%
$3,384	-	$3,420	16%
$3,421	-	$3,458	17%
$3,459	-	$3,495	18%
$3,496	-	$3,532	19%
$3,533	-	$50,000	20%
$50,001	-	$51,000	19%
$51,001	-	$51,500	18%
$51,501	-	$52,000	17%
$52,001	-	$52,500	16%
$52,501	-	$53,000	15%
$53,001	-	$53,500	14%
$53,501	-	$54,000	13%
$54,001	-	$54,500	12%
$54,501	-	$55,000	11%
$55,001	-	$55,500	10%
$55,501	-	$56,000	9%
$56,001	-	$56,500	8%
$56,501	-	$57,000	7%
$57,001	-	$57,500	6%
$57,501	-	$58,000	5%
$58,001	-	$58,500	4%
$58,501	-	$59,000	3%
$59,001	-	$59,500	2%
$59,501	-	$60,000	1%
Over $60,000			0%

SECTION 10. EFFECT UPON MANUAL RATES AND SCHEDULE RATING CREDITS.

A. Workers' Compensation manual rates shall not be adjusted because of implementation of this program.

B. Schedule rating plan credits given to policyholders for "competitive" reasons cannot be withdrawn. Schedule credits given for safety reasons may be reduced to offset the Workplace Safety Program premium credit.

C. A Ballast Factor may be introduced in the Experience Rating Program for all employers in the premium size ranges eligible for the Workplace Safety Program. This Ballast Factor may offset credits given to qualified employers, so that the Workplace Safety Program will neither increase nor decrease premiums for eligible employers in the aggregate.

SECTION 11. EFFECTIVE DATE.

The regulation shall become effective 30 days after the Commissioner's signature.

DAVID N. LEVINSON
Insurance Commissioner

August 30, 1990
Date

STATE OF DELAWARE
WORKERS' COMPENSATION HEALTH AND SAFETY INCENTIVE PROGRAM

QUESTIONNAIRE

GENERAL INFORMATION

Business Name: _____

Street Address: _____

City/Town: _____

Telephone #: _____

Person Completing Form: _____

Title: _____

Date Form Completed: _____

List All Sites to be Surveyed: _____

_____

_____

_____

_____

_____

Signed By: _____

Title: _____

* * * * *

DELAWARE EMPLOYER'S WORKPLACE HEALTH AND SAFETY INCENTIVE PROGRAM
GENERAL QUESTIONNAIRE

I. **SAFETY PHILOSOPHY**

1.	Do you adequately train and supervise your employees?	Yes No
2.	Do supervisors set a good example for your employees?	Yes No
3.	Are safety rules enforced at all levels?	Yes No
4.	Do you monitor the use and condition of protective equipment?	Yes No
5.	Do you practice consistent good housekeeping?	Yes No
6.	Do you perform periodic preventive maintenance?	Yes No
7.	Is all mechanical equipment inspected regularly?	Yes No
	a) Are all mechanical defects corrected before equipment is reused?	Yes No
	b) Is old or substandard equipment replaced?	Yes No
8.	Are you willing, and do you spend money on a regular basis to create a safer work environment?	Yes No
9.	Do you have a **complete safety program, with a written Policy Statement?** If so, attach a copy of the Statement.	

a) Do you have a Safety Coordinator, or someone designated to do that function? Yes No
b) Do you follow OSHA record keeping procedures? Yes No N/A
c) Are all accidents reviewed to determine the underlying cause, and do you eliminate hazards related to/causing the accident? Yes No
d) Do you conduct periodic safety inspections? Yes No
e) Are unsafe conditions improved where and when needed? Yes No
f) Are accidents promptly reported to you? Yes No
g) Do you have written emergency plans? Yes No

II. SAFETY PROMOTIONS

1. Do you have a safety committee? Yes No N/A
2. Do you have periodic meetings on safety topics? Yes No
3. Do you use safety posters; changed frequently? Yes No
4. Do you have a safety suggestion box? Yes No
5. Do you partially or fully subsidize the employees for their protective equipment? Yes No N/A

III. EMPLOYEE SELECTION AND TRAINING

1. Does job training begin before work actually begins? Yes No
   a) Does it cover job rules, use of equipment, job hazards, general Company safety rules, methods for reporting accidents and unsafe conditions? Yes No
2. After an employee starts work:
   a) Are all workers supervised on the job, especially the newer and less experienced ones? Yes No
   b) Do you get the cooperation of the older, more experienced employee? Yes No
   c) Do you enforce the use of protective equipment? Yes No
   d) Do you give periodic refresher courses on equipment use and safety rules? Yes No
   e) Do you make safety manuals and pamphlets available? Yes No
   f) Have you put up warning posters in strategic locations? Yes No

IV. EYE PROTECTION N/A

You should complete this section whenever employees are exposed to such hazards as chemical fumes, vapors, splashes, intense heat, molten metals, wood and metal chips; high dust levels.

1. Are safety glasses worn which meet or exceed ANSI standards? Yes No
   a) Do they have side shields? Yes No
   b) Are goggles worn where goggles are needed? Yes No
   c) Are all glasses regularly cleaned after each use, particularly the goggles? Yes No
2. Are safety shields worn? Yes No
   a) Over safety glasses? (for protection against chemical splash, glass breakage and severe impact hazards) Yes No
3. Are there eye or eye/face wash stations in areas where chemicals are handled? Yes No

V. FIRST AID

1. Are medical personnel readily available or on call? Yes No
2. Are emergency phone numbers posted in prominent places? Yes No
3. Do you have physician-approved first aid supplies; highly visible and close to employees; inspected and replenished continuously? Yes No
4. Do you have eye/face wash stations? Yes No N/A
5. Do you have shower facilities? Yes No N/A
6. Is there at least 1 worker or supervisor on each shift who has been technically trained and is competent and responsible for administering first aid treatment? Yes No
7. Do you keep records of all injuries and illnesses? Yes No

VI. HEARING PROTECTION N/A

Complete this section if your business has a DBA level of 85 or more.

1. Do you have a hearing conservation program? Yes No
   a) Do you comply with all OSHA or Delaware state standards where employees are exposed on a regular basis to high noise levels? Yes No
   b) Are workplace noise levels monitored? Yes No
   c) Do you give your employees annual hearing tests, with records maintained? Yes No
   d) Is proper hearing protection (ear muffs or ear plugs) furnished and/or required to be worn? Yes No
   e) Is this enforced? Yes No
   f) Penalties for violation (describe) _____
   _____
2. Do you give employees periodic rest periods, or alternate work away from the noise? Yes No
3. Do you change worker or job schedules to cut down on noise exposure? Yes No
4. Do you rotate or transfer personnel who show evidence of a significant shift in hearing threshold? Yes No

VII. HOUSEKEEPING AND MAINTENANCE

1. Do you store items in passageways, or on stairways or ramps? Yes No
2. Are all work areas and aisles free of congestion? Yes No
3. Any electrical cords strung across walkways? Yes No
   a) If so, are they properly marked and guarded? Yes No

4. Do you have specific storage areas? Yes No
   a) Do you always use proper and safe storage areas? Yes No
5. Are any loose floor mats safety-edged? Yes No
6. Any worn or frayed carpet, open carpet seams or curled edges? Yes No
7. Any holes, uncovered drains, protruding nails, splinters, loose boards or projections in floors? Yes No
8. Are there any false floors or platforms used to provide dry standing and walking surfaces? Yes No
9. Are all floors free of debris, lint, dust, oil, grease, paint or spray residue, granular material, sand, mud, ice or other slippery, traction-robbing material? Yes No
10. Is lighting adequate for all operations? Yes No
11. Is there a proper and functioning ventilation system? Yes No
12. Are all exits clearly marked and unobstructed? Yes No
13. Is there frequent pickup of refuse? Yes No

VIII. **MACHINE GUARDING** N/A

Complete this section only where machinery is in use.

1. Do you have only trained individuals operating or repairing machinery? Yes No
2. Are proper guards installed on all moving parts of the machines? Yes No
3. Does someone regularly inspect the guards to see that they are still in use, and mounted properly? Yes No
4. Are any defects remedied immediately? Yes No
5. Is corrective action taken against employees who remove guards or disengage safety devices? Yes No
6. Is the anchoring secure for fixed-location machinery? Yes No
7. Are lockout devices installed? Yes No
8. Are all circuits properly grounded? Yes No

IX. **MATERIALS HANDLING** N/A

Complete this section if you have significant storage and materials handling exposures.

1. Do you do any pre-employment screening for employees with a history of back problems? Yes No
2. Do you give training in proper lifting procedures? Yes No
3. Re: Heavy materials handling controls:
   a) Are your employees trained in the use of equipment? Yes No
   b) Is operation restricted to authorized employees only? Yes No
   c) Are proper safeguards installed which protect the operators from contact with moving parts of the machinery or with the load? Yes No
   d) Is the equipment on a preventive maintenance schedule? Yes No
   e) Is all equipment inspected at the start of each shift? Yes No
   f) Is the equipment **always** operated within its rated capacity? Yes No
   g) Are there good housekeeping and stacking procedures in storage areas? Yes No

X. **MEDICAL EVALUATION**

Where allowable under State and Federal guidelines:

1. Is the physical exam job-exposure oriented? Yes No
2. Does your examiner check for signs of drug or alcohol abuse? Yes No
3. Are pre-existing conditions noted and documented? Yes No
4. If respirators are worn, is there periodic pulmonary testing? Yes No
5. In noisy areas; is there periodic audiometric testing? Yes No
6. Do you encourage your employees to report any symptoms of illness between physical checkups? Yes No

XI. **PROTECTIVE CLOTHING AND EQUIPMENT** N/A

This section deals with protective clothing necessary for the job or jobs performed.

1. Does clothing comply with applicable regulations and guidelines? Yes No
2. Is clothing well-designed and made of proper materials? Yes No
3. Is it well-fitting; covering all exposed areas of the body? Yes No
4. Is it appropriate to the work being performed? Yes No
5. Is clothing cleaned, maintained & inspected on a regular basis? Yes No
6. Are safety shoes appropriate or required? Yes No
   a) If required, are they worn? Yes No
7. Are safety hats required? Yes No
   a) If required, are they worn? Yes No

XII. **RESPIRATORY PROTECTION** N/A

This section applies if your business has an exposure to respiratory hazards.

1. Oxygen deficiency hazard? Yes No
2. Vapor and particulate hazards (dusts, sprays, fumes, mists, fogs, smoke or smog)? Yes No
3. Any gaseous contaminants? Yes No
4. Are work areas monitored regularly for contaminant levels? Yes No
5. Are respirators required to be used? Yes No
   a) Are they properly fitted? Yes No
   b) Are instructions given in proper use? Yes No
   c) Are they cleaned, inspected and disinfected after each use? Yes No
   d) Are filters replaced on a regular, routine basis? Yes No

XIII. **SKIN PROTECTION** N/A

This section applies if your business manufactures or uses irritation-producing substances.

1. Are employees with a current or prior work history of dermatitis identified and assigned to another job? Yes No
2. For workers working in skin disorder-producing environments:
   a) Are the least irritating substances possible used? Yes No
   b) Is the process enclosed and separated from the worker? Yes No
   c) Is there continual good housekeeping, including **immediate cleanup of unavoidable spills**? Yes No
   d) Is proper protective clothing and equipment worn? Yes No
   e) Are water-soluble barrier creams used? Yes No
   f) Are wash-up facilities (including showers in certain work) provided? Yes No

XIV. **AUTOMOBILE** N/A

This section applies if you have employees who drive cars or trucks as a regular part of their work; also where employees drive their own cars on company business.

1. Is a good attitude evident on the part of the drivers, their supervisors and the union (if you have one) concerning individual and corporate driver safety responsibilities? Yes No
   a) Are scheduling and driving speeds reflective of this? Yes No
   b) Are Motor Vehicle Reports (MVR's) requested on all drivers at regular intervals? Yes No
   c) Are MVR's requested on all prospective employees, covering all states in which they have been licensed? Yes No
   d) Are regular driver training and safety meetings held? Yes No
      How often? _____
2. What actions are taken in connection with accidents or violations, and have they proven effective?
   Describe. _____
3. Any time pressures inherent in your operations? Yes No
   If "yes," describe. _____

DELAWARE EMPLOYERS' WORKPLACE HEALTH AND SAFETY INCENTIVE PROGRAM

XV. **GENERAL INFORMATION**

1. When did your insurance carrier last conduct an engineering and loss control inspection of your premises and operations?
   Date: _____
2. What workers' compensation recommendations have been made by them? _____
3. Have they been complied with? Yes No
4. Has an OSHA inspection ever been done? Yes No
   a) If so, were any recommendations made, citations issued; fines or penalties levied? Yes No
      If "yes," explain. _____
5. What regulatory authorities inspect your operations?
   a) How often? _____

Name of person completing this questionnaire: _____

Title: _____

Date: _____

State of Delaware

DAVID N. LEVINSON
INSURANCE COMMISSIONER

841 SILVER LAKE BLVD.
DOVER, DELAWARE 19901
302/739 - 4251
FACSIMILE 302/739 - 5280

Department of Insurance

First Year 1989

96 participants completed

Total of $360,313 credit differential on $1,892,329 manual premium.

Second Year 1990

131 participants completed

Total of $602,002 credit differential on $3,162,740 manual premium.

Third year 1991

115 participants completed

Total of $402,278 credit differential on $2,141,001 manual premium.

THIS YEAR IS NOT COMPLETED.

THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU OF MASSACHUSETTS
101 ARCH STREET - 5TH FLOOR, BOSTON, MA 02110
(617) 439-9030 FAX 439-6055

November 5, 1990

CIRCULAR LETTER NO. 1550

To All Members and Subscribers of the Bureau:

QUALIFIED LOSS MANAGEMENT PROGRAM - ASSIGNED RISKS
EFFECTIVE NOVEMBER 1, 1990

The Division of Insurance has approved a Qualified Loss Management Program applicable to assigned risk insureds written under The Massachusetts Workers' Insurance Plan to become effective 12:01 A.M., November 1, 1990 on new and renewal business only.

The purpose of this innovative program is to apply a prospective credit for three years, to the premium of assigned risk insureds who subscribe to a qualified loss management program, and remain in such program during that period.

As stated in the Filing Memorandum, by implementing a loss control management program, a number of management firms have demonstrated an ability to significantly reduce workers' compensation losses for their client employers. Utilization of this program will enable a subscribing employer to receive the immediate impact of anticipated improved experience at the inception of the first, second and third policy periods. At the end of the three-year period, the improved experience will enter into the experience rating period, reducing the employer's experience modification.

The eligibility of a loss management program for a credit and the size of the allowable credit, will be subject to the approval of The Workers' Compensation Rating and Inspection Bureau of Massachusetts, subject to the criteria set forth in the Filing Memorandum

The Filing Memorandum consists of the following sections:

1. Qualifications For Loss Management Firms
2. Submission of Loss Management Program For Approval
3. Requirements To Apply For And Determination Of A Credit
4. New Loss Management Firms
5. Administration Of A Loss Management Program By The Workers' Compensation Rating and Inspection Bureau of Massachusetts

Massachusetts Qualified Loss Management Program Endorsement
WC 20 04 02

Sample Premium Calculation For Risk Subject To Qualified Loss Management Program Credit

Loss management firms are encouraged to submit their programs to the Bureau for approval and determination of applicable credit as soon as possible.

NORMAN R. FONTAINE
Vice President

NRF/jd

Attachment

FILING MEMORANDUM

QUALIFIED LOSS MANAGEMENT PROGRAM

EFFECTIVE DATE:

To become effective 12:01 A.M. November 1, 1990 on new and renewal business only.

PURPOSE:

The purpose of this program is to apply a prospective credit, for three years, to the premium of Assigned Risk insureds who subscribe to a qualified loss management program and remain in such program during that period.

BACKGROUND:

By implementing a loss control management program, a number of management firms have demonstrated an ability to significantly reduce workers' compensation losses for their client employers. Although subscribing employers eventually pay less premium, assuming improved experience through the application of the experience rating plan, the delay factor in the plan, which provides for the evaluation of data six months after policy expiration, does not reflect such improved experience for a considerable length of time. Utilization of this program will enable a subscribing employer to receive the immediate impact of anticipated improved experience at the inception of the first, second and third policy periods. At the end of the three-year period the improved experience would enter into the experience rating period, reducing the employer's experience modification.

PROPOSAL:

The eligibility of a loss management program for a credit, and the size of the allowable credit, will be subject to the approval of The Workers' Compensation Rating and Inspection Bureau of Massachusetts and will be determinable solely by the loss reduction success experienced by all of the client employers of a loss management firm within the past seven (7) years. The credit will be extended to each eligible subscribing client employer for the first three (3) years that the program is in effect for that employer. The credits applicable to the third year are half those applicable to the first and second years. To avoid the possibility of an employer subscribing to a loss management program simply to obtain a credit and discontinuing their participation in the program after the credit is received, it is required that the employer participate in the program for six (6) months before eligibility for the credit is established. Eligibility then becomes retroactive to the date of the employer's entry into the program. Should the eligibility date for the credit differ from the policy inception date, eligibility shall be verified and the credit shall be pro-rated at the time of interim or final audit.

A provision in Massachusetts Qualified Loss Management Program Endorsement WC 20 04 02 will apply when a subscribing employer, or the carrier, terminates the subscribership agreement. A sample of the endorsement is attached.

Qualified Loss Management Program

1. Qualifications For Loss Management Firms

Any loss management firm, which has demonstrated an ability to reduce losses for its client employers, may submit a Loss Management Program to The Workers' Compensation Rating and Inspection Bureau of Massachusetts for approval, subject to its having met the following minimum qualifications.

a. Personnel

A loss management firm must evidence its ability to perform its services based upon the qualifications of its key operating personnel. Information must be submitted on the job-related training and experience of these personnel. There also should be credentialed specialists on the staff. These could include: certified safety professionals, board-certified rehabilitation specialists, licensed insurance advisors and medical doctors specializing in occupational health.

b. Safety

A loss management firm must have a structured approach in place which focuses top level management of the employer, as well as other personnel, on the issue of safety. There must be a means of measuring and insuring management commitment to implementing safe work practices in the client employer's workplace.

c. Post Injury Response

A Loss Management Program must contain plans of action and specific techniques which are designed to assist an injured worker in obtaining necessary medical care. It must also contain specified means of maintaining contact with the injured worker and continuing claims control throughout the recuperation period. A close relationship with medical providers should be included in this process.

d. Early Return to Work Provisions

A Loss Management Program must encourage an injured worker to return to work at the earliest possible time, even if it is in a modified capacity.

2. Submission Of Loss Management Program For Approval

In order to offer a credit to its client employers, a loss management firm must submit to and receive approval of a Loss Management Program from The Workers' Compensation Rating and Inspection Bureau of Massachusetts following the procedures outlined below and containing the key elements indicated.

a. A Loss Management Program containing essential information shall be submitted to The Workers' Compensation Rating and Inspection Bureau of Massachusetts with sufficient lead time for proper evaluation and determination of a credit prior to implementation.

b. After evaluation of the Loss Management Program, The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall make a determination as to its acceptability. If acceptable, The Workers' Compensation Rating and Inspection Bureau of Massachusetts will calculate the credit applicable to the program for a period of one (1) year and advise the loss management firm submitting the program, and the Massachusetts Division of Insurance, of its approval.

The loss management firm shall then advise all of its Assigned Risk client employers of the availability of the program.

c. Key elements that must be included in a Loss Management Program.

(1) The credit, as determined by The Workers' Compensation Rating and Inspection Bureau of Massachusetts, must be offered to every Assigned Risk insured subscriber client employer for the first three (3) years that the program is in place for that insured.

(2) The program must contain a provision stating that the credit applicable to the first year policy is subject to change on the second and third year policies.

(3) The program must contain a provision stating that a credit will not apply after the client employer has received a credit for three (3) years.

(4) The program must contain a provision stating that a client employer must be involved in the program for six (6) months before eligibility for the credit is established. Eligibility then becomes retroactive to the date of the employer's entry into the program. If eligibility for the credit is different from the policy inception date, eligibility will be verified and a pro-rated credit shall be computed at the time of interim or final audit.

(5) The program must contain a provision stating that in the event of termination of the program by either the loss management firm, the client employer or The Workers' Compensation Rating and Inspection Bureau of Massachusetts, the credit shall be pro-rated.

3. Requirements To Apply For And Determination Of A Credit

The following requirements apply to a loss management firm submitting a Loss Management Program.

The method for determining the credit is as follows:

a. The loss management firm must submit data, in a format prescribed by The Workers' Compensation Rating and Inspection Bureau of Massachusetts, on all its client employers who have Massachusetts workers' compensation insurance premium and commenced the program within the last seven (7) years. The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall have the right to inspect the books and business records of the loss management firm in order to verify that it is a complete list and accurately represents the experience of such client employers.

The data shall consist of copies of the experience rating modification calculations for the client employers. The object is to compare the experience for the year prior to the inception of the program to experience for the year subsequent to the inception of the program.

Example 1

Client starts Loss Management Program 7/1/85
Policy renews 7/1/85
Prior year's experience is for 7/1/84 to 6/30/85
Subsequent year's experience is for 7/1/85 to 6/30/86

Example 2

Client starts Loss Management Program 2/1/85
Policy renews 7/1/85
Prior year's experience is for 7/1/83 to 6/30/84
Subsequent year's experience is for 7/1/85 to 6/30/86

The required data is for the first report of the prior year and for the first report of the subsequent year. The Expected Losses, Expected Primary Losses, the Actual Losses and the Actual Primary Losses for each of these two (2) policy periods will be taken for each client employer. (The Massachusetts portion is used for interstate risks.) This information will be aggregated over all the client employers of the Loss Management Program.

This data covering the most recently available five-year period will be aggregated and then used to compute two experience modifications, one for the prior years and one for the subsequent years.

b. The qualification for a schedule rating credit is as follows:

Ratio of Experience Modification For Subsequent Years to that for Prior Years	First and Second Year Credit	Third Year Credit
.81 or less	10%	5%
More than .81 but at most .83	9%	4.5%
More than .83 but at most .85	8%	4%
More than .85 but at most .87	7%	3.5%
More than .87 but at most .89	6%	3%
More than .89 but at most .91	5%	2.5%
More than .91 but at most .93	4%	2%
More than .93 but at most .95	3%	1.5%
More than .95 but at most .97	2%	1%
More than .97 but at most .99	1%	.5%
More than .99	none	

Each Loss Management Program must requalify for a credit annually.

c. Basis For Applying The Credit

If the Loss Management Program submitted by a loss management firm contains data on client employers with at least three (3) governing classes, the credit will be applicable to all client employers in the program. Otherwise, the calculated credit shall apply only to those client employers whose governing class is in the submitted data. For employers with other governing classes, the credit for newly established loss management firms shall apply.

d. The credit will apply to the Massachusetts portion of the workers' compensation premium (excluding expense constant) of the client employers in the program. See EXHIBIT I.

e. The credit shall not apply to client employers insured under a retrospective rating plan or a loss sensitive dividend plan.

f. A credit, as determined by The Workers' Compensation Rating and Inspection Bureau of Massachusetts, shall apply to any client employer in good standing in the program for three (3) years after commencement of the program, subject to revision after the first and second years.

4. New Loss Management Firms

A newly established loss management firm may submit a Loss Management Program to The Workers' Compensation Inspection and Rating Bureau of Massachusetts for approval of a credit to apply to its subscriber client employers if:

a. The firm complies with the qualifications for loss management firms contained in Section 1.

b. The firm submits a Loss Management Program containing the key elements contained in Section 2.

c. The firm begins to submit the data required under Section 3 as soon as such data becomes available.

The credit for new loss management firms will be limited to 5% for risks in their first and second years and 2.5% for risks in their third year.

Three years after a new loss management firm has qualified, the credit for such a firm will begin to be based on its own data.

5. Administration Of A Loss Management Program By The Workers' Compensation Rating and Inspection Bureau of Massachusetts

a. The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall be authorized by the Massachusetts Division of Insurance to evaluate any Loss Management Program submitted by a loss management firm for purposes of offering client employers a credit, and shall issue a prompt notice of approval or disapproval.

The factors that The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall consider in the evaluation of such a program are as follow:

(1) qualifications of the loss management firm as listed in Section 1.

(2) elements that must be included in submission of a Loss Management Program as listed in Section 2.

(3) requirements to apply for and determination of a credit as listed in Section 3.

b. If a Loss Management Program is not approved by The Workers' Compensation Rating and Inspection Bureau of Massachusetts, and the loss management firm making the submission is unsatisfied with the decision of The Workers' Compensation Rating and Inspection Bureau of Massachusetts, the loss management firm may appeal to the Commissioner of Insurance. Upon reviewing such an appeal, the Commissioner may, if he finds sufficient grounds for the appeal, call a public hearing to resolve the dispute.

c. If the Commissioner has reason to believe that any loss management firm should be considered for removal from the credit plan, he shall so inform The Workers' Compensation Rating and Inspection Bureau of Massachusetts. The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall inform the Commissioner of what action, if any, it takes with respect to this Loss Management Program. If two (2) months from the notification of The Workers' Compensation Rating and Inspection Bureau of Massachusetts, the Loss Management Program still qualifies for the credit plan, the Commissioner of Insurance can if he chooses, call a public hearing to consider whether this Loss Management Program should be removed from the credit plan.

d. Each approved Qualified Loss Management Program must be resubmitted to The Workers' Compensation Rating and Inspection Bureau of Massachusetts annually, with up-dated data, for re-evaluation and calculation of a revised credit, if any.

MASSACHUSETTS QUALIFIED LOSS MANAGEMENT PROGRAM ENDORSEMENT

This endorsement applies to the insurance provided by this policy because Massachusetts is shown in Item 3.A. of the Information Page.

You are not eligible for a credit if this policy is written under a Retrospective Rating Plan or a loss sensitive dividend plan.

A. You may be eligible for a credit on your current annual premium if the conditions stated below are satisfied. You must participate in a Qualified Loss Management Program for six (6) months before eligibility for the credit is established. Eligibility then becomes retroactive to the date of your entry into the Program.

   1. The amount of credit for which you may be eligible will be based on the credit determined by The Workers' Compensation Rating and Inspection Bureau of Massachusetts to apply to all subscribers of the Qualified Loss Management Program to which you subscribe.

B. You will receive a premium credit if:

   1. You are subscriber to a Qualified Loss Management Program approved by The Workers' Compensation Rating and Inspection Bureau of Massachusetts to offer a credit to all of its subscribers.

   2. If the inception date of this policy is different from the date of approval of the credit for the Qualified Loss Management Program to which you subscribe, a pro-rata credit shall be computed at the time of interim or final audit.

   3. In the event of the termination of the Qualified Loss Management Program to which you subscribe by either the loss management firm, The Workers' Compensation Rating and Inspection Bureau of Massachusetts, or you, a pro-rated credit shall be computed at the time of termination.

NOTES:

1. This endorsement must be attached to an Assigned Risk policy showing Massachusetts in Item 3.A. of the Information Page, if the insured is a subscriber to a Qualified Loss Management Program approved by The Workers' Compensation Rating and Inspection Bureau of Massachusetts, and provided the policy is not written under a Retrospective Rating Plan or a loss sensitive dividend plan.

Sample Premium Calculation For Risk
Subject To Qualified Loss Management Program Credit

LOCATIONS, CLASSIFICATION AND PAYROLL IN MASSACHUSETTS
Calculation of Estimated Annual Premium:

Describe by location the duties of employees	Class Code	Number of Employees	Total Payroll	Rate	Premium
Office Machines - Installation	5191	12	264,131	2.71	7,158
Clerical Office Employees NOC	8810	2	33,600	0.39	131
Salesperson, Collectors or Messengers - Outside	8742				
Drivers, NOC	7380				
Employers Liability / /					

Total Premium	7,289
Experience Modification (1.11)	802
Standard Premium	8,091
ARAP Adjustment (1.14)	1,133
Less Premium Discount (if applicable)	340
Total	8,884
[1] Less Loss Management Program Credit (.10)	888
Expense Constant	155
Total Estimated Annual Premium	8,151
Mass. D.I.A. Assessment (1.2%) of Standard Premium	97
Total of Estimated Annual Premium and Mass. D.I.A. Assessment	8,248

[1] As promulgated by The Workers' Compensation Rating and Inspection Bureau of Massachusetts.

Qualified Loss Management Program

Time of Signing up with Loss Management Firm	Eligibility for Credit
5/1/90 or later	Full (2 1/2 Years)
11/1/89 to 4/30/90	2 Years
11/1/88 to 10/31/89	1 Year
Prior to 11/1/88	Nothing

THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU OF MASSACHUSETTS
101 ARCH STREET - 5TH FLOOR, BOSTON, MA 02110
(617) 439-9030 FAX 439-6055

April 30, 1991

CIRCULAR LETTER NO. 1566

To All Members and Subscribers of the Bureau

CLARIFICATION OF IMPLEMENTATION PROCEDURES FOR QUALIFIED LOSS MANAGEMENT PROGRAM - ASSIGNED RISKS

The attached Qualified Loss Management Program, approved by the Division of Insurance, replaces the Program attached to Circular Letter No. 1550 dated November 5, 1990.

The Program, as amended, continues to apply to new and renewal business written under the Massachusetts Workers' Compensation Assigned Risk Pool on and after 12:01 A.M., November 1, 1990.

In order to ensure the smooth implementation of this Program, certain procedures have been introduced to clarify the application of policy credits.

The principle changes appear in the Filing Memorandum, the page captioned, "2. Submission of Loss Management Program For Approval" (items 2.c (1) and 2.c. (4)) and in the revised Qualified Loss management Program Endorsement WC 20 04 02.

Essentially, these procedures will require that the applicable credit be calculated from the policy inception date nearest the subscription date to a qualified loss management program as opposed to the subscription date itself. The credit for the first policy year will be applied retroactively to the policy inception date, provided that the subscriber employer complies with the condition of having participated in the program for a minimum of six (6) months within the first policy year. If an employer subscriber became credit eligible by satisfying the condition of having participated in the program for a minimum of six (6) months after November 1, 1988, but before November 1, 1990, the applicable credit will also be calculated initially for the first policy year with a policy inception date November 1, 1990 and thereafter, subject to any limitations that may apply to the duration of credit as stated in the Filing Memorandum.

If there are less than six (6) months remaining on the policy when the employer subscribes to a qualified loss management program, and the employer subscriber satisfies the condition of having participated in such a program for six (6) months during the renewal policy term, the applicable credit will be applied retroactively to the inception date of the policy renewal.

It should be clearly understood that premium adjustments resulting from the application of any policy credit will be made at time of policy audit.

Prior to these changes, the Program provided for a pro-rata credit to be computed at the time of policy audit if the policy inception date was different from the date an employer subscribed to a program. This method of calculating credits would have resulted in credits being pro-rated over several policy years. As a result, the complexities and the administrative burden on all participants are eliminated with the revised method of applying credits.

Consistent with the original intent the amount of credit applied to the second and third policy years shall be based on the credit factor approved by the Bureau for the qualifying loss management firm and in effect on each policy effective date. The applicable credit is halved in the third policy year.

"Procedures For Implementation Of Qualified Loss Management Program" are also attached and should be followed closely.

The procedures include:

A. Introduction

B. Instructions For Loss Management Firm

1. Completion of Request For Qualified Loss Management Program Assigned Risk Credit, EXHIBIT A (2 sides)

2. Processing of Request For Qualified Loss Management Program Assigned Risk Credit Form By Loss Management Firm

C. Instructions For Bureau

1. Processing of Form Letter 1, EXHIBIT B

D. Instructions For Insurance Company (Servicing Carrier)

EXHIBIT C, contains unit statistical reporting information. A corresponding change in the Massachusetts Unit Statistical Plan is being filed with the Division of Insurance

The Bureau will maintain a complete confidential record of all information received and processed.

All qualified loss management firms are subject to an ongoing audit of their operations by Bureau legal and audit personnel to ensure adherence to the standards of performance that enabled them to become qualified.

Appropriate procedures are being distributed concurrently to all loss management firms that have been qualified to date.

Any questions regarding these procedures should be directed to Paul Meagher, Legal Counsel; Lorenzo Raimondi, Associate Legal Counsel; or to me.

NORMAN R. FONTAINE
Vice President

NRF/jd

Attachments

FILING MEMORANDUM

QUALIFIED LOSS MANAGEMENT PROGRAM
(REVISED 3/91)

EFFECTIVE DATE:

This Program applies to new and renewal business written under the Massachusetts Workers' Compensation Assigned Risk Pool on and after 12:01 A.M., November 1, 1990.

PURPOSE:

This Program applies a prospective credit to the premium of an assigned risk insured who subscribes to a qualified loss management program. The prospective credit is given for a period of up to three (3) policy years, provided the insured remains in the Program for a corresponding period of time.

BACKGROUND:

A number of loss management firms have demonstrated an ability to significantly reduce workers' compensation losses for their client companies by implementing a loss control management program. Through the application of the experience rating plan, companies with improved experience are able to realize sizeable reductions in premium. However, because the experience rating plan requires three (3) years of experience and the evaluation of data six (6) months after expiration of the third policy year, such improved experience is not reflected in the premium charges for a considerable length of time. Utilization of this Program can impact a subscribing employer's premium charges as early as the inception date of the first of three annual policy periods during which the subscribing employer completes a minimum of six (6) months participation in the Program. The appropriate credits are applied to the premiums for these three (3) annual policy periods, at the conclusion of which, the credits then end and the subscribing employer enters into an experience rating period with anticipated improved experience.

Approval Of Loss Management Program And Available Credit

A loss management program and the amount of allowable credit that can be offered by a sponsoring loss management firm to subscribing employers shall be subject to the approval of The Workers' Compensation Rating and Inspection Bureau of Massachusetts. The credit shall be primarily determined by the loss reduction success experienced by all of the subscribing employers of the sponsoring loss management firm for the past seven (7) years. The approved credit is applied uniformly to the premiums of all subscribing employers.

Application Of Credit To Subscriber's Policy

A credit is applied to the premium developed for a subscribing employer for up to three (3) policy years. The amount of the credit applied to the first policy year is based on the credit factor assigned to the loss management firm on the date the employer subscribes to the Program. The first year credit is applied retroactively to the policy inception date on condition the employer participates in the Program a minimum of six (6) months.

The amount of the credit applied to the second and third policy years shall be based on the credit factor assigned to the qualifying loss management firm and in effect on each policy effective date, except that the applicable credit is halved in the third policy year.

The subscribing employer may terminate participation in the Program upon three (3) years of continuous participation in the Program, without penalty.

ILLUSTRATIVE CALCULATIONS

In all examples, the loss management firm is assigned a credit factor (CF) of .10 effective January 1, 1991. Following re-evaluation, the firm is assigned a credit factor (CF) of .08 effective January 1, 1992 and subsequent years. Estimated Annual Premium (EAP) is $5,000. Policy is effective April 1, 1991. Three (3) years of continuous participation in the loss management program is assumed.

Example #1 - Subscription Date: 7/1/91 (eligibility within policy term)

1st Year Credit Applied and Effective 4/1/91
(EAP) (CF) = Credit or (5,000) x (.10) = 500

2nd Year Credit Applied and Effective 4/1/92
(EAP) (CF) = Credit or (5,000) x (.08) = 400

3rd Year Credit Applied and Effective 4/1/93
(EAP) (CF) = Credit or (5,000) x (.04) = 200

Example #2 - Subscription Date: 10/5/91 (eligibility outside policy term)

1st Year Credit Applied and Effective 4/1/92
(EAP) (CF) = Credit or (5,000) x (.10) = 500 *

2nd Year Credit Applied and Effective 4/1/93
(EAP) (CF) = Credit or (5,000) x (.08) = 400

3rd Year Credit Applied and Effective 4/1/94
(EAP) (CF) = Credit or (5,000) x (.04) = 200 **

* Credit factor of .10 is "locked in" on subscription date.
** Credit factor in effect on policy effective date applies; credit is halved in 3rd year.

Reduction In Available Credit Due To Participation Prior To Program Effective Date

An employer who has subscribed to an existing program of a qualified loss management firm prior to November 1, 1990, shall be subject to a reduction in credit in accordance with the following table:

Subscription Date	Extent of Credit
05/01/90 or later	Full credit
11/01/89 to 04/30/90	2 Years
11/01/88 to 10/31/89	1 Year
Prior to 11/01/88	No credit

The Massachusetts Qualified Loss Management Program Endorsement WC 20 04 02 must be attached to each Assigned Risk Policy for which a credit is given under this Program.

QUALIFIED LOSS MANAGEMENT PROGRAM

1. Qualifications For Loss Management Firms

Any loss management firm, which has demonstrated an ability to reduce losses for its client employers, may submit a Loss Management Program to The Workers' Compensation Rating and Inspection Bureau of Massachusetts for approval, subject to its having met the following minimum qualifications.

a. Personnel

A loss management firm must evidence its ability to perform its services based upon the qualifications of its key operating personnel. Information must be submitted on the job-related training and experience of these personnel. There also should be credentialed specialists on the staff. These could include: certified safety professionals, board-certified rehabilitation specialists, licensed insurance advisors and medical doctors specializing in occupational health.

b. Safety

A loss management firm must have a structured approach in place which focuses top level management of the employer, as well as other personnel, on the issue of safety. There must be a means of measuring and insuring management commitment to implementing safe work practices in the client employer's workplace.

c. Post Injury Response

A Loss Management Program must contain plans of action and specific techniques which are designed to assist an injured worker in obtaining necessary medical care. It must also contain specified means of maintaining contact with the injured worker and continuing claims control throughout the recuperation period. A close relationship with medical providers should be included in this process.

d. Early Return to Work Provisions

A Loss Management Program must encourage an injured worker to return to work at the earliest possible time, even if it is in a modified capacity.

2. Submission Of Loss Management Program For Approval

In order to offer a credit to its client employers, a loss management firm must submit to and receive approval of a Loss Management Program from The Workers' Compensation Rating and Inspection Bureau of Massachusetts following the procedures outlined below and containing the key elements indicated.

a. A Loss Management Program containing essential information shall be submitted to The Workers' Compensation Rating and Inspection Bureau of Massachusetts with sufficient lead time for proper evaluation and determination of a credit prior to implementation.

b. After evaluation of the Loss Management Program, The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall make a determination as to its acceptability. If acceptable, The Workers' Compensation Rating and Inspection Bureau of Massachusetts will calculate the credit applicable to the program for a period of one (1) year and advise the loss management firm submitting the program, and the Massachusetts Division of Insurance, of its approval.

The loss management firm shall then advise all of its Assigned Risk client employers of the availability of the program.

c. Key elements that must be included in a Loss Management Program.

(1) The approved loss management firm must offer its qualified loss management program to every assigned risk client wishing to avail itself of the credit assigned to the firm by The Workers' Compensation Rating and Inspection Bureau of Massachusetts.

(2) The program must contain a provision stating that the credit applicable to the first year policy is subject to change on the second and third year policies.

(3) The program must contain a provision stating that a credit will not apply after the client employer has received a credit for three (3) years.

(4) The program must contain a provision stating that a client employer must be involved in the program for six (6) months before eligibility for the credit is established. If the client becomes credit eligible during the first six (6) months of the policy term, the credit is applied retroactive to the policy effective date; otherwise, the credit is applied on the effective date of the first policy renewal during which the client completes six (6) months of participation in the program. The credit is pro-rated only when participation in the program terminates during the policy term, unless such termination occurs in the third annual policy period during which the client completes three (3) years of participation in the program.

(5) The program must contain a provision stating that in the event of termination of the program by either the loss management firm, the client employer or The Workers' Compensation Rating and Inspection Bureau of Massachusetts, the credit shall be pro-rated.

3 Requirements To Apply For And Determination Of A Credit

The following requirements apply to a loss management firm submitting a Loss Management Program.

The method for determining the credit is as follows:

a. The loss management firm must submit data, in a format prescribed by The Workers' Compensation Rating and Inspection Bureau of Massachusetts, on all its client employers who have Massachusetts workers' compensation insurance premium and commenced the program within the last seven (7) years. The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall have the right to inspect the books and business records of the loss management firm in order to verify that it is a complete list and accurately represents the experience of such client employers.

The data shall consist of copies of the experience rating modification calculations for the client employers. The object is to compare the experience for the year prior to the inception of the program to experience for the year subsequent to the inception of the program.

Example 1

Client starts Loss Management Program 7/1/85
Policy renews 7/1/85
Prior year's experience is for 7/1/84 to 6/30/85
Subsequent year's experience is for 7/1/85 to 6/30/86

Example 2

Client starts Loss Management Program 2/1/85
Policy renews 7/1/85
Prior year's experience is for 7/1/83 to 6/30/84
Subsequent year's experience is for 7/1/85 to 6/30/86

The required data is for the first report of the prior year and for the first report of the subsequent year. The Expected Losses, the Expected Primary Losses, the Actual Losses and the Actual Primary Losses for each of these two (2) policy periods will be taken for each client employer. (The Massachusetts portion is used for interstate risks.) This information will be aggregated over all the client employers of the Loss Management Program.

This data covering the most recently available five-year period will be aggregated and then used to compute two experience modifications, one for the prior years and one for the subsequent years.

b. The qualification for a schedule rating credit is as follows:

Ratio of Experience Modification For Subsequent Years to that for Prior Years	First and Second Year Credit	Third Year Credit
.81 or less	10%	5%
More than .81 but at most .83	9%	4.5%
More than .83 but at most .85	8%	4%
More than .85 but at most .87	7%	3.5%
More than .87 but at most .89	6%	3%
More than .89 but at most .91	5%	2.5%
More than .91 but at most .93	4%	2%
More than .93 but at most .95	3%	1.5%
More than .95 but at most .97	2%	1%
More than .97 but at most .99	1%	.5%
More than .99	none	

Each Loss Management Program must requalify for a credit annually.

c. Basis For Applying The Credit

If the Loss Management Program submitted by a loss management firm contains data on client employers with at least three (3) governing classes, the credit will be applicable to all client employers in the program. Otherwise, the calculated credit shall apply only to those client employers whose governing class is in the submitted data. For employers with other governing classes, the credit for newly established loss management firms shall apply.

d. The credit will apply to the Massachusetts portion of the workers' compensation premium (excluding expense constant) of the client employers in the program. See EXHIBIT I.

e. The credit shall not apply to client employers insured under a retrospective rating plan or a loss sensitive dividend plan.

f. A credit, as determined by The Workers' Compensation Rating and Inspection Bureau of Massachusetts, shall apply to any client employer in good standing in the program for three (3) years after commencement of the program, subject to revision after the first and second years.

4. New Loss Management Firms

A newly established loss management firm may submit a Loss Management Program to The Workers' Compensation Inspection and Rating Bureau of Massachusetts for approval of a credit to apply to its subscriber client employers if:

a. The firm complies with the qualifications for loss management firms contained in Section 1.

b. The firm submits a Loss Management Program containing the key elements contained in Section 2.

c. The firm begins to submit the data required under Section 3 as soon as such data becomes available.

The credit for new loss management firms will be limited to 5% for risks in their first and second years and 2.5% for risks in their third year.

Three years after a new loss management firm has qualified, the credit for such a firm will begin to be based on its own data.

5. Administration Of A Loss Management Program By The Workers' Compensation Rating and Inspection Bureau of Massachusetts

a. The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall be authorized by the Massachusetts Division of Insurance to evaluate any Loss Management Program submitted by a loss management firm for purposes of offering client employers a credit, and shall issue a prompt notice of approval or disapproval.

The factors that The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall consider in the evaluation of such a program are as follow:

(1) qualifications of the loss management firm as listed in Section 1.

(2) elements that must be included in submission of a Loss Management Program as listed in Section 2.

(3) requirements to apply for and determination of a credit as listed in Section 3.

b. If a Loss Management Program is not approved by The Workers' Compensation Rating and Inspection Bureau of Massachusetts, and the loss management firm making the submission is unsatisfied with the decision of The Workers' Compensation Rating and Inspection Bureau of Massachusetts, the loss management firm may appeal to the Commissioner of Insurance. Upon reviewing such an appeal, the Commissioner may, if he finds sufficient grounds for the appeal, call a public hearing to resolve the dispute.

c. If the Commissioner has reason to believe that any loss management firm should be considered for removal from the credit plan, the Commissioner shall so inform The Workers' Compensation Rating and Inspection Bureau of Massachusetts. The Workers' Compensation Rating and Inspection Bureau of Massachusetts shall inform the Commissioner of what action, if any, it takes with respect to this Loss Management Program. If two (2) months from the notification of The Workers' Compensation Rating and Inspection Bureau of Massachusetts, the Loss Management Program still qualifies for the credit plan, the Commissioner may choose to call a public hearing to consider whether this Loss Management Program should be removed from the credit plan.

d. Each approved Qualified Loss Management Program must be resubmitted to The Workers' Compensation Rating and Inspection Bureau of Massachusetts annually, with up-dated data, for re-evaluation and calculation of a revised credit, if any.

MASSACHUSETTS QUALIFIED LOSS MANAGEMENT PROGRAM ENDORSEMENT

1. The credit factor shown below will be applied to your policy premium because you subscribed to a Qualified Loss Management Program and became credit eligible on the date also shown below. Premium adjustment will be made at time of audit.

2. The appropriate credit will be applied to your policy premiums for three (3) successive annual policy periods starting with the first policy year during which you become credit eligible. The credit is calculated from the effective date of each policy year. The credit applicable to the first policy year is subject to change on the second and third policy years. The applicable credit is halved in the third policy year.

3. In the event your participation in the Program terminates, for any reason, a pro-rata credit will be applied at audit. This provision does not apply after you have continuously participated in the Program for a minimum of three (3) years as determined by your subscription date.

4. This endorsement does not apply if your policy is written under a Retrospective Rating Plan or loss sensitive dividend plan.

SCHEDULE

Name of Qualified Loss Management Program:_____

Subscription Date:_____

Eligibility Date:_____

Credit Factor:_____%

NOTES:

1. This endorsement **must** be attached to an Assigned Risk policy showing Massachusetts in Item 3.A. of the Information Page, if the insured is a subscriber to a Qualified Loss Management Program approved by The Workers' Compensation Rating and Inspection Bureau of Massachusetts and becomes credit eligible **before** policy issuance or **during** the policy term. This endorsement may not be used for more than three (3) consecutive years for the same insured.

2. This endorsement **may not** be attached to any policy which:

   a) Expires **before** the insured becomes credit eligible.

   b) Is written under a Retrospective Rating Plan or loss sensitive dividend plan.

3. The company may use its own attachment clause and method of execution.

Sample Premium Calculation For Risk

Subject To Qualified Loss Management Program Credit

LOCATIONS, CLASSIFICATION AND PAYROLL IN MASSACHUSETTS
Calculation of Estimated Annual Premium:

Describe by location the duties of employees	Class Code	Number of Employees	Total Payroll	Rate	Premium
Office Machines - Installation	5191	12	264,131	2.71	7,158
Clerical Office Employees NOC Salesperson, Collectors or Messengers - Outside Drivers, NOC Employers Liability / /	8810 8742 7380	2	33,600	0.39	131
				Total Premium	7,289
				Experience Modification (1.11)	802
				Standard Premium	8,091
				ARAP Adjustment (1.14)	1,133
				Less Premium Discount (if applicable)	340
				Total	8,884
				[1] Less Loss Management Program Credit (.10)	888
				Expense Constant	155
				Total Estimated Annual Premium	8,151
				Mass. D.I.A. Assessment (1.2%) of Standard Premium	97
				Total of Estimated Annual Premium and Mass. D.I.A. Assessment	8,248

[1] As promulgated by The Workers' Compensation Rating and Inspection Bureau of Massachusetts.

PROCEDURES FOR IMPLEMENTATION OF QUALIFIED LOSS MANAGEMENT PROGRAM

A. INTRODUCTION

When a loss management firm approved by the Bureau becomes qualified to offer a policy credit to a subscriber assigned risk insured employer, the following procedures apply in order for the credit to be processed on the first year policy. The same procedures are to be followed on the second and third year policies if the loss management firm continues to be qualified to offer a credit and the subscriber employer continues to be eligible to receive a credit.

B. INSTRUCTIONS FOR LOSS MANAGEMENT FIRM

1. Completion of Request For Qualified Loss Management Program Assigned Risk Credit. EXHIBIT A (2 sides)

SIDE 1

When an assigned risk insured employer subscribes to the Program of a qualified loss management firm, the firm shall complete Sections I, II and III of Request For Qualified Loss Management Program Assigned Risk Credit form and have the authorized representative of the subscriber employer sign (with title) and enter date in Section IV, in DUPLICATE. The firm shall retain both forms in file with a suspense date six (6) months from date the subscriber employer entered the Program.

I. SUBSCRIBER EMPLOYER INFORMATION

1. Name of Subscriber Employer: Enter the complete legal name of the employer.

2. Subscriber Employer's Federal Identification Number: This is a Program requirement.

3. Mailing Address: Include a post office box, if any.

4. Principle Location: This is the principle Massachusetts location. A post office box is not acceptable.

5. Other Massachusetts Locations: If the subscriber employer operates at locations in Massachusetts other than the principle location, show each additional location. Use additional sheet if necessary. It is IMPORTANT to note that a policy credit request will be processed only if a qualified loss management firm provides its Program services at all Massachusetts locations of a subscriber employer.

6. Date of Entry Into Loss Management Program: This item is IMPORTANT since it determines to which policy the first credit will apply.

7. Has subscriber employer previously enrolled in a Loss Management Program? [ ] Yes [ ] No
If yes, give name of loss management firm.

This item is IMPORTANT since it may determine the period of time of a subscriber employer's credit.

II. **INSURANCE POLICY INFORMATION**

Enter name of current insurance company, policy number and policy effective date.

III. **LOSS MANAGEMENT FIRM INFORMATION**

1. Enter entire name of loss management firm approved by the Bureau.

2. Enter date that the firm qualified initially to offer a policy credit to subscriber employers.

3. Enter amount of approved credit applicable on, date subscriber employer entered into Program.

4. Enter date credit referred to in 3. above was approved by the Bureau.

IV. **SUBSCRIBER EMPLOYER'S ACKNOWLEDGEMENT**

The request form must be signed by an authorized representative of the subscriber employer certifying that it has subscribed to the Program offered by the firm shown in III. 1. above and that it fully understands the General Terms of Qualified Management Program shown on the reverse side of the form (Side 2). The Request For Credit form and the duplicate should be signed in original.

V. **VERIFICATION OF ELIGIBILITY BY LOSS MANAGEMENT FIRM**

Six (6) months from the date the subscriber employer has entered the Program, the loss management firm will complete Section V. Verification of Eligibility By Loss Management Firm of the form, in DUPLICATE, as follows:

1. Enter date that the subscriber employer completed six (6) months of participation in the Program.

2. Enter signature and title of authorized representative of loss management firm and date. Both the request form and the duplicate should be signed in original.

2. **Processing of Request For Qualified Loss Management Program Assigned Risk Credit Form By Loss Management Firm**

When the subscriber employer has participated for six (6) months in the Program and has become credit eligible, the loss management firm sends Request For Credit form, in DUPLICATE, to the Bureau at the address shown at top of form for transmittal to insurance company with request to issue policy credit.

C. **INSTRUCTIONS FOR BUREAU**

1. Upon receipt of completed Request For Credit form from the loss management firm, the Bureau enters all information on the form into its systems.

2. Bureau retains original Request For Credit form for its records.

3. If the dates shown on the Request For Credit form indicate that the subscriber employer entered the Program in the first six (6) months of the current policy term, and completed the six (6) months subscription eligibility requirement within the current policy term, the Bureau will send the duplicate original of the form to the subscriber employer's current insurance company with Form Letter 1, EXHIBIT B requesting the issuance of Massachusetts Qualified Loss Management Program Endorsement WC 20 04 02 and the processing of a policy credit retroactive to the current policy inception date, to be applied as a premium adjustment at time of audit.

4. If the dates shown on the Request For Credit form indicate that the subscriber employer entered the Program in the last six (6) months of the policy term, and will not comply with the six (6) months subscription eligibility requirement until a date within the renewal policy term, the Bureau will send the duplicate original of the form to the subscriber employer's renewal policy insurance company with Form Letter 1, EXHIBIT B requesting the issuance of Massachusetts Qualified Loss Management Program Endorsement WC 20 04 02 and the processing of a policy credit retroactive to the renewal policy inception date, to be applied as a premium adjustment at time of audit.

D. **INSTRUCTIONS FOR INSURANCE COMPANY (SERVICING CARRIER)**

1. Upon receipt of Form Letter 1, EXHIBIT B and completed duplicate original Request For Credit form from the Bureau, the insurance company will issue Massachusetts Qualified Loss Management Program Endorsement WC 20 04 02 and process a policy credit retroactive to either a) the current policy inception date or b) the renewal policy inception date (see C.3. or C.4. above), to be applied as a premium adjustment at time of audit.

EXHIBIT A

REQUEST FOR MASSACHUSETTS QUALIFIED LOSS MANAGEMENT PROGRAM ASSIGNED RISK CREDIT

THE WORKERS' COMPENSATION RATING AND INSPECTION BUREAU OF MASSACHUSETTS
101 ARCH STREET - 5TH FLOOR BOSTON MA 02110
(617) 439-9030

Please type or print answers to all questions and mail in DUPLICATE to: WCRIB, P.O. BOX 9005 BOSTON, MA 02205 Attn: Legal

The Undersigned qualified loss management firm hereby requests that their approved credit be applied to the Massachusetts operations of the workers' compensation policy of the subscriber assigned risk insured employer indicated below.

I. SUBSCRIBER EMPLOYER INFORMATION

1. _____
Name of Subscriber Employer

2. _____
Subcriber Employer's Federal Identification Number

3. _____
Mailing Address (No.) (Street) (City) (State) (Zip) (Phone)

4. _____
Principle Location (No.) (Street) (City) (State) (Zip) (Phone)

* 5. _____
Other Massachusetts Location (No.) (Street) (City) (State) (Zip) (Phone)

_____
Other Massachusetts Location (No.) (Street) (City) (State) (Zip) (Phone)

_____
Other Massachusetts Location (No.) (Street) (City) (State) (Zip) (Phone)

6. _____
Date of Entry into Loss Management Program

7. Has subscriber employer previously enrolled in a loss management program? [ ] Yes [ ] No

If yes, give name of loss management firm:

_____

* List additional locations, if any, on supplemental page.

II. INSURANCE POLICY INFORMATION:

Insurance Company Current Policy Number Policy Effective Date

_____

III. LOSS MANAGEMENT FIRM INFORMATION

1. _____
Name of Loss Management Firm

2. _____
Date Firm Qualified

3. _____
Amount of Approved Credit

4. _____
Date Credit Approved

IV. SUBSCRIBER EMPLOYER'S ACKNOWLEDGMENT

The Undersigned Subscriber Employer acknowledges that it has subscribed to the Qualified Loss Management Program offered by the firm shown above and that it fully understands the terms of the Program as outlined on the reverse side of this form.

_____
Authorized Signature and Title Date

V. VERIFICATION OF ELIGIBILITY BY LOSS MANAGEMENT FIRM

1. The Subscriber Employer shown above completed six (6) months of participation in our Program on _____
Date

2. Authorized Signature and Title: _____
Date

GENERAL TERMS OF QUALIFIED LOSS MANAGEMENT PROGRAM

1. The credit on policy premium must be offered to the subscriber for the first three (3) years of participation in the Program.

   The credit cannot be offered after the subscriber has received credits based on three (3) years of participation.

2. The credit applicable to the first policy year is subject to change in the second and third policy years.

3. The subscriber must participate in the Program for a minimum of six (6) months to become credit eligible.

4. The credit will start on the inception date of the first policy year during which the subscriber becomes credit eligible.

5. Premium adjustments resulting from the application of any policy credit will be made at time of policy audit.

6. In the event the subscriber's participation in the Program terminates by reason of: (a) termination of the Program by either the loss management firm, or The Workers' Compensation Rating and Inspection Bureau of Massachusetts, or (b) withdrawal from the Program by the subscriber, a pro-rata credit will be applied at policy audit of the policy term during which such termination occurs.

7. Approval of a Qualified Loss Management Program by The Workers' Compensation Rating and Inspection Bureau of Massachusetts is based on information and other data available to the Bureau, at the time of approval, and does not constitute a warranty of the quality or effectiveness of services offered by the loss management firm.

QUALIFIED LOSS MANAGEMENT PROGRAM - ASSIGNED RISKS

REQUEST FOR ENDORSEMENT AND POLICY CREDIT

COMPANY:

DATE:

BUREAU FILE NO.:

LOSS MANAGEMENT FIRM:

INSURED:

POLICY NO.:

EFFECTIVE DATE:

Due to the above insured's participation in the Program of the above Qualified Loss Management Firm, we are enclosing REQUEST FOR MASSACHUSETTS QUALIFIED LOSS MANAGMENT PROGRAM ASSIGNED RISK CREDIT.

1. Please endorse Massachusetts Qualified Loss Management Program Endorsement WC 20 04 02 to the above policy effective at inception date, and

2. Process Policy Credit on above policy effective at inception date, subject to premium adjustment at time of audit.

3. The above credit is:

   [ ] First Year Credit [ ] Second Year Credit [ ] Third Year Credit (half year)

4. The insured subscribed to a Loss Management Program prior to November 1, 1990, and therefore the credit is restricted to:

   [ ] One Year [ ] Two Years

   If no entry, insured is credit eligible for three years.

OTHER COMMENTS:

STATISTICAL REPORTING

The earned premium dollar adjustment amount due to the application of the Qualified Loss Management Program Assigned Risk policy credit must be reported on unit statistical reports under Classification Code 9880. This amount must be reported on lines D, E, F or G since it is not subject to experience modification.

The Loss Management Program credit to the premium does not affect Standard Premium. The Standard Premium is not reduced by the credit.

THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU OF MASSACHUSETTS
101 ARCH STREET - 5TH FLOOR, BOSTON, MA 02110
(617) 439-9030 FAX 439-6055

October, 1991

Update on Qualified Loss Management Program

The Qualified Loss Management Program (QLMP) is now eleven months old. We thought it would be helpful to you at this time if we provided some background and implementation information.

As you know, the QLMP is designed to apply a premium credit of up to 10% at audit to those assigned risk insureds who subscribe to a qualified loss management firm that has been approved by the Bureau. The insured becomes eligible for the credit after being in the program for six months, and can receive the credit at policy audit for three years (one-half credit during the third year) if they continue to subscribe to the services of a loss management firm.

The Bureau has approved 23 loss management firms for participation in the program which amounts to about a sixty per cent approval rate based on the number of applications received. When the Bureau receives an application to become approved as a qualified loss management firm, it conducts a careful review of the firm's qualifications in the following areas:

-Personnel
-Safety
-Post Injury Response
-Early Return to Work provisions

If the firm qualifies, the amount of the credit that it can offer is then determined by an actuarial review of the firm's success in reducing the losses of its clients. The data for the most recent five-year period is reviewed, and a credit ranging from 0-10% is assigned to the firm based on its experience. Many of the approved firms do not have sufficient experience to evaluate and are given "new entrant status." These firms are eligible to offer a 5% credit for three years, or until enough data is available to evaluate them as experienced programs.

To date, approximately 20% of the firms are experience rated. The rest have been assigned new entrant status. However, the Bureau expects to have sufficient data to experience rate a number of those firms next year. The list of participants changes on a frequent basis as firms are added and deleted from the program. The amount of the credit assigned to individual firms is not released by the Bureau, nor do we control their price structures. That type of information can be obtained by an insured through contact with the individual firms.

An insured becomes credit eligible once they have been with an approved firm for six months. When the Bureau receives a request for credit, we conduct a telephone audit of the insured to ensure that the appropriate activity is occurring. If the insured has an unsatisfactory audit, the Bureau will either deny the credit or point out program weaknesses and require corrective action where appropriate. If the audit is satisfactory, we direct the carrier to endorse the policy with the appropriate credit. The credit is applied at the time of policy audit. Since the program is less than a year old, we have processed fewer than a hundred applications for credit. However, we are seeing more and more applications for credit each week, and expect a dramatic increase as the program matures. To date, the following information based on estimated premiums is available:

Total Approved Credit Eligible Policies	Total Estimate of Premium	Total Credit Amount	Total Failed or Unsatisfactory Audits
80	13,907,774	900,188	21

The program is primarily intended to help to lower losses in the assigned risk pool which is losing hundreds of millions of dollars each year. The insured who subscribes to the program should benefit not only from credit, but over the long run through lower losses and an improved experienced modification. Its prospects of being written in the voluntary market will also hopefully improve. The employees should benefit from a safer workplace, quicker quality medical treatment when they are injured, and a company policy of returning the employee to the appropriate job at the appropriate time.

Due to the length of time that it takes for policy information to be accumulated and evaluated, it may be at least another year and possibly two before any definitive data is available on which the program can be judged. If you, or members of your company, have any questions or are in need of additional information, please do not hesitate to call on us.

PAUL F. MEAGHER
Legal Counsel

LORENZO A. RAIMONDI
Associate Legal Counsel

PFM/dc N921
Enclosure

SAFETY AND HEALTH ACHIEVEMENT RECOGNITION PROGRAM

With **S.H.A.R.P.** Oklahoma employers may earn a reduction in their workers' compensation insurance premium upon successful completion of the occupational safety and health consultation services program. To qualify for participation in the program, a company must meet the following criteria at this time:

1. The company must be listed as high hazard according to the most current OSHA listing;
2. They must have an employee range of 50 to 250;
3. They must have an experience modification above 1.25

EMPLOYERS SHOULD:

§ Request Oklahoma Department of Labor's **S.H.A.R.P.** consultation services;
§ Implement an effective safety and health program;
§ Correct all identified hazards;
§ Reduce the lost workday incidence rate by one-third the extent it exceeds the national average for that industry;
§ Record a 10% reduction in severity of claims, or have no claims;
§ Obtain certification of successful completion of the **S.H.A.R.P.** program from the Oklahoma Department of Labor.

ALL YOU MUST DO IS REQUEST THE SERVICE, AND WE WILL PROVIDE IT TO YOU AT NO COST.

Comprehensive consultation services include the following:

* Appraisal of all mechanical and environmental hazards and physical work practices;
* Appraisal of the present job safety and health program or the establishment of one;
* A conference with management on the findings;
* A written report of recommendations and agreements;
* Training and assistance with implementing recommendations;
* Follow-up to assure that any required corrections are made.

FOR FURTHER INFORMATION,
WRITE OR CALL
THE **OSHA CONSULTATION DIVISION:**

OKLAHOMA DEPARTMENT OF LABOR
4001 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105
405/528-1500.....Ext. 276

RECEIVED

WORKERS' COMPENSATION INSURANCE PREMIUM REDUCTION SCHEDULE

Premium	Potential Reduction
Up to $5,000	15%
$5,001 to $29,000	14%
$29,001 to $53,000	13%
$53,001 to $77,000	12%
$77,001 to $101,000	11%
$101,001 and Up	10%

National Council on Compensation Insurance

Southern Region
Government, Consumer and Industry Affairs

Roy O. Woo
Director

August 27, 1990

State Board for Property and
Casualty Rates
State of Oklahoma
P.O. Box 53066
Oklahoma City, OK 73105

Re: Safety and Health Achievement Recognition Program (SHARP)

Dear Board Members:

In accordance with the applicable statutes in the State of Oklahoma and at the direction of the Oklahoma Classification and Rating Committee, it is proposed that a premium reduction schedule be adopted to reflect the provisions of SB 272 for insureds who successfully complete the Oklahoma Department of Labor Employers Safety Program (SHARP).

Attached are filing exhibits reflecting the purpose, background, proposal and impact of this filing.

This filing is proposed to be applicable to new and renewal business effective 12:01 AM, September 1, 1990.

This filing is made on behalf of the members and subscribers of the National Council on Compensation Insurance writing workers compensation insurance in the State of Oklahoma.

Respectfully submitted,

NATIONAL COUNCIL ON COMPENSATION

ROY O. WOOD

ROW\tb

Enclosure

RECEIVED
AUG 29 1990
Oklahoma Insurance Department
Property & Casualty Division

SAFETY AND HEALTH ACHIEVEMENT RECOGNITION PROGRAM (SHARP)

(To be effective 12:01 AM, September 1, 1990, applicable to new and renewal business only.)

PURPOSE

The purpose of this program is to provide a schedule of premium reductions to employers who are certified through the Oklahoma Department of Labor Employer Safety Program (SHARP) in accordance with the provisions of SB 272.

BACKGROUND

In 1988, the Oklahoma Legislature passed SB 485 making provisions for premium reductions for a band of insureds from the maximum minimum premium to the experience rating threshold who successfully completed, and were certified in, the DOL Employer Safety Program. The Oklahoma Board for Property and Casualty Rates ultimately approved an up front premium reduction of 15% for qualified insureds to be applicable to the first renewal policy after certification and each subsequent policy as long as certification was maintained.

In 1990, the Oklahoma Legislature expanded the eligibility for premium reductions to all employers certified in the program through the enactment of SB 272.

The details of the certification process are found in SB 272 (Exhibit I).

PROPOSAL

It is proposed that the following premium reduction schedule be applicable to the first new or renewal policy subsequent to employers certification through SHARP and to each subsequent renewal policy as long as certification is maintained.

PREMIUM	REDUCTION
Up to $5,000	15%
5,000 to 29,000	14%
29,001 to 53,000	13%
53,001 to 77,000	12%
77,001 to 101,000	11%
101,000 and up	10%

SHARP (continued)

Premium reductions apply to standard premium and are adjusted on audit. Standard premium is defined as manual premium adjusted by experience rating, but prior to premium discount and expense constant. An example is found in Exhibit II.

Certification in the program requires a documented ten percent reduction in the dollar amount of claims "as a result of attending the (program)". Participation in the program probably will not coincide with an employer's workers' compensation policy. There is also a concern over whether "as a result of attending" should be a measurement during the DOL program or after. The latter of these two options would tend only to allow application of the premium reduction at least one year later than the former.

In the interest of allowing the employer to realize the premium reduction at the earliest possible point in time, we propose that the one-year period of time that an employer is participating in the program be used as the base period. The base period would then be compared to the preceding twelve-month period in order to measure whether or not the ten percent reduction in dollar amount of claims was achieved. The source of this information would be the Unit Statistical Plan (Unit) reports submitted by the employer's insurer. Please refer to Exhibit III for graphic representation.

* Since participation in the program would not necessarily coincide with the employer's workers' compensation policy, we propose the following steps be taken.

Unit reports that would encompass the two consecutive periods of time, would be provided to the DOL directly from NCCI. There is a possibility that a third report would be required, depending upon where the base period fell relative to the policy period. The unit report gives the date of accident; therefore, the DOL would be able to determine how many claims occurred and what the value is in order to measure whether or not the employer had achieved this requirement. Please refer to Exhibit IV.

The unit reports provided would be on a first report for the base period and for the comparison year, unless the comparison year contained any open claims. If open claims did exist in the comparison year, a second report (updated evaluation) would be required. This is normal to the unit reporting process.

Although the certification process would involve the DOL, employer, insurer and NCCI, a risk would not be eligible for a premium reduction until the DOL notifies the insuring carrier. The employer would be eligible for the premium reduction as of the next new or renewal policy subsequent to certification.

The role of the insurer and NCCI should not be overlooked in the

DOL program. With this in mind, we propose that, when an employer is enrolled in the DOL program, the insurer, agent and NCCI be notified immediately regarding the employer's participation. Relative to the insurer and agent, this would prevent the "shock" that might occur (otherwise) if the insurer were unaware that a premium reduction would be required on their policyholder, at some future date.

In addition to the notification to the insurer, the NCCI field office would be notified in order that it could prepare its files for sending unit reports to the DOL when required. To this end, it would be important for DOL to obtain and provide NCCI certain information relative to the insured's prior policy. That information would include the carrier's name, policy effective date and policy number. This would be applicable to both the policy effective at the beginning of the base period (current) and the comparison year (expired) policy.

Finally, NCCI will be preparing an endorsement that would be attached to an insured's policy for which a premium reduction would be applicable as a result of certification in the Employer Safety Program. It would be expected that the endorsement would notify the insured of applicability of the premium reduction, a premium reduction table, and the method of calculation.

IMPACT

Since its inception, no employer has been certified or received premium reduction through the DOL program. Due to the certification process, no insureds are expected to qualify until late 1991 or early 1992. As a result, no adjustments to rate level has been made. To the extent that an adjustment is necessary, SB 272 makes a provision for reflection of the impact in future rate filings.

IMPLEMENTATION

SHARP will be implemented by a change in the Basic Manual state special page. Effective September 1, language pertaining to the Workplace Safety Program will be replaced by language relative to the Safety and Health Achievement Recognition Program (Exhibit V).

Premium reductions will continue to be reported under Statistical Code 9880 as previously approved.

EXHIBIT I

An Act

ENROLLED SENATE
BILL NO. 272

BY: SHEDRICK, BROWN, MILES-LaGRANGE, TAYLOR, HERBERT and CAIN of the SENATE

and

STEIDLEY of the HOUSE

AN ACT RELATING TO INSURANCE; AMENDING SECTION 1, CHAPTER 317, O.S.L. 1988 (36 O.S. SUPP. 1989, SECTION 924.2), WHICH RELATES TO WORKERS' COMPENSATION PREMIUM REDUCTION FOR SAFETY PROGRAM PARTICIPATION; MODIFYING LANGUAGE RELATING TO ELIGIBILITY OF EMPLOYERS; DELETING LANGUAGE WHICH RESTRICTS ELIGIBILITY TO CERTAIN PREMIUM RANGE; AND PROVIDING AN EFFECTIVE DATE.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY Section 1, Chapter 317, O.S.L. 1988 (36 O.S. Supp. 1989, Section 924.2), is amended to read as follows:

Section 924.2 A. Any rate, schedule of rates or rating plan for workers' compensation insurance submitted to or filed with the State Board for Property and Casualty Rates, or fixed by the Board of Managers of the State Insurance Fund, and premiums, by whatever name, for workers' compensation for self-insureds except for group self-insured associations shall provide for an appropriate reduction in premium charges, by whatever name, for those eligible insured employers who have successfully participated in the occupational safety and health consultation, education and training program administered by the Commissioner of the Department of Labor pursuant to Section 414 of Title 40 of the Oklahoma Statutes.

B. All insurance companies writing workers' compensation insurance in this state, including the State Insurance Fund, and all self-insureds providing workers' compensation insurance except for group self-insured associations, shall allow an appropriate reduction in premium charges to all eligible employers who qualify for the reduction pursuant to the provisions of this section.

C. Eligible employers shall be those employers:

1. ~~Whose premiums are less than that required to be eligible for experience rating but greater than the maximum minimum premium as determined by the rating plan filed by a licensed rating organization whose members represent at least fifty percent (50%) of the workers'~~

~~compensation insurers licensed in this state~~ Who are insured by an insurance company writing workers' compensation insurance in this state;

2. Who are self-insured; or

3. Who are insured by the State Insurance Fund.

7 D. In order to qualify for the reduction in workers' compensation insurance premium, an employer shall successfully participate annually in the occupational safety and health consultation, education and training program administered by the Department of Labor. Successful participation shall be defined as:

1. Undergoing a safety and health hazard survey of the workplace, including an evaluation of the employer's safety and health program and onsite interviews with employees by the Department's consultant;

2. Correcting all hazards identified during the onsite visit within a reasonable period of time as established by the Department;

3. Establishing an effective workplace safety and health program and implementing program provisions within a reasonable period of time as established by the Department. The program shall include:

a. demonstration of management commitment to worker safety and health,

b. procedures for identifying and controlling workplace hazards,

c. development and communication of safety plans, rules and work procedures, and

d. training for supervisors and employees in safe and healthful work practices;

4. Reducing by one-third (1/3) or more the extent to which the lost workday case rate, as measured by the Department of Labor, was above the national average for the industry at the time the employer elected to participate in the occupational safety and health consultation, education and training program, or maintaining a rate at or below the national average for the industry; and

5. Documenting a reduction in workers' compensation claims for the preceding year by showing one of the following:

a. a ten percent (10%) reduction in the dollar amount of claims,

b. a ten percent (10%) reduction in the severity of claims, or

c. no reported claims,

as a result of attending the occupational safety and health consultation, education and training program administered by the Department of Labor.

E. Upon successful participation in the occupational safety and health consultation, education and training program as defined in subsection D of this section, an employer shall be issued a certificate by the Commissioner of the Department of Labor which shall be the basis of qualification for the reduction in workers'

compensation insurance premium, by whatever name. The certificate shall qualify the employer for a premium reduction for a one-year period.

F. The Insurance Commissioner, the Administrator of the Workers' Compensation Court and the State Insurance Fund Commissioner shall maintain records documenting reductions in workers' compensation insurance premiums granted pursuant to this section and shall make an annual report of such reductions to the President Pro Tempore of the Senate and the Speaker of the House of Representatives by January 1 of each year. Insurers shall report such premium reductions in their annual statement.

G. The State Insurance Fund shall instruct its actuary to continually review the insurance premium credit program, developed and implemented pursuant to Section ~~3 of this act~~ 142a of Title 85 of the Oklahoma Statutes, to determine if the program is detrimental to the financial stability of the Fund. If the actuary determines that the program contributes detrimentally to the financial stability of the Fund, the actuary shall immediately recommend to the State Insurance Fund Commissioner that the safety premium reduction cease for a one-year period.

SECTION 2. This act shall become effective September 1, 1990.

Passed the Senate the 5th day of March, 1990.

President of the Senate

Passed the House of Representatives the 8th day of March, 1990.

Speaker of the House of Representatives

EXHIBIT II

PREMIUM IMPACT ESTIMATED VS. EARNED

(FOR ILLUSTRATION ONLY)

Assume a risk named Ace Pipe Company has been certified in the DOL Employer Safety Program. Their current experience modification is .85. Their standard estimated premium would be calculated as follows:

Code	Description	Payroll	Rate $100 payroll	Premium
3028	Pipe or tube mfg. Iron or steel & drivers	500,000	7.43	37,150
8742	Outside Sales	100,000	.83	830
8810	Clerical	75,000	.39	293
	Manual Premium			38,273
	Experience Modification			x .85
	Standard Premium			32,532
9880	Employer Safety Program Credit (32,532 x 13%)			-4,229
	Revised Standard Premium *			28,303

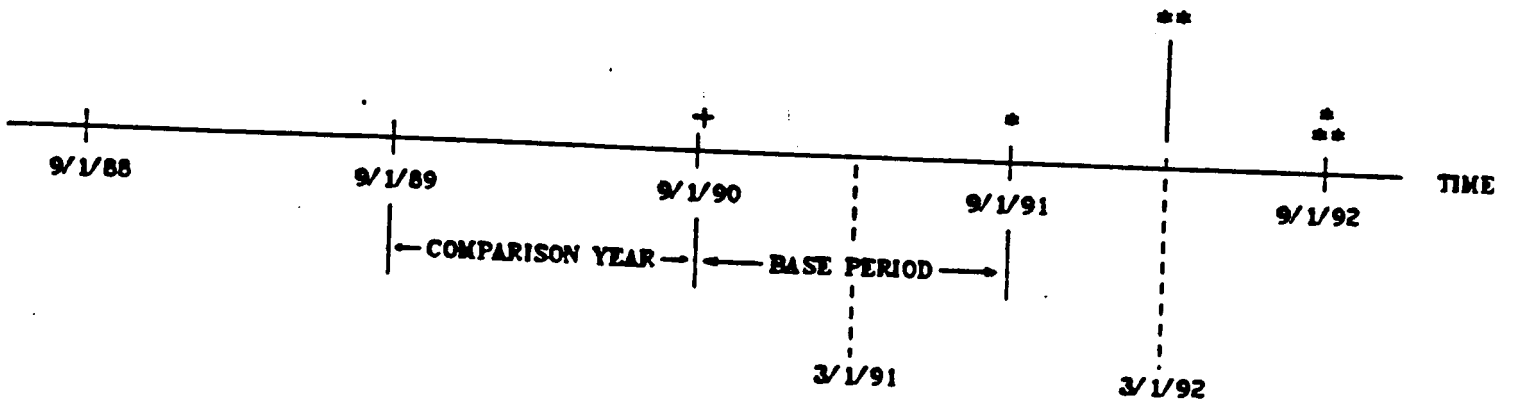
Assume after audit the payrolls for each classification were revised causing the final premium and credit to be somewhat different.

3028	575,000	7.43	42,723
8742	121,000	.83	1,004
8810	96,000	.39	374
	Manual Premium		44,101
	Experience Modification		x .85
	Standard Premium		37,406
9880	Employer Safety Program Credit (37,486 x 13%)		-4,863
	Revised Standard Premium *		32,543

* Prior to premium discount and expense constant

EXHIBIT III

BASE PERIOD DETERMINATION
(Coinciding w/Policy Anniversary Date)



\+ - entry into DOL Employer Safety Program - beginning of base period

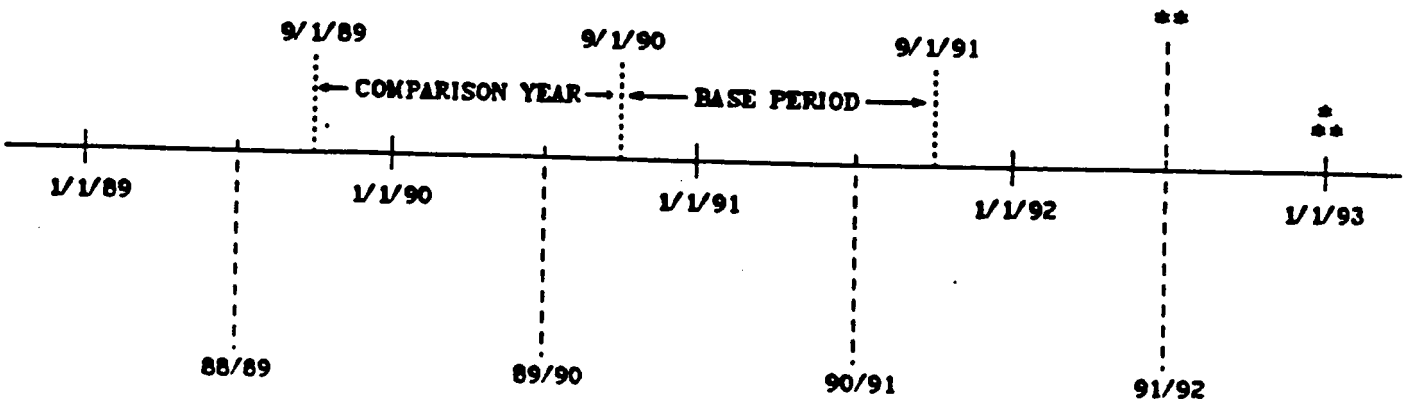
* - conclusion of training by DOL - end of base period (12 months)

** - USP valuation date. Report submitted to NCCI - employer eligible for certification

*** - application of premium reduction for 92-93 policy

Unit statistical reporting is based upon valuation of a policy 18 months after its inception and reporting to NCCI no later than 20 months. Therefore, assuming an employer enters the Program at a date coinciding with its policy anniversary date of Sept 1, the first unit report on the policy would be available on March 1 (18 months later).

BASE PERIOD DETERMINATION
(Not Coinciding W/Policy Anniversary Date)



** - valuation date of 91/92 policy. Employer eligible for certification

*** - application of premium reduction to 93/94 policy

Assume the employer has a 1/1 policy anniversary date and enters the DOL Program on 9/1/90. To enable DOL to establish comparative 12-month periods, unit reports would be required from the 89/90, 90/91 and 91/92 policy periods. DOL would then only use claims occurring between 9/1/90 and 9/1/91 for the base period and 9/1/89 and 9/1/90 for the comparison year.

EXHIBIT V

BASIC MANUAL OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY

PRESENT LANGUAGE:

WORKPLACE SAFETY PROGRAM

Upon successful completion of the Oklahoma Department of Labor's Occupational Safety and Health Consultation and Training Program, and upon insurer receipt of certification, eligible employers shall receive premium credit, as of policy effective date, effective on new and renewal policies as of November 1, 1988 and subsequent. Employer participation in this program is voluntary and available premium credit is limited to qualifying employers.

Eligible employers shall be those whose premiums are less than that required to qualify for experience rating but greater than the maximum minimum premium for the state.

Verification of insured loss history in connection with final certification in accordance with the Occupational Safety and Health Consultation and Training Program shall be made available from the National Council on Compensation Insurance from past insurer records as filed in accordance with the Unit Statistical Plan Manual.

Certification by the Department of Labor will entitle the insured to a premium credit of 15% for a one-year period beginning with the first policy effective subsequent to receipt of certification. Annual renewal of the Department of Labor certificates in accordance with the requirements of the Occupational Safety and Health Consultation and Training Program will entitle the insured to the 15% premium credit.

PROPOSED LANGUAGE:

SAFETY AND HEALTH ACHIEVEMENT RECOGNITION PROGRAM (SHARP)

Upon successful completion of the Oklahoma Department of Labor's Occupational Safety and Health Consultation and Training Program, and upon insurer receipt of certification, eligible employers shall receive premium reduction as of policy effective date, effective on new and renewal policies as of September 1, 1990 and subsequent. Employer participation in this program is voluntary and available premium reduction is limited to qualifying employers.

Verification of insured loss history in connection with final certification in accordance with the Occupational Safety and Health Consultation and Training Program shall be made available from the National Council on Compensation Insurance from past insurer records as filed in accordance with the Unit Statistical Plan Manual.

Certification by the Department of Labor will entitle the insured to a premium reduction of:

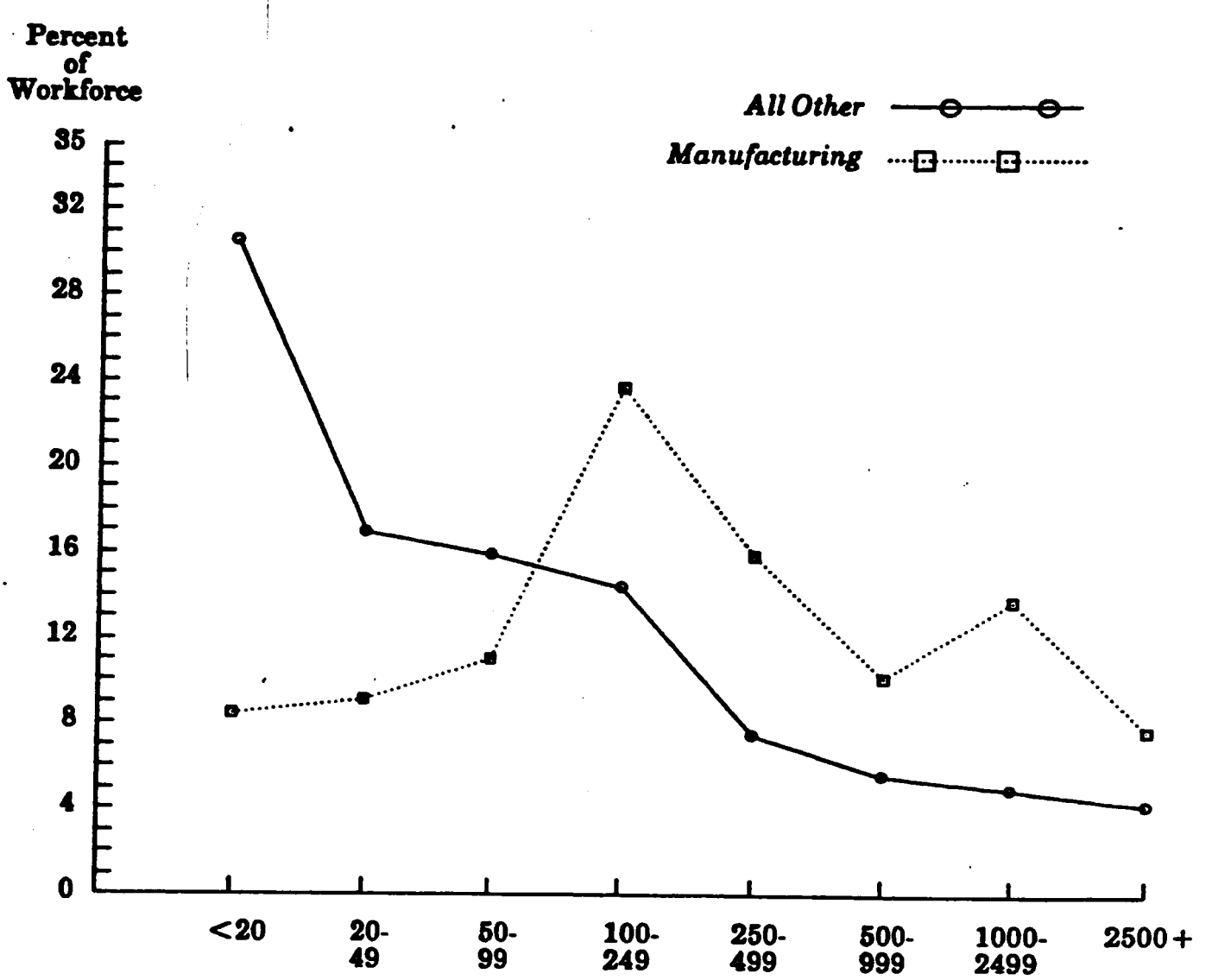
PREMIUM	REDUCTION
Up to $ 5,000	15%
5,000 to 29,000	14%
29,001 to 53,000	13%
53,001 to 77,000	12%
77,001 to 101,000	11%
101,001 and up	10%

Premium reductions are for a one-year period beginning with the first policy effective subsequent to

(Exhibit V continues on next page)

receipt of certification. Annual renewal of the Department of Labor certificates in accordance with the requirements of the Occupational Safety and Health Consultation and Training Program will entitle the insured to the premium reduction in accordance with the schedule.

Manufacturing Employment Size and All Other, Private Sector Industry, Oklahoma, 1988



SOURCE: Oklahoma Department of Labor, Information Services Division

OKLAHOMA MANUFACTURING
INJURY & ILLNESS RATE AND EMPLOYMENT
BY EMPLOYMENT SIZE

SIZE	EMPLOYMENT	TOTAL CASES 100	LWD CASES 100
1-3	1,780	1.5	1.5
4-10	7,197	4.4	2.4
11-19	5,068	12.3	5.1
20-49	14,954	15.5	7.6
50-99	18,116	21.6	10.3
100-249	38,801	18.9	8.5
250-499	25,945	14.6	6.8
500-999	16,589	11.9	5.7
1000-2499	22,333	14.7	5.9
2500-OVER	12,646	22.5	7.8

E. Each participant shall successfully complete an approved course each two (2) years to continue to be eligible for the discount on insurance.

Added by Laws 1985, c. 122, § 1, eff. Jan. 1, 1986. Amended by Laws 1990, c. 297, § 1, eff. Sept. 1, 1990.

Section 5 of Laws 1990, c. 297 provides for an effective date.

Section 2 of Laws 1985, c. 122 provides for an effective date.

Title of Act:

An Act relating to insurance; requiring certain provisions in automobile liability insurance rate schedules or rating plans; providing exceptions; requiring certain insurance companies to allow premium reductions for eligible persons; specifying approved instructors; providing for certain certificates; limiting eligibility; providing for codification; and providing an effective date. Laws 1985, c. 122.

§ 924.2. Rating plans for workers' compensation self-insureds—Reduced premium charges for successful participation in occupational safety and health programs—Qualification—Certificate—Records—Review of premium credit program

A. Any rate, schedule of rates or rating plan for workers' compensation insurance submitted to or filed with the State Board for Property and Casualty Rates, or fixed by the Board of Managers of the State Insurance Fund, and premiums, by whatever name, for workers' compensation for self-insureds except for group self-insured associations shall provide for an appropriate reduction in premium charges, by whatever name, for those eligible insured employers who have successfully participated in the occupational safety and health consultation, education and training program administered by the Commissioner of the Department of Labor pursuant to Section 414 of Title 40 of the Oklahoma Statutes.

B. All insurance companies writing workers' compensation insurance in this state, including the State Insurance Fund, and all self-insureds providing workers' compensation insurance except for group self-insured associations, shall allow an appropriate reduction in premium charges to all eligible employers who qualify for the reduction pursuant to the provisions of this section.

C. Eligible employers shall be those employers:

1. Who are insured by an insurance company writing workers' compensation insurance in this state;

2. Who are self-insured; or

3. Who are insured by the State Insurance Fund.

D. In order to qualify for the reduction in workers' compensation insurance premium, an employer shall successfully participate annually in the occupational safety and health consultation, education and training program administered by the Department of Labor. Successful participation shall be defined as:

1. Undergoing a safety and health hazard survey of the workplace, including an evaluation of the employer's safety and health program and onsite interviews with employees by the Department's consultant;

2. Correcting all hazards identified during the onsite visit within a reasonable period of time as established by the Department;

3. Establishing an effective workplace safety and health program and implementing program provisions within a reasonable period of time as established by the Department. The program shall include:

a. demonstration of management commitment to worker safety and health,

b. procedures for identifying and controlling workplace hazards,

c. development and communication of safety plans, rules and work procedures, and

d. training for supervisors and employees in safe and healthful work practices;

4. Reducing by one-third (⅓) or more the extent to which the lost workday case rate, as measured by the Department of Labor, was above the national average for the industry at the time the employer elected to participate in the occupational safety and health consultation, education and training program, or maintaining a rate at or below the national average for the industry; and

5. Documenting a reduction in workers' compensation claims for the preceding year by showing one of the following:

a. a ten percent (10%) reduction in the dollar amount of claims,

b. a ten percent (10%) reduction in the severity of claims, or

c. no reported claims,

as a result of attending the occupational safety and health consultation, education and training program administered by the Department of Labor.

E. Upon successful participation in the occupational safety and health consultation, education and training program as defined in subsection D of this section, an employer shall be issued a certificate by the Commissioner of the Department of Labor which shall be the basis of qualification for the reduction in workers' compensation insurance premium, by whatever name. The certificate shall qualify the employer for a premium reduction for a one-year period.

F. The Insurance Commissioner, the Administrator of the Workers' Compensation Court and the State Insurance Fund Commissioner shall maintain records documenting reductions in workers' compensation insurance premiums granted pursuant to this section and shall make an annual report of such reductions to the President Pro Tempore of the Senate and the Speaker of the House of Representatives by January 1 of each year. Insurers shall

report such premium reductions in their annual statement.

G. The State Insurance Fund shall instruct its actuary to continually review the insurance premium credit program, developed and implemented pursuant to Section 142a of Title 85 of the Oklahoma Statutes, to determine if the program is detrimental to the financial stability of the Fund. If the actuary determines that the program contributes detrimentally to the financial stability of the Fund, the actuary shall immediately recommend to the State Insurance Fund Commissioner that the safety premium reduction cease for a one-year period.

Added by Laws 1988, c. 317, § 1, eff. Nov. 1, 1988. Amended by Laws 1990, c. 2, § 1, eff. Sept. 1, 1990.

Section 2 of Laws 1990, c. 2, provides for an effective date.
Section 6 of Laws 1988, c. 317, provides for an effective date.

§ 924.3. Appeals of rating classifications

The State Board for Property and Casualty Rates shall adopt rules and regulations creating a procedure for an employer to appeal its rating classification for workers' compensation insurance to the Board. Any hearings pursuant to this procedure shall be subject to the Administrative Procedures Act.[1]

Added by Laws 1990, c. 283, § 21, eff. Sept. 1, 1990.

[1] Sections 250 et seq. and 301 et seq. of title 75.

§§ 925 to 927. Repealed by Laws 1987, c. 210, § 38, eff. July 1, 1987.

§ 928. Rating organizations

A. Every group, corporation, unincorporated association, organization of insurers, partnership or individual, whether located within or outside this state, may make application to the Board for license as a rating organization for such kinds of insurance, or subdivision or class of risk or a part or combination thereof as are specified in its application and shall file: (1) a copy of its constitution, its articles of agreement or association, or its certificate of incorporation, and of its bylaws, rules and regulations governing the conduct of its business, (2) a list of its members and subscribers, (3) the name and address of a resident of this state upon whom notices or orders of the Board or process affecting such rating organization may be served, and (4) a statement of its qualifications as a rating organization. If the Board finds that the applicant is competent, trustworthy and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association, or certificate of incorporation and its bylaws, rules and regulations governing the conduct of its business conform to the requirements of law, it may issue a license specifying the kinds of insurance, or subdivision or class of risk, or part or combination thereof, for which the applicant is authorized to act as a rating organization. Every such application shall be granted or denied in whole or in part by the Board within ninety (90) days of the date of its filing with it. Licenses pursuant to this section shall remain in effect for one (1) year until suspended or revoked by the Board. The fee for said license shall be Five Hundred Dollars ($500.00).

B. Licenses issued pursuant to this section may be suspended or revoked by the Board, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this section. The Board shall not revoke or suspend the license of any rating organization until it has given not less than thirty (30) days' notice of the proposed revocation or suspension and of the grounds alleged therefor. In lieu of revoking or suspending a license, the Board may impose a penalty of not more than One Hundred Dollars ($100.00) for each violation. Each day such violation continues shall constitute a separate offense.

C. Every rating organization shall notify and file promptly with the Board every change in: (1) its constitution, its articles of agreement or association, or its certificate of incorporation and its bylaws, rules and regulations governing the conduct of its business, (2) its list of members and subscribers, and (3) the name and address of the resident of this state designated by it upon whom notices or orders of the Board or process affecting such rating organization may be served.

D. Subject to rules and regulations which have been approved by the Board as reasonable, each rating organization shall permit any insurer, not a member, to be a subscriber to its rating services for any kind of insurance, subdivision or class of risk, or a part or combination thereof, for which it is authorized to act as a rating organization. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers. The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber shall, at the request of any subscriber or any such insurer, be reviewed by the Board at a hearing held upon at least ten (10) days' written notice to such rating organization and to such subscriber or insurer. If the Board finds that such rule or regulation is unreasonable in its application to subscribers, it shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within thirty (30) days after it was made, the insurer may request a review by the Board as if the application had been rejected. If the Board finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, it shall order the rating organization to admit the insurer as a subscriber. If it finds that the action of the rating organization

Rules and Procedures—
California Workers' Compensation Retrospective Rating Plan

SECTION VII—TABLE OF RATING VALUES

TABLE I

Loss Conversion Factor—1.20

Rating Formula: Retrospective Premium = (Basic Premium Ratio x Standard Premium) + (Loss Conversion Factor x Losses) subject to Minimum and Maximum Retrospective Premiums as shown in table:

	Percentages of California Prem.				Percentages of California Prem.		
Standard Premium (See Footnote)	Basic Premium	Minimum Retro-spective Premium	Maximum Retro-spective Premium	Standard Premium (See Footnote)	Basic Premium	Minimum Retro-spective Premium	Maximum Retro-spective Premium
$ 25,000	41.1%	77.1%	179.4%	$100,000	37.2%	60.3%	153.8%
27,500	41.0	76.0	178.4	105,000	36.9	59.7	152.6
30,000	40.9	74.8	177.4	110,000	36.7	59.1	151.3
32,500	40.8	73.7	176.4	115,000	36.5	58.4	150.0
35,000	40.7	72.5	175.4	120,000	36.3	57.7	148.5
37,500	40.6	71.8	174.2	125,000	36.2	57.5	147.6
40,000	40.5	71.1	173.0	130,000	36.1	57.3	146.8
42,500	40.4	70.3	171.7	135,000	36.0	57.1	146.0
45,000	40.3	69.6	170.5	140,000	35.9	56.9	145.2
47,500	40.2	68.9	169.3	145,000	35.7	56.6	144.4
50,000	40.0	68.2	167.9	150,000	35.6	56.4	143.6
52,500	39.7	67.4	166.6	160,000	35.4	56.0	142.0
55,000	39.5	66.7	165.2	170,000	35.1	55.4	140.4
57,500	39.2	65.9	163.9	180,000	34.9	54.9	138.8
60,000	39.0	65.2	162.5	190,000	34.6	54.3	137.2
62,500	38.9	64.9	162.0	200,000	34.4	54.1	136.6
65,000	38.7	64.5	161.5	212,500	34.2	53.8	136.0
67,500	38.6	64.2	160.9	225,000	34.0	53.6	135.3
70,000	38.4	63.8	160.4	237,500	33.8	53.3	134.6
72,500	38.3	63.4	159.9	250,000	33.6	53.0	133.9
75,000	38.2	63.1	159.3	262,500	33.4	52.8	133.2
80,000	38.0	62.3	158.3	275,000	33.2	52.5	132.5
85,000	37.8	61.6	157.2	287,500	33.0	52.2	131.8
90,000	37.6	61.2	156.1	300,000	32.8	52.0	131.0
95,000	37.4	60.7	155.0	312,500	32.6	51.7	130.3

Rules and Procedures—
California Workers' Compensation Retrospective Rating Plan

TABLE OF RATING VALUES (Continued)

Standard Premium (See Footnote)	Percentages of California Prem. Basic Premium	Minimum Retrospective Premium	Maximum Retrospective Premium	Standard Premium (See Footnote)	Percentages of California Prem. Basic Premium	Minimum Retrospective Premium	Maximum Retrospective Premium
$325,000	32.4%	51.4%	129.6%	$850,000	29.2%	44.7%	118.3%
337,500	32.2	51.2	128.8	900,000	29.2	44.5	118.1
350,000	32.0	50.9	128.1	950,000	29.1	44.4	117.8
362,500	31.9	50.7	127.8	1,000,000	29.1	44.3	117.6
375,000	31.8	50.5	127.5	1,100,000	29.0	44.1	117.1
387,500	31.7	50.3	127.1	1,200,000	29.0	43.9	116.7
400,000	31.6	50.1	126.8	1,300,000	28.9	43.6	116.2
412,500	31.5	49.9	126.5	1,400,000	28.8	43.4	115.7
425,000	31.4	49.7	126.2	1,500,000	28.7	43.2	115.2
437,500	31.4	49.5	125.9	1,600,000	28.7	42.9	114.8
450,000	31.3	49.2	125.5	1,700,000	28.6	42.7	114.3
462,500	31.2	49.0	125.2	1,800,000	28.5	42.4	113.8
475,000	31.1	48.8	124.9	1,900,000	28.5	42.1	113.3
487,500	31.0	48.6	124.6	2,000,000	28.4	41.8	112.9
500,000	30.9	48.4	124.2	2,100,000	28.3	41.5	112.4
525,000	30.7	48.0	123.6	2,200,000	28.3	41.3	111.9
550,000	30.5	47.6	122.9	2,300,000	28.2	41.0	111.4
575,000	30.3	47.1	122.3	2,400,000	28.1	40.7	111.0
600,000	30.1	46.7	121.6	2,500,000 & over	28.1	40.4	110.5
625,000	29.9	46.3	121.0				
650,000	29.7	45.9	120.3				
675,000	29.5	45.4	119.7				
700,000	29.3	45.0	119.0				
750,000	29.3	44.9	118.8				
800,000	29.2	44.8	118.5				

If the earned standard premium for the Policy lies between any two of the figures in the Standard Premium column, the percentages shall apply on the basis of the next lower standard premium in the table, provided, however, that if the earned standard premium of the Policy is less than $25,000, the percentages for a standard premium of $25,000 shall apply.

D. THE RETROSPECTIVE PREMIUM FORMULA WHEN ADDITIONAL ELECTIVE PREMIUM ELEMENTS ARE INCLUDED

The retrospective premium for a risk which has elected either or both of the additional elective premium elements is determined by the following formula:

Retrospective Premium =

1. Basic Premium

   plus

2. Converted Losses

   plus

3. Excess Loss Premium

   plus

4. Retrospective Development Premium
5. Multiply the sum of 1 + 2 + 3 + 4 by the Tax Multiplier

Note: Include item 3 or 4 or both in the formula depending on whether such elective premium elements are in the retrospective agreement.

The result of this calculation is the retrospective premium when the risk has elected one or both of the elective premium elements. The retrospective premium shall not be less than the Minimum Retrospective Premium nor more than the Maximum Retrospective Premium.

II. RETROSPECTIVE RATING OPTIONS TO BE ELECTED BY THE RISK

A. EXPLANATION

This Plan includes five Retrospective Rating Options which control the premium which results from the Retrospective Premium Formula. When the insured and the insurance carrier agree that this Plan shall apply to a risk, one of the Retrospective Rating Options shall be designated in the agreement as the basis on which the retrospective premium will be determined.

The selection of a Retrospective Rating Option depends upon how the insured and the carrier evaluate the suitability of a specific option.

B. TYPES OF RETROSPECTIVE RATING OPTIONS

There are two types of Retrospective Rating Options:

1. The first type of Retrospective Rating Option is based upon factors in standard tables which are included in this Plan. Refer to Part Four—Premium Computation Tables. Such Retrospective Rating Options may be applied to the risk in a single state or, if the risk operates in more than one state, the designated option may apply on an interstate basis. Rating options I, II, III and IV are of this type and are described below:

   Retrospective Rating Option I: The Minimum Retrospective Premium will be less than the Standard Premium but the Maximum Retrospective Premium for the risk will be equal to the Standard Premium.

   Retrospective Rating Option II: The Minimum Retrospective Premium will be less than the Standard Premium and the Maximum Retrospective Premium will be more than the Standard Premium. By using this option, the insured ventures paying more than Standard Premium for the opportunity to obtain greater savings for controlled losses.

   Retrospective Rating Option III: The Minimum Retrospective Premium is not specified in the table for this option. It depends only on the result of the retrospective premium formulas in I-A and D of this Section of the Plan. The Maximum Premium will be more than the Standard Premium and will be the same as for Retrospective Rating Option II. Although the basic premium is higher than in Option II, there is a reward in Option III for unusually good loss results.

   Retrospective Rating Option IV: The Minimum Retrospective Premium will be less than the Standard Premium and the Maximum Retrospective Premium will be more than the Standard Premium. The difference between this option and options II and III is that option IV provides a narrower range of minimum and maximum retrospective premiums. Favorable losses result in savings and there is protection against poor experience producing higher maximum premiums provided by the other options.

2. The second type of Retrospective Rating Option is not based upon standard tables to determine the premium factors. Factors for this option are determined for each risk by agreement between the insured and the insurance

carrier, subject to the procedures described below:

Retrospective Rating Option V: The Basic Premium is determined by using the Table of Expense Ratios to determine the insurance carrier expenses and the Table of Insurance Charges for the remainder of the Basic Premium. The Loss Conversion Factor and Minimum and Maximum Retrospective Premium are subject tc agreement between the insured and the insurance carrier. The Tax Multiplier, Excess Loss Premium and Retrospective Development Premium are determined on the basis of the state or states included in this option.

(a) Retrospective Rating Option V may be applied to any of the following types of insurance alone or to any combination of such insurance:

Workers Compensation and Employers Liability

Third Party Liability Insurance for Commercial Lines

Commercial Automobile Physical Damage

Other Types of Insurance specified in the Retrospective Rating Plan Issued by the Insurance Services Office.

For illustrations and examples of combinations, refer to the Retrospective Rating Plan issued by the Insurance Services Office.

Note: When Rating Option V includes Workers Compensation and other commercial casualty insurance, the total retrospective premium, including the minimum and maximum retrospective premium, is determined on the basis of all insurance in the plan.

(b) For an interstate risk, an average of the specified state tax multipliers weighted by the state shall be used.

(c) The Loss Conversion Factor for Retrospective Rating Option V shall not be higher than 1.25 for stock insurance carriers nor higher than 1.47 for non-stock insurance carriers.

Refer to Appendix for explanations and examples on the use of Retrospective Rating Option V.

C. THREE YEAR PLAN—OPTIONAL

1. Retrospective Rating Options I, II, III and IV may also be applied to a risk for a period of three years. Refer to Part One-III-B for eligibility requirements. The factors for determining the retrospective premium for this option are in Part Four—Premium Computation Tables which includes tables designed for 3 year plans.
2. Retrospective Rating Option V may also be applied to a risk for a period of three years. Follow the procedure and examples cited in B-2 above, but determine the insurance carrier expenses on the basis of the annual Standard Premium and the remainder of the Basic Premium by use of the Standard Premium for the 3 year period of the Plan.

D. LONG TERM OR WRAP-UP CONSTRUCTION PROJECTS

1. Retrospective Rating Option V may be applied to such projects in the following manner:
   a. The project may be insured under a series of 1 year policies. Use Rule II-B above.
   b. The project may be insured under a series of 3 year policies. Use Rule II-C above.
   c. The Plan shall apply to such projects so that the Retrospective Premium is computed on the basis of the Standard Premium for the entire duration of the project.

Note: For determining retrospective premium for plans applied on a three year basis, or Long Term or Wrap-Up Construction Projects, any revision in Tax Multipliers and Excess Loss Premium Factors shall be applied to policies as of the first normal anniversary date of the risk, which is on or after the date of such revision, unless the revision is authorized for application to outstanding policies.

III. CANCELATION OF POLICY

A. EXPLANATION

While the Cancelation Condition of the Standard Policy permits cancelation by the insured or insurance carrier, the premium determination for a canceled policy is controlled by Rule X—Cancelation in the New York Manual for Workers Compensation and Employers Liability Insurance.

1987 DIVIDEND REPORT SUMMARY

All Carriers – Excluding Retrospective Policies

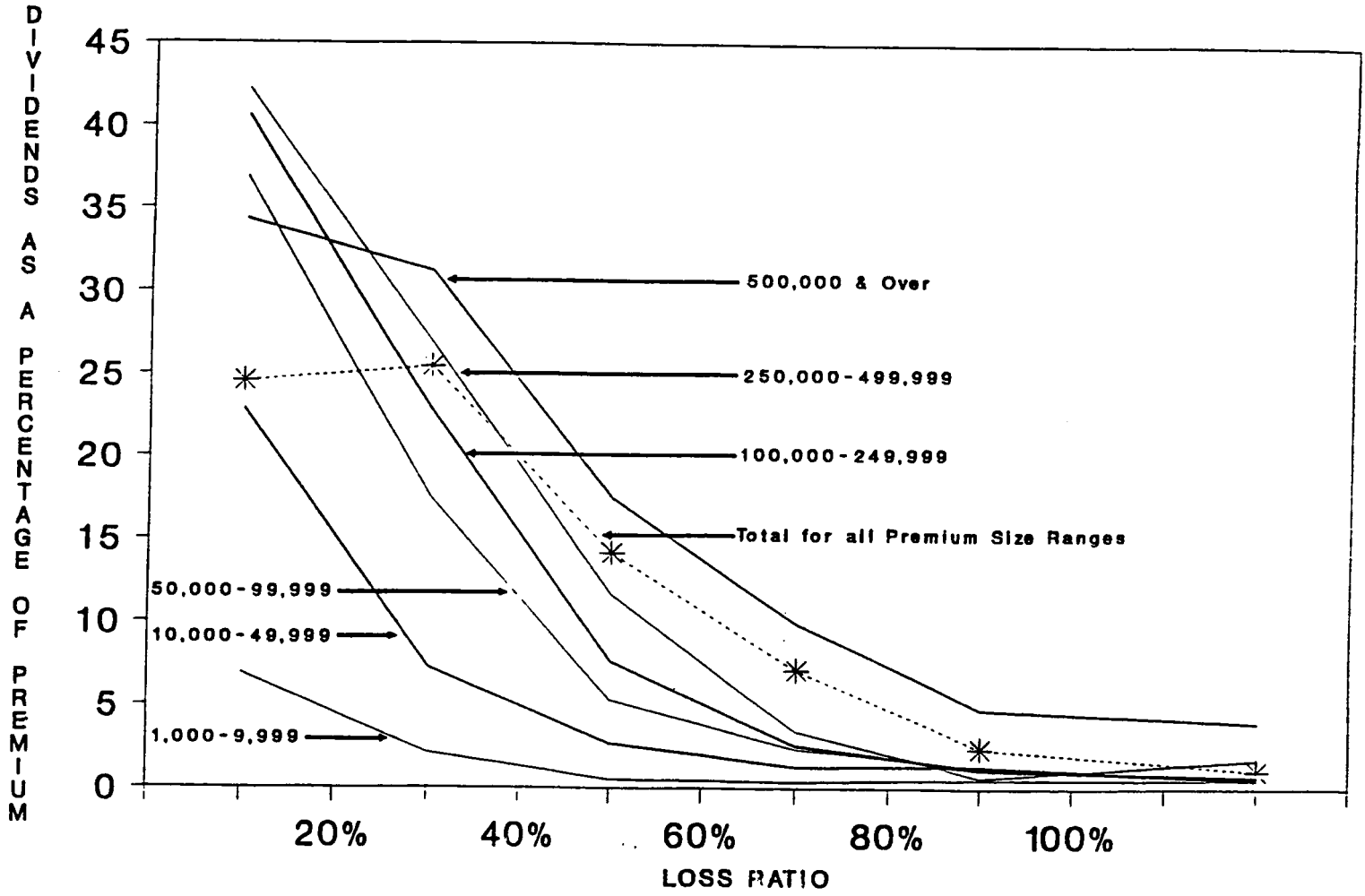
INCURRED DIVIDENDS AS A PERCENTAGE OF PREMIUM

Premium Size	Loss Ratio 0-20%	21-40%	41-60%	61-80%	81-100%	Over 100%	Total
Less than 1,000	0	0	0	0	1	0	0
1,000 - 9,999	7	2	1	0	1	1	6
10,000 - 49,999	23	7	3	1	1	1	16
50,000 - 99,999	37	17	5	2	1	0	20
100,000 - 249,999	41	23	8	3	1	1	18
250,000 - 499,999	42	27	12	3	1	2	17
500,000 and over	34	31	17	10	5	4	19
Totals	25	25	14	7	2	1	17

INCURRED DIVIDEND RATIOS

For Policy Year 1987-Excluding Retrospective Policies

By Premium Size Ranges



SECTION 6.0

ACTUARIAL REPORT REGARDING WORKERS' COMPENSATION SELF-INSURANCE

SUMMARY I-1

OVERALL SYNOPSIS OF SURVEY RESPONSES II-2

EXHIBITS AIS-1

ACTUARIAL REPORT REGARDING
WORKERS' COMPENSATION SELF-INSURANCE

JANUARY 24, 1992

Prepared by
AIS Risk Consultants, Inc.
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908-303-7470

ACTUARIAL REPORT REGARDING
WORKERS' COMPENSATION SELF-INSURANCE

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Memorandum

Item	Section	Pages
Summary	I	1-2
Overall Synopsis of Survey Responses	II	2-7

ACTUARIAL REPORT REGARDING
WORKERS' COMPENSATION SELF-INSURANCE

Exhibits

Item	Exhibit Number
Survey Form Mailed to Self-Insurance Regulatory Agencies	AIS-1, Sheets 1-7
Summary of Self-Insurance Survey Responses	AIS-2
Detailed Responses to Survey Questions	AIS-3, Sheets 1-35
Payments from Self-Insurance - California, 1979-1988	AIS-4, Sheet 1
Payments from Self-Insurance - Countrywide, 1979-1988	AIS-4, Sheet 2
1988 Payments from Self-Insurance - by State	AIS-5, Sheets 1-2

ACTUARIAL REPORT REGARDING
WORKERS' COMPENSATION SELF-INSURANCE

I Summary

AIS Risk Consultants was retained by the California Workers' Compensation Rate Study Commission (WCRSC) to review how self-insurance functions in California, and compare it to other states' programs. In our analysis we have relied upon data and information supplied by the WCRSC, various self-insurance regulatory agencies and other generally accepted sources. While we used our overall knowledge and experience to assess the reasonableness of the information provided, we have not performed an independent audit of the information supplied.

Based upon our review, the following overall observations can be made.

(1) California self-insurance generally operates in a manner similar to that in most other states.

(2) A large percentage of California's workers' compensation benefit payments are made through self-insurance. Self-insurance was responsible for about 30% of all workers' compensation payments in California during 1988. This is an increase from about 24% in 1979.

During 1988, only three states had higher percentages of payments from self-insurance.

Countrywide, 19% of workers' compensation payments came form self-insurance during 1988. This was an increase from about 14% in 1979.

(3) In California, workers' compensation aggregate excess cannot be purchased from an admitted carrier. We found no other state with this requirement. In fact, for many states, it was a requirement that the insurer be an admitted carrier.

A great deal of the information used in this report came from a survey sent to self-insurance regulatory agencies throughout the country. A total of 37 responses, from 33 different states, were received. Five of the responses dealt only with individual self-insurance. Also, another five of the responses dealt only with group self-insurance. Exhibit AIS-1 is a blank copy of the survey form mailed to the self-insurance regulatory agencies. A summary of the yes/no answers received for the survey questions is shown in Exhibit AIS-2. The detailed comments received in response to

specific survey questions is shown in Exhibit AIS-3. Set forth below is an overall synopsis of the responses received.

II Overall Synopsis of Survey Responses

(1) Does your state allow individual self-insurance for: Private Companies / Public Entities

All states which responded indicated that they allowed individual self-insurance for private companies. Based upon other sources, we know of only three states which do not allow individual self-insurance. These are North Dakota, Texas (a law effective 1/1/91 will allow self-insurance as of 1/1/93) and Wyoming.

Only one of the states which responded indicated that they did not allow self-insurance for public entities. In Idaho, public entities are by statute insured through the State Insurance Fund.

The share of loss payments covered by self-insurance for California and countrywide, during the period from 1979 to 1988, is shown in Exhibit AIS-4. The share of loss payments covered by self-insurance during 1988 for each state is shown in Exhibit AIS-5.

(2) Does your state allow group self-insurance for: Private Companies / Public Entities

California allows group self-insurance for public entities, but not for private companies.

Group self-insurance in other states is not as commonly accepted as individual self-insurance. However, it is still allowed by the vast majority of states. Group self-insurance was allowed for private companies in 23 of the 32 states which responded. Public group self-insurance was allowed in 26 of the 32 states which responded.

(3) Is there a filing fee required when applying for permission to self-insurance? If yes, please indicate the amount of the fee.

California charges a $100 fee per application for private self-insurers. No application fee is charged for public self-insurers.

Somewhat more than half the states which responded indicated that they charge an application fee. For those

states that charge, the common range of fees was from around $100 to $500. However, some states charge considerably more. For example, Colorado charges $1,600 and Maine charges $1,000.

(4) Are self-insurers required to post financial guarantees? If yes, how much is required (including any minimum amounts) and how is the determination of the amount made.

In California, only private self-insurers are required to post security deposits. The minimum amount is $220,000 or 135% of the self-insurer's expected future liabilities for payment of compensation, whichever is greater.

Almost every state requires that self-insurers post financial guarantees. The minimum security values ran from $100,000 to $750,000. Many factors go into the determination of the actual amount required. These factors include: (a) excess insurance, (b) previous premiums and losses, (c) risk for the industry, (d) financial stability and (e) various actuarial and mathematical formulas.

(5) Which types of financial guarantees are self-insureds allowed to use.

California allows financial guarantees to take the form of cash, approved securities, surety bonds or letters of credit.

Among other states, surety bonds are the most commonly accepted form of security, with all states accepting this. This is followed in order of acceptance by letters of credit, cash and financial assets. Three states mentioned using a parental guarantee.

(6) Are the financial guarantees required to follow standard forms and conditions?

For California, surety bonds must use state issued forms. Letters of credit (LOC) must follow model LOC language. Also, all parent companies must assume and guarantee the liabilities of their subsidiaries by written agreement and Board resolution in addition to the security deposit itself.

Almost every state had standard forms and conditions that the financial guarantees must follow. Only one state indicated that they would consider forms other than their standard.

(7) Are there any restrictions regarding where a self-insured can obtain financial guarantees from (e.g., solvency requirements for surety company or bank, etc.)?

For California, the surety company has to be admitted by the Department of Insurance. Banks must have top 3 investment grade rating for credit by Moody's or Standard & Poors.

About 80% of the responding states placed restrictions on where the self-insured can obtain the financial guarantee. For a surety bond, the restriction was that the company be licensed to transact surety business in the state. For letters of credit, the typical requirement was that it be issued by a state or federally chartered bank.

(8) Are self-insureds required to maintain excess insurance?

In California, excess insurance is voluntary. No credit is given for it in calculating the security deposit.

About 70% of the responding states required excess coverage. The most common form of excess coverage required was per occurrence, followed by annual aggregate.

(9) Are there any restrictions regarding where a self-insured can obtain excess insurance (e.g., minimum Best's rating)?

For California, self-insureds must give the office of Self Insurance Plans a copy of certificate of insurance for file and report on annual report. Also, aggregate excess cannot be obtained from an admitted insurer.

About 65% of the responding states indicated some limitation on where the excess insurance could be purchased. The most common restriction was that the excess insurer be licensed to do business in that particular state. A few states referred to a minimum Best's rating or financial strength.

(10) Are self-insureds required to pay fees, assessments, etc.

The costs applicable in California cover (a) license fee for office of Self Insurance Plans, (b) user funding assessment for Division of Workers' Compensation and (c)

insolvency assessments for bankruptcies.

Only one of the responding states (for both individual and group) did not have fees, assessments, etc. levied on self-insurers (this state did not consider the second injury fund assessment to be a self-insurer assessment).

(11) For what term does authority to self-insurance last?

In California, authority to self-insurance is continuous until revoked.

For other states, about 45% authorize self-insurance on an annual basis, the other states using authorization on a continuous basis until revoked.

(12) Under what conditions can authority for self-insurance be revoked?

In California, self-insurance can be terminated on a voluntary or involuntary (Labor Code 3702) basis. Labor Code 3702 states in part:

> A certificate of consent to self-insure may be revoked by the director at any time for good cause after a hearing. Good cause includes, among other things, the impairment of the solvency of the employer to the extent that there is a marked reduction of the employer's financial strength, failure to maintain a security deposit as required by Section 3701, failure to pay assessments of the Self-Insurers' Security Fund, frequent or flagrant violations of state safety and health orders, the failure or inability of the employer to fulfill his or her obligations, or any of the following practices by the employer or his or her agent in charge of the administration of obligations under this division: ...

This is similar to the reasons provided for revocation of authority to self-insure in other states. Some of the reasons given for other states were: (a) deterioration in financial condition, (b) not posting required security, (c) not filing required forms, (d) failure to properly adjust claims, (e) failure to pay claims, (f) failure to comply with applicable statutes or regulations, (g) failure to pay assessments and (h) any reasonable cause.

(13) Are actuarial certifications required from self-insureds?

California does not require such a certification.

The vast majority of other states also do not require actuarial certifications.

(14) Are audits required to be performed regarding the self-insured program?

California requires that audits be performed. They are done by a state agency.

About half of the responding states indicated that they require audits of the self-insurers. Of these, the performance of the audits are split about 50% : 50% between state agencies and independent auditors.

(15) Are self-insured service organizations (e.g., claim adjusters) required to meet any standards?

In California, there are standards for self-insured service organizations. They are: (a) must be licensed by office of Self Insurance Plans and (b) qualified persons (by examination) must do self-insured claims.

About 65% of the responding states imposed standards on self-insured service organizations. The most common standard is the licensing or overseeing of claim adjusters.

(16) Are self-insureds required to have a safety program?

In California, there needs to be an effective safety and health program pursuant to Cal/OSHA regulations. Evaluations are done by licensed California professional engineers and a written report is submitted with the application.

About 55% of the responding states indicated that a safety program was required.

(17) Does a guarantee fund exist for self-insureds?

California has such a fund. It operates in accordance with Labor Code 3740 - 3747, "Self-Insurers' Security Fund". The purpose of this Fund is stated as follows, "It is the intent of the Legislature in enacting this article to provide for the continuation of workers' compensation benefits delayed due to the failure of a private self-insured employer

to meet compensation obligations when the employers' security deposit is either inadequate or not immediately accessible for the payment of benefits." Labor Code Section 3701.5 deals, in part, with payments to be made by the Fund when an employer cannot meet the workers' compensation payment obligations.

Just about half the responding states indicated that a guarantee fund existed.

(18) Please provide a description of the process by which your agency determines who is allowed to self-insure; including any minimum requirements (e.g., assets, net worth, payroll, employees, premium, etc.) that self-insureds must meet.

In California, the following process is used:

(a) Public Sector - Complete short application and resolutions of governing board (no qualification required as public sector has right to self insure).

(b) Private sector - Complete 20 page application, meet financial guidelines, post deposit required, provide parental guarantee (if parent exists).

The process described for other states is very similar in general terms. The main concern seems to be with the financial condition of the prospective self-insurer. Other items mentioned were loss history and ability to handle a self-insurance program.

REQUEST FOR INFORMATION REGARDING
WORKERS' COMPENSATION SELF-INSURANCE

(1) Does your state allow individual self-insurance for:

Private Companies Yes _____ No _____

Public Entities Yes _____ No _____

(2) Does your state allow group self-insurance for:

Private Companies Yes _____ No _____

Public Entities Yes _____ No _____

(3) Is there a filing fee required when applying for permission to self-insurance? Yes _____ No _____

If yes, please indicate the amount of the fee.

(4) Are self-insurers required to post financial guarantees? Yes _____ No _____

If yes, how much is required (including any minimum amounts) and how is the determination of the amount made.

(5) Which of the following types of financial guarantees are self-insureds allowed to use.

(A) Trust funds - cash Yes _____ No _____

(B) Trust funds - financial assets Yes _____ No _____

(C) Surety bonds Yes _____ No _____

(D) Letters of credit Yes _____ No _____

(E) Other Yes _____ No _____

If yes, please describe.

(6) Are the financial guarantees required to follow standard forms and conditions? Yes _____ No _____

If yes, please describe.

(7) Are there any restrictions regarding where a self-insured can obtain financial guarantees from (e.g., solvency requirements for surety company or bank, etc.)? Yes _____ No _____

If yes, please describe.

(8) Are self-insureds required to maintain excess insurance? Yes _____ No _____

If yes, which kinds and in what amount?

(A) Per occurrence Yes _____ No _____

Amount _____

(B) Annual aggregate Yes _____ No _____

Amount _____

(C) Per accident per payment year Yes _____ No _____

Amount _____

(D) Other Yes _____ No _____

Amount _____

If yes, please describe.

(9) Are there any restrictions regarding where a self-insured can obtain excess insurance (e.g., minimum Best's rating) Yes _____ No _____

If yes, please describe.

(10) Are self-insureds required to pay fees, assessments, etc. Yes _____ No _____

If yes, please describe.

(11) For what term does authority to self-insurance last?

(A) One Year _____

(B) Continuous until revoked _____

(C) Other (please explain) _____

(12) Under what conditions can authority for self-insurance be revoked?

(13) Are actuarial certifications required from self-insureds? Yes _____ No _____

If yes, how often are they required and who can prepare them (e.g., member of Casualty Actuarial Society, etc.)?

(14) Are audits required to be performed regarding the self-insured program? Yes _____ No _____

If yes, by whom, and what is covered in the audit?

(A) State agency _____

(B) Independent auditors _____

(C) Other (please explain) _____

(15) Are self-insured service organizations (e.g., claim adjusters) required to meet any standards? Yes _____ No _____

If yes, what are the standards?

(16) Are self-insureds required to have a safety program? Yes _____ No _____

If yes, what are the standards for such a program?

(17) Does a guarantee fund exist for self-insureds? Yes _____ No _____

If yes, how does it operate?

(18) Please provide a description of the process by which your agency determines who is allowed to self-insure; including any minimum requirements (e.g., assets, net worth, payroll, employees, premium, etc.) that self-insureds must meet.

(19) Please provide a copy of the reports, filings and forms self-insureds are required to submit.

(20) Please provide a copy and/or citations of the statutes, regulations, rules, forms, policies, etc. that govern self-insurance.

(21) Please provide a copy of the last three annual reports describing self-insurance.

(22) Please fill out the attached form regarding the extent of workers' compensation self-insurance in your state.

(23) Is there any other information that would assist in evaluating the effectiveness of self-insurance as an alternate market for providing workers' compensation coverage.

(24) Please provide the name, address and phone number of the person we can contact regarding this survey.

Name:

Address:

Phone:

Please return this survey to:

Marianne E. Papay
AIS Risk Consultants, Inc.
4400 Route 9 South
Freehold, N.J. 07728
908-303-7470

(22) Please fill out the following table regarding workers' compensation self-insurance in your jurisdiction.

Jurisdiction: _____

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Number of Self-Insureds		Payroll Covered		Losses Paid		Losses Incurred	
Year	Individual	Group	Individual	Group	Individual	Group	Individual	Group
1980								
1981								
1982								
1983								
1984								
1985								
1986								
1987								
1988								
1989								
1990								

WORKERS' COMPENSATION RATE STUDY COMMISSION

Summary of Self-Insurance Survey Responses

State	Response to Question																									
	1a	1b	2a	2b	3	4	5a	5b	5c	5d	5e	6	7	8	8a	8b	8c	8d	9	10	11	13	14	15	16	17
Alabama	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y	N					Y	Y	B	N	N	Y	N	Y
Arizona	Y	Y	Y	Y	N	Y	N	N	Y	Y	Y	Y	Y	N					Y	Y	A	N	N	Y	Y	Y
Arkansas	Y	Y	Y	Y	Y	Y	N	N	Y	N	Y	Y	Y	N					Y	Y	A	N	Y, A,C	Y	N	Y
California	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N					N	Y	B	N	Y, A	Y	Y	Y
Colorado	Y	Y	Y	Y	Y	Y	Y		Y					Y	Y	Y			Y	Y	B	N	N	Y	Y	Y
Connecticutt	Y	Y	Y	Y	N	Y	N	N	Y	N	Y	N	N	Y	Y	N	N	N	Y	Y	A, B	N	N	N	Y	N
Delaware	Y	Y	N	N	N	N	NA	NA	NA	NA	NA	NA	NA	N					N	Y	B	N	N	N	N	N
Georgia	Y	Y	Y	Y	Y	Y	N	N	Y	N	N	Y	Y	Y	Y	Y, N	N		Y	Y	B	N	Y, B	Y, N	Y	Y
Idaho	Y	N	N	N	N	Y	Y	N	Y	N	Y	Y	Y	N					Y	Y	B	N	Y, A	Y	N	N
Illinois	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	N					N		B, C	N	N, B	N	N	Y
Iowa	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N					Y	Y	A	Y	Y, A,B	N	Y	N
Kansas - Group Only			Y	Y	N	N	NA	NA	NA	NA	NA	NA	NA	Y					Y	Y	A, B	N	Y, B	N	Y	N
Kentucky - Indiv Only	Y	Y			N	Y	N	N	Y	Y	Y	Y	N	Y	Y				N	N	A	N	N	Y	N	N
Kentucky - Group Only			Y	Y	N	Y			Y			Y	N	Y	Y	Y			Y	N	A	Y	N	Y	N	N
Louisiana - Indiv Only	Y	Y			Y	Y			Y	Y	Y	Y	Y	Y	Y					Y	A	N	N	Y	Y	N
Louisiana - Group Only			Y	Y	Y	Y			Y			Y	N	Y	Y	Y	N	N	N	Y	B	N	Y, B	Y	N	N
Maine	Y	Y	Y	Y	Y	Y	Y	Y	Y	N		Y	Y	Y	Y	Y			Y	Y	A	Y	N	Y	Y	Y
Mass. - Indiv Only	Y	Y			N	Y			Y			Y	Y	Y					Y	Y	A	N	Y, B		Y	N
Michigan	Y	Y	Y	Y	N	Y	N	N	Y	Y		Y	Y	Y	Y	Y, N	N	N	Y	Y	A	N	N	Y	N	Y
Montana	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	N	Y	Y	A	N	N	Y	Y	Y
Nevada	Y	Y	N	N	Y	Y	N	N	Y	Y	Y	Y	Y	Y					N	Y	B	N	Y, A,B	Y	N	Y
New Hampshire	Y	Y	Y	Y	N	Y	Y	Y	Y			Y	Y	Y	Y	Y			N	Y	B	N	Y, A	Y	Y	N
New Jersey	Y	Y	N	Y	N	Y			Y			Y	Y	Y					Y	Y	B	N	N	N	N	N
New Mexico - Indiv Only	Y	Y			Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	B	N	Y, A	Y	Y	Y
New Mexico - Group Only			Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y			Y	Y	B	Y	Y, A	Y	Y	N
New York	Y	Y	Y	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y				Y	Y	B	N	Y, A	Y	Y	Y
Oklahoma	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y	N	Y							A		Y, B	Y	Y	Y
Pennsylvania	Y	Y	N	N	Y	Y	N	N	Y	N	N	Y	Y	Y	N	N	Y	N	N	Y	A	N	N	N	N	N
South Carolina	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y	Y					Y	Y	B	N	Y, A	N	N	N
South Dakota	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N					Y	Y	A	N	N	N	N	N
Tennessee	Y	Y	Y	Y	Y, N	Y	N	Y	Y	N	N	Y	Y	Y	Y	N			Y	Y	B	N	Y, B	Y	Y	N
Utah	Y	Y	N	N	Y	Y	N	N	Y	Y	N	Y	Y	Y	Y	Y	Y		N	Y	A	N	N		N	Y
Vermont	Y	Y	Y	Y	N	Y	Y	N	Y	Y	N	Y	Y	Y	Y	N	N	N	Y	Y	A	N	N	N	Y	N
Virginia - Indiv Only	Y	Y			Y	Y	N	N	Y	N	Y	Y	N	N					N	Y	B	N	N	N	Y	N
Virginia - Group Only			Y	Y	N	Y			Y		Y	Y	Y	Y	N	Y	Y	N	Y	Y	B	N	Y, B	Y	N	Y
Washington	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	N					N	Y	B	N	Y, A	Y	Y	Y
Wisconsin	Y	Y	N	N	Y	Y, N	Y		Y			Y	Y	Y, N					Y	Y	A	N	Y, B	N	Y	Y
Totals:																										
Yes	32	31	23	26	21	35	14	7	35	19	15	33	27	26	17	12	4	1	23	33	0	4	19	23	21	18
No	0	1	9	6	17	3	14	18	0	8	8	1	7	12	2	6	6	7	12	2	0	32	18	13	16	19
NA	0	0	0	0	0	0	2	2	2	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0
A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	11	0	0	0
B	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21	0	11	0	0	0
C	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0

REQUEST FOR INFORMATION REGARDING
WORKERS' COMPENSATION SELF-INSURANCE

(1) Does your state allow individual self-insurance for:

Private Companies **Yes _____ No _____**

Public Entities **Yes _____ No _____**

Idaho - Public entities are by statute insured through the State Insurance Fund.

New Jersey - Public entities are not under the oversight of the DOI.

(2) Does your state allow group self-insurance for:

Private Companies **Yes _____ No _____**

Public Entities **Yes _____ No _____**

Alabama - Group self-insurance is allowed for some public entities.

Idaho - For private companies, the only form of "group insurance" that has been allowed are the reciprocal insurance carriers: Workers' Compensation Exchange, Truckers Insurance Exchange, and Associated Loggers Inc.

New Jersey - Municipalities, Community Colleges, Hospitals may form pools.

New Mexico (Group) - Section 52-6-2

Washington - For public entities only school districts and hospitals may form pools.

(3) Is there a filing fee required when applying for permission to self-insurance? Yes _____ No _____

If yes, please indicate the amount of the fee.

California - Private self insurers-$100/application.
Public self insurers-no fees.

Colorado - $1600 Individual

Georgia - $500

Illinois - $500 non-refundable application fee

$500 renewal fee for every year after approval

These fees are paid for each and every separate legal entity under the self-insurance program. ($500 for each one).

Iowa - $100

Louisiana (Group) - $1500

Louisiana (Individual) - There is a $100 application fee and a $100 renewal fee.

Maine - $1000

Massachusetts (Individual) - No for individual corporations who self-insure.

Nevada - $200 non-refundable fee

New Jersey - A proposed regulation will impose a $1000 fee.

New Mexico (Individual) - $150

New Mexico (Group) - Section 52-6-5, the group applying for group self-insurance must submit a $500 non-refundable filing fee.

Oklahoma - $500

Pennsylvania - $100/applicant. Applications are required for each parent company as well as each subsidiary seeking exemption.

South Carolina - $100 Individual
$ 25 Group Member

South Dakota - $600

Tennessee - No-we don't have fee for individual self-insurers
Yes-we have a $500 filing fee for groups

Utah - Initial application - $900
Renewal fee (yearly) - $500

Virginia (Individual) - $200

Virginia (Group) - A fee of $300 is required upon licensure.

Washington - $250

Wisconsin - $300

(4) Are self-insurers required to post financial guarantees? Yes _____ No _____

If yes, how much is required (including any minimum amounts) and how is the determination of the amount made.

Alabama - Amount required-minimum security by administrative code is $200,000. Can by as high as $4 or $5 million.

Determination of amount:

1. Excess insurance, if any, and retention amount
2. Previous years premiums and losses
3. Risks involved for that industry
4. Financial stability
5. An amount is determined by a combination of the foregoing i.e. the higher of excess insurance retention or cumulative sum of two highest years in premiums or losses.

Arizona - Option I-Securities must be greater than $100,000. Option II-Securities equal to 125% of the total outstanding liability (minimum amount is $100,000).

Arkansas - All private entities are required to post either a surety bond or CD's that are drawn on an acceptable Arkansas financial institution. The minimum security requirement is $200,000. The prescribed deposit is set by thorough review of the certified financial statement, loss history and previous modification factors.

California - Only private self insurers are required to post security deposits if this is what you mean by "financial guarantees."

Colorado - Min- $300,000 bond or more depending upon exposure. Parental indemnification.

Connecticut - Surety bonds in the amount of the self-insurer's retention, determined on an individual basis.

Georgia - $250,000 set by statute

Idaho - Regulations Governing Self-Insured Employers - Self insured employers shall maintain a deposit with the Idaho State Treasurer in the form of cash, U.S. obligations, Idaho Municipal bonds, or a surety bond in

the form provided in the amount of $50,000, plus 5% of the employer's average annual payroll in the State of Idaho for the three preceding years, not in excess of $10,000,000 if such employer was originally approved by the Commission subsequent to April 30, 1984 and $5,000,000 if such employer was originally approved by the Commission prior to May 1, 1984. In addition thereto, the self-insured employer shall deposit additional security in an amount equal to all outstanding and unpaid awards of compensation under the Workmen's Compensation Law. All security deposited by the self-insured employer shall be maintained as a trust fund exclusively for the purpose of securing payments by the employer of the compensation required by the Workmen's Compensation Law. Any withdrawal of security deposited hereunder must be approved by the Commission.

Minimum	
Basic Deposit	$ 50,000.00
Minimum Average Annual Payroll $4,000,000 @ 5%	200,000.00
Outstanding Awards (Factored at zero)	.00
TOTAL	$250,000.00

Illinois - The minimum amount of security required is $200,000.

Iowa - Minimum surety bond - $200,000. Determined from a grading of a company's financials applied to its last three years of work comp experience.

Kentucky (Individual) - $150,000 min. or 3-yr. claims avg., whichever is greater

Kentucky (Group) - $250,000 min surety or .05% of annual premium collected, whichever greater.

Louisiana (Group) - $100,000

Louisiana (Individual) - The minimum security that Louisiana requires is $100,000. The total incurred for the last three years of loss data is averaged and then multiplied by a factor of 110%. If this figure is larger than the $100,000, we would require the larger.

Maine - See Title 39.MRSA and Rule 250.

Massachusetts (Individual) - for individual corporations - losses incurred and losses to be incurred.

Michigan - $100,000 minimum for private employers. Incurred amounts are discretionary.

Montana - The department may waive this requirement.

The greater of: $250,000 or an avg. of the workers' comp liabilities incurred by the employer in MT for the past 3 calendar years.

Nevada - Minimum of $100,000 - actual is based on a formula. Securities may be in the form of TCD, Letter of Credit or surety bond.

New Hampshire - Minimum $250,000. Between 1.5 to 2 times future expected reserves.

New Jersey - Current minimum is $100,000. Regulation proposes $500,00 minimum. Current bonds are generally self-insured retention on excess policy plus average losses over last three years.

New Mexico (Individual) - Surety bond or letter of credit - minimum amount $200,000. The amount of surety is determined by the director and is based on an audit review of past losses and financial conditions of the applicant. The parental guarantee is an additional requirement of all subsidiaries.

New Mexico (Group) - Section 52-6-5 B-2. Security in a form and amount prescribed by either a surety bond or letter of credit. A certificate of deposit is acceptable if a contract is agreed upon between the group and legal counsel of workers' compensation administration.

New York - Section 316.1 of the Rules and Regulations stipulate that the minimum exposure deposit required be at least:

a) The product of the statutory maximum weekly compensation rate for total disability multiplied by 52, multiplied by 30; or

b) One and one-half the self-insurer's retention, as specified on the certification of excess reinsurance contracts filed with the Chair, but in no event less than $200,000.

Security Deposits are computed using a complex actuarial formula.

Pennsylvania -
- minimum $200,000

- Above minimum, security requirements are established through a review of workers' compensation losses over the past 3 to 5 years, the reserves established, and the financial status of the organization. Security

requirements are most often set for new self insureds at the total of the incurred insured losses for the past three years. For renewal applicants, security is set at least at the level of current reserves.

Data is not maintained separately for public and private organizations.

South Carolina - Minimum $250,000
Individuals - 1.5% of average of last three years claims paid
Groups - .75% of average of last three years claims paid

South Dakota - SDCL 62-5-10:
...in a total amount equal to the greater of
(1) Two hundred fifty thousand dollars; or
(2) Twice the amount of compensation claims paid by the employer during the preceding calendar year; or
(3) The amount designated by the employer as reserve for workers' compensation claims

Tennessee - Minimum amount $250,000.
We make a judgment call based on the type of industry, total size of operations in the state, loss experience, financial status, and the excess workers' comp retention.

Utah - Bond or letter of credit only accepted for financial guarantees with a $100,000 minimum. Public entities may request a waiver of the financial guaranty.

Vermont - As a general rule private corporations are required to post a bond or LOC at the greater of their retention (Excess) level or the AEC level. This is a general rule. The statute and rules give our commissioner great latitude in setting security requirements and in the approval or disapproval of self-insurers (that is private self-insurers). Public self-insurers are not regulated by our department and are therefore not required by this department to post anything.

Virginia (Individual) - Minimum of $750,000. Additional amounts based on financial strength, industry risk, and general claims experience.

Virginia (Group) - Insurance Regulation 16 requires deposit of $250,000

Washington- The minimum surety is $290,000. Surety is determined annually by means of an actuarial evaluation of reserves reported by self-insurers for each accident year. There is no maximum. Surety covers 100% of the estimated liability.

Wisconsin - Minimum - $500,000. Depends on claim value and financials.

(5) Which of the following types of financial guarantees are self-insureds allowed to use.

(A) Trust funds - cash	**Yes** _____	**No** _____
(B) Trust funds - financial assets	**Yes** _____	**No** _____
(C) Surety bonds	**Yes** _____	**No** _____
(D) Letters of credit	**Yes** _____	**No** _____
(E) Other	**Yes** _____	**No** _____

If yes, please describe.

Alabama - As of Jan. 1, 1990 all individual self-insurers belong to the Alabama Workmen's Compensation Self-Insurers Fund. Securities in place before Jan. 1, 1990 were CD's, LOC's, surety bonds, and U.S. Treasury Notes and Bonds.

Arizona - Bonds of the United States or Federal Land Banks or of the state of Arizona.

Arkansas - CD's must be issued by an acceptable Arkansas bank.

California - Approved securities (state, local or federal bonds, notes, etc.) comes under (E) Other.

Connecticut - Letters of credit are no longer allowed. Parental guaranty to assume the liabilities of subsidiary companies covered under a parent's authorization to self-insure. Required in addition to a surety bond.

Delaware - N/A

Idaho -
Surety Bonds - Specific penalty bonds on form prescribed.

Other - U.S. Treasury Bonds and Notes, Idaho Municipal Bonds, Bank Time Certificates of Deposit on an Idaho Bank assigned to the Idaho State Treasurer.

Illinois - The trust fund or escrow account with financial assets can only be U.S. Government Securities or Illinois Negotiable bonds.

Kansas (Group) - N/A

Kentucky (Individual) - Escrow KY covering certificates of deposit or U.S. Treasury Bills/T. Notes.

Louisiana (Group) - Treasury bills, Louisiana bonds, and C.D. with Louisiana bank

Louisiana (Individual) - Surety bonds, letters of credit and CD's - *see Section 1709(A,B,&C).

Maine - See Title 39 MRSA

Massachusetts (Individual) - Negotiable securities.

Nevada - TSDs

New Mexico (Individual) - Other is parental guarantee. The parental guarantee is an additional requirement for all subsidiaries.

New Mexico (Group) - Certificates of deposit only by contract between the group and legal council of workers' compensation administration.

New York - Investment Grade Securities and cash

Oklahoma - Certificate of Deposit, Approved government securities

Pennsylvania - In most cases a surety bond is required. New regulations have been drafted to permit the use of a letter of credit for security purposes.

South Dakota - Certificate of deposit, approved government securities.

Tennessee - We allow for surety bonds and also U.S. Gov't Securities that don't have principal pay down, also we accept certificates of deposit from Tennessee banks.

Virginia (Individual) - Parental guarantees may be required.

Virginia (Group) - Securities, surety bonds or endorsement on excess insurance policies are allowed. They must be on deposit with the State Treasurer.

Washington - Can use surety bonds only if self-insurer has a net worth of $500 million.

(6) Are the financial guarantees required to follow standard forms and conditions? Yes _____ No _____

If yes, please describe.

Alabama - CD's, LOC's must be made to the Director of Industrial Relations. Surety Bonds & LOC's must be as shown in a specified form. U.S. Treasury notes and bonds must be assigned to the Director of Industrial Relations.

Arizona - Bonds must be on forms prescribed by the commission. Letters of Credit must contain certain requirements of the Commission.

Arkansas - All security documents must be made payable to the Arkansas Workers' Compensation Commission and are held in trust for the self-insurer.

California - Surety bonds must use state issued forms. LOC's must follow model LOC language. Also all parent companies must assume and guarantee the liabilities of their subsidiaries by written agreement and Board resolution in addition to the security deposit itself.

Connecticut - We provide sample bond forms.
We will review all other text for acceptability.

Delaware - N/A

Idaho - There must also be a custody agreement between the self-insurer and the Idaho State Treasurer in place prior to submission of securities.

Illinois - The forms for security instruments are provided.

Kansas (Group) - N/A

Kentucky (Individual) - We have a form for our L.C. and bond.

Kentucky (Group) - Best's B+ XII or A IX.

Louisiana (Group) - Cannot be released or substituted for without permission of DOI.

Louisiana (Individual) - This office has its own for surety bonds and LOC's. The CD's that are given as security must have special words as to the payee.

Maine - Provides the bond form.

Massachusetts (Individuals) - Commonwealth form for surety bond.

Montana - See ARM 24.29.702D.

Nevada - Wording for Letters of Credit are supplied by the Nevada State Treasurer's office. Must contain a 90 day cancellation clause. Must be on a federally insured financial institution or confirmed by one.

New Hampshire - Applicants use state of N.H. forms.

New Jersey - Form provided.

New Mexico (Individual) - Evergreen clause and letter of credit on a New Mexico financial institution.

New Mexico (Group) - Section 52-6-5 B-2

1) Surety bond and security deposit in a form and amount prescribed by the director.

2) Certificate of deposit by contract only.

New York - Securities rated as Investment Grade in accordance with the State Banking Law. The formats of the Surety Bond and Letters of Credit are prescribed by the Chairwoman of the Workers' Compensation Board.

Pennsylvania - Standard surety bond required.

South Carolina - Surety Bond, Letter of Credit

Tennessee - Surety bonds must be on our bond forms. Securities & CD's must be pledged to the Commissioner of Insurance

Utah - Bond Standard Form. Letter of Credit Form & Memorandum of Understanding.

Vermont - We have specific forms that we require.

Virginia (Individual) - There are required forms both for the surety bond and for the parental guarantee.

Virginia (Group) - Standard Surety Bond

Washington - We provide the surety forms for bonds, escrow accounts and letters of credit.

Wisconsin - Trust agreement

(7) Are there any restrictions regarding where a self-insured can obtain financial guarantees from (e.g., solvency requirements for surety company or bank, etc.)? Yes _____ No _____

If yes, please describe.

Alabama -
1. Surety companies must be "admitted" or "licensed" in Alabama before a surety bond is accepted.

2. Banks must be members of the FDIC. Savings & Loans, credit unions, must be approved by and members of the appropriate federal regulatory agency.

Arizona - Letters of Credit must be issued by a federal or Arizona state chartered bank with an Arizona branch office or correspondent bank.

Arkansas - If a surety bond is used, the Surety carrier must be an admitted and approved Corporate Surety. Licensing of insurance carriers is done through the Arkansas Insurance Commission.

California -
1. Surety company has to be admitted in California with Dept of Insurance.

2. Banks must have top 3 investment grade rating for credit by Moody's or Standard & Poors.

Delaware - N/A

Georgia - Carriers authorized to write surety lines of coverage in Georgia.

Idaho -
Surety Bonds - (Preferred form of security) Issued only by carriers authorized to write surety in Idaho.

U.S. Treasury Bonds & Notes (book entry) State of Idaho Bank authorized to accept book entry U.S. Treasury securities (Currently First Security Bank of Idaho-Boise)

State of Idaho Bonds

Certificates of Deposit - Must be issued by an Idaho Bank, assigned to the Idaho State Treasurer

Illinois - Banks must have trust authority in Illinois for escrow or trust accounts.

Kansas (Group) - N/A

Louisiana (Individual) - *See section 1709. The banks that are intending to write LOC's for this office must file a bank fact sheet. Information from the fact sheet will determine if this office will allow the bank to

write such an instrument.

Maine - See Title 39 MRSA

Massachusetts (Individual) - Surety bonds must be written with a company authorized to conduct the business of suretyship in Massachusetts.

Michigan - Surety companies must be admitted to do business in Michigan. LOC must be from state chartered bank, federally chartered bank or confirmed by one of the preceding if issued by any other type of bank.

Montana - Surety bonds only from companies certified by the U.S. Dept. of Treasury as "Company Holding Certificates of Authority as Acceptable Sureties on Federal Bonds and as Acceptable Reinsuring Companies."

Nevada - Must ALWAYS be a federally insured Nevada institution.

New Hampshire - N.H. list of suitable banking facilities and bond.

New Jersey - Surety company must be authorized to do surety in New Jersey.

New Mexico (Individual) - Must be financially solvent. New Mexico financial institution.

New Mexico (Group) - Section 52-6-5 B-2

1) Surety Bond - Must by issued by a corporate surety company authorized to transact business in this state.

2) Security Deposit - Shall be limited to bonds or other evidences of indebtedness issued, assumed or guaranteed by the United States of America or by an agency or instrumentality there of.

3) Certificates of Deposit - Federally insured bank.

New York - Surety company must be authorized to write such line by State Department of Insurance. Bank must appear on qualified list issued by National Association of Insurance Commissioners or meet requirements to appear on such list.

Pennsylvania - Bond must be written by a licensed surety company whose Pennsylvania per risk retention limit exceeds the penal sum of the bond.

South Carolina - Surety Company: licensed S.C. carrier Letter of Credit: Issued or confirmed by bank chartered

in S.C. or federally chartered with S.C. branch

South Dakota - SDCL 62-5-10...on a form required by the department, a bond, written by a surety company authorized by the division of insurance to write surety bonds...
SDCL 62-5-11

Tennessee - Surety bonds can only be obtained from insurance companies licensed in the state of TN. Also, the company must be in good standing with the department. Banks must be members of the Federal Reserve System, and part of the FDIC.

Utah - Letter of Credit restrictions.

Vermont - Bonds from a licensed VT company. LOC's must be approved and must be a U.S. bank.

Virginia (Group) - Licensed surety company or excess insurer. Only certain types of investments are allowed - see Insurance Regulation 16.

Washington - Letters of credit are only accepted from banks in the state of Washington and those which meet our financial requirements. The financial strength of surety providers is subject to our evaluation.

Wisconsin - Surety companies must be licensed in Wisconsin.

(8) Are self-insureds required to maintain excess insurance? Yes _____ No _____

If yes, which kinds and in what amount?

(A) Per occurrence Yes _____ No _____

Amount _____

(B) Annual aggregate Yes _____ No _____

Amount _____

(C) Per accident per payment year Yes _____ No _____

Amount _____

(D) Other Yes _____ No _____

Amount _____

If yes, please describe.

Arkansas - If required, the minimum excess insurance requirements shall be determined by the Commission.

California - Excess coverage is voluntary. No credit is given for it in calculating the security deposit.

Colorado - Per occurrence amount-conditional. Annual aggregate amount-allowed, amount conditional.

Connecticut - per occurrence amount- 10mm to statutory depending on exposure

Georgia - Per occurrence amount - at least one million. Annual aggregate amount - statutory.

Idaho - Not currently required, but strongly recommended.

Illinois - Excess Insurance is not required but sometimes is highly recommended.

Iowa - Not generally, but if a company has minimum financial qualifications or is in a high risk industry, we have the authority to require excess coverage.

Kansas (Group) - Group self-insureds are required to maintain excess insurance in accordance with K.S.A. 44-582(m) or K.S.A. 12-2618(h). No specific amounts are prescribed by law.

Kentucky (Individual) - Coal companies only. Per occurrence amount-$100,000 per man underground at any one time.

Kentucky (Group) - Per occurrence amount-$2 mil. Annual aggregate amount-$1 mil or 50% of prem, whichever greater.

Louisiana (Group) - per occurrence amount-$2,000,000
annual aggregate amount -$2,000,000

Louisiana (Individual) - per occurrence amount-$250,000 (min). *See section 1713 of Title 40, Chapter 17.

Maine - See Title 39 MRSA

Massachusetts (Individual) - Excess insurance is negotiated with the Department.

Michigan - Per occurrence amount-discretionary.
Annual aggregate-discretionary.
Annual aggregate amount-discretionary.

Montana - per occurrence amount - no specific amount
annual aggregate amount - no specific amount

Nevada - The limits are per the self-insured's choice. We do require an S.I.R. minimum of $100,000.

New Hampshire - There shall be no gap between the excess coverage and the guarantee.

New Jersey - Current do not require specific type or amount.

New Mexico (Individual) -
per occurrence amount - $250,000.
annual aggregate - $250,000.
per accident per payment year - $250,000.
other(specific) - $250,000.

The majority of our self-insurers purchase occurrence excess insurance; however, a small percentage have purchased either annual aggregate, accident, or specific excess insurance. Our statutes do not specify the type of excess insurance required.

New Mexico (Group) - per occurrence amount - $250,000
per aggregate amount - $1,000,000

New York - per occurrence amount-flexible
Requirement may be waived by Chairwoman, if supported by appropriate financial data.

Pennsylvania - Required in certain cases. Per occurrence amount - left to the discretion of the applicant. Per accident per payment year- $100,000 - $150,000 per accident per year retention. Although self-insureds are not universally required to maintain excess insurance, many are individually required to obtain excess insurance as a condition of being granted self-insured status. For those applicants who are not required to obtain excess, excess is never-the-less encouraged.

South Carolina - Specific coverage. Aggregate coverage upon review

South Dakota - Excess insurance is expected and may be required

Tennessee - per occurrence amount-different amounts negotiable. We sometimes require aggregate coverage but

the majority of our S-I companies do not have it. The retention and limits are negotiable.

Utah - All of the above are. Each entity is evaluated separately.

Vermont - per occurrence amount-statutory

Virginia (Individual) - Excess coverage is considered as part of the application review process, and once in place is to be maintained.

Virginia (Group) - Annual aggregate amount-at least $5,000,000 above 90% to 100% attachment point.
Per accident per payment year amount-at least $5,000,000 above $250,000 to $400,000 attachment point

Wisconsin - Note: It usually is a form of specific per occurrence.

(9) Are there any restrictions regarding where a self-insured can obtain excess insurance (e.g., minimum Best's rating) Yes _____ No _____

If yes, please describe.

Alabama - Excess insurance carrier must be an "admitted/licensed" for that business in this state before they will be recognized.

Arizona - Companies authorized by the Department of Insurance to sell excess insurance.

Arkansas - Please see Part 1, D of rule 5. This section outlines the requirements that a writer of excess insurance must meet. All policies must be written by a recognized admitted or approved carrier that is acceptable by this Commission.

California - Must give Self-Insurance Plans (SIP) a copy of certificate of insurance for life and report on annual report.

Colorado - Must be Colorado admitted carrier.

Connecticut - Connecticut licensed workers' compensation carrier.

Georgia - Must be licensed to write in Georgia.

Idaho - Insurance carrier writing excess insurance must have authority to write excess insurance in the State of

Idaho.

Iowa - Insurer has to be licensed in Iowa or on the "White List."

Kansas (Group) - Group self-insurers are required to obtain their excess insurance through companies licensed to transact business in Kansas.

Kentucky (Group) - Best's A IX of B+ XII

Louisiana (Individual) - *See section 1713.

Maine - See Title 39 MRSA

Massachusetts (Individual) - Must be written with a company authorized to conduct this business in Massachusetts.

Michigan - Aggregate must be from admitted company.

Montana - Best's rating of A+, A or B+ required

Nevada - Must be a company licensed to do business in Nevada. Also must be countersigned resident agent

New Jersey - Company must be authorized in New Jersey.

New Mexico (Group) - Section 52-6-4 H. Excess insurance must be in a form, in an amount and by an insurance company acceptable to the director.

New York - Insurer must be authorized to write such line by Insurance Department. Form of Policy must be approved by Insurance Department.

South Carolina - S.C. licensed carriers

South Dakota - SDCL 65-5-2

Tennessee - Insurance carrier must be a licensed company in the state and in good standing. Although we don't go by minimum Best's rating, we only accept those who have exceptional financial strength.

Utah - However, the Commission reviews all excess carriers each year based on Best ratings.

Vermont - Must be a licensed VT carrier approved by Vermont Banking, Insurance and Securities.

Virginia (Group) - Licensed insurer or approved surplus lines insurer.

Wisconsin - Company must be licensed in state.

(10) Are self-insureds required to pay fees, assessments, etc. Yes _____ No _____

If yes, please describe.

Alabama - Assessments-only by the Alabama W.C. Self-Insurers Guaranty Association which in turn guarantees the security amount set by this division.

Arizona - 3% Administrative Fund Tax, 1.5% Special Fund Tax.

Arkansas - There is a one time application fee of $100. There is also a annual tax assessment on all WC policies issued in Arkansas. The maximum tax would be calculated at 3% of the manual premium calculation. The assessment for 1991 will be 2.25%.

California -
1. License Fees for SIP
2. User Funding Assessments for Div of W/C
3. Insolvency Assessments for bankruptcies.

Colorado - $1600 application s-i admn-fund. 4.8% prem equiv. tax for spl. funds & div. or w.c. administration.

Connecticut - Based on total paid losses in the previous calendar year; Administrative - 4% pro rata, Second Injury Fund - up to *5% whenever the fund is below $1mm.
*Multiple assessments/yr allowed.

Delaware - 1 % assessment is due January 30 and October 1 of each year. A special assessment can be collected if the fund gets below $750,000.

A tax of 1% is collected April 1, June 15, September 15, and March 1 of the following year.

Georgia - Administration of Board, Administration of Subsequent Injury Trust Fund, Self-Insurers Guarantee Trust Fund.

Idaho - Semi-Annually a self-insured employer is required to compute a semi-annual premium for workers' compensation insurance as using the current NCCI classifications and rates, factor a 2% premium tax and submit the tax report and tax payment to the Industrial Commission. The reports and payments are due not later than March 3, and July 31 each year for the preceding six months periods. (Form 1099 workers' compensation non-insured contractors must also be reported in the

salary figures and premium taxes computed)

Illinois - The assessments and fees to be paid to the workers' compensation funds are handled in Chicago. The person to contact is Chuck Kusar at 312/814-6625. He is the Chief Financial Officer for the Industrial Commission.

Iowa - $100 - application fee, $100 certificate fee, Assessment for Second Injury Fund.

Kansas (Group) - Group self-insurers are required to finance the expense of the regulation of pools as set forth in K.S.A. 44-587 or K.S.A. 12-2623. The pools are also required to pay the directors' administrative assessment to support the administrative functions of the Division of Workers' Compensation and pay an assessment to the Kansas Workers' Compensation Fund (Second Injury Fund) as set forth in K.S.A. 44-589(a) or K.S.A. 12-2625(a). Lastly, group-funded workers' compensation pools are also required to pay a 1% premium tax annually as set forth in K.S.A. 44-588 or K.S.A. 12-2624.

Kentucky (Individual) - With exception of 17% special fund assessment of simulated premium pursuant to statutory formula - for funding of second injury fund.

Kentucky (Group) - With exception of 17% special fund assessment of premium collected -- for funding of second injury fund.

Louisiana (Group) - In accordance with their agreements among themselves.

Louisiana (Individual) -

1. Budgetary assessment- This assessment is approximately 2.5% times the prior year paid indemnity benefits.

2. Second Injury Fund Assessment - The current assessment rate equals 2% of the workers' compensation manual premium for the preceding calendar year.

Maine - See Title 39 MRSA

Massachusetts (Individual) - All SI's must pay an annual assessment of "about" 2% manual premium. This assessment will vary from year to year.

Michigan - Fees on assessments are based on prior year indemnity payout and are paid into the Second Injury Fund, Silicosis, Logging, and Dust Disease Fund,

Self-Insured Security Fund and Safety Education and Training Levy.

Montana - Rehabilitation Assessment, Subsequent Injury Assessment, and Administrative Assessment

Nevada - Self-insureds are billed for their insolvency fund assessment of .0025 of the current security deposit.

New Hampshire - Administration fund, special fund for active cases, second injury fund.

New Jersey - There is a second injury fund assessment by the Department of Labor. The proposed regulation requires payment for a risk assessment report. Proposed legislation will create a guaranty fund.

New Mexico (Individual) - An assessment is paid to both the subsequent injury fund and self-insureds' guarantee fund based on a percentage of the paid claims.

New Mexico (Group) - An irrevocable application of $500.

New York - Subject to all assessments required of Insurance Carriers, Special Assessment against private self-insurers to pay for costs of administering self-insurance program. Private self-insurers are also assessed to reimburse the Workers' Compensation Board for expending administrative funds to pay benefits in cases where security deposits were insufficient.

Pennsylvania - Self-insureds pay three prorata assessments annually based on the total workers' compensation losses paid in the previous year. The assessments are for the Administration Fund; Subsequent Injury Fund, and Supersedeas Fund.

South Carolina - Self-insurance tax and second injury fund assessment.

South Dakota - SDCL 62-4-35

Tennessee - 4.4% Premium Tax

Utah -Yearly premium tax of up to 8% of what their manual premium would have been for the Employers' Reinsurance Fund (perm totals), Uninsured Employers Fund and for General Revenue.

Vermont - 1% Workers' Compensation Administration Fund

Assessment of all losses incurred. $500 fee to second injury fund fee for deaths.

Virginia (Individual) - Assessment is annual and based on a percentage of the calculated manual premium--15/16 of a percent for this year.

Virginia (Group) - Maintenance tax to both the State Corporation Commission's Bureau of Insurance and the Virginia Workers' Compensation Commission.

Washington - Self-insurers pay quarterly assessments as follows:

- Administration which pays the cost of the program and is based on so many cents per dollar of reported claims expense

- Second Injury Fund which provides relief from costs of claims which occur after a worker's pre-existing condition. Per dollar of claims expense.

- Supplemental Pension Assessment-for cost of living increases in indemnity benefits. This assessment is based on the number of worker hours reported. The worker may be charged for one half of this assessment.

Wisconsin -

1. Assessment for second injury fund. Based on certain injuries.
2. Assessment for division operating budget.
3. Assessment for other bankrupt self-insurers (has never been enforced as yet)

(11) For what term does authority to self-insurance last?

(A) One Year _____

(B) Continuous until revoked _____

(C) Other (please explain) _____

Connecticut - Continuous until revoked for muncipalities only.

Delaware - Self-Insurance will not be revoked unless the payroll classification forms are not submitted by January 30 of each year. A renewal certificate is sent every December to cover the next year.

Illinois - The term is continuous until revoked, however, the privilege is reviewed in a renewal process every year.

Kansas (Group) - Group-funded workers' compensation pools licensed under K.S.A. 44-581, et seq. receive one year Certificates of Authority expiring on April 30 of each year. Municipal group-funded pools licensed under K.S.A. 12-2616, et seq. writing workers' compensation coverage are issued continuous certificates which are valid unless revoked.

Kentucky (Individual) - Must seek renewal at year by filing new appl. & cert'd audit, etc.

Kentucky (Group) - Must file annually for re-cert.

Louisiana (Individual) - Each self-insured is re-evaluated each year to see if they are still in good standings.

Massachusetts (Individual) - Individual corporations are licensed annually.

New Jersey - Proposed regulation changes to one year.

New Mexico (Group) - The group certificate of approval remains in effect until terminated at the request of the group or revoked by the director pursuant to provisions of section 52-6-23 NMSA 1978.

South Dakota - September 1 to August 31

(12) Under what conditions can authority for self-insurance be revoked?

Alabama - Financial reasons, failure of the employer to faithfully discharge his obligations according to the agreements contained in the application to self-insure, or for continued violation of some reasonable rule or regulation prescribed by the Director of Industrial Relations.

Arizona - R4-13-212

Arkansas -
1. A deterioration of a company's financial statement.
2. Not posting prescribed securities.
3. Non-filing and payment of required annual forms and taxes.

California -
1. Voluntary Revocation
2. Involuntary - See Labor Code 3702

Colorado - Default

Connecticut - Failure to adjust claims with due diligence, failure to provide requested security.

Delaware - If the payroll classification forms are not returned by January 30, the Board may, upon 60 days notice and a hearing to the employer, revoke the certificate upon presentation of satisfactory evidence for such revocation. After the expiration of 1 year from such revocation, the Board may grant a new certificate to the employer upon his petition. Section 2375 of the Workers' Comp. Law.

Georgia - Failure to pay claims.

Idaho -
1. Failure to comply with the Regulations Governing Self-Insured Employers

2. Financial Insolvency (Financial reports to be submitted annually for review)

Illinois - *Lack of security on file.
*The minimum requirements are not met according to Admn. Code 50 Part 7100.70.

Iowa - See 1AC 191-57.11

Kansas (Group) - Certificates of Authority for group self-insurance may be revoked in accordance with K.S.A. 44-584 or K.S.A. 12-2620.

Kentucky (Individual) - Fail to pay claims, filing of bankruptcy.

Kentucky (Group) - Insolvency, fail pay claims, any non-compliance with regulatory requirements.

Louisiana (Group) - Non-compliance with law

Louisiana (Individual) -
A. A downward turn in the financial condition of the self-insured to a level that is not conducive to handle such an obligation.

B. Non-payment of claims.

Maine - See Title 39 MRSA and Rule 250.

Massachusetts (Individual) -
1. Failure to promptly pay claims.
2. Failure to pay assessments within 30 days.
3. any reasonable cause.

Michigan -
-Failure to maintain security requirements
-Failure to maintain solvency

Montana - If it is determined that the employer no longer has the necessary financial resources and ability to pay the compensation, benefits and all liabilities likely to be incurred.

Nevada - Failure to pay claims timely,
Failure to meet $2.5 tangible net worth (may place an LOC for $2.5 million as an alternative),
Failure of Third Party Administrator (agent for self-insured) to perform timely,
Failure to provide a requested increase to a security deposit,
Failure to provide ANY records requested by the Commissioner of Insurance

New Hampshire - Labor Commissioner decision.

New Jersey - Company placed in liquidation.

New Mexico (Individual) - Failure of the employer to comply with provisions of the act or regulations. Insolvency of employer or any surety or guarantor - or impairment of any aspect of the employers financial requirements.

New Mexico (Group) - Revocation may occur if the group fails to comply with any of the provisions in Section 52-6-23 including group self-insurance act 52-6-1 to 52-6-25 NMSA 1978.

New York - For good cause shown.

Pennsylvania -
- Default on payment of workers' compensation payments.

- Failure to maintain/obtain any of the following as required security bond, excess insurance, or parental guaranty.

- Inability to show financial ability to continue to pay workers' compensation claims.

- Repeatedly or unreasonably fails to pay promptly compensation.

South Carolina - Insolvency (Financial condition),
Failure to pay claims,
Failure to pay assessments,
Failure to report to the commission

South Dakota - Insolvency of employer, Failure to comply with Title 62

Tennessee - Poor financial condition, leverage buyouts, change in ownership, failure to handle claims properly, inability or neglect in paying claims, inability to retain excess cover or security.

Virginia (Individual) - Failure to meet requirements of Virginia Workers' Compensation Act.

Virginia (Group) - See Section 16 of Insurance Regulation 16.

Utah - Failure to maintain the Dunn & Bradstreet rating per rule or notice of cancellation of the bond or LOC.

Washington - See RCW 51.14.080

Wisconsin - Misrepresent financials.
Lack of claim payments or poor claim payment record, etc.

(13) Are actuarial certifications required from self-insureds? Yes _____ No _____

If yes, how often are they required and who can prepare them (e.g., member of Casualty Actuarial Society, etc.)?

Colorado - Effective on the part of this department.

Illinois - They are not required but sometimes in special cases are requested.

Iowa - Every year by a member of the AAA or other qualified loss reserve specialist.

Kentucky (Group) - Only where is aggregate stop gap between the stop loss and premium. Collected to cover the unfunded gap. Certain groups may furnish one in lieu of aggregate excess if they qualify.

Louisiana (Group) - This will be proposed to 1992 legislature at regular session. - annually

Maine - See Title 39 MRSA and Rule 250.

Michigan - Are required on some group fund programs.

New Jersey - But are required in proposed regulation.

New Mexico (Group) - Section 52-6-12. Actuarial certifications are required on or before the last day of

the sixth month following the end of the group's fiscal year. The actuarial opinion shall be given by a member of the American Academy of Actuaries or other qualifying loss reserve specialist as defined in the annual statement adopted by the National Association of Insurance Commissioners.

South Dakota - The Department of Labor has actuarial reviews performed on all applications

(14) Are audits required to be performed regarding the self-insured program? Yes _____ No _____

If yes, by whom, and what is covered in the audit?

(A) State agency _____

(B) Independent auditors _____

(C) Other (please explain) _____

Arkansas - Each self-insured completes a self audit at the end of each calendar year. The state has also initiated an audit program this year. State personnel will audit all self-insurers the next few years.

Delaware - A financial statement must be submitted each year with the payroll classification forms.

Illinois - The audits are not required on every self-insurer. They are requested on special occasions and are done by an independent auditor.

Kansas (Group) - Group self-insureds are required to annually submit an independently audit[ed] financial statement. Most pools submit an independent audit prepared by a certified public accountant. Kansas law also requires group-funded pools to receive an examination by the insurance department once every five years.

Louisiana (Group) - Annual

Louisiana (Individual) - *Audits are not required but this office may has the authority to perform audits as the case may warrant.

Michigan - Claims and financial audits are not required on individual S.I. but are required by group funds.

Nevada - State Agency-claim files, reserves & systems
Independent Auditors-annual audited financial statements

New Mexico (Individual) - Financial, claims, safety

New Mexico (Group) - Section 52-6-7 and Section 52-9-17. The director may examine the affairs, transactions, accounts, records and assets and liabilities of each group as often as the director deems advisable.

New York - Review reserves of outstanding death and disability cases.

Pennsylvania - Annual review of the financial status of the organization and its workers' compensation losses and reserves are conducted by the Bureau of Workers' Compensation for renewal purposes.

Virginia (Group) - Also examined by the Bureau of Insurance.

Washington - See "Preparing for Your Self-Insurance Audit"

(15) Are self-insured service organizations (e.g., claim adjusters) required to meet any standards? Yes _____ No _____

If yes, what are the standards?

Alabama - See 480-3-2-.10 Self-insurance service organizations.

Arizona - Must be approved by Industrial Commission of Arizona's (ILA) claim manager.

Arkansas - Any company that is involved in handling WC claims must satisfy this Commission that they have qualified people to handle all claims.

California -
1. Licensed by SIP
2. Qualified persons (by examination) must do self-insured claims.

Colorado - Adjusters must be licensed by division of insurance.

Connecticut - But must be a resident adjustor.

Delaware - Every self-insurer must advise the Board in writing who will be adjusting their claims.

Georgia - Adjusters must be licensed

Idaho - If the self-insurer maintains an office of the company in Idaho, and the company adjusts its own claims at that office, they do not need to use a licensed adjuster. If they use a contract adjuster that adjuster is required to be licensed in Idaho.

Kentucky (Individual) - Adjusters must take a test at KYDOI and be licensed by that agency.

Kentucky (Group) - (See individual S-I answer)

Louisiana (Group) - $50,000 surety bond

Louisiana (Individual) - See Section 1715 of Title 40, Chapter 17.

Maine - Licensed under Title 24A MRSA Chapter 17 & 18.

Massachusetts (Individual) - TPA's are not authorized to investigate, adjust or settle claims for individual self-insurers in Massachusetts.

Montana - In-State adjuster is required.

Nevada - Pursuant to NRS 683A by which the Third Party Administrator is licensed

New Hampshire - State of N.H. certified.

New Mexico (Individual) - New Mexico licensed

New Mexico (Group) - Must be licensed in the state of New Mexico.

New York - Must be licensed by Workers' Compensation Board.

Tennessee - Although we don't license claim adjusters, we do have the right to approve or disapprove a service company when a self-insurer makes application. We treat approval of the service company as part of the overall approval of the self-insurers.

Virginia (Group) - See Section 14 of Insurance Regulation 16.

Washington - A staff member must pass a test demonstrating knowledge of Washington workers' compensation law. The test is administered by the Department.

(16) Are self-insureds required to have a safety program? **Yes _____ No _____**

If yes, what are the standards for such a program?

Arizona - Arizona Division of Safety & Health standards must by met. ADOSH must approve all applications and renewals.

California - Effective safety and health programs pursuant to Cal/OSHA regulations. Evaluations done currently by licensed California professional engineer and written report submitted with application.

Kansas (Group) - Group self-insurance programs are required to have safety programs, our statutes set forth no specific standards for such programs.

Louisiana (Individual) - It must be administered by an approved service company, or the company must have a qualified safety/loss prevention person employed.

Maine - None are prescribed by statute or regulation.

Massachusetts (Individual) - Standards may vary from corporation to corporation, depending on the amount or type of hazardous exposure.

Montana - None specified in the law. The only requirement is that they present evidence of an effective safety program.

Nevada - Safety programs are not mandatory. However, we review them at examination time and include comments in the audit report as to adequacy and reducing costs.

New Mexico (Individual) - Approved by the director.

New Mexico (Group) - Demonstrates procedures to provide safety engineering service ensuring a program acceptable to the director.

New York - No standard has been established.

Pennsylvania - Legislation has been introduced which requires a safety program and active safety committee in order to obtain self-insurance status.

Utah - This is not currently a requirement but it will become a requirement in 1992.

Vermont - Informal

Virginia (Individual) - State Labor and Industry standards.

Washington - See "General, Medical, Educational and First Aid Requirements"

Wisconsin - None specified

(17) Does a guarantee fund exist for self-insureds? **Yes _____ No _____**

If yes, how does it operate?

Alabama - See Act No. 89-533.

Arkansas - Enabling legislation was passed during the 1991 legislative session that would allow for the creation of an Arkansas Guarantee Fund for privately owned individual and group self-insurers.

California - See Labor Code 3740-3747-Security Fund and Section 3701.5.

Colorado - Immediate payment fund assessed pre default. Guarantee fund assessed post default.

Connecticut - All employers contribute to the Second Injury Fund

Georgia - Assessments

Illinois - Handled in the Chicago office. It basically protects and pays employees' claims when the company that they work for becomes insolvent.

Kansas (Group) - There is no Guaranty Fund in existence for group self-insureds in Kansas; however, the Kansas Workers' Compensation Fund would provide benefits to qualifying claimants if a group self-insurer is insolvent. The Fund would then seek to be reimbursed by the insolvent self-insurer.

Kentucky (Individual) - We attempted but were met with strong opposition by the coal people and KY S.I. Assn.

Maine - See Title 39 MRSA.

Montana - All individual self-insureds must belong to the fund. Initial membership costs $1,000 and members may be assessed as the need arises to cover costs incurred by the fund.

Nevada - The insolvency fund based on .0025 of the

current security deposit of each self-insured current monthly deposit. It has been mandated by the legislature that this fund is unavailable for any other use. It is used exclusively to pay self-insured claims should it be necessary.

New Mexico (Individual) - As of January 1991, each self-insured contributes one percent of his paid losses for the immediate preceding year or an average of the preceding three years New Mexico losses, whichever is less. After three years of consecutive contributions a certified self-insured shall no longer be required to pay unless the fund becomes insolvent.

New York - Board makes payment in first instance out of administrative funds. Subsequently, makes post-assessment against private self-insurers.

Pennsylvania - Legislation has been introduced which includes a provision for a guarantee fund.

Utah - The guarantee fund for self-insureds is a part of Uninsured Employers' Fund. By statute, all self-insureds can be assessed up to 2% of a manual premium if one of the self-insureds goes bankrupt.

Washington - See RCW 51.14.077 "Industrial Insurance Laws" and WAC 296-15-065 "Rules & Regulations for Self-Insured Employers"

Wisconsin - Yes and no. It exists in the statutes but has, as yet, never been activated. It calls for assessing each member with a written order (municipalities do not have written orders) equally the first year and subsequently according to employees.

(18) Please provide a description of the process by which your agency determines who is allowed to self-insure; including any minimum requirements (e.g., assets, net worth, payroll, employees, premium, etc.) that self-insureds must meet.

Arkansas - Individual self-insured applicants must have an audited financial statement that develops a minimum net worth of $250,000, a current ratio of 1 to 1, and be able to purchase either a surety bond or CD in an amount prescribed by the Commission. Groups must have members that develop a minimum of $1,000,000 of net worth.

California -
a. Public Sector - Complete short application and resolutions of governing board. (No qualification

required as public sector has right to self insure).

b. Private Sector - Complete 20 page application, meet financial guidelines, post deposit required, provide parental guarantee (if parent exists).

Connecticut - 3 yrs. of audited financial statements

- 3 yrs of Connecticut payroll
- 3 yrs of loss history for CT operations
- No minimum payroll or premium
- Positive net worth, working capital and income must exceed estimated loss exposure.
- A good loss history is considered

Delaware - A self-insurer must provide the Board with the following requirements:

1. A recent financial statement
2. completed application
3. 3 year past history of claims

There are no requirements as far as the number of employees. A copy should have assets in the millions and those assets must be able to cover the liabilities.

Idaho - Audited financial statements of the prospective self-insurer are reviewed. Loss records, as recorded at the Idaho Industrial Commission, are reviewed. Each prospective self-insurer must meet the minimum Idaho Average Payroll of $4,000,000, post the required security deposits with the Idaho State Treasurer, and contract with an Idaho in-state adjuster. The application process usually takes 3-5 months. Approval dates are usually limited to the beginning of quarterly periods (January 1, April 1, July 1 and October 1) of each year because of the annual payroll/premium tax audits that must be reconciled to the payroll reports submitted to the Idaho Department of Employment.

Iowa - See 1AC 57.5

Kansas (Group) - The provisions regarding the requirements for group self-insurance in Kansas are set out in K.S.A. 44-581, et seq. and K.S.A. 12-2618, et seq.

Louisiana (Individual) -
1. The company must have a minimum net worth of $750,000.

2. The current ratio should by 1:5 to 1
3. The debt equity ratio should be no higher than 3 to 1.
4. The company must demonstrate the ability to handle a self-insured program.

Maine - See Title 39 MRSA and Rule 250.

Massachusetts (Individual) -
1. bond and reinsurance are required.
2. good standard and Poor's and Moody's ratings are required.
3. good loss experience.
4. 3 year history of profitability.
5. minimum of 300 employees.
6. minimum of $750,000 annual premium.

Montana - See Admin. Rules which detail what is examined by the Division.

New Hampshire - Individually determined.

New Jersey - Applications are reviewed by the Property/Casualty Insurance Company Admissions Committee and recommendation is made to the Commissioner who has the final right of approval.

New Mexico (Individual) -
1. Net worth of one million dollars.

2. An approved claims management system.

3. An approved risk management system.

4. A reserve for all open claims.

5. Excess workers' compensation insurance with a $250,000 retention and statutory limits.

6. A surety bond or a letter of credit in approved form for a minimum of $200,000.

7. Submit to an annual audit by the Director of the New Mexico Workers' Compensation Administration or his representative.

8. An approved safety program in force.

9. Current audited financial statements by a Certified Public Accountant.

10. Past three years' claims history.

11. Parental guarantee if employer is a subsidiary.

12. Resolution by board of directors guaranteeing workers'compensation liability of the parent company and the subsidiary, if applicable.

New Mexico (Group) - Section 62-6-4 and Section 52-6-5 "A" through "G"

1) A group self-insured must file with the director an application for a certificate of approval.

2) At minimum, a group self-insured must have a combined net worth of $3,000,000.

New York - No statutory requirements, except that applicant must demonstrate sufficient financial resources to pay required benefits.

Pennsylvania - No minimum established by law or regulation. Granting of self-insurance is based on determination by the Bureau that applicant has demonstrated the financial ability to make certain the payment of compensation benefits.

South Dakota - Must be approved by actuary and the Department of Labor

Tennessee - We don't have any minimum amounts such as assets, net worth, payroll etc. We do require that a company be financially strong, with considerable net worth. We look at trends in the profits, net worth, debt etc. We do set a minimum premium. We require that a self-insurer have at least $200,000 in premium to self-insure. Under certain circumstances we'll make exception to this, for example, if the self-insurer is self-insured in a large number of other states, we'll allow them to self-insure in Tennessee (with a smaller premium) as part of their overall program.

Utah - The process for self-insurance requirements are set forth in our rules. Minimum net worth of $10 million.

Virginia (Group) - See Sections 4 and 5 of Insurance regulation 16.

Washington - Applicants must demonstrate:
- financial ability to continue in business and pay benefits (the applicant must have a $2 million net worth and be in business for three years under present ownership). Three years audited financial statements are required with the application. These are subject to standard financial and cash flow analysis on a comparative basis.

- existence of a safety program with a record of accident prevention.

Wisconsin - Must have 5 years audited financials. Should have premium in excess of $200,000.

CALIFORNIA WORKERS' COMPENSATION
Payments From Self-Insurance

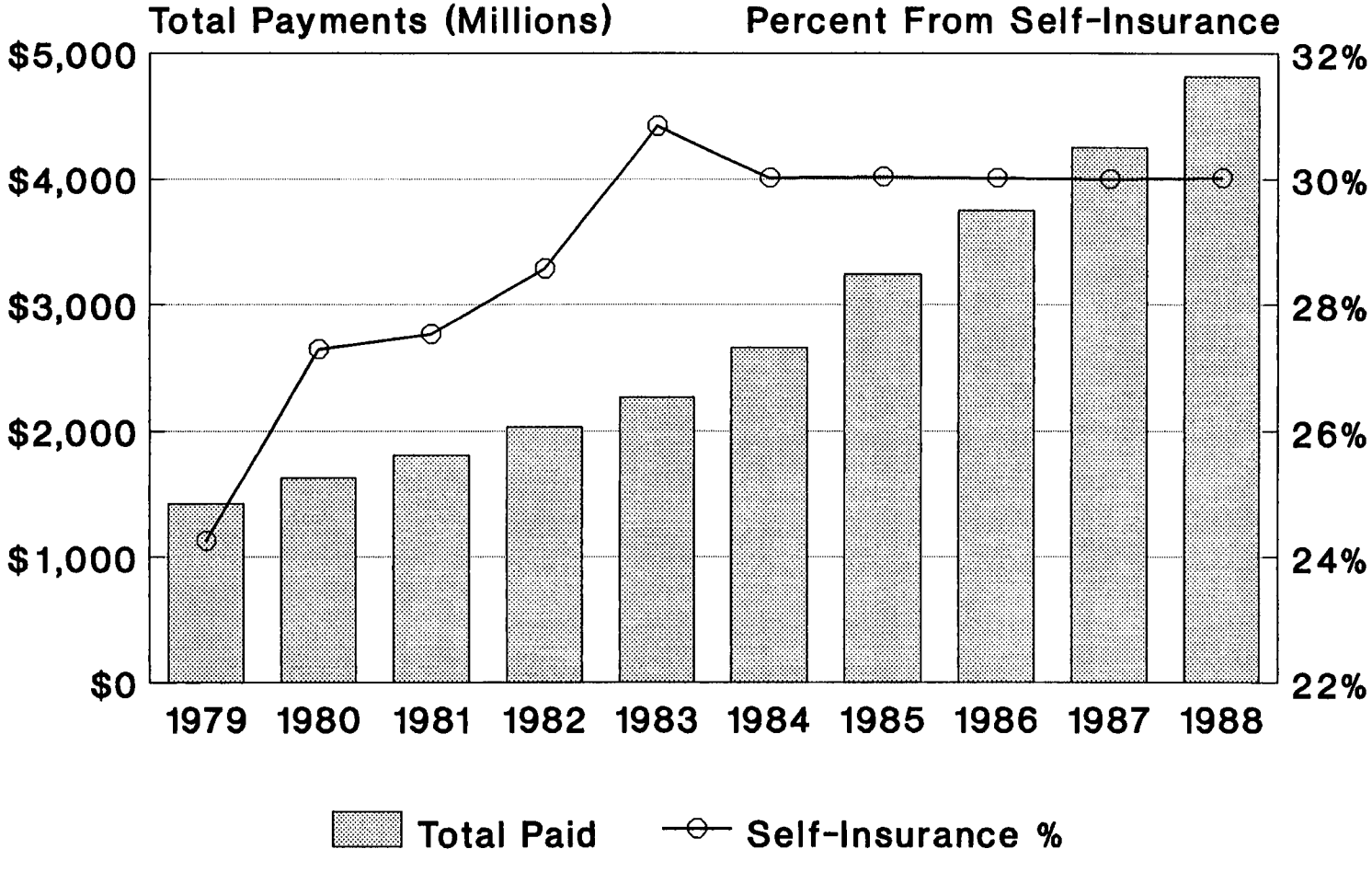


Exhibit AIS-4, Sheet 1

COUNTRYWIDE WORKERS' COMPENSATION
Payments From Self-Insurance

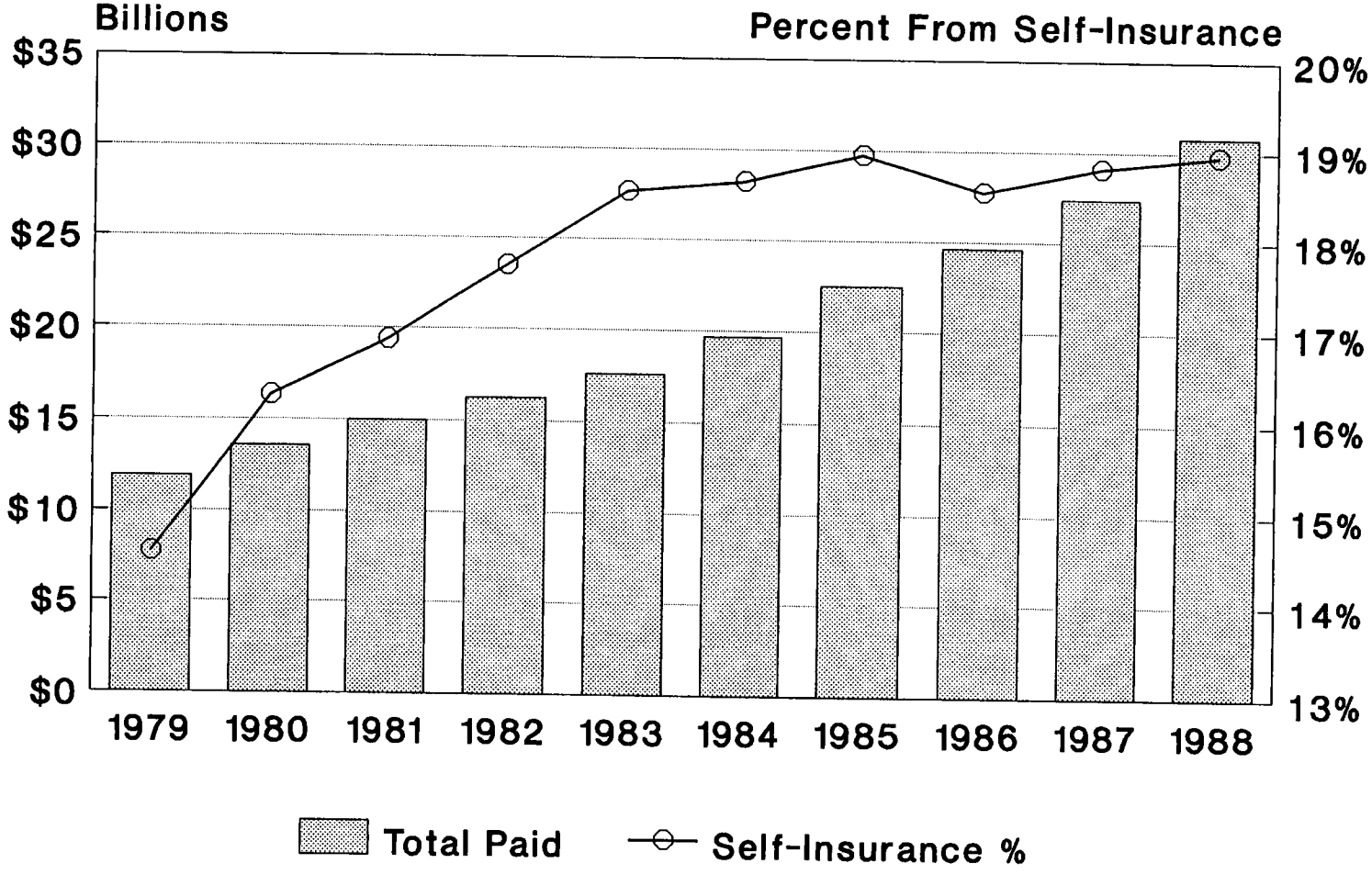


Exhibit AIS-4, Sheet 2

Workers' Compensation Payments - 1988
(In Thousands)

State	Total	Private Insurance	State & Fed. Funds	Self Insurance	Percent Self Insurance
Alabama	$310,568	$221,568	$0	$89,000	28.7%
Alaska	$119,595	$97,895	$0	$21,700	18.1%
Arizona	$300,887	$126,670	$118,217	$56,000	18.6%
Arkansas	$176,814	$133,914	$0	$42,900	24.3%
California	$4,810,305	$2,548,616	$817,689	$1,444,000	30.0%
Colorado	$474,482	$196,913	$205,869	$71,700	15.1%
Connecticut	$495,535	$390,535	$0	$105,000	21.2%
Delaware	$57,345	$42,945	$0	$14,400	25.1%
D.C.	$80,597	$64,497	$0	$16,100	20.0%
Florida	$1,421,550	$888,550	$0	$533,000	37.5%
Georgia	$580,766	$500,766	$0	$80,000	13.8%
Hawaii	$151,144	$111,144	$0	$40,000	26.5%
Idaho	$84,983	$52,030	$24,753	$8,200	9.6%
Illinois	$1,277,476	$932,476	$0	$345,000	27.0%
Indiana	$244,703	$216,703	$0	$28,000	11.4%
Iowa	$169,464	$161,464	$0	$8,000	4.7%
Kansas	$197,473	$166,473	$0	$31,000	15.7%
Kentucky	$292,872	$219,872	$0	$73,000	24.9%
Louisiana	$565,141	$452,141	$0	$113,000	20.0%
Maine	$314,353	$259,853	$0	$54,500	17.3%
Maryland	$396,734	$259,933	$76,801	$60,000	15.1%
Massachusetts	$858,587	$787,587	$0	$71,000	8.3%
Michigan	$1,010,014	$549,610	$70,404	$390,000	38.6%
Minnesota	$501,901	$369,454	$16,447	$116,000	23.1%
Mississippi	$154,799	$143,299	$0	$11,500	7.4%
Missouri	$378,777	$312,777	$0	$66,000	17.4%
Montana	$150,436	$46,035	$91,101	$13,300	8.8%
Nebraska	$101,311	$86,611	$0	$14,700	14.5%
Nevada	$236,861	$861	$200,000	$36,000	15.2%
New Hampshire	$143,153	$124,953	$0	$18,200	12.7%
New Jersey	$682,437	$575,437	$0	$107,000	15.7%
New Mexico	$168,121	$157,121	$0	$11,000	6.5%
New York	$1,344,539	$662,127	$432,412	$250,000	18.6%
North Carolina	$334,179	$267,179	$0	$67,000	20.0%
North Dakota	$44,441	$124	$44,317	$0	0.0%
Ohio	$1,716,339	$6,339	$1,260,000	$450,000	26.2%
Oklahoma	$301,992	$166,992	$65,000	$70,000	23.2%
Oregon	$555,769	$217,505	$245,264	$93,000	16.7%
Pennsylvania	$1,499,049	$1,098,417	$100,632	$300,000	20.0%
Rhode Island	$168,322	$155,322	$0	$13,000	7.7%
South Carolina	$207,909	$178,909	$0	$29,000	13.9%
South Dakota	$40,156	$34,656	$0	$5,500	13.7%
Tennessee	$341,270	$310,270	$0	$31,000	9.1%
Texas	$2,461,702	$2,461,702	$0	$0	0.0%
Utah	$115,563	$29,201	$68,362	$18,000	15.6%
Vermont	$43,636	$39,636	$0	$4,000	9.2%
Virginia	$408,904	$334,904	$0	$74,000	18.1%
Washington	$705,478	$13,478	$550,000	$142,000	20.1%
West Virginia	$363,391	$735	$249,656	$113,000	31.1%
Wisconsin	$422,163	$335,163	$0	$87,000	20.6%
Wyoming	$45,594	$751	$44,843	$0	0.0%

Workers' Compensation - 1988
% Payments from Self-Insurance

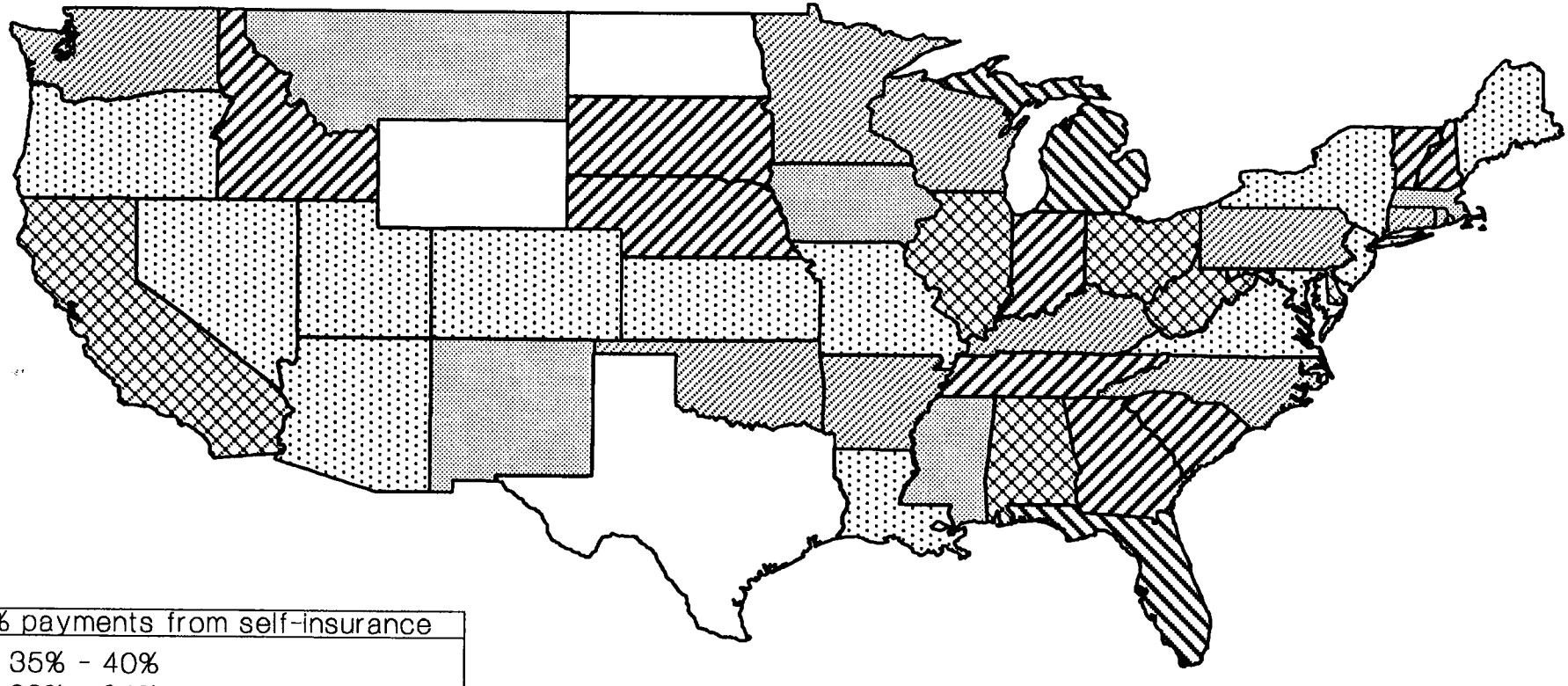
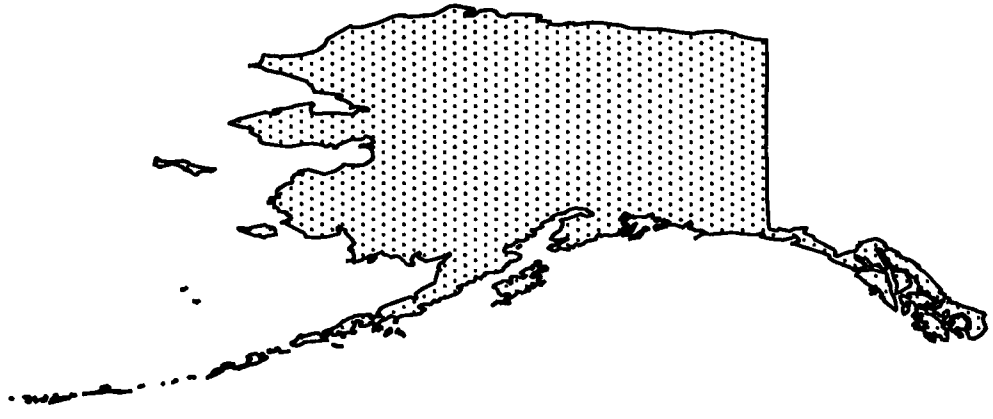


Exhibit AIS-5, Sheet 2a

Workers' Compensation - 1988
% Payments from Self-Insurance - AK & HI



% payments from self-insurance
35% - 40%
26% - 34%
21% - 25%
16% - 20%
10% - 15%
1% - 9%
0%

Exhibit AIS-5, Sheet 2b

SECTION 7.0

ACTUARIAL REPORT COMPARING THE OPERATIONS OF EXCLUSIVE AND COMPETITIVE WORKERS' COMPENSATION STATE FUNDS

SUMMARY I-1

FINANCIAL CONDITION II-2

EFFICIENCY MEASURES III-8

RATING STRUCTURE IV-10

RATE LEVEL V-12

SERVICES PROVIDED BY STATE FUNDS VI-12

FOOTNOTES 13

EXHIBITS AIS-1

ACTUARIAL REPORT COMPARING THE OPERATIONS OF EXCLUSIVE AND COMPETITIVE WORKERS' COMPENSATION STATE FUNDS

JANUARY 24, 1992

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ACTUARIAL REPORT COMPARING THE OPERATIONS OF EXCLUSIVE AND COMPETITIVE WORKERS' COMPENSATION STATE FUNDS

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Memorandum

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ACTUARIAL REPORT COMPARING THE OPERATIONS OF EXCLUSIVE AND COMPETITIVE WORKERS' COMPENSATION STATE FUNDS

Exhibits

Item	Exhibit Number
Premium to Surplus Ratio- Exclusive State Funds	AIS-1, Sheet 1
Premium to Surplus Ratio- Competitive State Funds	AIS-1, Sheet 2
Premium to Surplus Ratio- Graph of Exclusive vs. Competitive vs. California	AIS-1, Sheet 3
Premium to Surplus Ratio- Graph Comparing Exclusive State Funds	AIS-1, Sheet 4
Loss & LAE Reserve to Surplus	AIS-2, Sheets 1-4
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Exhibits (Continued)

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Workers' Compensation Rate Level Changes- Nevada	AIS-19, Sheet 1
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Workers' Compensation Payments - Percent from State & Federal Funds - Exclusive States	Appendix B
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New York Retrospective Rating Plans	Appendix D

Exhibits (Continued)

Item	Exhibit Number
State Fund Services:	
Arizona	Appendix E
Maryland	Appendix F
Michigan	Appendix G
Nevada	Appendix H
Ohio	Appendix I
Oregon	Appendix J
Pennsylvania	Appendix K
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ACTUARIAL REPORT COMPARING THE OPERATIONS OF EXCLUSIVE AND COMPETITIVE WORKERS' COMPENSATION STATE FUNDS

I Summary

AIS Risk Consultants was retained by the California Workers' Compensation Rate Study Commission (WCRSC) to review the condition of exclusive State Funds and compare it to that of competitive State Funds. In our analysis we have relied upon data and information supplied by the WCRSC, the American Association of State Compensation Insurance Funds (AASCIF), various State Funds and other generally accepted sources. While we used our overall knowledge and experience to assess the reasonableness of the information provided, we have not performed an independent audit of the information supplied. In addition, we have used the values supplied by the State Funds for various financial items (e.g., loss reserves) and have not made our own independent analysis of the reasonableness of those values.

There are six exclusive State Funds operating in the United States. They are: (1) Nevada, (2) North Dakota, (3) Ohio, (4) Washington, (5) West Virginia and (6) Wyoming.

There are thirteen competitive State Funds operating in the United States. They are: (1) Arizona, (2) California, (3) Colorado, (4) Idaho, (5) Maryland, (6) Michigan, (7) Minnesota, (8) Montana, (9) New York, (10) Oklahoma, (11) Oregon, (12) Pennsylvania and (13) Utah.

Within each of these two groups (i.e., exclusive and competitive), there are many differences in the operations of the State Funds. That is, many factors other than exclusive vs. competitive impact a State Fund's operations.

We examined three main areas of State Funds' operations. They were (1) financial condition, (2) efficiency and (3) overall rate structure.

Based upon our review, the following general patterns emerged.[1]

(1) Exclusive State Funds, based upon traditional measures of solvency,[2] appear to be in worse financial condition than competitive State Funds.

(2) Based upon three measures of efficiency[3], exclusive State Funds appear to operate more efficiently than competitive State Funds.

(3) The overall rating structure for exclusive State Funds appears to be somewhat less flexible than for

competitive State Funds.

(4) During the last several years, rates changes for exclusive State Funds have been in the range of 10% per year. This is not significantly different than the countrywide rate changes for workers' compensation.[4]

(5) Virtually all of the State Funds, both exclusive and competitive, provide a range of services to their policyholders. These services cover claims management, loss control, cost containment, rehabilitation and safety.

II Financial Condition

The financial condition of exclusive and competitive State Funds were compared using a number of measures. These were: (1) premium to surplus ratio, (2) reserve to surplus ratio, (3) change in premium writings, (4) operating profit ratio and its component parts, (5) average investment yield, (6) change in surplus, (7) liabilities to liquid assets, (8) agents and premium balances to surplus and (9) existence of reinsurance.

In general, the exclusive State Funds typically fared worse than the competitive State Funds. However, as previously pointed out, there exists a wide variation between the results of the funds within each of these two categories.

The following sections describes each of these tests in more detail.

Premium to Surplus

The purpose of this ratio is explained as follows:

> A company's surplus provides a cushion for absorbing above-average losses. The premium to surplus ratio measures the adequacy of this cushion. The higher the ratio, the more risk the company bears in relation to the surplus available to absorb loss variations.[5]

The premium to surplus ratio for the State Funds are shown in Exhibit AIS-1. The values for the exclusive and competitive State Funds from 1986 to 1990 are shown in Sheets 1 and 2, respectively. A graph of the values by year are shown in Sheet 3 for exclusive State Funds, competitive State Funds and the California State Fund. The variation in this ratio between the six exclusive State Funds is shown in Sheet

4. This same format of exhibits was used for each of the statistical ratios examined.

The standard for this test is a ratio between 0 and 3.

None of the exclusive State Funds achieved an acceptable value on a long-term basis. In fact, only two of the exclusive funds kept a positive surplus during the five year period.

The competitive funds, as a whole, achieved an acceptable value in every year. However, some of these funds did fall outside the standard range in one or more years. The ratio for the competitive funds combined has been increasing (i.e., getting more risky) in recent years, but it is still within the acceptable range. The California ratio was higher than the average competitive fund ratio from 1986 to 1989, but was lower in 1990.

Reserve to Surplus

Just as surplus exists to provide a cushion against premium deficiencies, it also is intended to serve as a cushion against reserve deficiencies. The first purpose is measured by the premium to surplus ratio. The second purpose is measured by the reserve to surplus ratio. The loss plus loss adjustment expense (LAE) reserve to surplus ratio for the State Funds are shown in Exhibit AIS-2.

No generally accepted standard exists for this ratio. The value for the property casualty insurance industry as a whole has been about 2.0 in recent years. For companies predominating writing commercial casualty business, the ratio has been about 2.8 in recent years. For companies predominating writing medical malpractice business, the ratio has averaged about 6.5 in recent years. These latter company groupings consist of long-tailed lines of insurance, similar to workers' compensation. Therefore, the reserve to surplus ratio for these companies may be a better benchmark than for all companies combined, which would include lines like fire and allied which produce very low reserve levels. Using these historic ratios, a maximum reserve to surplus ratio of 2 to 5 would appear reasonable.

These benchmarks provide only a very rough guide as to what could be considered an acceptable reserve to surplus ratio. The volume of reserves generated depends upon the payout pattern of claims. This will vary dramatically between lines of insurance. It will also vary for a given line of insurance, such as workers' compensation, across states depending upon the benefit structure and its administration.

None of the exclusive State Funds achieved a value close to the above benchmarks. In fact, only two of the exclusive funds averaged a positive surplus during the five year period.

The competitive funds, as a whole, were within the acceptable range from 1986 to 1989. They fell outside the benchmark during 1990. The ratio for the competitive funds combined has been increasing (i.e., getting more risky) in recent years. The California ratio has been lower than that for the average competitive fund.

Change in Premium Writings

The purpose of this ratio is explained as follows:

> Major increases or decreases in net premiums written indicate a lack of stability in the company's operations. A major increase in premium may signal abrupt entry into new lines of business or sales territories. In addition, such an increase in writings may be a sign that the company is increasing cash inflow to meet loss payments.[6]

This ratio is shown in Exhibit AIS-3. The standard for this test is a ratio between -33% and +33%.

All of the exclusive State Funds achieved an acceptable value on a long-term basis. The same is true for the competitive funds. The average value for California has been fairly close to that for the competitive funds as a whole.

Overall Operating Ratio

The purpose of this ratio is explained as follows:

> The overall operating ratio is a measure of the profitability of an insurance company. Over the long run, the profitability of the business is a principal determinant of the company's financial solidity and solvency.[7]

This ratio is shown in Exhibit AIS-4. The standard for this test is a ratio greater than 0. This would indicate that a profit was made.

Only one of the exclusive State Funds achieved an acceptable value on a long-term basis. Two had small losses. The other three suffered significant operating losses.

The competitive funds, as a whole, meet the standard in four of the five years (in 1990, one fund had a significant operating loss which caused the overall profit to be negative). Most of these funds had at least one year with an operating loss. The ratio for the competitive funds combined has been decreasing (i.e., getting less profitable) in recent years. The average California operating profit ratio has been just about at the average competitive fund value.

The component parts of the operating ratio are the (a) loss ratio, (b) expense ratio, (c) dividend ratio and (d) investment plus other income ratio. These are shown in Exhibits AIS-5 through AIS-8.

The loss ratios for the exclusive funds have all been significantly above 1.0 for each fund in each year. This indicates that more than 100% of premium is being returned in the form of benefits.[8] The exclusive fund ratio has been decreasing over time, from 1.88 in 1986 to 1.19 in 1990. The average loss ratio over the five year period has been 1.42. The loss ratios for the competitive funds has been substantially less. The five year average is 0.92. However, it has been increasing over time from 0.81 in 1986 to 1.01 in 1990. The California loss ratio has been considerably less than that for the average competitive fund. During the five year period, the ratio has been 0.81. The ratio for California has been fairly consistent from 1986 to 1990. As a rough basis of comparison, the countrywide workers' compensation loss ratio for private carriers has been in the range from 80% to 85%.

The expense ratios for the exclusive funds have been very small. The five year average has been 8%. The competitive fund expense ratios have been quite a bit higher, averaging 19% from 1986 to 1990. The California average ratio of 17% is somewhat below the competitive fund average. As a rough measure of comparison, the countrywide expense ratio for private insurance companies writing workers' compensation is about 28%.[9]

Dividends have been essentially non-existent for the exclusive funds. Competitive funds have returned about 10% of premium in the form of dividends. The California fund has averaged a return of 17% of premium.[10] The private carrier dividend ratio has been in the range of 6% in recent years.

The exclusive funds have generated a substantial amount of revenue from investment and other income. This source of revenue averaged 43% of premium across all these funds during the five period. For the competitive funds, the ratio was 27%, still a significant amount. For California, this source

of income averaged 20% of premium.[11]

Average Investment Yield

The purpose of this ratio is explained as follows:

> In addition to measuring one important element in profitability, the investment yield also provides an indication of the general quality of the company's investment portfolio.[12]

This ratio is shown in Exhibit AIS-9. The standard for this test is a ratio larger than 5%.

All but one of the exclusive State Funds achieved an acceptable value on a long-term basis.[13]

Each of the competitive funds achieved an acceptable result on this test. The average value for the exclusive, competitive and California funds were all fairly similar.

Change in Surplus

The purpose of this ratio is explained as follows:

> The change in surplus is, in a sense, the ultimate measure of the improvement or deterioration in the company's financial condition during the year.[14]

This ratio is shown in Exhibit AIS-10. The standard for this test is a ratio between -10% and +50%.

For four of the exclusive funds, this test does not produce meaningful results because the surplus was negative. For the other two exclusive funds, one was just inside the acceptable range at the low end, the other just outside the range at the higher end.

The competitive funds, as a whole, passed this test from 1987 to 1989, but failed in 1990. The failure in 1990 was due essentially to the results for two funds. One had a significant surplus change because of a substantial reserve adjustment (Colorado). The other suffered a large reduction in surplus because of a legislative transfer of funds (Pennsylvania). The California fund came within the acceptable range in each year.

Liabilities to Liquid Assets

The purpose of this ratio is explained as follows:

> The ratio of liabilities to liquid assets is a measure of the company's ability to meet the financial demands that may be placed upon it. It also provides a rough indication of the possible implications for policyholders if liquidation becomes necessary.[15]

This ratio is shown in Exhibit AIS-11. The standard for this test is a ratio no more than 105%.

Three of the exclusive funds passed this test, and three failed, over the period from 1986 to 1990.

The competitive funds, as a whole, passed this test every year. However, the ratio did jump significantly in 1990, mostly for the same reasons discussed in connection with the prior test. The California fund came within the acceptable range in each year. It has also been somewhat better than the overall competitive fund ratio.

Agents & Premium Balances to Surplus

The purpose of this ratio is explained as follows:

> The ratio of agents' balances to surplus measures the degree to which solvency depends upon an asset which frequently cannot be realized in the event of liquidation. In addition, the ratio is reasonably effective in distinguishing troubled from sound companies.[16]

This ratio is shown in Exhibit AIS-12. The standard for this test is a ratio no more than 0.40.

All of the exclusive funds, except Wyoming, failed this test.[13]

The competitive funds, as a whole, passed this test every year. However, the ratio has been increasing each year from 1986 to 1990. The California fund came within the acceptable range in each year. It has also been moderately better than the overall competitive fund ratio.

Reinsurance Protection

Catastrophe reinsurance would protect the assets of a State Fund from major unexpected events which result in a

significant amount of losses.[17] Exhibit AIS-13 indicates which State Funds have obtained reinsurance protection against catastrophic events. Only one of the six exclusive funds has obtained reinsurance coverage. Twelve out of the thirteen competitive funds have this type of coverage. This is another instance, where in general, the exclusive funds appear to be less financially solid than the competitive funds.

Summary

A table showing the results for each of the financial solvency tests we examined is set forth in Exhibit AIS-14. It can be seen that, overall, the exclusive funds fared worse on these tests than did the competitive funds. This would indicate that the competitive funds are in better financial condition.

III **Efficiency Measures**

The data available allowed for three measurements of the operating "efficiency" of the State Funds. These tests were (1) expense ratios, (2) number of policies per employee and (3) number of claims per employee.

Expense Ratio

The expense ratio[18] was discussed previously in connection with insurer profitability results. Expense ratios are shown in Exhibit AIS-6. Both exclusive and competitive funds have much lower expense ratios than private insurance carriers. However, the exclusive funds have had an average expense ratio less than half that of the competitive funds (i.e., average of 8% for exclusive funds vs. average of 19% for competitive funds).

Number of Policies Per Employee

The next statistic examined was the number of policies per employee. This is shown in Exhibit AIS-15.

The five year average for the exclusive funds was 107 policies per employee. The ratio has been going down over time, from 134 during 1986 to 88 during 1990. The five year average policies per employee ranged from a low of 49 for Nevada to a high of 297 for North Dakota.

The five year average for the competitive funds was 70 policies per employee. The ratio has been going down over

time, from 85 during 1986 to 60 during 1990. The five year average polices per employee ranged from a low of 38 for Oregon to a high of 208 for Montana.

The five year average for the California fund was 62 policies per employee. The ratio has been going down over time, from 88 during 1986 to 52 during 1990.

Number of Accidents Per Employee

The final statistic examined was the number of accidents per employee. This is shown in Exhibit AIS-16.

The five year average for the exclusive funds was 182 accidents per employee. The ratio has been going down over time, from 217 during 1986 to 147 during 1990. The five year average polices per employee ranged from a low of 99 for Nevada to a high of 373 for Wyoming.

The five year average for the competitive funds was 85 accidents per employee. The ratio has been going down over time, from 105 during 1986 to 71 during 1990. The five year average polices per employee ranged from a low of 46 for Oregon to a high of 334 for Utah.

The five year average for the California fund was 68 accidents per employee. The ratio has been going down over time, from 99 during 1986 to 54 during 1990.

Summary

By each the above three measures, exclusive State Funds would appear to operate more efficiently than competitive State Funds. California was somewhat better compared to the overall competitive funds with regard to the expense ratio. California was somewhat worse with regard to the number of policies and accidents handled per employee.

The issue of efficiency in operations is a complex one that cannot be analyzed simply using statistical measures. High expense ratios and a high number of employees per policy and/or accident may on the surface appear inefficient. However, it could also mean a higher level of service from both a quantitative and qualitative point of view. The end result of the higher level of service could be a lower overall cost if losses are reduced.[19]

IV Rating Structure

Five different aspects of the overall rating structure of State Funds were examined. These were (1) number of rating classifications, (2) experience rating plans, (3) retrospective rating plans, (4) dividend plans and (5) rating discounts. These different rating aspects, by fund, are displayed in Exhibit AIS-17.

Number of Rating Classifications

Three of the four exclusive funds for which data were available had from 92 to 225 rating classes. One exclusive fund had 937 rating classes. The competitive funds for which data were available had between approximately 300 to 700 rating classes.

The more rating classes which are available, the greater the potential equity for rating among various insureds. Of course, the number of classes will be limited by practical considerations as well as the credibility of the experience.

Experience Rating

All of the exclusive and competitive funds have experience rating plans.[20] The eligibility requirements vary within both the exclusive and competitive fund groups. However, overall the eligibility requirements are somewhat lower in the exclusive than in the competitive funds. The eligibility requirements for California appear to be the highest of any fund.

Some of the competitive funds also have claim rating plans which operate below the eligibility requirements of the experience rating plan. Claim rating plans only take into account the number of indemnity claims. They do not take into account the dollar value of the claim, as is the case for experience rating.

Retrospective Rating

Most of the exclusive and competitive funds have retrospective rating plans.[21] The main elements of a retrospective rating plan are the minimum premium, maximum premium and basic premium. The minimum premium is the least amount that an insured can pay, no matter how good the experience. The maximum premium is the most an insured can pay, no matter how bad the experience. The basic premium covers the insurance company's expenses, profit, charge for the maximum premium limitation (less the minimum premium

credit) and, if applicable, a charge for a limitation on the largest amount that can be charged for any one accident.

Retrospective rating plans can be segregated into two broad categories. Tabular plans consist of tables setting out the three basic elements. The NCCI has four tabular plans. A fifth plan is a custom designed plan. The insured and the insurer determine each of the three elements, within the constraint of the total system expected to be in balance. Descriptions of the four tabular and one custom plan, taken from the New York Compensation Insurance Rating Bureau's Retrospective Rating Plan Manual, is given in Appendix D.

The California fund has one tabular plan. The number of retrospective rating plans available in California is a Rating Bureau, not a State Fund, issue.

Dividends

Only two of the four exclusive funds can issue dividends. During the past five years, only one exclusive fund has issued a dividend, and it was fairly small. All of the competitive funds can issue dividends, although four of these funds have not done so in the last five years.

Discounts

Discounts fall into two basic categories. One is a premium discount, which reflects the lower expense needs, relative to premium, for larger policy sizes. This was discussed in the report dealing with the ratemaking procedures used in California. The other is a deviation below standard manual rates.

None of the exclusive funds issue discounts.

All of the competitive funds, except California, use discounts.

Summary

The overall rating structure appears to be somewhat less flexible for exclusive than for competitive funds. Exclusive funds have (1) somewhat less rating classes, (2) somewhat lower eligibility requirements for experience rating, (3) make less use of dividends and (4) do not use discounts.

V Rate Level

Information on average rate levels and rate level changes was available for three exclusive state funds. The results are summarized below:

State Fund	Average Rate : 1990	Average Rate Change : 87 - 90
Nevada	$4.04	11.9%
Ohio	$3.13	7.5%
West Virginia	$2.53	10.0%

The rate changes for exclusive funds from 1987 to 1990 is in the range of 10%. This is similar to the average countrywide rate increase in workers' compensation rates for private insurance companies during this time period.

Comparisons of average rates across states can show differences in the average cost of workers' compensation coverage. However, they cannot show whether the rate in a given state is too high or low. The average rate by state will vary for numerous reasons not related to rate adequacy. Some of the reasons are differences in statutory benefits, administration of the system, economic conditions, the legal system, social attitudes, employment mix, safety programs, the cost of health care, etc.

VI Services Provided by State Funds

Virtually all of the State Funds, both exclusive and competitive, provide a range of services to their policyholders.[22] These services cover claims management, loss control, cost containment, rehabilitation and safety. A copy of various literature supplied by the funds regarding the services they provide is included in Appendices E through L.

Footnotes:

[1] Again, it should be remembered that there were large variations between State Funds within both the exclusive and competitive groups.

[2] It can be argued that traditional insurance solvency standards should not be applied to exclusive State Funds. Because of the monopolistic and compulsory nature of workers' compensation in these states, a contention can be made that these funds operate more like the Social Security system than an insurance mechanism. If this is correct, then traditional measures of solvency may not be applicable and the more important issue could be whether these Funds will be able to pay benefits as they come due.

[3] The three measure of efficiency used were expense ratios, number of policies per employee and number of claims per employee. The issue of efficiency is a very complex one that cannot be determined solely by statistical factors. For instance, low expense ratios could be associated with poor service in underwriting and claim adjustment. This in turn could lead to decreased revenues and increased losses. The end result would be a higher cost of insurance, even though expenses are low.

[4] Approved rate changes for workers' compensation has been in the range of 10% per year during the last several years. Insurers have asserted that they really needed about twice the amounts which were approved. For exclusive State Funds, there is no way of knowing what was "really needed", since the filed and implemented rates would be identical.

[5] Using the NAIC Insurance Regulatory Information System - Property and Liability Edition (1987), National Association of Insurance Commissioners (NAIC), page 6

[6] NAIC, Ibid., page 8

[7] NAIC, Ibid., page 14

[8] These are not benefits actually paid. Some of the losses shown in the financial statements represent reserves for future anticipated benefit payments.

[9] This comparison should be used with caution. State Funds can have inherent expense advantages compared to private insurance companies with regard to items such as premium taxes and acquisition expenses.

[10] A direct comparison of the California and other competitive fund dividend ratios is probably not proper. Part of the dividends returned by the California fund

represent excessive expenses for larger insureds which are built into the manual rate level. The other funds do not receive this extra premium through the manual rate, but instead give larger insureds the benefit of the expense savings at the start of the policy.

[11] The investment income ratio is influenced by three main factors. These are the amount available for investment, the return earned on the investment and the premium base. The amount available for investment is related to the level of reserves which, as was previously discussed, depends upon the payout pattern of losses. This will vary from state to state based upon the statutory benefit provisions and the administration of the workers' compensation system. The premium base will vary depending upon the adequacy of the rate level. An inadequate rate will tend to produce a lower premium base, and hence a larger ratio when premiums are in the denominator.

[12] NAIC, Ibid., page 15

[13] The Wyoming fund failed this test. However, there were several suspicious entries in the Wyoming financial statements. Therefore, the amount of credence that can be placed on this, and other, values from those statements is subject to question.

[14] NAIC, Ibid., page 18

[15] NAIC, Ibid., page 20

[16] NAIC, Ibid., page 21

[17] Examples of these events would be the collapse of a building or an explosion in a factory.

[18] This expense ratio takes into account all operating expenses of the fund. This would include acquisition, general, premium taxes (if applicable), miscellaneous taxes; licence and fees, and loss adjustment expenses.

[19] Losses can be reduced two ways. The first is through accident prevention, which eliminates losses from happening. This would be accomplished by improving workplace safety. The second is through loss control. This involves minimizing the financial impact of losses which have occurred. This could include rehabilitation and job programs.

[20] Experience rating adjusts the premium for a prospective rating period based upon the loss experience in prior periods. This adjustment is made before the policy period.

[21] Retrospective rating adjusts the premium for a

prospective period based upon the losses that emerge during that given period. The adjustments to the premium are made retrospectively, after the expiration of the policy, when the actual losses are known. The eligibility requirements for retrospective rating are much larger than for experience rating. A typical eligibility requirement for retrospective rating is an annual expected standard premium of $20,000.

[22] Only two funds, West Virginia and Wyoming, indicated that they did not provide accident prevention services. They said that these services are provided by other regulatory agencies. We have not made an independent examination of the quantity or quality of the services provided by each fund. We have instead relied upon the information supplied by the funds.

Exclusive State Funds - Premium to Surplus Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Nevada			
Premiums	$153,101	$163,694	$187,883	$249,818	$310,688	$213,037
Surplus	$52,173	$52,146	$44,260	$41,536	$36,229	$45,269
Premium/Surplus	2.93	3.14	4.24	6.01	8.58	4.71
			North Dakota			
Premiums	$20,003	$20,314	$22,458	$26,701	$36,973	$25,290
Surplus	$50,659	$27,156	$871	($18,556)	($78,155)	($3,605)
Premium/Surplus	0.39	0.75	25.78	-1.44	-0.47	-7.02
			Ohio			
Premiums	$1,045,751	$983,926	$1,273,549	$1,493,996	$2,059,323	$1,371,309
Surplus	($1,817,119)	($2,237,912)	($2,139,670)	($1,921,095)	($2,017,028)	($2,026,565)
Premium/Surplus	-0.58	-0.44	-0.60	-0.78	-1.02	-0.68
			Washington			
Premiums	NA	$572,012	$628,618	$628,300	$751,803	$645,183
Surplus	NA	$107,538	$91,570	$200,679	$307,414	$176,800
Premium/Surplus	NA	5.32	6.86	3.13	2.45	3.65
			West Virginia			
Premiums	$140,700	$170,500	$156,200	$195,800	$210,500	$174,740
Surplus	$128,900	($90,600)	($283,500)	($404,300)	($584,000)	($246,700)
Premium/Surplus	1.09	-1.88	-0.55	-0.48	-0.36	-0.71
			Wyoming			
Premiums	$37,000	$27,122	$27,776	$28,384	$44,661	$32,989
Surplus	$11,000	($2,015)	($15,719)	($13,536)	$0	($4,054)
Premium/Surplus	3.36	-13.46	-1.77	-2.10	ERR	-8.14
			Total			
Premiums	$1,396,555	$1,937,568	$2,296,484	$2,622,999	$3,413,948	$2,333,511
Surplus	($1,574,387)	($2,143,687)	($2,302,188)	($2,115,272)	($2,335,540)	($2,094,215)
Premium/Surplus	-0.89	-0.90	-1.00	-1.24	-1.46	-1.11

Competitive State Funds - Premium to Surplus Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Arizona			
Premiums	$149,962	$171,834	$193,699	$204,430	$231,531	$190,291
Surplus	$69,966	$75,477	$65,585	$73,450	$83,178	$73,531
Premium/Surplus	2.14	2.28	2.95	2.78	2.78	2.59
			California			
Premiums	$1,038,219	$1,451,486	$1,773,357	$1,807,093	$1,829,618	$1,579,955
Surplus	$576,365	$627,434	$713,350	$779,076	$790,805	$697,406
Premium/Surplus	1.80	2.31	2.49	2.32	2.31	2.27
			Colorado			
Premiums	$174,568	$191,640	$220,671	$233,924	$266,371	$217,435
Surplus	$56,375	$58,249	$53,036	$58,244	($199,987)	$5,183
Premium/Surplus	3.10	3.29	4.16	4.02	-1.33	41.95
			Idaho			
Premiums	$27,738	$34,190	$42,403	$49,998	$62,805	$43,427
Surplus	$29,908	$37,976	$38,371	$37,324	$38,448	$36,405
Premium/Surplus	0.93	0.90	1.11	1.34	1.63	1.19
			Maryland			
Premiums	$66,976	$100,286	$116,783	$126,441	$149,753	$112,048
Surplus	$69,637	$85,865	$95,635	$105,256	$108,820	$93,043
Premium/Surplus	0.96	1.17	1.22	1.20	1.38	1.20
			Michigan			
Premiums	$81,129	$125,161	$146,281	$154,599	$186,674	$138,769
Surplus	$84,630	$66,874	$89,438	$81,767	$36,917	$71,925
Premium/Surplus	0.96	1.87	1.64	1.89	5.06	1.93
			Minnesota			
Premiums	$23,025	$34,195	$43,539	$45,781	$50,997	$39,507
Surplus	$7,015	$7,104	$8,838	$13,901	$14,896	$10,351
Premium/Surplus	3.28	4.81	4.93	3.29	3.42	3.82
			Montana			
Premiums	$50,861	$70,161	$85,865	$88,448	$93,795	$77,826
Surplus	($81,022)	($149,169)	($157,333)	($217,650)	($221,869)	($165,409)
Premium/Surplus	-0.63	-0.47	-0.55	-0.41	-0.42	-0.47
			New York			
Premiums	$525,396	$649,583	$809,354	$868,488	$1,129,873	$796,539
Surplus	$677,653	$724,740	$765,367	$829,093	$738,154	$747,001
Premium/Surplus	0.78	0.90	1.06	1.05	1.53	1.07
			Oklahoma			
Premiums	$76,398	$83,626	$88,809	$93,450	$107,630	$89,983
Surplus	$60,694	$59,390	$50,041	$54,451	$62,709	$57,457
Premium/Surplus	1.26	1.41	1.77	1.72	1.72	1.57
			Oregon			
Premiums	$217,416	$246,217	$247,522	$230,101	$185,279	$225,307
Surplus	$44,846	$32,103	$153,346	$144,340	$148,996	$104,726
Premium/Surplus	4.85	7.67	1.61	1.59	1.24	2.15
			Pennsylvania			
Premiums	$84,533	$108,203	$125,489	$146,703	$220,534	$137,092
Surplus	$304,012	$379,203	$374,502	$321,937	$86,233	$293,177
Premium/Surplus	0.28	0.29	0.34	0.46	2.56	0.47
			Utah			
Premiums	$51,200	$56,966	$59,207	$74,000	$90,066	$66,288
Surplus	$26,174	$35,113	$37,130	$43,400	$51,571	$38,678
Premium/Surplus	1.96	1.62	1.59	1.71	1.75	1.71
			Total			
Premiums	$2,567,421	$3,323,548	$3,952,979	$4,123,456	$4,604,926	$3,714,466
Surplus	$1,926,253	$2,040,359	$2,287,306	$2,324,589	$1,738,871	$2,063,476
Premium/Surplus	1.33	1.63	1.73	1.77	2.65	1.80

State Funds
Premium to Surplus Ratio

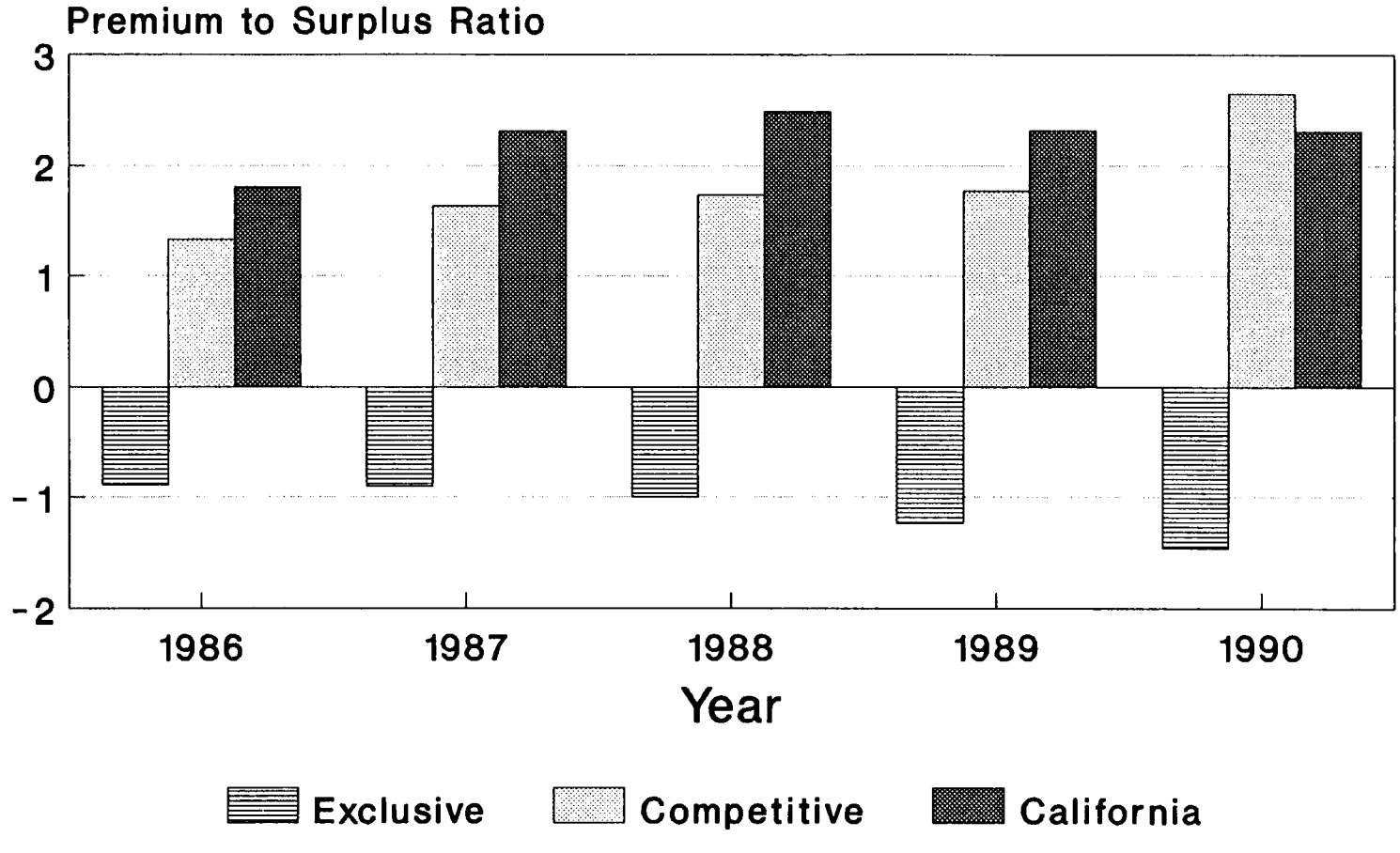


Exhibit AIS-1, Sheet 3

Exclusive State Funds
Premium to Surplus Ratio
Average 1986-1990

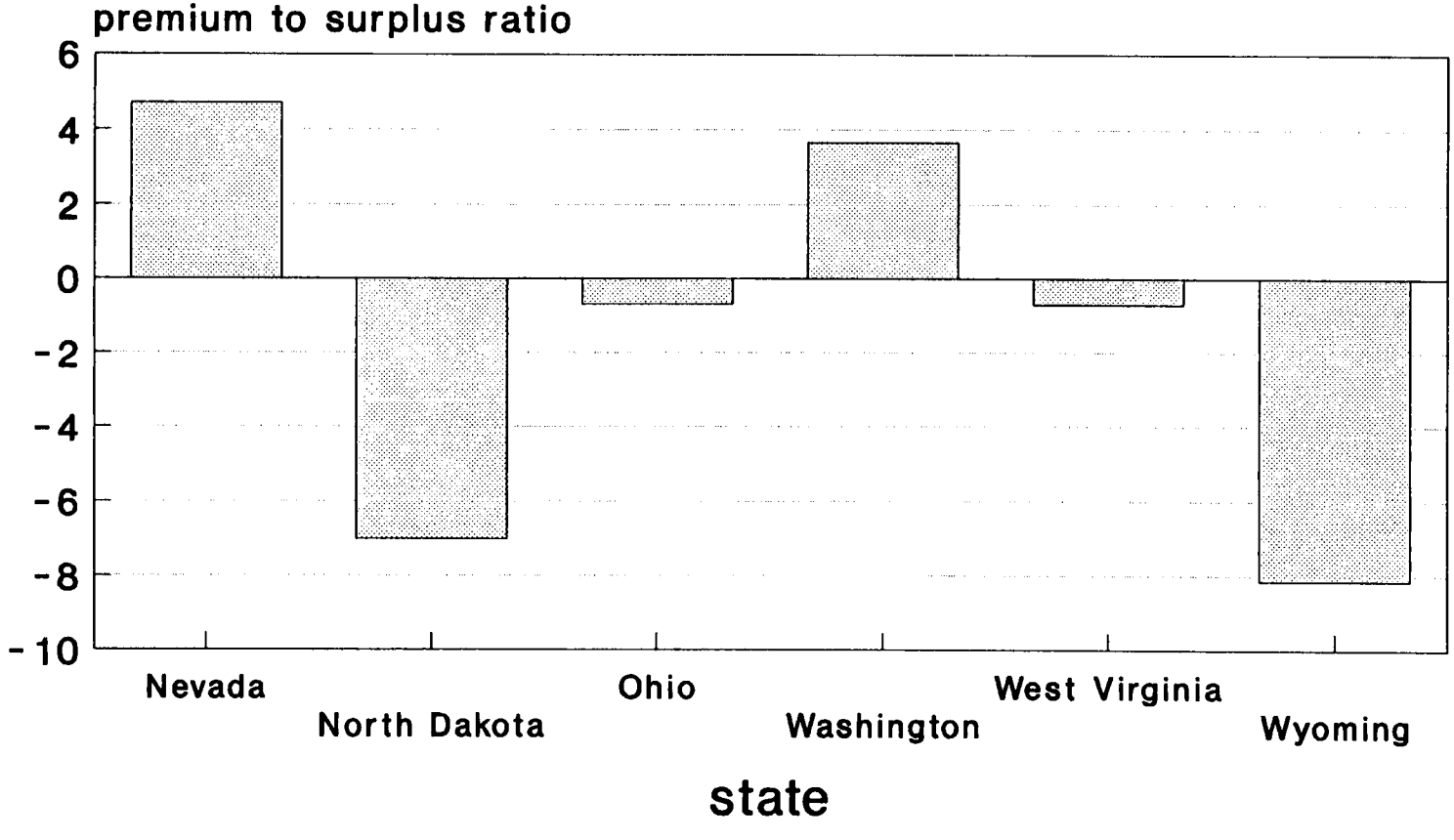


Exhibit AIS-1, Sheet 4

Exclusive State Funds - Loss & LAE Reserve to Surplus
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Nevada			
Loss & LAE Reserve	$508,457	$552,972	$590,254	$650,070	$703,724	$601,095
Surplus	$52,173	$52,146	$44,260	$41,536	$36,229	$45,269
Reserve/Surplus	9.75	10.60	13.34	15.65	19.42	13.28
			North Dakota			
Loss & LAE Reserve	$135,292	$153,733	$170,964	$177,032	$222,600	$171,924
Surplus	$50,659	$27,156	$871	($18,556)	($78,155)	($3,605)
Reserve/Surplus	2.67	5.66	196.28	-9.54	-2.85	-47.69
			Ohio			
Loss & LAE Reserve	$8,183,928	$8,581,027	$9,155,949	$10,229,798	$10,817,150	$9,393,570
Surplus	($1,817,119)	($2,237,912)	($2,139,670)	($1,921,095)	($2,017,028)	($2,026,565)
Reserve/Surplus	-4.50	-3.83	-4.28	-5.32	-5.36	-4.64
			Washington			
Loss & LAE Reserve	$2,652,034	$2,949,702	$3,343,533	$3,586,611	$3,900,377	$3,286,451
Surplus	($15,403)	$107,538	$91,570	$200,679	$307,414	$138,360
Reserve/Surplus	-172.18	27.43	36.51	17.87	12.69	23.75
			West Virginia			
Loss & LAE Reserve	$658,700	$874,900	$988,600	$1,024,900	$1,163,400	$942,100
Surplus	$128,900	($90,600)	($283,500)	($404,300)	($584,000)	($246,700)
Reserve/Surplus	5.11	-9.66	-3.49	-2.53	-1.99	-3.82
			Wyoming			
Loss & LAE Reserve	$0	$8,483	$8,746	$8,949	$0	$5,236
Surplus	$11,000	($2,015)	($15,719)	($13,536)	$0	($4,054)
Reserve/Surplus	0.00	-4.21	-0.56	-0.66	ERR	-1.29
			Total			
Loss & LAE Reserve	$9,486,377	$13,120,817	$14,258,046	$15,677,360	$16,807,251	$13,869,970
Surplus	($1,574,387)	($2,143,687)	($2,302,188)	($2,115,272)	($2,335,540)	($2,094,215)
Reserve/Surplus	-6.03	-6.12	-6.19	-7.41	-7.20	-6.62

Competitive State Funds - Loss & LAE Reserve to Surplus
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Arizona			
Loss & LAE Reserve	$446,217	$516,065	$602,353	$681,568	$776,687	$604,578
Surplus	$69,966	$75,477	$65,585	$73,450	$83,178	$73,531
Reserve/Surplus	6.38	6.84	9.18	9.28	9.34	8.22
			California			
Loss & LAE Reserve	$1,769,733	$2,284,426	$2,915,555	$3,584,485	$4,106,682	$2,932,176
Surplus	$576,365	$627,434	$713,350	$779,076	$790,805	$697,406
Reserve/Surplus	3.07	3.64	4.09	4.60	5.19	4.20
			Colorado			
Loss & LAE Reserve	$384,251	$410,000	$435,001	$450,353	$722,801	$480,481
Surplus	$56,375	$58,249	$53,036	$58,244	($199,987)	$5,183
Reserve/Surplus	6.82	7.04	8.20	7.73	-3.61	92.70
			Idaho			
Loss & LAE Reserve	$41,246	$43,934	$51,161	$60,366	$65,474	$52,436
Surplus	$29,908	$37,976	$38,371	$37,324	$38,448	$36,405
Reserve/Surplus	1.38	1.16	1.33	1.62	1.70	1.44
			Maryland			
Loss & LAE Reserve	$165,500	$209,390	$248,500	$334,000	$409,750	$273,428
Surplus	$69,637	$85,865	$95,635	$105,256	$108,820	$93,043
Reserve/Surplus	2.38	2.44	2.60	3.17	3.77	2.94
			Michigan			
Loss & LAE Reserve	$217,200	$272,933	$333,649	$394,611	$507,745	$345,228
Surplus	$84,630	$66,874	$89,438	$81,767	$36,917	$71,925
Reserve/Surplus	2.57	4.08	3.73	4.83	13.75	4.80
			Minnesota			
Loss & LAE Reserve	$17,685	$30,122	$43,795	$52,288	$61,876	$41,153
Surplus	$7,015	$7,104	$8,838	$13,901	$14,896	$10,351
Reserve/Surplus	2.52	4.24	4.96	3.76	4.15	3.98
			Montana			
Loss & LAE Reserve	$138,118	$196,599	$206,428	$264,595	$294,464	$220,041
Surplus	($81,022)	($149,169)	($157,333)	($217,650)	($221,869)	($165,409)
Reserve/Surplus	-1.70	-1.32	-1.31	-1.22	-1.33	-1.33
			New York			
Loss & LAE Reserve	$1,832,946	$2,095,647	$2,394,613	$2,694,897	$3,266,246	$2,456,870
Surplus	$677,653	$724,740	$765,367	$829,093	$738,154	$747,001
Reserve/Surplus	2.70	2.89	3.13	3.25	4.42	3.29
			Oklahoma			
Loss & LAE Reserve	$190,216	$230,936	$248,915	$277,649	$308,657	$251,275
Surplus	$60,694	$59,390	$50,041	$54,451	$62,709	$57,457
Reserve/Surplus	3.13	3.89	4.97	5.10	4.92	4.37
			Oregon			
Loss & LAE Reserve	$982,206	$1,088,766	$1,080,012	$1,168,055	$1,154,173	$1,094,642
Surplus	$44,846	$32,103	$153,346	$144,340	$148,996	$104,726
Reserve/Surplus	21.90	33.91	7.04	8.09	7.75	10.45
			Pennsylvania			
Loss & LAE Reserve	$560,446	$598,790	$663,527	$686,546	$785,787	$659,019
Surplus	$304,012	$379,203	$374,502	$321,937	$86,233	$293,177
Reserve/Surplus	1.84	1.58	1.77	2.13	9.11	2.25
			Utah			
Loss & LAE Reserve	$109,170	$122,051	$140,382	$159,400	$184,170	$143,035
Surplus	$26,174	$35,113	$37,130	$43,400	$51,571	$38,678
Reserve/Surplus	4.17	3.48	3.78	3.67	3.57	3.70
			Total			
Loss & LAE Reserve	$6,854,934	$8,099,659	$9,363,891	$10,808,813	$12,644,512	$9,554,362
Surplus	$1,926,253	$2,040,359	$2,287,306	$2,324,589	$1,738,871	$2,063,476
Reserve/Surplus	3.56	3.97	4.09	4.65	7.27	4.63

State Funds
Loss & LAE Reserve to Surplus

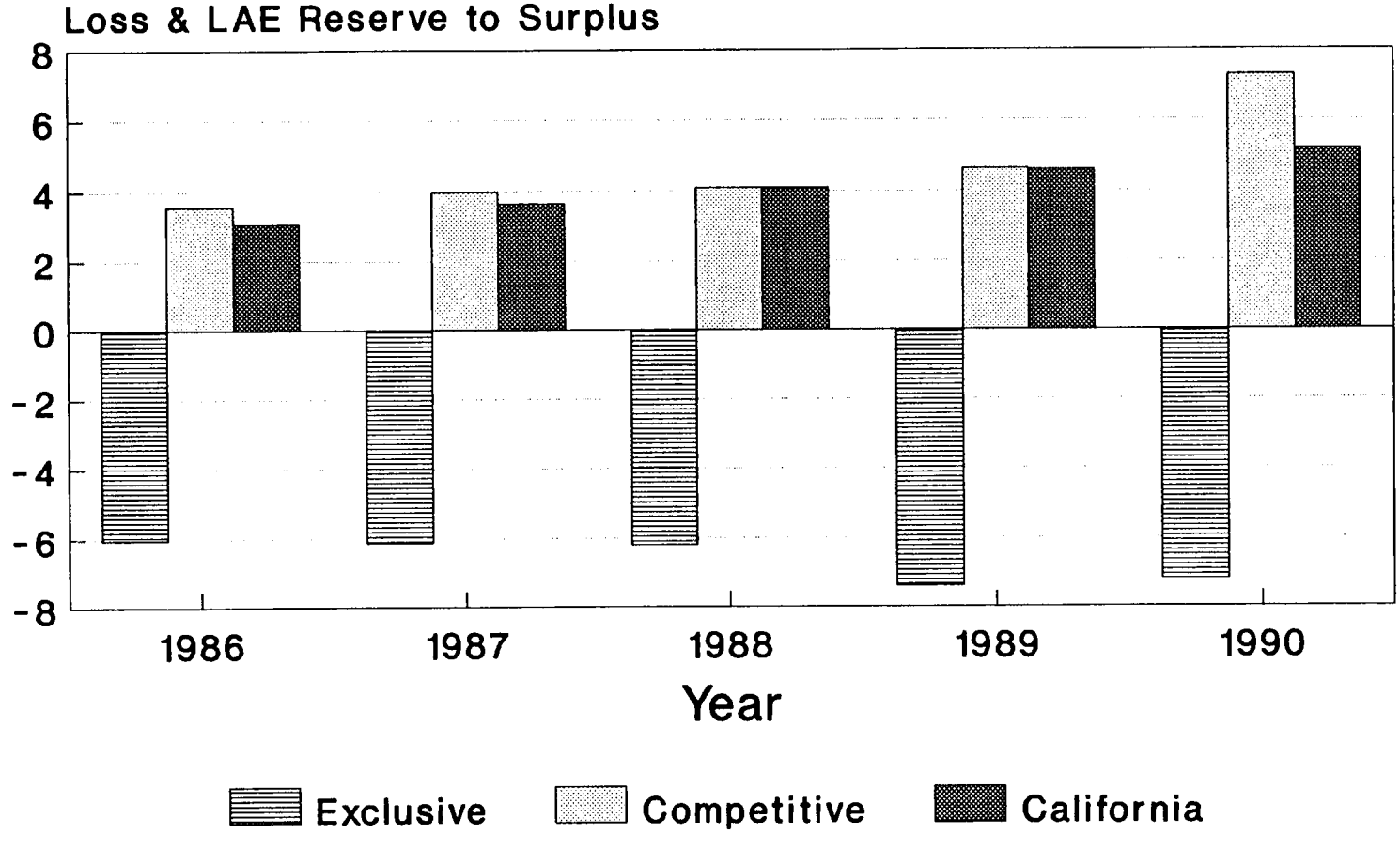


Exhibit AIS-2, Sheet 3

Exclusive State Funds
Loss & LAE Reserve to Surplus
Average 1986-1990

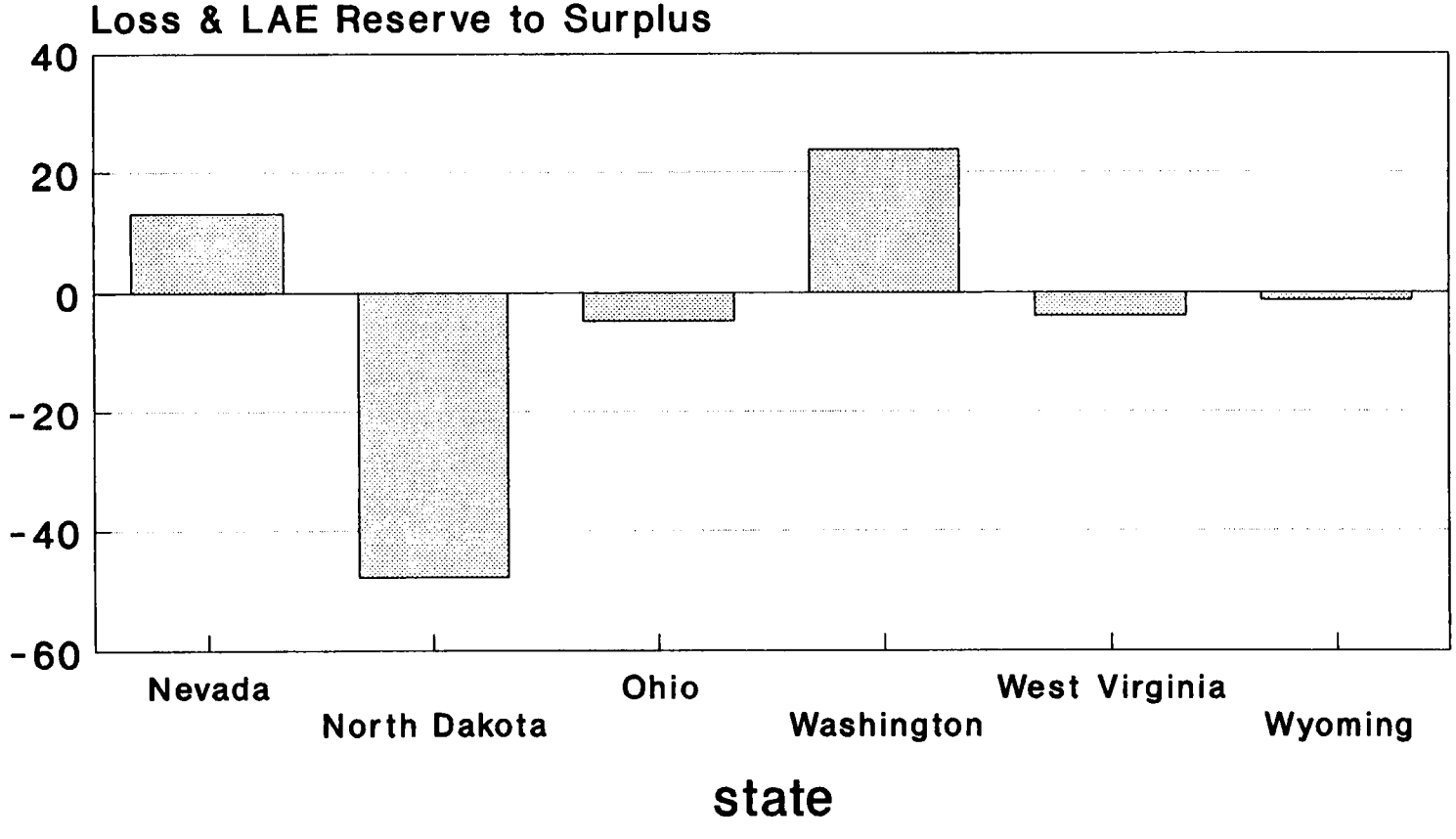


Exhibit AIS-2, Sheet 4

Exclusive State Funds - Change in Writings
(amounts in 000's)

	1986	1987	1988	1989	1990	87-90 Average
			Nevada			
Premiums	$153,101	$163,694	$187,883	$249,818	$310,688	$228,021
Net Change in Premiums	NA	6.9%	14.8%	33.0%	24.4%	19.8%
			North Dakota			
Premiums	$20,003	$20,314	$22,458	$26,701	$36,973	$26,612
Net Change in Premiums	NA	1.6%	10.6%	18.9%	38.5%	17.4%
			Ohio			
Premiums	$1,045,751	$983,926	$1,273,549	$1,493,996	$2,059,323	$1,452,699
Net Change in Premiums	NA	-5.9%	29.4%	17.3%	37.8%	19.7%
			Washington			
Premiums	NA	$572,012	$628,618	$628,300	$751,803	$669,574 *
Net Change in Premiums	NA	NA	9.9%	-0.1%	19.7%	9.8% *
			West Virginia			
Premiums	$140,700	$170,500	$156,200	$195,800	$210,500	$183,250
Net Change in Premiums	NA	21.2%	-8.4%	25.4%	7.5%	11.4%
			Wyoming			
Premiums	$37,000	$27,122	$27,776	$28,384	$44,661	$31,986
Net Change in Premiums	NA	-26.7%	2.4%	2.2%	57.3%	8.8%
			Total			
Premiums Excl. Washington	$1,396,555	$1,365,556				
Premiums Incl. Washington		$1,937,568	$2,296,484	$2,622,999	$3,413,948	$2,567,750
Net Change in Premiums	NA	-2.2%	18.5%	14.2%	30.2%	15.2%

*88-90 Average

Competitive State Funds - Change in Writings
(amounts in 000's)

	1986	1987	1988	1989	1990	87-90 Average
			Arizona			
Premiums	$149,962	$171,834	$193,699	$204,430	$231,531	$200,374
Net Change in Premiums	NA	14.6%	12.7%	5.5%	13.3%	11.5%
			California			
Premiums	$1,038,219	$1,451,486	$1,773,357	$1,807,093	$1,829,618	$1,715,389
Net Change in Premiums	NA	39.8%	22.2%	1.9%	1.2%	16.3%
			Colorado			
Premiums	$174,568	$191,640	$220,671	$233,924	$266,371	$228,152
Net Change in Premiums	NA	9.8%	15.1%	6.0%	13.9%	11.2%
			Idaho			
Premiums	$27,738	$34,190	$42,403	$49,998	$62,805	$47,349
Net Change in Premiums	NA	23.3%	24.0%	17.9%	25.6%	22.7%
			Maryland			
Premiums	$66,976	$100,286	$116,783	$126,441	$149,753	$123,316
Net Change in Premiums	NA	49.7%	16.4%	8.3%	18.4%	23.2%
			Michigan			
Premiums	$81,129	$125,161	$146,281	$154,599	$186,674	$153,179
Net Change in Premiums	NA	54.3%	16.9%	5.7%	20.7%	24.4%
			Minnesota			
Premiums	$23,025	$34,195	$43,539	$45,781	$50,997	$43,628
Net Change in Premiums	NA	48.5%	27.3%	5.1%	11.4%	23.1%
			Montana			
Premiums	$50,861	$70,161	$85,865	$88,448	$93,795	$84,567
Net Change in Premiums	NA	37.9%	22.4%	3.0%	6.0%	17.3%
			New York			
Premiums	$525,396	$649,583	$809,354	$868,488	$1,129,873	$864,325
Net Change in Premiums	NA	23.6%	24.6%	7.3%	30.1%	21.4%
			Oklahoma			
Premiums	$76,398	$83,626	$88,809	$93,450	$107,630	$93,379
Net Change in Premiums	NA	9.5%	6.2%	5.2%	15.2%	9.0%
			Oregon			
Premiums	$217,416	$246,217	$247,522	$230,101	$185,279	$227,280
Net Change in Premiums	NA	13.2%	0.5%	-7.0%	-19.5%	-3.2%
			Pennsylvania			
Premiums	$84,533	$108,203	$125,489	$146,703	$220,534	$150,232
Net Change in Premiums	NA	28.0%	16.0%	16.9%	50.3%	27.8%
			Utah			
Premiums	$51,200	$56,966	$59,207	$74,000	$90,066	$70,060
Net Change in Premiums	NA	11.3%	3.9%	25.0%	21.7%	15.5%
			Total			
Premiums	$2,567,421	$3,323,548	$3,952,979	$4,123,456	$4,604,926	$4,001,227
Net Change in Premiums	NA	29.5%	18.9%	4.3%	11.7%	16.1%

State Funds
Change in Writings

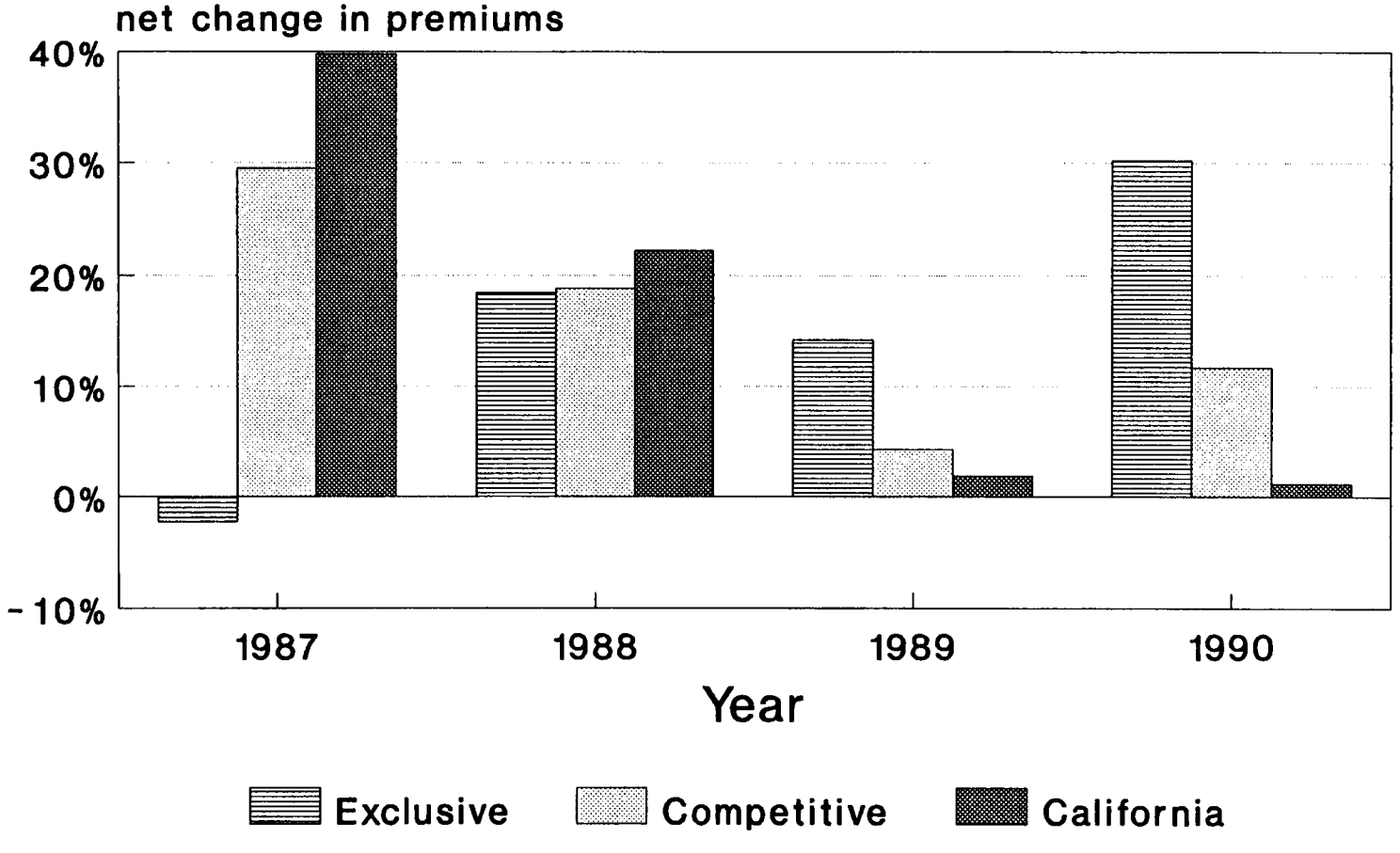


Exhibit AIS-3, Sheet 3

Exclusive State Funds
Change in Writings
Average 1987-1990

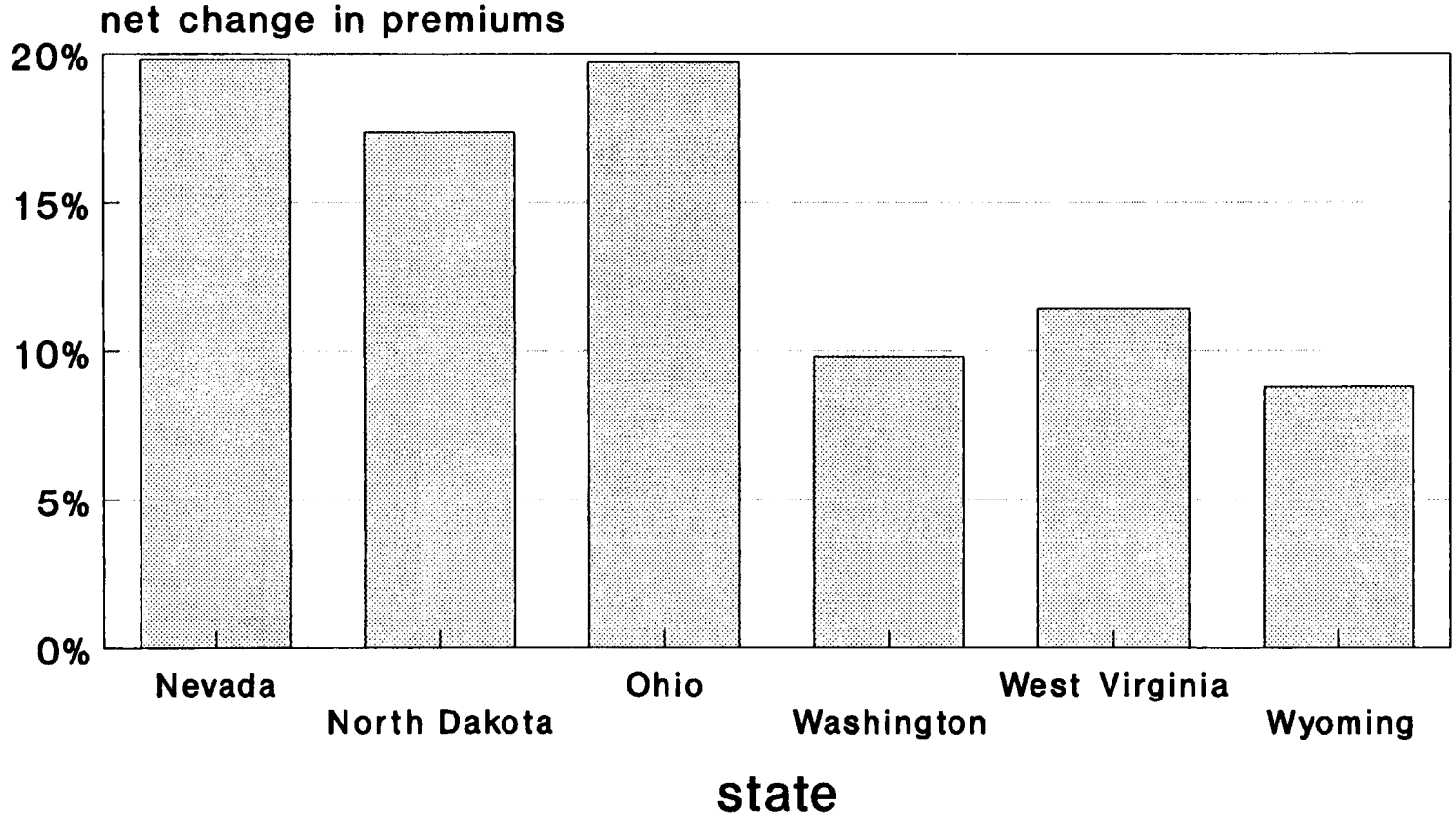


Exhibit AIS-3, Sheet 4

Exclusive State Funds - Operating Profit Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Nevada			
Net Income After Dividends	$2,039	($1,104)	($7,940)	($1,999)	($5,406)	($2,882)
Premiums	$153,101	$163,694	$187,883	$249,818	$310,688	$213,037
Operating Profit Ratio	0.01	-0.01	-0.04	-0.01	-0.02	-0.01
			North Dakota			
Net Income After Dividends	($10,915)	($23,413)	($26,292)	($33,020)	($58,323)	($30,393)
Premiums	$20,003	$20,314	$22,458	$26,701	$36,973	$25,290
Operating Profit Ratio	-0.55	-1.15	-1.17	-1.24	-1.58	-1.20
			Ohio			
Net Income After Dividends	($581,113)	$1,343	$139,301	($152,081)	$140,714	($90,367)
Premiums	$1,045,751	$983,926	$1,273,549	$1,493,996	$2,059,323	$1,371,309
Operating Profit Ratio	-0.56	0.00	0.11	-0.10	0.07	-0.07
			Washington			
Net Income After Dividends	NA	$122,941	($15,969)	$109,110	$106,734	$80,704
Premiums	NA	$572,012	$628,618	$628,300	$751,803	$645,183
Operating Profit Ratio	NA	0.21	-0.03	0.17	0.14	0.13
			West Virginia			
Net Income After Dividends	$0	($91,600)	($156,700)	($42,500)	($79,700)	($74,100)
Premiums	$140,700	$170,500	$156,200	$195,800	$210,500	$174,740
Operating Profit Ratio	0.00	-0.54	-1.00	-0.22	-0.38	-0.42
			Wyoming			
Net Income After Dividends	($13,000)	($13,145)	($18,247)	($16,399)	($7,563)	($13,671)
Premiums	$37,000	$27,122	$27,776	$28,384	$44,661	$32,989
Operating Profit Ratio	-0.35	-0.48	-0.66	-0.58	-0.17	-0.41
			Total			
Net Income After Dividends	($602,989)	($4,978)	($85,847)	($136,889)	$96,456	($146,849)
Premiums	$1,396,555	$1,937,568	$2,296,484	$2,622,999	$3,413,948	$2,333,511
Operating Profit Ratio	-0.43	-0.003	-0.04	-0.05	0.028	-0.06

Competitive State Funds - Operating Profit Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Arizona			
Net Income After Dividends	$9,212	$5,743	($9,899)	$7,598	$10,509	$4,633
Premiums	$149,962	$171,834	$193,699	$204,430	$231,531	$190,291
Operating Profit Ratio	0.06	0.03	-0.05	0.04	0.05	0.02
			California			
Net Income After Dividends	$74,110	$67,212	$106,470	$95,704	$23,850	$73,469
Premiums	$1,038,219	$1,451,486	$1,773,357	$1,807,093	$1,829,618	$1,579,955
Operating Profit Ratio	0.07	0.05	0.06	0.05	0.01	0.05
			Colorado			
Net Income After Dividends	($10,607)	$5,671	($2,361)	($1,097)	($245,505)	($50,780)
Premiums	$174,568	$191,640	$220,671	$233,924	$266,371	$217,435
Operating Profit Ratio	-0.06	0.03	-0.01	0.00	-0.92	-0.23
			Idaho			
Net Income After Dividends	$8,179	$7,533	$418	$994	$8,842	$5,193
Premiums	$27,738	$34,190	$42,403	$49,998	$62,805	$43,427
Operating Profit Ratio	0.29	0.22	0.01	0.02	0.14	0.12
			Maryland			
Net Income After Dividends	$15,127	$16,926	$14,799	$4,320	$4,884	$11,211
Premiums	$66,976	$100,286	$116,783	$126,441	$149,753	$112,048
Operating Profit Ratio	0.23	0.17	0.13	0.03	0.03	0.10
			Michigan			
Net Income After Dividends	($30,173)	$12,669	$13,552	($11,419)	($38,707)	($10,816)
Premiums	$81,129	$125,161	$146,281	$154,599	$186,674	$138,769
Operating Profit Ratio	-0.37	0.10	0.09	-0.07	-0.21	-0.08
			Minnesota			
Net Income After Dividends	$3,269	$1,956	$1,414	$4,739	$1,894	$2,654
Premiums	$23,025	$34,195	$43,539	$45,781	$50,997	$39,507
Operating Profit Ratio	0.14	0.06	0.03	0.10	0.04	0.07
			Montana			
Net Income After Dividends	($52,051)	($67,336)	($8,164)	($60,317)	($4,219)	($38,417)
Premiums	$50,861	$70,161	$85,865	$88,448	$93,795	$77,826
Operating Profit Ratio	-1.02	-0.96	-0.10	-0.68	-0.04	-0.49
			New York			
Net Income After Dividends	$462,924	$95,993	$91,217	$94,318	($5,833)	$147,724
Premiums	$525,396	$649,583	$809,354	$868,488	$1,129,873	$796,539
Operating Profit Ratio	0.88	0.15	0.11	0.11	-0.01	0.19
			Oklahoma			
Net Income After Dividends	$19,336	($1,304)	($511)	$2,771	($3,261)	$3,406
Premiums	$76,398	$83,626	$88,809	$93,450	$107,630	$89,983
Operating Profit Ratio	0.25	-0.02	-0.01	0.03	-0.03	0.04
			Oregon			
Net Income After Dividends	($6,633)	$8,349	($49,911)	($10,373)	$46,452	($2,423)
Premiums	$217,416	$246,217	$247,522	$230,101	$185,279	$225,307
Operating Profit Ratio	-0.03	0.03	-0.20	-0.05	0.25	-0.01
			Pennsylvania			
Net Income After Dividends	$89,477	$77,408	$57,235	$91,556	($3,337)	$62,468
Premiums	$84,533	$108,203	$125,489	$146,703	$220,534	$137,092
Operating Profit Ratio	1.06	0.72	0.46	0.62	-0.02	0.46
			Utah			
Net Income After Dividends	($21,499)	$6,759	$2,017	$6,270	$9,509	$611
Premiums	$51,200	$56,966	$59,207	$74,000	$90,066	$66,288
Operating Profit Ratio	-0.42	0.12	0.03	0.08	0.11	0.01
			Total			
Net Income After Dividends	$560,671	$237,579	$216,276	$225,064	($194,922)	$208,934
Premiums	$2,567,421	$3,323,548	$3,952,979	$4,123,456	$4,604,926	$3,714,466
Operating Profit Ratio	0.22	0.07	0.05	0.05	-0.04	0.06

State Funds
Operating Profit Ratio

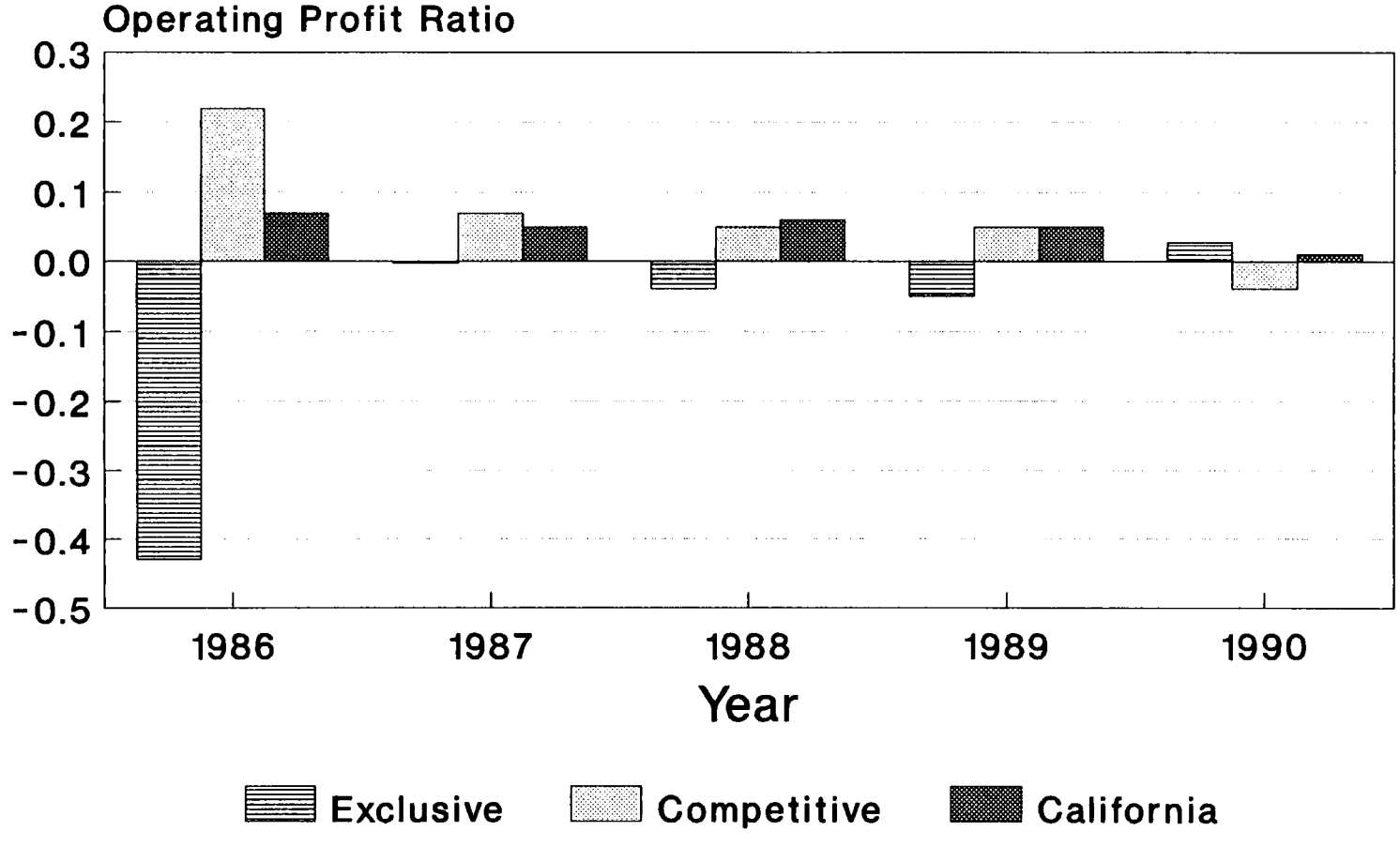


Exhibit AIS-4, Sheet 3

Exclusive State Funds
Operating Profit Ratio
Average 1986-1990

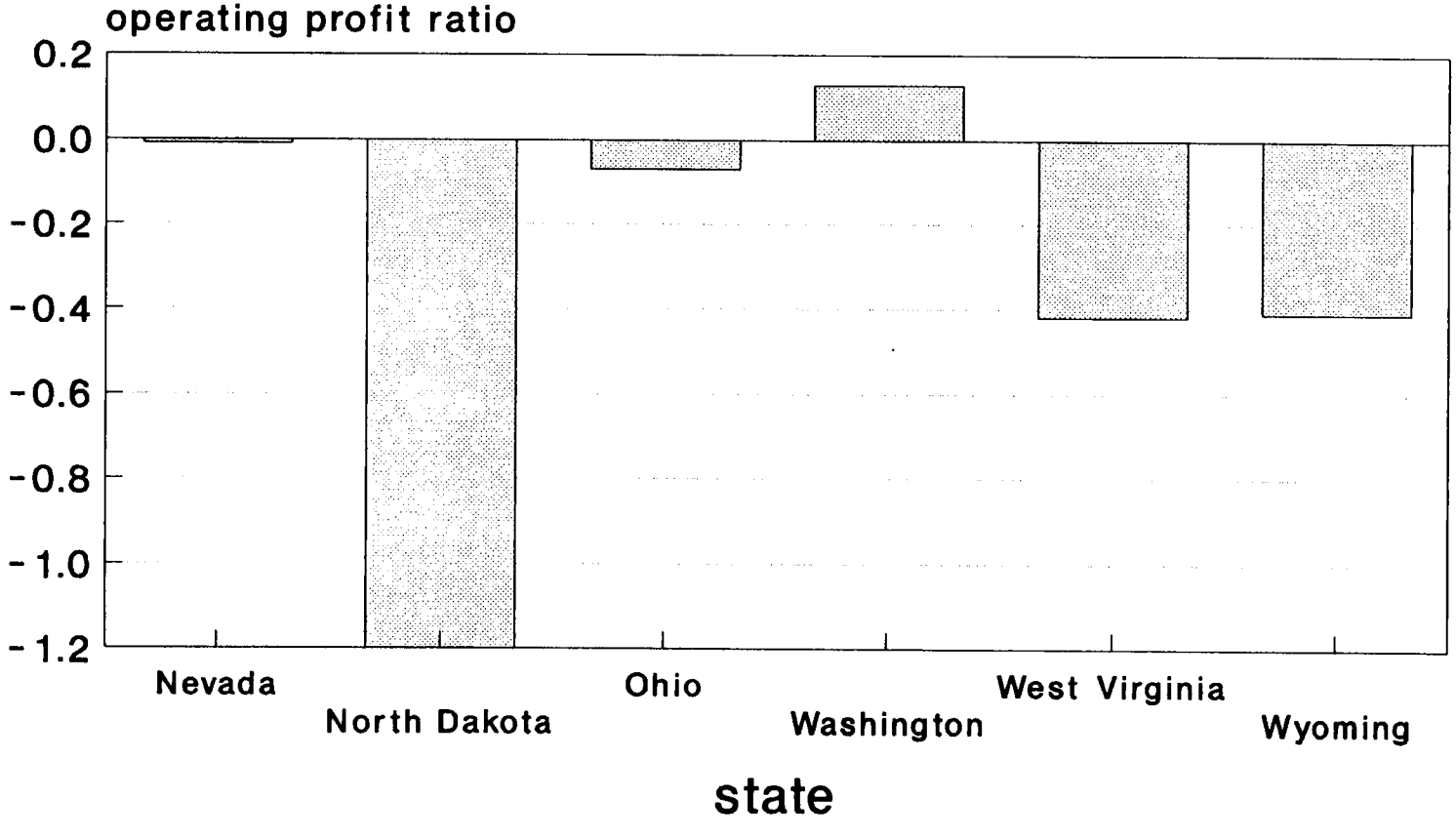


Exhibit AIS-4, Sheet 4

Exclusive State Funds - Loss Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Nevada			
Incurred Losses	$189,982	$201,184	$224,551	$276,612	$338,791	$246,224
Premiums	$153,101	$163,694	$187,883	$249,818	$310,688	$213,037
Loss Ratio	1.24	1.23	1.20	1.11	1.09	1.16
			North Dakota			
Incurred Losses	$51,365	$59,978	$64,200	$72,586	$107,488	$71,123
Premiums	$20,003	$20,314	$22,458	$26,701	$36,973	$25,290
Loss Ratio	2.57	2.95	2.86	2.72	2.91	2.81
			Ohio			
Incurred Losses	$2,118,388	$1,503,210	$1,672,448	$2,243,931	$2,366,208	$1,980,837
Premiums	$1,045,751	$983,926	$1,273,549	$1,493,996	$2,059,323	$1,371,309
Loss Ratio	2.03	1.53	1.31	1.50	1.15	1.44
			Washington			
Incurred Losses	NA	$747,893	$887,827	$771,301	$868,486	$818,877
Premiums	NA	$572,012	$628,618	$628,300	$751,803	$645,183
Loss Ratio	NA	1.31	1.41	1.23	1.16	1.27
			West Virginia			
Incurred Losses	$221,700	$324,700	$363,400	$271,900	$330,400	$302,420
Premiums	$140,700	$170,500	$156,200	$195,800	$210,500	$174,740
Loss Ratio	1.58	1.90	2.33	1.39	1.57	1.73
			Wyoming			
Incurred Losses	$50,000	$43,190	$44,843	$45,661	$51,055	$46,950
Premiums	$37,000	$27,122	$27,776	$28,384	$44,661	$32,989
Loss Ratio	1.35	1.59	1.61	1.61	1.14	1.42
			Total			
Incurred Losses	$2,631,435	$2,880,155	$3,257,269	$3,681,991	$4,062,428	$3,302,656
Premiums	$1,396,555	$1,937,568	$2,296,484	$2,622,999	$3,413,948	$2,333,511
Loss Ratio	1.88	1.49	1.42	1.40	1.19	1.42

Competitive State Funds - Loss Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Arizona			
Incurred Losses	$149,418	$158,442	$200,677	$198,079	$246,482	$190,620
Premiums	$149,962	$171,834	$193,699	$204,430	$231,531	$190,291
Loss Ratio	1.00	0.92	1.04	0.97	1.06	1.00
			California			
Incurred Losses	$834,105	$1,109,107	$1,390,766	$1,531,136	$1,541,874	$1,281,398
Premiums	$1,038,219	$1,451,486	$1,773,357	$1,807,093	$1,829,618	$1,579,955
Loss Ratio	0.80	0.76	0.78	0.85	0.84	0.81
			Colorado			
Incurred Losses	$198,992	$198,329	$229,982	$249,309	$518,685	$279,059
Premiums	$174,568	$191,640	$220,671	$233,924	$266,371	$217,435
Loss Ratio	1.14	1.03	1.04	1.07	1.95	1.28
			Idaho			
Incurred Losses	$17,703	$19,691	$30,852	$36,335	$37,653	$28,447
Premiums	$27,738	$34,190	$42,403	$49,998	$62,805	$43,427
Loss Ratio	0.64	0.58	0.73	0.73	0.60	0.66
			Maryland			
Incurred Losses	$71,586	$102,527	$115,911	$189,090	$181,679	$132,159
Premiums	$66,976	$100,286	$116,783	$126,441	$149,753	$112,048
Loss Ratio	1.07	1.02	0.99	1.50	1.21	1.18
			Michigan			
Incurred Losses	$108,647	$108,374	$120,717	$142,187	$196,459	$135,277
Premiums	$81,129	$125,161	$146,281	$154,599	$186,674	$138,769
Loss Ratio	1.34	0.87	0.83	0.92	1.05	0.97
			Minnesota			
Incurred Losses	$15,084	$21,224	$28,545	$25,955	$33,372	$24,836
Premiums	$23,025	$34,195	$43,539	$45,781	$50,997	$39,507
Loss Ratio	0.66	0.62	0.66	0.57	0.65	0.63
			Montana			
Incurred Losses	$99,287	$138,031	$100,387	$155,905	$123,350	$123,392
Premiums	$50,861	$70,161	$85,865	$88,448	$93,795	$77,826
Loss Ratio	1.95	1.97	1.17	1.76	1.32	1.59
			New York			
Dividends	$93,908	$591,724	$704,514	$742,914	$1,188,288	$664,270
Premiums	$525,396	$649,583	$809,354	$868,488	$1,129,873	$796,539
Dividend Ratio	0.18	0.91	0.87	0.86	1.05	0.83
			Oklahoma			
Incurred Losses	$65,337	$92,458	$100,478	$101,858	$121,993	$96,425
Premiums	$76,398	$83,626	$88,809	$93,450	$107,630	$89,983
Loss Ratio	0.86	1.11	1.13	1.09	1.13	1.07
			Oregon			
Incurred Losses	$274,369	$287,353	$335,226	$273,556	$166,432	$267,387
Premiums	$217,416	$246,217	$247,522	$230,101	$185,279	$225,307
Loss Ratio	1.26	1.17	1.35	1.19	0.90	1.19
			Pennsylvania			
Incurred Losses	$84,314	$113,297	$157,917	$127,774	$216,696	$140,000
Premiums	$84,533	$108,203	$125,489	$146,703	$220,534	$137,092
Loss Ratio	1.00	1.05	1.26	0.87	0.98	1.02
			Utah			
Incurred Losses	$67,474	$56,823	$63,528	$72,190	$84,184	$68,840
Premiums	$51,200	$56,966	$59,207	$74,000	$90,066	$66,288
Loss Ratio	1.32	1.00	1.07	0.98	0.93	1.04
			Total			
Incurred Losses	$2,080,224	$2,997,380	$3,579,500	$3,846,288	$4,657,147	$3,432,108
Premiums	$2,567,421	$3,323,548	$3,952,979	$4,123,456	$4,604,926	$3,714,466
Loss Ratio	0.81	0.90	0.91	0.93	1.01	0.92

State Funds
Loss Ratio

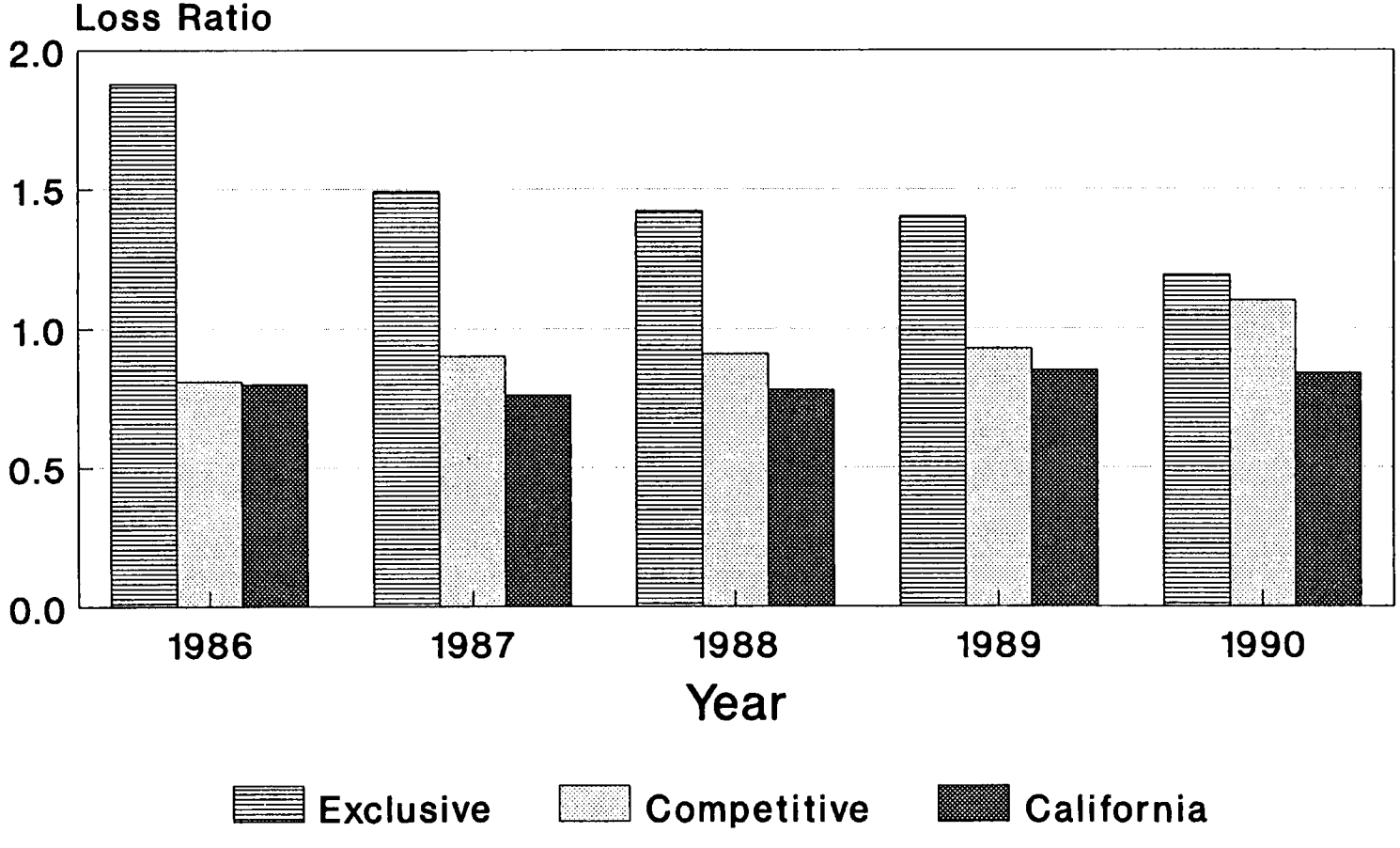


Exhibit AIS-5, Sheet 3

Exclusive State Funds
Loss Ratio
Average 1986-1990

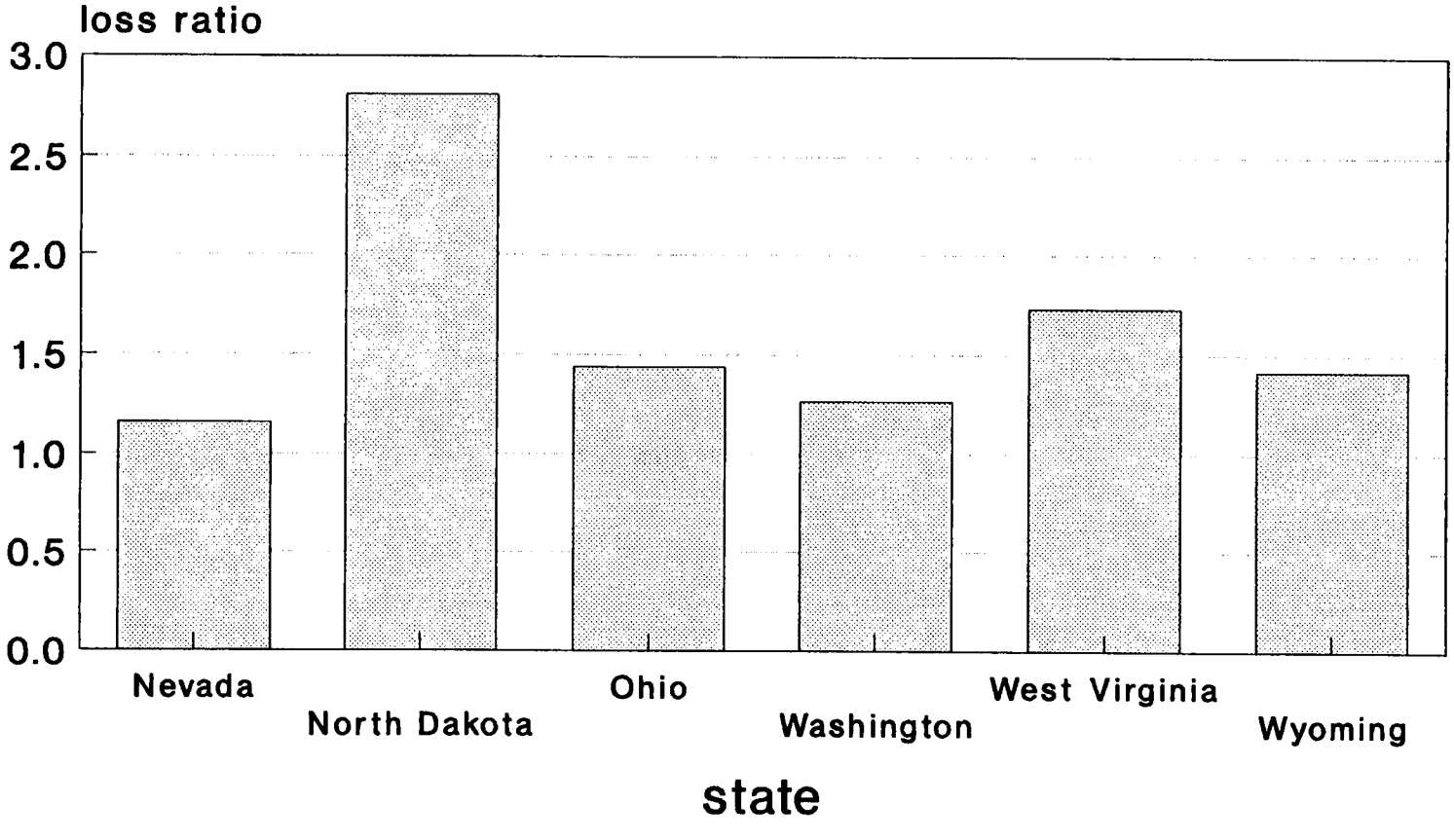


Exhibit AIS-5, Sheet 4

Exclusive State Funds - Expense Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Nevada			
Expense	$21,744	$25,509	$29,367	$31,590	$38,702	$29,382
Premiums	$153,101	$163,694	$187,883	$249,818	$310,688	$213,037
Expense Ratio	0.14	0.16	0.16	0.13	0.12	0.14
			North Dakota			
Expense	$2,379	$4,738	$3,828	$3,052	$4,067	$3,613
Premiums	$20,003	$20,314	$22,458	$26,701	$36,973	$25,290
Expense Ratio	0.12	0.23	0.17	0.11	0.11	0.14
			Ohio			
Expense	$31,921	$26,801	$33,532	$5,283	$199,131	$59,334
Premiums	$1,045,751	$983,926	$1,273,549	$1,493,996	$2,059,323	$1,371,309
Expense Ratio	0.03	0.03	0.03	0.00	0.10	0.04
			Washington			
Expense	NA	$56,323	$97,001	$102,495	$126,436	$95,564
Premiums	NA	$572,012	$628,618	$628,300	$751,803	$645,183
Expense Ratio	NA	0.10	0.15	0.16	0.17	0.15
			West Virginia			
Expense	$13,600	$15,000	$16,200	$15,300	$15,300	$15,080
Premiums	$140,700	$170,500	$156,200	$195,800	$210,500	$174,740
Expense Ratio	0.10	0.09	0.10	0.08	0.07	0.09
			Wyoming			
Expense	$0	$1,965	$2,379	$2,123	$1,912	$1,676
Premiums	$37,000	$27,122	$27,776	$28,384	$44,661	$32,989
Expense Ratio	0.00	0.07	0.09	0.07	0.04	0.05
			Total			
Expense	$69,644	$130,336	$182,307	$159,843	$385,548	$185,536
Premiums	$1,396,555	$1,937,568	$2,296,484	$2,622,999	$3,413,948	$2,333,511
Expense Ratio	0.05	0.07	0.08	0.06	0.11	0.08

Competitive State Funds - Expense Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Arizona			
Expense	$35,700	$38,997	$40,260	$41,873	$38,784	$39,123
Premiums	$149,962	$171,834	$193,699	$204,430	$231,531	$190,291
Expense Ratio	0.24	0.23	0.21	0.20	0.17	0.21
			California			
Expense	$165,794	$236,667	$281,349	$296,528	$325,816	$261,231
Premiums	$1,038,219	$1,451,486	$1,773,357	$1,807,093	$1,829,618	$1,579,955
Expense Ratio	0.16	0.16	0.16	0.16	0.18	0.17
			Colorado			
Expense	$21,803	$20,687	$26,370	$29,275	$37,938	$27,215
Premiums	$174,568	$191,640	$220,671	$233,924	$266,371	$217,435
Expense Ratio	0.12	0.11	0.12	0.13	0.14	0.13
			Idaho			
Expense	$3,441	$4,204	$5,079	$6,349	$8,117	$5,438
Premiums	$27,738	$34,190	$42,403	$49,998	$62,805	$43,427
Expense Ratio	0.12	0.12	0.12	0.13	0.13	0.13
			Maryland			
Expense	$7,695	$10,104	$12,758	$14,084	$18,286	$12,585
Premiums	$66,976	$100,286	$116,783	$126,441	$149,753	$112,048
Expense Ratio	0.11	0.10	0.11	0.11	0.12	0.11
			Michigan			
Expense	$35,950	$37,229	$44,543	$39,351	$74,877	$46,390
Premiums	$81,129	$125,161	$146,281	$154,599	$186,674	$138,769
Expense Ratio	0.44	0.30	0.30	0.25	0.40	0.33
			Minnesota			
Expense	$6,561	$9,753	$13,863	$15,942	$17,594	$12,743
Premiums	$23,025	$34,195	$43,539	$45,781	$50,997	$39,507
Expense Ratio	0.28	0.29	0.32	0.35	0.35	0.32
			Montana			
Expense	$6,921	$6,249	$8,009	$8,893	$11,057	$8,226
Premiums	$50,861	$70,161	$85,865	$88,448	$93,795	$77,826
Expense Ratio	0.14	0.09	0.09	0.10	0.12	0.11
			New York			
Expense	$137,744	$143,741	$203,492	$223,385	$148,827	$171,438
Premiums	$525,396	$649,583	$809,354	$868,488	$1,129,873	$796,539
Expense Ratio	0.26	0.22	0.25	0.26	0.13	0.22
			Oklahoma			
Expense	$11,105	$11,594	$11,194	$14,647	$14,805	$12,669
Premiums	$76,398	$83,626	$88,809	$93,450	$107,630	$89,983
Expense Ratio	0.15	0.14	0.13	0.16	0.14	0.14
			Oregon			
Expense	$63,253	$58,152	$62,819	$70,576	$59,445	$62,849
Premiums	$217,416	$246,217	$247,522	$230,101	$185,279	$225,307
Expense Ratio	0.29	0.24	0.25	0.31	0.32	0.28
			Pennsylvania			
Expense	$4,590	$8,870	$13,643	$28,958	$44,039	$20,020
Premiums	$84,533	$108,203	$125,489	$146,703	$220,534	$137,092
Expense Ratio	0.05	0.08	0.11	0.20	0.20	0.15
			Utah			
Expense	$8,425	$6,522	$10,806	$11,800	$15,044	$10,519
Premiums	$51,200	$56,966	$59,207	$74,000	$90,066	$66,288
Expense Ratio	0.16	0.11	0.18	0.16	0.17	0.16
			Total			
Expense	$508,982	$592,769	$734,185	$801,661	$814,629	$690,445
Premiums	$2,567,421	$3,323,548	$3,952,979	$4,123,456	$4,604,926	$3,714,466
Expense Ratio	0.20	0.18	0.19	0.19	0.18	0.19

State Funds
Expense Ratio

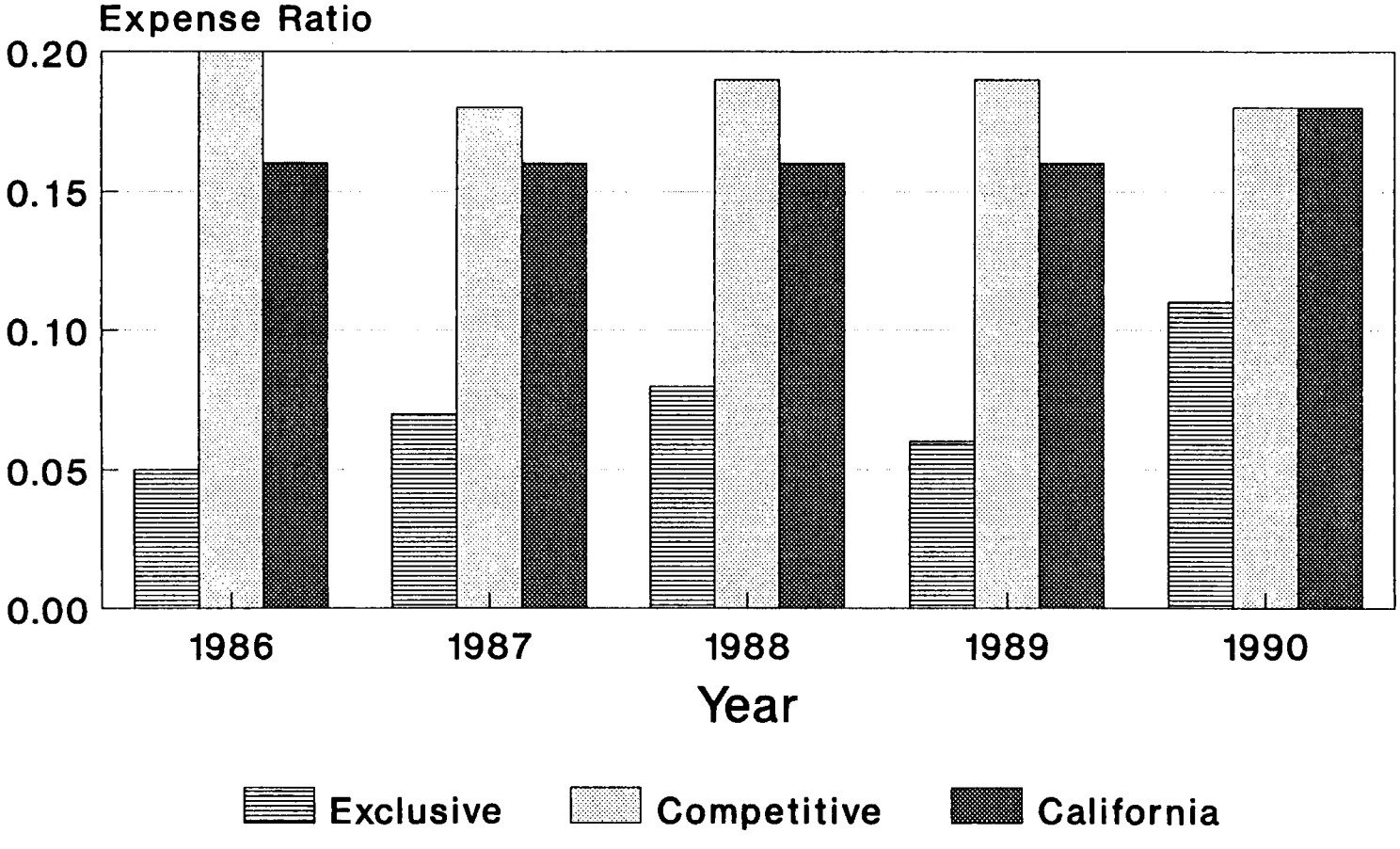


Exhibit AIS-6, Sheet 3

Exclusive State Funds
Expense Ratio
Average 1986-1990

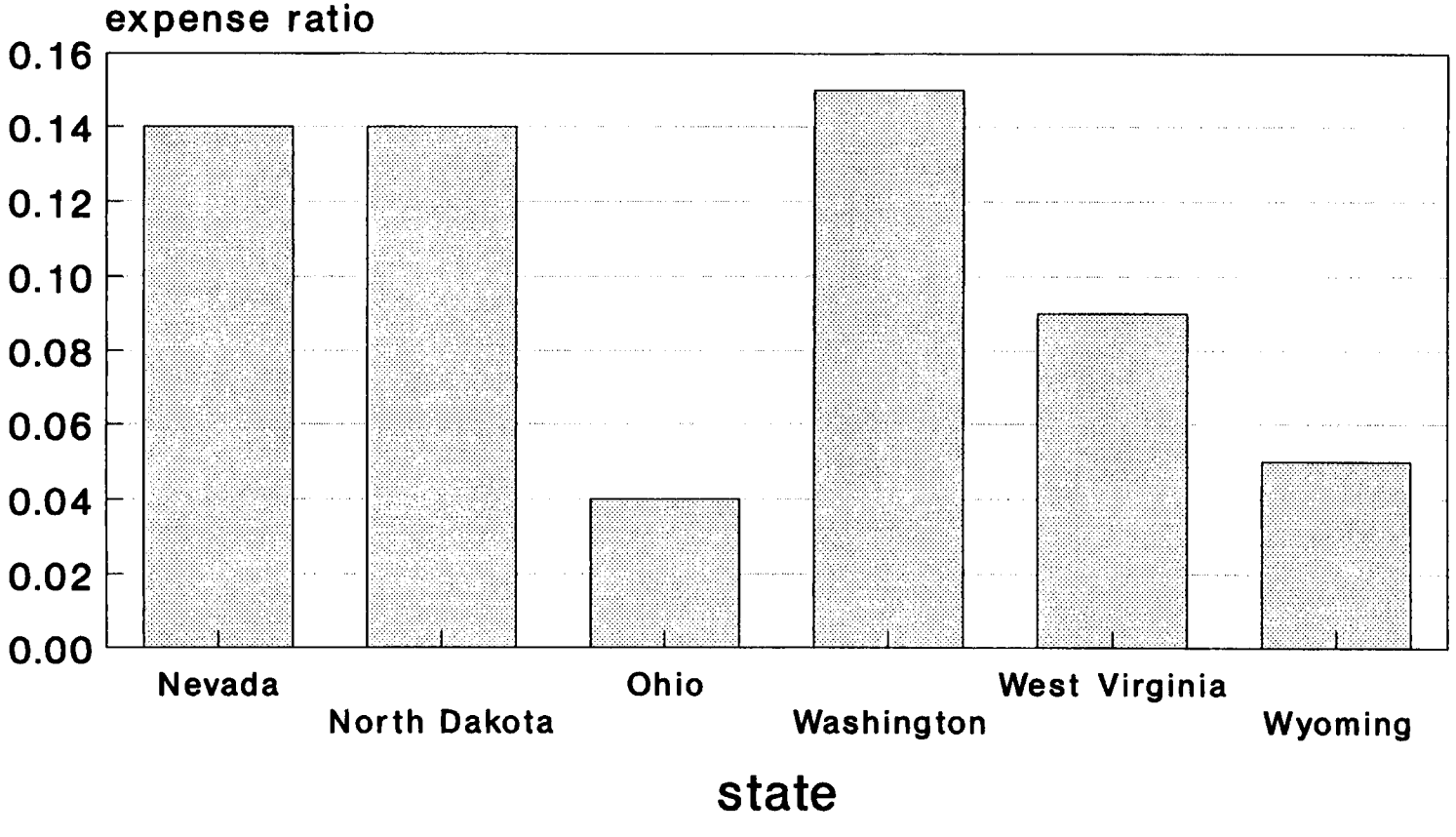


Exhibit AIS-6, Sheet 4

Exclusive State Funds - Dividend Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Nevada			
Dividends	$0	$2,109	$0	$0	$0	$422
Premiums	$153,101	$163,694	$187,883	$249,818	$310,688	$213,037
Dividend Ratio	0.00	0.01	0.00	0.00	0.00	0.002
			North Dakota			
Dividends	$0	$0	$0	$0	$0	$0
Premiums	$20,003	$20,314	$22,458	$26,701	$36,973	$25,290
Dividend Ratio	0.00	0.00	0.00	0.00	0.00	0.00
			Ohio			
Dividends	$0	$0	$0	$0	$0	$0
Premiums	$1,045,751	$983,926	$1,273,549	$1,493,996	$2,059,323	$1,371,309
Dividend Ratio	0.00	0.00	0.00	0.00	0.00	0.00
			Washington			
Dividends	NA	$0	$0	$0	$0	$0
Premiums	NA	$572,012	$628,618	$628,300	$751,803	$645,183
Dividend Ratio	NA	0.00	0.00	0.00	0.00	0.00
			West Virginia			
Dividends	$0	$0	$0	$0	$0	$0
Premiums	$140,700	$170,500	$156,200	$195,800	$210,500	$174,740
Dividend Ratio	0.00	0.00	0.00	0.00	0.00	0.00
			Wyoming			
Dividends	$0	$0	$0	$0	$0	$0
Premiums	$37,000	$27,122	$27,776	$28,384	$44,661	$32,989
Dividend Ratio	0.00	0.00	0.00	0.00	0.00	0.00
			Total			
Dividends	$0	$2,109	$0	$0	$0	$422
Premiums	$1,396,555	$1,937,568	$2,296,484	$2,622,999	$3,413,948	$2,333,511
Dividend Ratio	0.00	0.001	0.00	0.00	0.00	0.0002

Competitive State Funds - Dividend Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Arizona			
Dividends	$20,000	$30,000	$30,000	$30,000	$18,200	$25,640
Premiums	$149,962	$171,834	$193,699	$204,430	$231,531	$190,291
Dividend Ratio	0.13	0.17	0.15	0.15	0.08	0.13
			California			
Dividends	$187,168	$277,322	$291,760	$254,373	$358,187	$273,762
Premiums	$1,038,219	$1,451,486	$1,773,357	$1,807,093	$1,829,618	$1,579,955
Dividend Ratio	0.18	0.19	0.16	0.14	0.20	0.17
			Colorado			
Dividends	$0	$0	$0	$0	$0	$0
Premiums	$174,568	$191,640	$220,671	$233,924	$266,371	$217,435
Dividend Ratio	0.00	0.00	0.00	0.00	0.00	0.00
			Idaho			
Dividends	$6,178	$10,821	$15,292	$17,349	$19,377	$13,803
Premiums	$27,738	$34,190	$42,403	$49,998	$62,805	$43,427
Dividend Ratio	0.22	0.32	0.36	0.35	0.31	0.32
			Maryland			
Dividends	$0	$0	$0	$0	$0	$0
Premiums	$66,976	$100,286	$116,783	$126,441	$149,753	$112,048
Dividend Ratio	0.00	0.00	0.00	0.00	0.00	0.00
			Michigan			
Dividends	$0	$1,139	$5,319	$30,340	$3,646	$8,089
Premiums	$81,129	$125,161	$146,281	$154,599	$186,674	$138,769
Dividend Ratio	0.00	0.01	0.04	0.20	0.02	0.06
			Minnesota			
Dividends	$0	$1,391	$875	$1,357	$2,452	$1,215
Premiums	$23,025	$34,195	$43,539	$45,781	$50,997	$39,507
Dividend Ratio	0.00	0.04	0.02	0.03	0.05	0.03
			Montana			
Dividends	$0	$0	$0	$0	$0	$0
Premiums	$50,861	$70,161	$85,865	$88,448	$93,795	$77,826
Dividend Ratio	0.00	0.00	0.00	0.00	0.00	0.00
			New York			
Dividends	$71,031	$31,563	$37,359	$39,758	$55,585	$47,059
Premiums	$525,396	$649,583	$809,354	$868,488	$1,129,873	$796,539
Dividend Ratio	0.14	0.05	0.05	0.05	0.05	0.06
			Oklahoma			
Dividends	$0	$0	$0	$0	$0	$0
Premiums	$76,398	$83,626	$88,809	$93,450	$107,630	$89,983
Dividend Ratio	0.00	0.00	0.00	0.00	0.00	0.00
			Oregon			
Dividends	($235)	($391)	($123)	($233)	$20,430	$3,890
Premiums	$217,416	$246,217	$247,522	$230,101	$185,279	$225,307
Dividend Ratio	-0.001	-0.002	-0.0005	-0.001	0.11	0.02
			Pennsylvania			
Dividends	$0	$0	$0	$0	$53,915	$10,783
Premiums	$84,533	$108,203	$125,489	$146,703	$220,534	$137,092
Dividend Ratio	0.00	0.00	0.00	0.00	0.24	0.08
			Utah			
Dividends	$8,650	$0	$0	$0	$0	$1,730
Premiums	$51,200	$56,966	$59,207	$74,000	$90,066	$66,288
Dividend Ratio	0.17	0.00	0.00	0.00	0.00	0.03
			Total			
Dividends	$292,792	$351,845	$380,482	$372,944	$531,792	$385,971
Premiums	$2,567,421	$3,323,548	$3,952,979	$4,123,456	$4,604,926	$3,714,466
Dividend Ratio	0.11	0.11	0.10	0.09	0.12	0.10

State Funds
Dividend Ratio

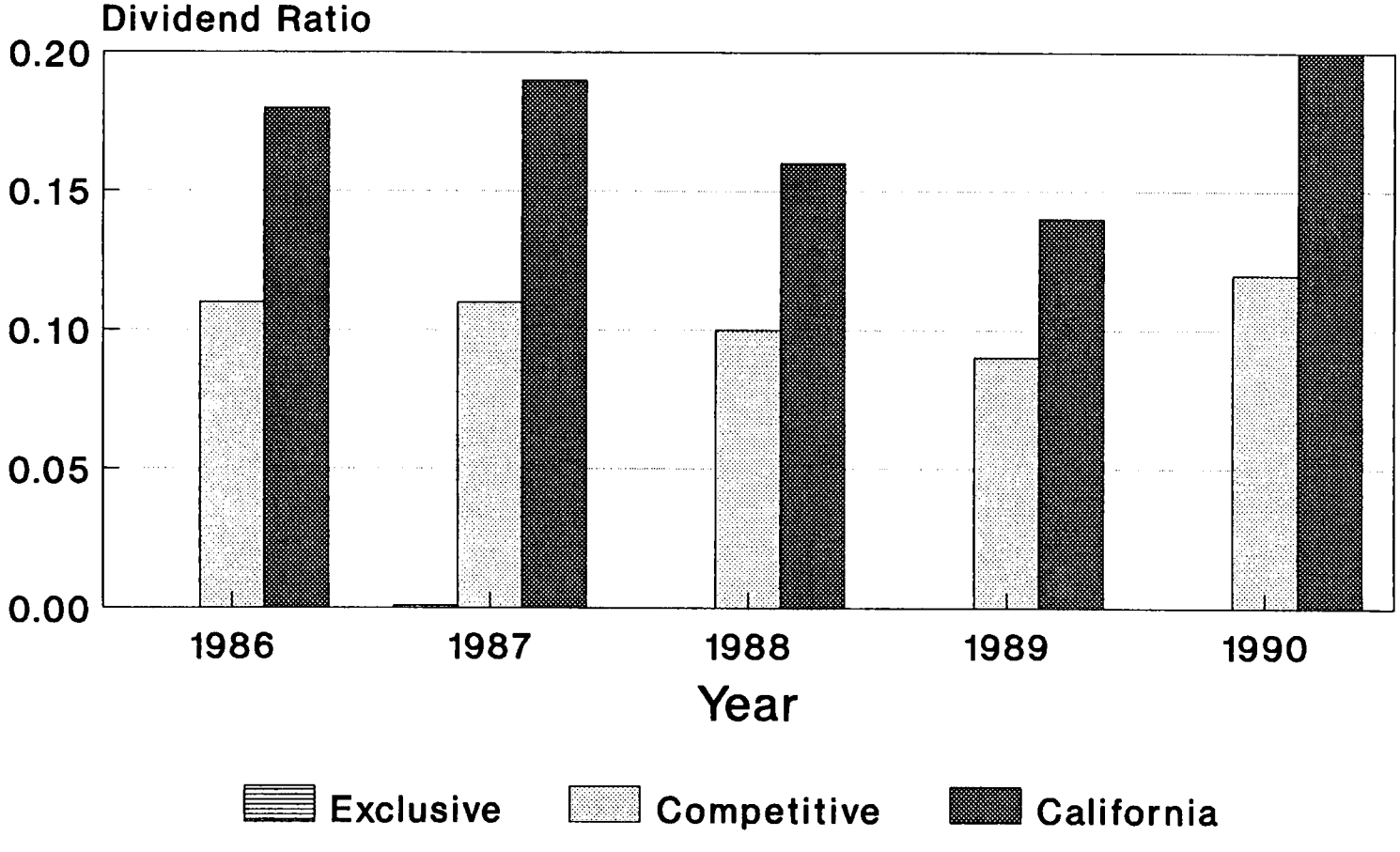


Exhibit AIS-7, Sheet 3

Exclusive State Funds
Dividend Ratio
Average 1986-1990

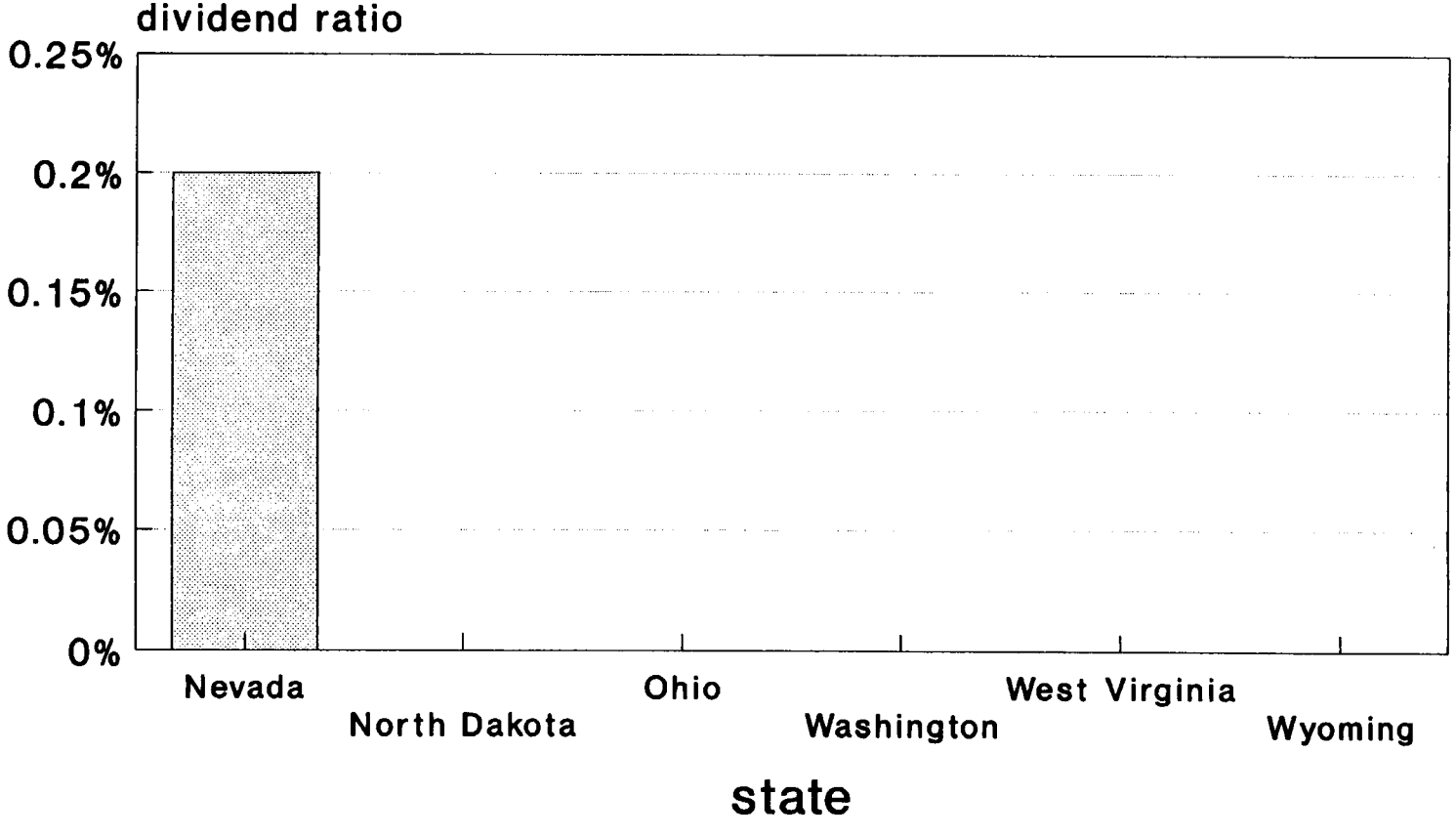


Exhibit AIS-7, Sheet 4

Exclusive State Funds - Investment Income Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Nevada			
Investment & Other Income	$60,664	$64,004	$58,095	$56,385	$61,399	$60,109
Premiums	$153,101	$163,694	$187,883	$249,818	$310,688	$213,037
Investment Income Ratio	0.40	0.39	0.31	0.23	0.20	0.28
			North Dakota			
Investment & Other Income	$22,826	$20,989	$19,278	$15,917	$16,259	$19,054
Premiums	$20,003	$20,314	$22,458	$26,701	$36,973	$25,290
Investment Income Ratio	1.14	1.03	0.86	0.60	0.44	0.75
			Ohio			
Investment & Other Income	$523,445	$547,428	$571,732	$603,137	$646,730	$578,494
Premiums	$1,045,751	$983,926	$1,273,549	$1,493,996	$2,059,323	$1,371,309
Investment Income Ratio	0.50	0.56	0.45	0.40	0.31	0.42
			Washington			
Investment & Other Income	NA	$355,145	$340,241	$354,606	$349,853	$349,961
Premiums	NA	$572,012	$628,618	$628,300	$751,803	$645,183
Investment Income Ratio	NA	0.62	0.54	0.56	0.47	0.54
			West Virginia			
Investment & Other Income	$94,600	$77,600	$66,700	$48,900	$55,500	$68,660
Premiums	$140,700	$170,500	$156,200	$195,800	$210,500	$174,740
Investment Income Ratio	0.67	0.46	0.43	0.25	0.26	0.39
			Wyoming			
Investment & Other Income	$0	$4,888	$1,199	$3,001	$743	$1,966
Premiums	$37,000	$27,122	$27,776	$28,384	$44,661	$32,989
Investment Income Ratio	0.00	0.18	0.04	0.11	0.02	0.06
			Total			
Investment & Other Income	$701,535	$1,070,054	$1,057,245	$1,081,946	$1,130,484	$1,008,253
Premiums	$1,396,555	$1,937,568	$2,296,484	$2,622,999	$3,413,948	$2,333,511
Investment Income Ratio	0.50	0.55	0.46	0.41	0.33	0.43

Competitive State Funds - Investment Income Ratio
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Arizona			
Investment & Other Income	$64,368	$61,348	$67,337	$73,120	$84,444	$70,123
Premiums	$149,962	$171,834	$193,699	$204,430	$231,531	$190,291
Investment Income Ratio	0.43	0.36	0.35	0.36	0.36	0.37
			California			
Investment & Other Income	$222,958	$238,822	$296,988	$370,650	$420,109	$309,905
Premiums	$1,038,219	$1,451,486	$1,773,357	$1,807,093	$1,829,618	$1,579,955
Investment Income Ratio	0.21	0.16	0.17	0.21	0.23	0.20
			Colorado			
Investment & Other Income	$35,620	$33,047	$33,320	$43,563	$44,747	$38,059
Premiums	$174,568	$191,640	$220,671	$233,924	$266,371	$217,435
Investment Income Ratio	0.20	0.17	0.15	0.19	0.17	0.18
			Idaho			
Investment & Other Income	$7,763	$8,059	$9,238	$11,029	$11,184	$9,455
Premiums	$27,738	$34,190	$42,403	$49,998	$62,805	$43,427
Investment Income Ratio	0.28	0.24	0.22	0.22	0.18	0.22
			Maryland			
Investment & Other Income	$27,432	$29,271	$26,665	$81,053	$55,096	$43,903
Premiums	$66,976	$100,286	$116,783	$126,441	$149,753	$112,048
Investment Income Ratio	0.41	0.29	0.23	0.64	0.37	0.39
			Michigan			
Investment & Other Income	$33,295	$34,250	$37,850	$45,860	$49,601	$40,171
Premiums	$81,129	$125,161	$146,281	$154,599	$186,674	$138,769
Investment Income Ratio	0.41	0.27	0.26	0.30	0.27	0.29
			Minnesota			
Investment & Other Income	$1,889	$3,180	$3,329	$5,132	$6,777	$4,061
Premiums	$23,025	$34,195	$43,539	$45,781	$50,997	$39,507
Investment Income Ratio	0.08	0.09	0.08	0.11	0.13	0.10
			Montana			
Investment & Other Income	$3,296	$6,783	$14,367	$16,033	$36,393	$15,374
Premiums	$50,861	$70,161	$85,865	$88,448	$93,795	$77,826
Investment Income Ratio	0.06	0.10	0.17	0.18	0.39	0.20
			New York			
Investment & Other Income	$240,211	$213,440	$227,228	$231,887	$256,994	$233,952
Premiums	$525,396	$649,583	$809,354	$868,488	$1,129,873	$796,539
Investment Income Ratio	0.46	0.33	0.28	0.27	0.23	0.29
			Oklahoma			
Investment & Other Income	$19,380	$19,122	$22,352	$25,826	$25,907	$22,517
Premiums	$76,398	$83,626	$88,809	$93,450	$107,630	$89,983
Investment Income Ratio	0.25	0.23	0.25	0.28	0.24	0.25
			Oregon			
Investment & Other Income	$113,338	$107,246	$100,489	$103,425	$107,480	$106,396
Premiums	$217,416	$246,217	$247,522	$230,101	$185,279	$225,307
Investment Income Ratio	0.52	0.44	0.41	0.45	0.58	0.47
			Pennsylvania			
Investment & Other Income	$93,848	$91,372	$103,306	$101,585	$90,779	$96,178
Premiums	$84,533	$108,203	$125,489	$146,703	$220,534	$137,092
Investment Income Ratio	1.11	0.84	0.82	0.69	0.41	0.70
			Utah			
Investment & Other Income	$11,850	$13,138	$17,144	$16,260	$18,671	$15,413
Premiums	$51,200	$56,966	$59,207	$74,000	$90,066	$66,288
Investment Income Ratio	0.23	0.23	0.29	0.22	0.21	0.23
			Total			
Investment & Other Income	$875,248	$859,078	$959,613	$1,125,423	$1,208,182	$1,005,509
Premiums	$2,567,421	$3,323,548	$3,952,979	$4,123,456	$4,604,926	$3,714,466
Investment Income Ratio	0.34	0.26	0.24	0.27	0.26	0.27

State Funds
Investment Income Ratio

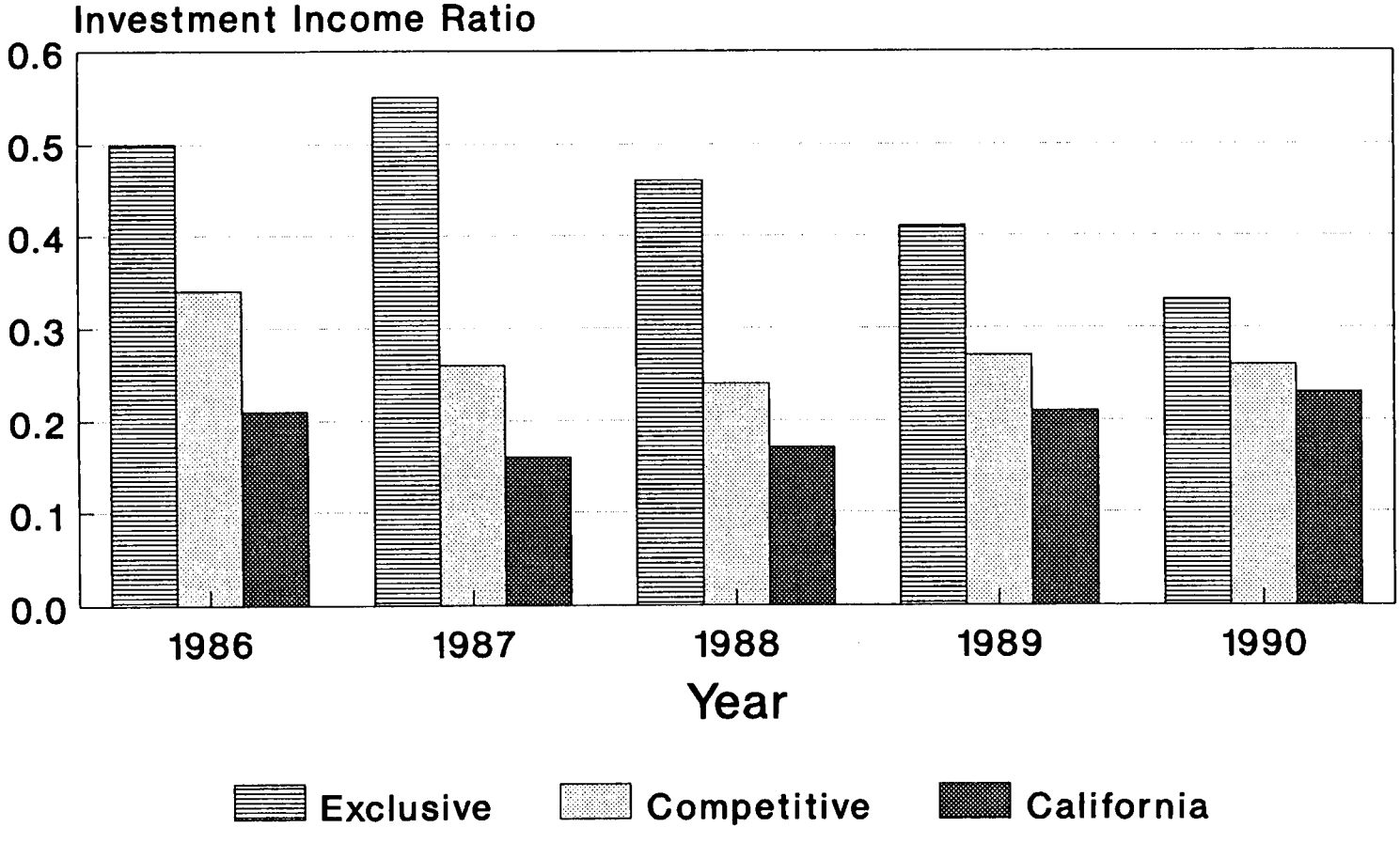


Exhibit AIS-8, Sheet 3

Exclusive State Funds
Investment Income Ratio
Average 1986-1990

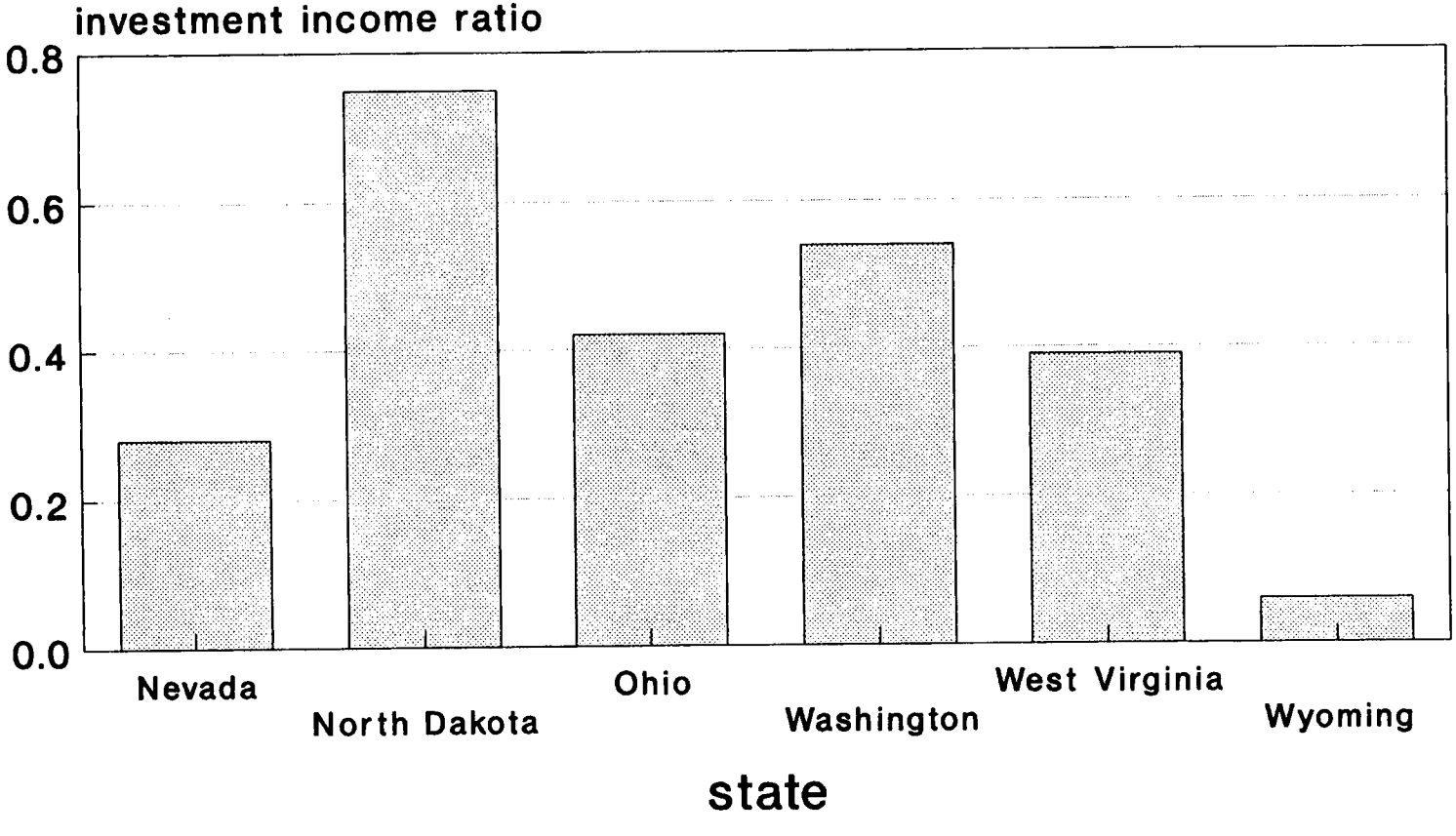


Exhibit AIS-8, Sheet 4

Exclusive State Funds - Average Investment Yield
(amounts in 000's)

	1986	1987	1988	1989	1990	87-90 Average
			Nevada			
Net Investment Income	$34,342	$52,566	$40,808	$48,566	$49,734	$47,919
Year-End Invested Assets	$494,139	$542,857	$571,005	$616,546	$662,079	$577,129
Average Investment Yield	NA	0.101	0.073	0.082	0.078	0.083
			North Dakota			
Net Investment Income	$21,000	$18,382	$16,914	$14,769	$12,768	$15,708
Year-End Invested Assets	$186,839	$182,106	$175,994	$164,476	$154,898	$173,361
Average Investment Yield	NA	0.100	0.094	0.087	0.080	0.091
			Ohio			
Net Investment Income	$410,634	$427,268	$459,415	$542,515	$599,109	$507,077
Year-End Invested Assets	$5,451,892	$5,318,980	$5,895,998	$7,012,011	$7,918,646	$6,228,065
Average Investment Yield	NA	0.079	0.082	0.084	0.080	0.081
			Washington			
Net Investment Income	NA	$355,145	$330,300	$308,304	$336,505	$332,564
Year-End Invested Assets	$2,554,060	$2,902,307	$3,240,183	$3,616,902	$4,009,304	$3,260,269
Average Investment Yield	NA	0.130	0.108	0.090	0.088	0.102
			West Virginia			
Net Investment Income	$94,600	$77,600	$66,700	$48,900	$55,500	$62,175
Year-End Invested Assets	$742,700	$722,800	$680,700	$607,000	$575,200	$667,363
Average Investment Yield	NA	0.106	0.095	0.076	0.094	0.093
			Wyoming			
Net Investment Income	$0	$1,916	$0	$0	$0	$479
Year-End Invested Assets	$23,000	$11,468	$10,736	$18,283	$11,197	$14,396
Average Investment Yield	NA	0.111	0.000	0.000	0.000	0.033
			Total			
Net Investment Income	$560,576	$932,877	$914,137	$963,054	$1,053,616	$965,921
Year-End Invested Assets	$9,452,630	$9,680,518	$10,574,616	$12,035,218	$13,331,324	$10,920,582
Average Investment Yield	NA	0.098	0.090	0.085	0.083	0.088

Competitive State Funds - Average Investment Yield
(amounts in 000's)

	1986	1987	1988	1989	1990	87-90 Average
			Arizona			
Net Investment Income	$50,914	$56,918	$65,972	$73,787	$80,041	$69,180
Year-End Invested Assets	$530,041	$617,072	$697,450	$787,414	$886,545	$702,557
Average Investment Yield	NA	0.099	0.100	0.099	0.096	0.098
			California			
Net Investment Income	$205,804	$238,438	$296,348	$370,155	$419,966	$331,227
Year-End Invested Assets	$2,325,572	$2,879,364	$3,577,622	$4,496,889	$5,100,066	$3,666,674
Average Investment Yield	NA	0.092	0.092	0.092	0.088	0.090
			Colorado			
Net Investment Income	$36,818	$35,262	$38,521	$43,352	$44,516	$40,413
Year-End Invested Assets	$462,430	$489,781	$507,733	$508,050	$529,182	$500,343
Average Investment Yield	NA	0.074	0.077	0.085	0.086	0.081
			Idaho			
Net Investment Income	$6,588	$7,310	$8,608	$10,532	$11,303	$9,438
Year-End Invested Assets	$83,232	$99,507	$113,819	$127,461	$147,377	$114,023
Average Investment Yield	NA	0.080	0.081	0.087	0.082	0.083
			Maryland			
Net Investment Income	$21,116	$19,925	$25,890	$31,749	$36,079	$28,411
Year-End Invested Assets	$248,789	$317,637	$367,714	$410,200	$475,762	$364,457
Average Investment Yield	NA	0.070	0.076	0.082	0.081	0.078
			Michigan			
Net Investment Income	$33,344	$35,005	$38,757	$47,916	$50,518	$43,049
Year-End Invested Assets	$351,868	$428,808	$503,429	$563,487	$615,671	$494,873
Average Investment Yield	NA	0.090	0.083	0.090	0.086	0.087
			Minnesota			
Net Investment Income	$1,639	$2,949	$3,351	$5,211	$6,337	$4,462
Year-End Invested Assets	$30,421	$44,274	$58,385	$72,832	$82,070	$57,934
Average Investment Yield	NA	0.079	0.065	0.079	0.082	0.077
			Montana			
Net Investment Income	$7,965	$6,258	$3,578	$2,812	$3,869	$4,129
Year-End Invested Assets	$47,951	$35,311	$27,983	$22,773	$46,602	$33,336
Average Investment Yield	NA	0.150	0.113	0.111	0.112	0.124
			New York			
Net Investment Income	$243,969	$234,288	$246,365	$255,690	$274,019	$252,591
Year-End Invested Assets	$2,654,500	$2,519,416	$2,811,089	$3,007,432	$3,170,356	$2,812,591
Average Investment Yield	NA	0.091	0.092	0.088	0.089	0.090
			Oklahoma			
Net Investment Income	$17,381	$19,122	$22,294	$25,769	$25,642	$23,207
Year-End Invested Assets	$245,778	$277,642	$299,339	$335,717	$377,275	$306,056
Average Investment Yield	NA	0.073	0.077	0.081	0.072	0.076
			Oregon			
Net Investment Income	$79,766	$85,592	$91,986	$107,858	$112,192	$99,407
Year-End Invested Assets	$959,894	$1,047,334	$1,156,980	$1,274,758	$1,282,966	$1,150,126
Average Investment Yield	NA	0.085	0.083	0.089	0.088	0.086
			Pennsylvania			
Net Investment Income	$78,445	$85,584	$92,408	$95,466	$91,392	$91,213
Year-End Invested Assets	$845,085	$958,319	$1,014,605	$1,012,569	$930,216	$968,286
Average Investment Yield	NA	0.095	0.094	0.094	0.094	0.094
			Utah			
Net Investment Income	($650)	$11,057	$13,289	$16,260	$18,475	$14,770
Year-End Invested Assets	$136,723	$157,960	$176,746	$200,962	$232,216	$180,034
Average Investment Yield	NA	0.075	0.079	0.086	0.085	0.082
			Total			
Net Investment Income	$783,099	$837,708	$947,367	$1,086,557	$1,174,349	$1,011,495
Year-End Invested Assets	$8,922,284	$9,872,425	$11,312,894	$12,820,544	$13,876,304	$11,351,289
Average Investment Yield	NA	0.089	0.089	0.090	0.088	0.089

State Funds
Average Investment Yield

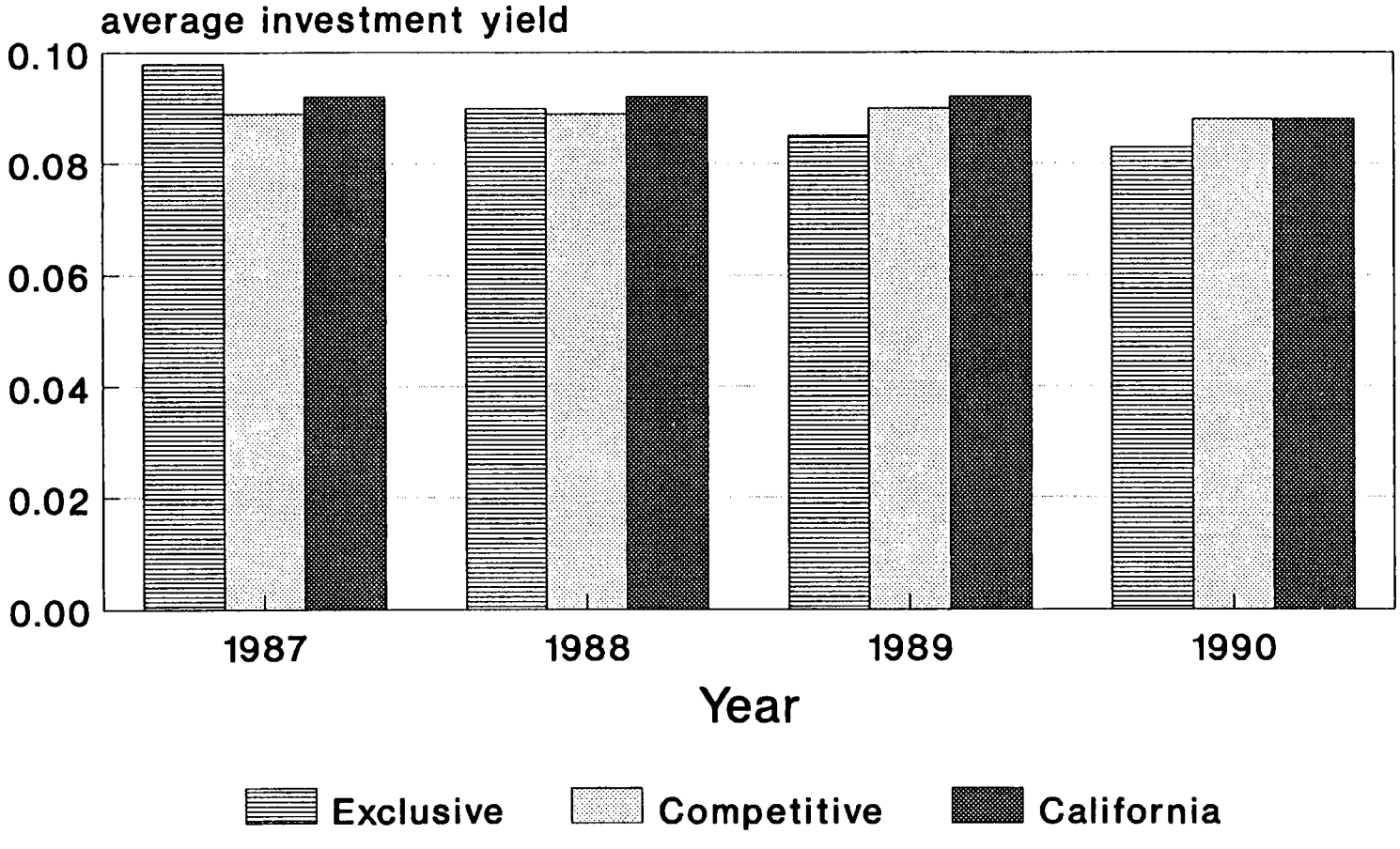


Exhibit AIS-9, Sheet 3

Exclusive State Funds
Average Investment Yield
Average 1987-1990

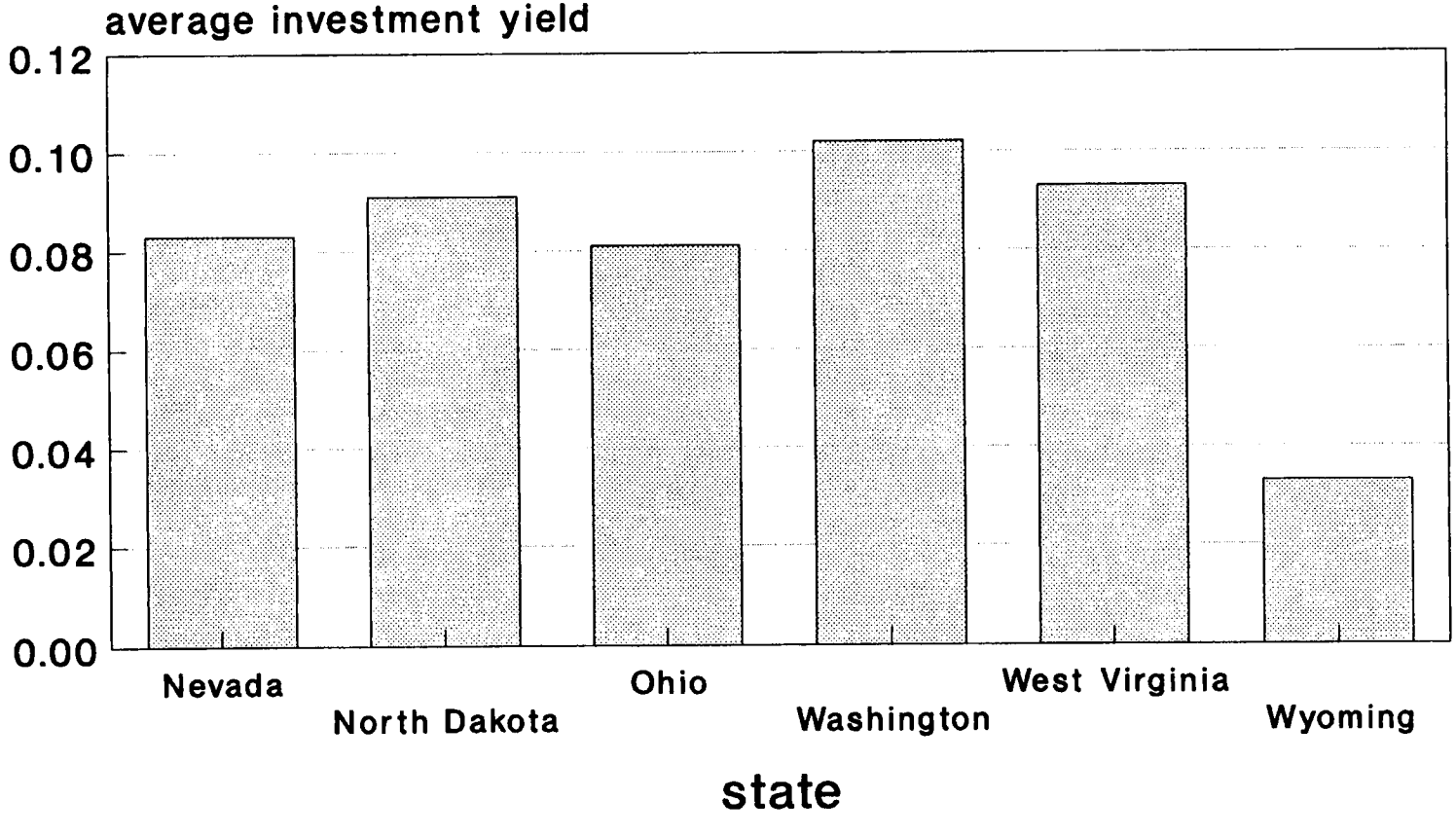


Exhibit AIS-9, Sheet 4

Exclusive State Funds - Change in Surplus
(amounts in 000's)

	1986	1987	1988	1989	1990	87-90 Average
			Nevada			
Surplus	$52,173	$52,146	$44,260	$41,536	$36,229	$43,543
Net Change in Surplus	NA	-0.1%	-15.1%	-6.2%	-12.8%	-8.5%
			North Dakota			
Surplus	$50,659	$27,156	$871	($18,556)	($78,155)	($17,171)
Net Change in Surplus	NA	-46.4%	-96.8%	NMF	NMF	NMF
			Ohio			
Surplus	($1,817,119)	($2,237,912)	($2,139,670)	($1,921,095)	($2,017,028)	($2,078,926)
Net Change in Surplus	NA	NMF	NMF	NMF	NMF	NMF
			Washington			
Surplus	($15,403)	$107,538	$91,570	$200,679	$307,414	$199,888
Net Change in Surplus	NA	NMF	-14.8%	119.2%	53.2%	52.5%
			West Virginia			
Surplus	$128,900	($90,600)	($283,500)	($404,300)	($584,000)	($340,600)
Net Change in Surplus	NA	NMF	NMF	NMF	NMF	NMF
			Wyoming			
Surplus	$11,000	($2,015)	($15,719)	($13,536)	$0	($7,818)
Net Change in Surplus	NA	NMF	NMF	NMF	NMF	NMF
			Total			
Surplus	($1,589,790)	($2,143,687)	($2,302,188)	($2,115,272)	($2,335,540)	($2,224,172)
Net Change in Surplus	NA	NMF	NMF	NMF	NMF	NMF

NMF = Not Meaningful

Competitive State Funds - Change in Surplus
(amounts in 000's)

	1986	1987	1988	1989	1990	87-90 Average
			Arizona			
Surplus	$69,966	$75,477	$65,585	$73,450	$83,178	$74,423
Net Change in Surplus	NA	7.9%	-13.1%	12.0%	13.2%	5.0%
			California			
Surplus	$576,365	$627,434	$713,350	$779,076	$790,805	$727,666
Net Change in Surplus	NA	8.9%	13.7%	9.2%	1.5%	8.3%
			Colorado			
Surplus	$56,375	$58,249	$53,036	$58,244	($199,987)	($7,615)
Net Change in Surplus	NA	3.3%	-8.9%	9.8%	NMF	NMF
			Idaho			
Surplus	$29,908	$37,976	$38,371	$37,324	$38,448	$38,030
Net Change in Surplus	NA	27.0%	1.0%	-2.7%	3.0%	7.1%
			Maryland			
Surplus	$69,637	$85,865	$95,635	$105,256	$108,820	$98,894
Net Change in Surplus	NA	23.3%	11.4%	10.1%	3.4%	12.0%
			Michigan			
Surplus	$84,630	$66,874	$89,438	$81,767	$36,917	$68,749
Net Change in Surplus	NA	-21.0%	33.7%	-8.6%	-54.9%	-12.7%
			Minnesota			
Surplus	$7,015	$7,104	$8,838	$13,901	$14,896	$11,185
Net Change in Surplus	NA	1.3%	24.4%	57.3%	7.2%	22.5%
			Montana			
Surplus	($81,022)	($149,169)	($157,333)	($217,650)	($221,869)	($186,505)
Net Change in Surplus	NA	NMF	NMF	NMF	NMF	NMF
			New York			
Surplus	$677,653	$724,740	$765,367	$829,093	$738,154	$764,339
Net Change in Surplus	NA	6.9%	5.6%	8.3%	-11.0%	2.5%
			Oklahoma			
Surplus	$60,694	$59,390	$50,041	$54,451	$62,709	$56,648
Net Change in Surplus	NA	-2.1%	-15.7%	8.8%	15.2%	1.5%
			Oregon			
Surplus	$44,846	$32,103	$153,346	$144,340	$148,996	$119,696
Net Change in Surplus	NA	-28.4%	377.7%	-5.9%	3.2%	86.7%
			Pennsylvania			
Surplus	$304,012	$379,203	$374,502	$321,937	$86,233	$290,469
Net Change in Surplus	NA	24.7%	-1.2%	-14.0%	-73.2%	-15.9%
			Utah			
Surplus	$26,174	$35,113	$37,130	$43,400	$51,571	$41,804
Net Change in Surplus	NA	34.2%	5.7%	16.9%	18.8%	18.9%
			Total			
Surplus	$1,926,253	$2,040,359	$2,287,306	$2,324,589	$1,738,871	$2,097,781
Net Change in Surplus	NA	5.9%	12.1%	1.6%	-25.2%	-1.4%

State Funds
Change in Surplus

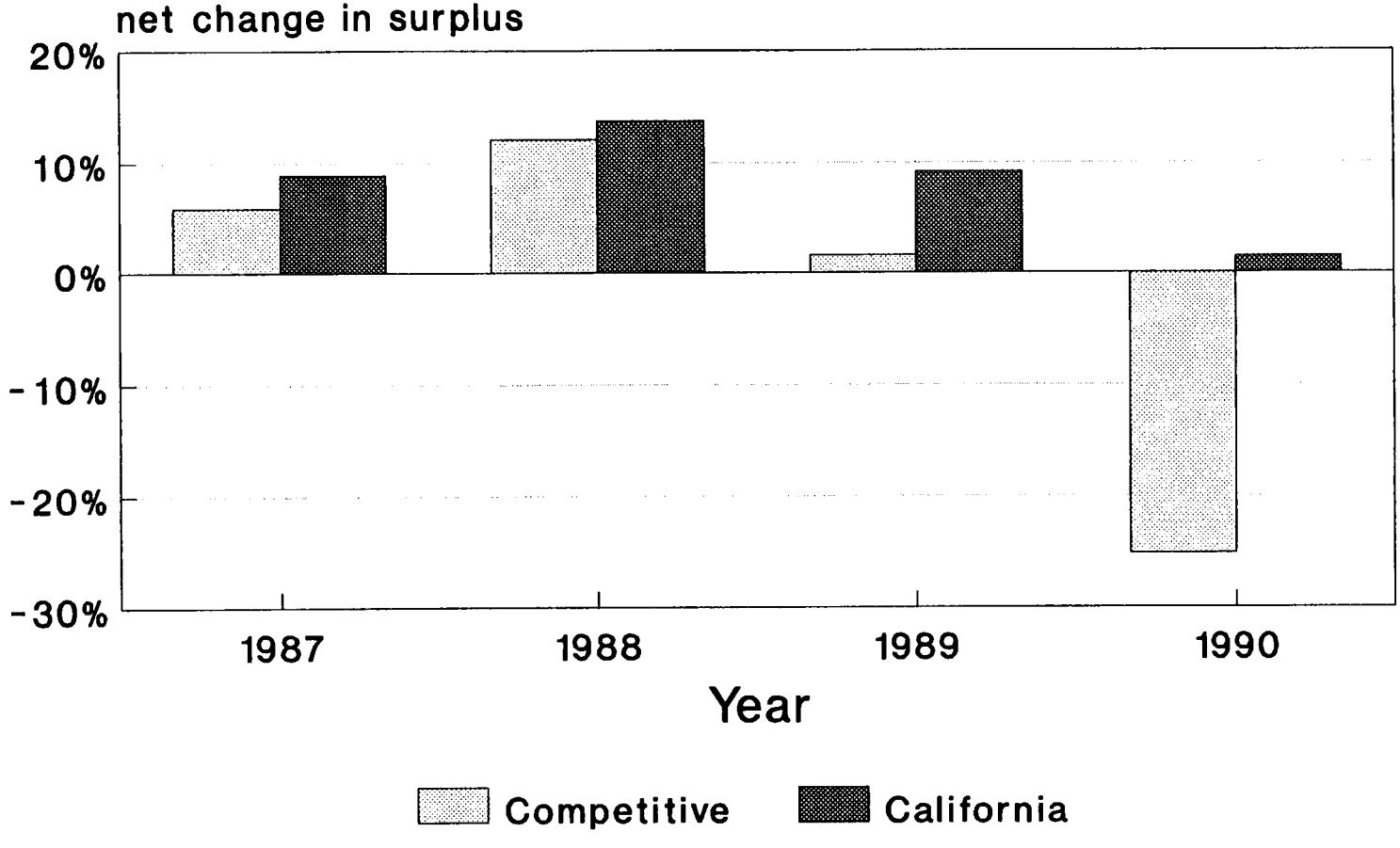


Exhibit AIS-10, Sheet 3

Exclusive State Funds - Liabilities to Liquid Assets
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Nevada			
Total Liabilities	$536,728	$572,350	$610,879	$680,418	$740,488	$628,173
Liquid Assets	$542,715	$595,105	$631,136	$692,149	$751,733	$642,568
Liabilities to Liquid Assets	0.99	0.96	0.97	0.98	0.99	0.98
			North Dakota			
Total Liabilities	$143,153	$161,705	$181,128	$188,684	$240,741	$183,082
Liquid Assets	$193,455	$188,477	$181,446	$169,557	$161,745	$178,936
Liabilities to Liquid Assets	0.74	0.86	1.00	1.11	1.49	1.02
			Ohio			
Total Liabilities	$8,301,255	$8,707,973	$9,320,982	$10,404,582	$11,183,434	$9,583,645
Liquid Assets	$6,026,024	$6,043,321	$6,730,198	$7,943,380	$9,372,150	$7,223,015
Liabilities to Liquid Assets	1.38	1.44	1.38	1.31	1.19	1.33
			Washington			
Total Liabilities	$2,740,928	$2,981,935	$3,377,175	$3,653,092	$3,993,476	$3,349,321
Liquid Assets	$2,724,100	$3,088,723	$3,468,744	$3,853,771	$4,291,183	$3,485,304
Liabilities to Liquid Assets	1.01	0.97	0.97	0.95	0.93	0.96
			West Virginia			
Total Liabilities	$668,900	$881,200	$1,034,300	$1,084,500	$1,233,600	$980,500
Liquid Assets	$797,800	$773,200	$732,600	$670,900	$649,600	$724,820
Liabilities to Liquid Assets	0.84	1.14	1.41	1.62	1.90	1.35
			Wyoming			
Total Liabilities	$0	$13,483	$26,454	$31,819	$8,750	$16,101
Liquid Assets	$23,000	$11,468	$10,736	$18,283	$11,197	$14,937
Liabilities to Liquid Assets	0.00	1.18	2.46	1.74	0.78	1.08
			Total			
Total Liabilities	$12,390,964	$13,318,646	$14,550,918	$16,043,095	$17,400,489	$14,740,822
Liquid Assets	$10,307,094	$10,700,294	$11,754,860	$13,348,040	$15,237,608	$12,269,579
Liabilities to Liquid Assets	1.20	1.24	1.24	1.20	1.14	1.20

Competitive State Funds - Liabilities to Liquid Assets
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Arizona			
Total Liabilities	$495,460	$580,899	$677,469	$760,550	$855,858	$674,047
Liquid Assets	$563,577	$652,971	$739,746	$830,637	$935,735	$744,533
Liabilities to Liquid Assets	0.88	0.89	0.92	0.92	0.91	0.91
			California			
Total Liabilities	$1,935,163	$2,501,642	$3,152,602	$4,032,429	$4,609,955	$3,246,358
Liquid Assets	$2,456,838	$3,060,713	$3,791,502	$4,742,188	$5,320,795	$3,874,407
Liabilities to Liquid Assets	0.79	0.82	0.83	0.85	0.87	0.84
			Colorado			
Total Liabilities	$452,514	$482,638	$496,327	$497,953	$774,016	$540,690
Liquid Assets	$508,772	$540,134	$549,339	$555,271	$573,104	$545,324
Liabilities to Liquid Assets	0.89	0.89	0.90	0.90	1.35	0.99
			Idaho			
Total Liabilities	$55,922	$64,480	$79,329	$94,020	$114,027	$81,556
Liquid Assets	$84,828	$101,187	$116,378	$130,381	$151,067	$116,768
Liabilities to Liquid Assets	0.66	0.64	0.68	0.72	0.75	0.70
			Maryland			
Total Liabilities	$186,642	$241,447	$284,720	$372,297	$451,651	$307,351
Liquid Assets	$255,890	$326,799	$379,358	$422,473	$490,441	$374,992
Liabilities to Liquid Assets	0.73	0.74	0.75	0.88	0.92	0.82
			Michigan			
Total Liabilities	$314,311	$414,301	$479,082	$546,003	$663,494	$483,438
Liquid Assets	$398,033	$475,779	$560,588	$620,221	$691,845	$549,293
Liabilities to Liquid Assets	0.79	0.87	0.85	0.88	0.96	0.88
			Minnesota			
Total Liabilities	$33,945	$53,106	$68,113	$81,144	$79,675	$63,197
Liquid Assets	$40,960	$59,868	$75,123	$93,045	$90,653	$71,930
Liabilities to Liquid Assets	0.83	0.89	0.91	0.87	0.88	0.88
			Montana			
Total Liabilities	$151,426	$211,557	$222,072	$280,083	$324,767	$237,981
Liquid Assets	$63,813	$54,845	$56,765	$54,658	$73,482	$60,713
Liabilities to Liquid Assets	2.37	3.86	3.91	5.12	4.42	3.92
			New York			
Total Liabilities	$2,587,369	$2,725,380	$2,988,192	$3,394,340	$4,027,408	$3,144,538
Liquid Assets	$2,734,264	$2,623,678	$2,925,326	$3,132,113	$3,312,081	$2,945,492
Liabilities to Liquid Assets	0.95	1.04	1.02	1.08	1.22	1.07
			Oklahoma			
Total Liabilities	$209,263	$237,817	$269,862	$305,942	$342,696	$273,116
Liquid Assets	$258,687	$294,455	$317,263	$357,570	$402,568	$326,109
Liabilities to Liquid Assets	0.81	0.81	0.85	0.86	0.85	0.84
			Oregon			
Total Liabilities	$1,053,594	$1,170,614	$1,180,786	$1,297,310	$1,303,253	$1,201,111
Liquid Assets	$1,074,811	$1,176,822	$1,304,206	$1,410,375	$1,418,933	$1,277,029
Liabilities to Liquid Assets	0.98	0.99	0.91	0.92	0.92	0.94
			Pennsylvania			
Total Liabilities	$566,983	$610,219	$681,867	$735,944	$883,252	$695,653
Liquid Assets	$870,571	$986,117	$1,056,406	$1,057,668	$969,510	$988,054
Liabilities to Liquid Assets	0.65	0.62	0.65	0.70	0.91	0.70
			Utah			
Total Liabilities	$124,649	$139,423	$157,688	$176,999	$204,255	$160,603
Liquid Assets	$149,673	$174,536	$193,874	$219,653	$255,571	$198,661
Liabilities to Liquid Assets	0.83	0.80	0.81	0.81	0.80	0.81
			Total			
Total Liabilities	$8,167,241	$9,433,523	$10,738,109	$12,575,014	$14,634,307	$11,109,639
Liquid Assets	$9,460,717	$10,527,904	$12,065,874	$13,626,253	$14,685,785	$12,073,307
Liabilities to Liquid Assets	0.86	0.90	0.89	0.92	1.00	0.92

State Funds
Liabilities to Liquid Assets

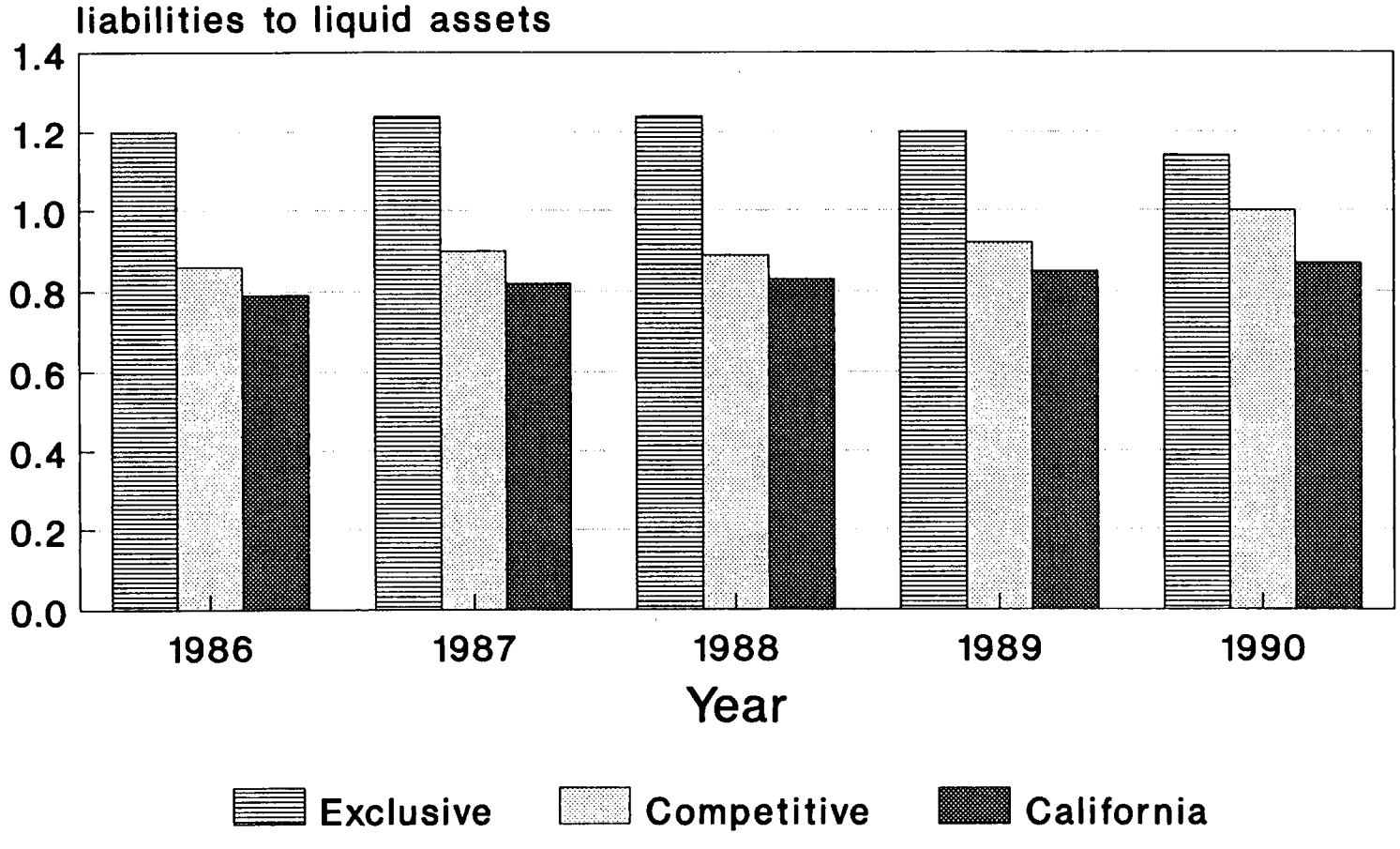


Exhibit AIS-11, Sheet 3

Exclusive State Funds
Liabilities to Liquid Assets
Average 1986-1990

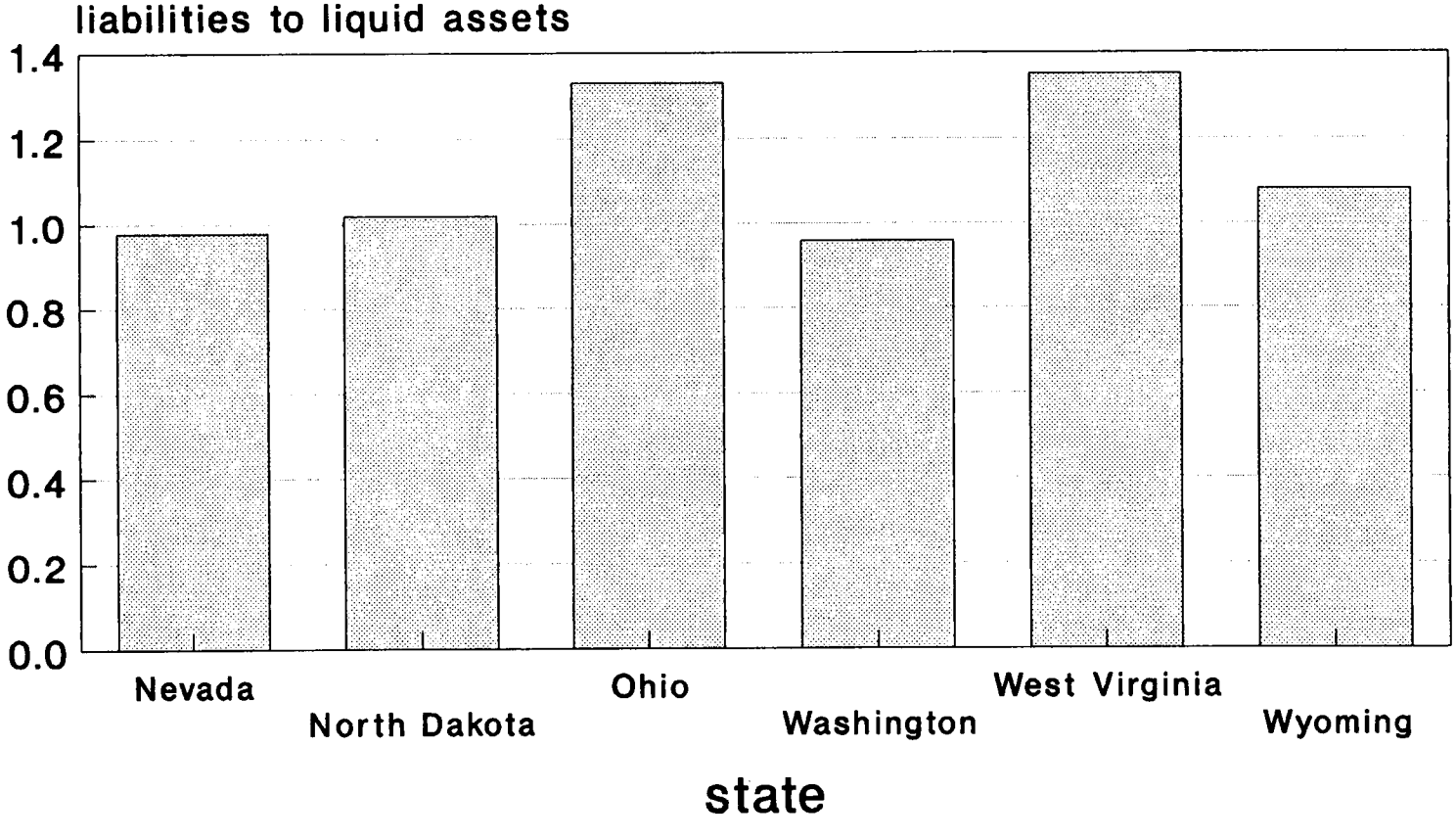


Exhibit AIS-11, Sheet 4

Exclusive State Funds - Agents Balances to Surplus
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Nevada			
Premium Due But Not Collected	$38,834	$41,811	$51,163	$66,005	$80,131	$55,589
Surplus	$52,173	$52,146	$44,260	$41,536	$36,229	$45,269
Agents Balances to Surplus	0.74	0.80	1.16	1.59	2.21	1.23
			North Dakota			
Premium Due But Not Collected	$2,544	$2,535	$2,465	$2,544	$3,892	$2,796
Surplus	$50,659	$27,156	$871	($18,556)	($78,155)	($3,605)
Agents Balances to Surplus	0.05	0.09	2.83	-0.14	-0.05	-0.78
			Ohio			
Premium Due But Not Collected	$488,038	$640,196	$746,686	$847,264	$1,348,247	$814,086
Surplus	($1,817,119)	($2,237,912)	($2,139,670)	($1,921,095)	($2,017,028)	($2,026,565)
Agents Balances to Surplus	-0.27	-0.29	-0.35	-0.44	-0.67	-0.40
			Washington			
Premium Due But Not Collected	$139,912	$143,496	$164,303	$175,160	$202,634	$165,101
Surplus	($15,403)	$107,538	$91,570	$200,679	$307,414	$138,360
Agents Balances to Surplus	-9.08	1.33	1.79	0.87	0.66	1.19
			West Virginia			
Premium Due But Not Collected	$36,100	$37,900	$39,100	$51,600	$63,500	$45,640
Surplus	$128,900	($90,600)	($283,500)	($404,300)	($584,000)	($246,700)
Agents Balances to Surplus	0.28	-0.42	-0.14	-0.13	-0.11	-0.19
			Wyoming			
Premium Due But Not Collected	$0	$0	$0	$0	$0	$0
Surplus	$11,000	($2,015)	($15,719)	($13,536)	$0	($4,054)
Agents Balances to Surplus	0.00	0.00	0.00	0.00	ERR	0.00
			Total			
Premium Due But Not Collected	$705,428	$865,938	$1,003,717	$1,142,573	$1,698,404	$1,083,212
Surplus	($1,589,790)	($2,143,687)	($2,302,188)	($2,115,272)	($2,335,540)	($2,097,295)
Agents Balances to Surplus	-0.44	-0.40	-0.44	-0.54	-0.73	-0.52

Competitive State Funds - Agents Balances to Surplus
(amounts in 000's)

	1986	1987	1988	1989	1990	Average
			Arizona			
Premium Due But Not Collected	$24,615	$24,985	$30,197	$30,929	$36,218	$29,389
Surplus	$69,966	$75,477	$65,585	$73,450	$83,178	$73,531
Agents Balances to Surplus	0.35	0.33	0.46	0.42	0.44	0.40
			California			
Premium Due But Not Collected	$70,372	$109,543	$130,070	$146,275	$118,762	$115,004
Surplus	$576,365	$627,434	$713,350	$779,076	$790,805	$697,406
Agents Balances to Surplus	0.12	0.17	0.18	0.19	0.15	0.16
			Colorado			
Premium Due But Not Collected	$39,353	$42,758	$34,139	$39,456	$37,114	$38,564
Surplus	$56,375	$58,249	$53,036	$58,244	($199,987)	$5,183
Agents Balances to Surplus	0.70	0.73	0.64	0.68	-0.19	7.44
			Idaho			
Premium Due But Not Collected	$296	$371	$734	$634	$1,113	$630
Surplus	$29,908	$37,976	$38,371	$37,324	$38,448	$36,405
Agents Balances to Surplus	0.01	0.01	0.02	0.02	0.03	0.02
			Maryland			
Premium Due But Not Collected	$4,209	$6,822	$7,594	$6,867	$8,331	$6,765
Surplus	$69,637	$85,865	$95,635	$105,256	$108,820	$93,043
Agents Balances to Surplus	0.06	0.08	0.08	0.07	0.08	0.07
			Michigan			
Premium Due But Not Collected	$36,829	$37,758	$48,804	$48,034	$65,593	$47,404
Surplus	$84,630	$66,874	$89,438	$81,767	$36,917	$71,925
Agents Balances to Surplus	0.44	0.56	0.55	0.59	1.78	0.66
			Minnesota			
Premium Due But Not Collected	$10,185	$14,770	$15,970	$19,259	$7,410	$13,519
Surplus	$7,015	$7,104	$8,838	$13,901	$14,896	$10,351
Agents Balances to Surplus	1.45	2.08	1.81	1.39	0.50	1.31
			Montana			
Premium Due But Not Collected	$14,637	$18,599	$28,057	$31,236	$26,281	$23,762
Surplus	($81,022)	($149,169)	($157,333)	($217,650)	($221,869)	($165,409)
Agents Balances to Surplus	-0.18	-0.12	-0.18	-0.14	-0.12	-0.14
			New York			
Premium Due But Not Collected	$24,482	$50,637	$56,990	$70,186	$85,296	$57,518
Surplus	$677,653	$724,740	$765,367	$829,093	$738,154	$747,001
Agents Balances to Surplus	0.04	0.07	0.07	0.08	0.12	0.08
			Oklahoma			
Premium Due But Not Collected	$11,377	$16,063	$16,714	$17,767	$21,102	$16,605
Surplus	$60,694	$59,390	$50,041	$54,451	$62,709	$57,457
Agents Balances to Surplus	0.19	0.27	0.33	0.33	0.34	0.29
			Oregon			
Premium Due But Not Collected	$97,597	$106,914	$123,629	$109,397	$107,893	$109,086
Surplus	$44,846	$32,103	$153,346	$144,340	$148,996	$104,726
Agents Balances to Surplus	2.18	3.33	0.81	0.76	0.72	1.04
			Pennsylvania			
Premium Due But Not Collected	$3,529	$5,115	$20,219	$26,732	$22,887	$15,696
Surplus	$304,012	$379,203	$374,502	$321,937	$86,233	$293,177
Agents Balances to Surplus	0.01	0.01	0.05	0.08	0.27	0.05
			Utah			
Premium Due But Not Collected	$10,700	$12,923	$14,295	$15,000	$19,559	$14,495
Surplus	$26,174	$35,113	$37,130	$43,400	$51,571	$38,678
Agents Balances to Surplus	0.41	0.37	0.38	0.35	0.38	0.37
			Total			
Premium Due But Not Collected	$348,181	$447,258	$527,412	$561,772	$557,559	$488,436
Surplus	$1,926,253	$2,040,359	$2,287,306	$2,324,589	$1,738,871	$2,063,476
Agents Balances to Surplus	0.18	0.22	0.23	0.24	0.32	0.24

State Funds
Agents Balances to Surplus

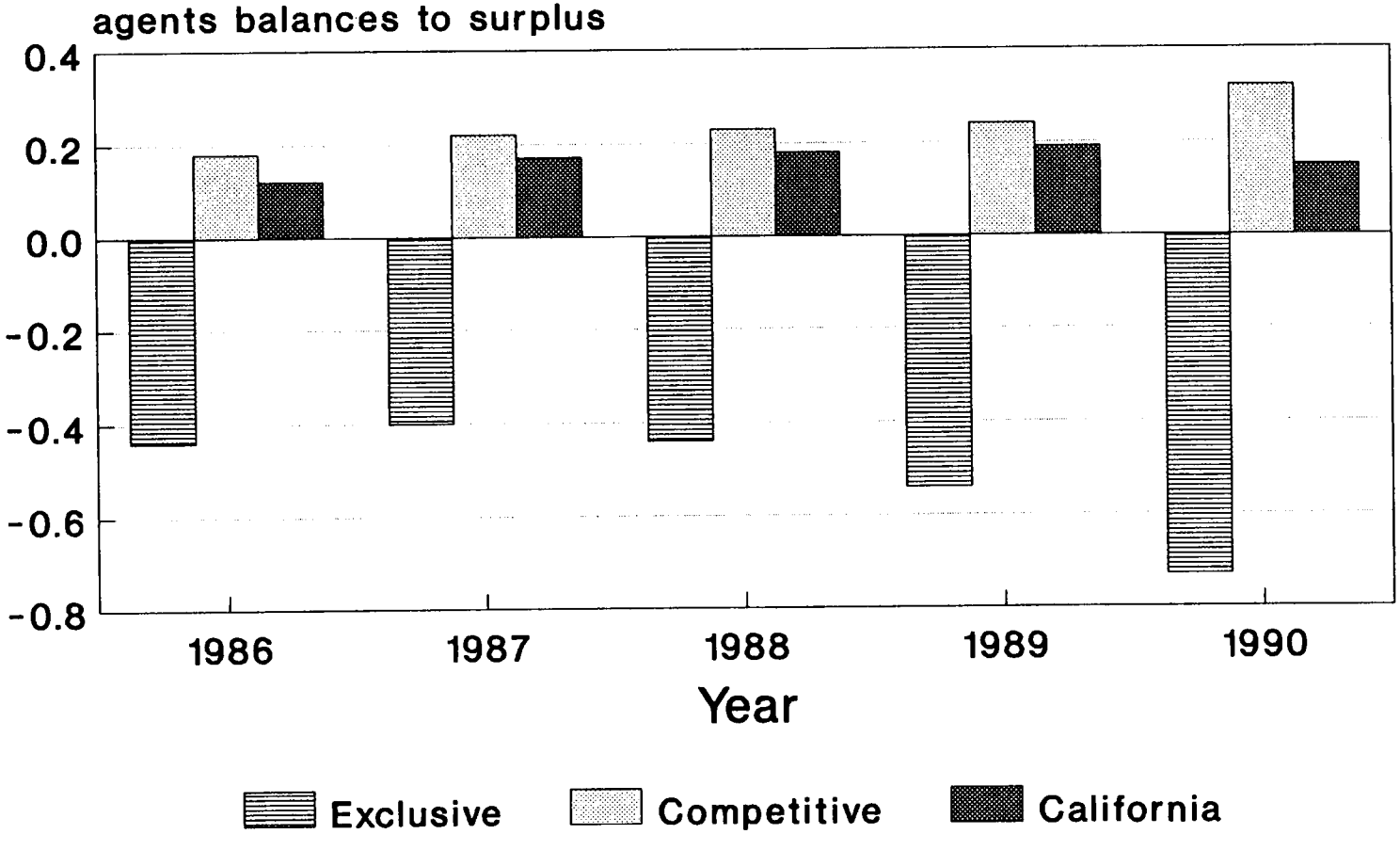


Exhibit AIS-12, Sheet 3

Exclusive State Funds
Agents Balances to Surplus
Average 1986-1990

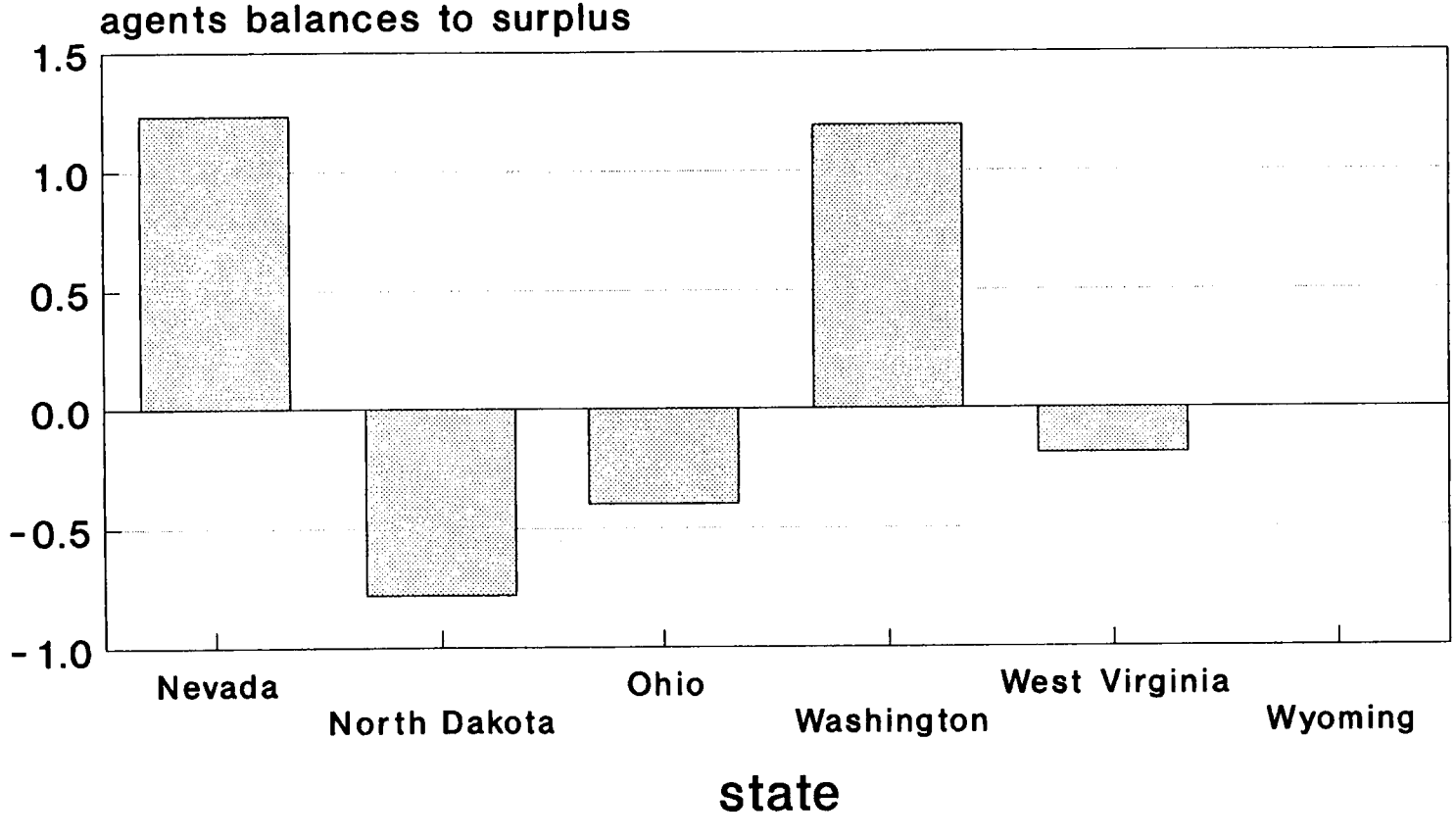


Exhibit AIS-12, Sheet 4

COMPARISON OF REINSURANCE COVERAGE OBTAINED BY STATE FUNDS

	Reinsurance Obtained	Amount of State Fund's Retention	Reinsurance Coverage Limit
		Exclusive State Funds	
Nevada	Yes	$5,000,000	$15,000,000
North Dakota	No		
Ohio	No		
Washington	No		
West Virginia	No		
Wyoming	No		
		Competitive State Funds	
Arizona	Yes	$5,000,000	$21,000,000
California	Yes	$10,000,000	$300,000,000
Colorado	Yes	$5,000,000	$20,000,000
Idaho	Yes	$1,000,000	$45,000,000
Maryland	Yes	$2,000,000	$25,000,000
Michigan	Yes	$2,000,000	$48,000,000
Minnesota	Yes		
Montana	Yes	$2,000,000	$18,000,000
New York	Yes		
Oklahoma	Yes	$2,000,000	$38,000,000
Oregon	Yes	$5,000,000	$45,000,000
Pennsylvania	No		
Utah	Yes	$3,000,000	$40,000,000

COMPARISON OF SELECTED FINANCIAL SOLVENCY TESTS FOR STATE FUNDS

State Fund	Premium to Surplus	Reserve to Surplus	Change in Writings	Operating Profit	Investment Yield	Change in Surplus	Liabilities to Liquid Assets	Premium Balances to Surplus	Reinsurance Protection Obtaind
				Exclusive State Funds					
Nevada	4.71*	13.28*	0.198	-0.01*	0.083	-0.085	0.98	1.23*	Yes
North Dakota	-7.02*	-47.69*	0.174	-1.20*	0.091	NMF*	1.02	-0.78*	No
Ohio	-0.68*	-4.64*	0.197	-0.07*	0.081	NMF*	1.33*	-0.40*	No
Washington	3.65*	23.75*	0.098	0.13	0.102	0.525*	0.96	1.19*	No
West Virginia	-0.71*	-3.82*	0.114	-0.42*	0.093	NMF*	1.35*	-0.19*	No
Wyoming	-8.14*	-1.29*	0.088	-0.41*	0.033*	NMF*	1.08*	0.00	No
				Competitive State Funds					
Arizona	2.59	8.22*	0.115	0.02	0.098	0.050	0.91	0.40	Yes
California	2.27	4.20	0.163	0.05	0.090	0.083	0.84	0.16	Yes
Colorado	41.95*	92.7*	0.112	-0.23*	0.081	NMF*	0.99	7.44*	Yes
Idaho	1.19	1.44	0.227	0.12	0.083	0.071	0.70	0.02	Yes
Maryland	1.20	2.94	0.232	0.10	0.078	0.120	0.82	0.07	Yes
Michigan	1.93	4.80	0.244	-0.08*	0.087	-0.127*	0.88	0.66*	Yes
Minnesota	3.82*	3.98	0.231	0.07	0.077	0.225	0.88	1.31*	Yes
Montana	-0.47*	-1.33*	0.173	-0.49*	0.124	NMF*	3.92*	-0.14*	Yes
New York	1.07	3.29	0.214	0.19	0.090	0.025	1.07*	0.08	Yes
Oklahoma	1.57	4.37	0.090	0.04	0.076	0.015	0.84	0.29	Yes
Oregon	2.15	10.45*	-0.032	-0.01*	0.086	0.867*	0.94	1.04*	Yes
Pennsylvania	0.47	2.25	0.278	0.46	0.094	-0.159*	0.70	0.05	No
Utah	1.71	3.70	0.155	0.01	0.082	0.189	0.81	0.37	Yes
				Acceptable Range					
No Less Than	0.00	0.00	-0.33	0.00	0.050	-0.10	N/A	0.00	
No More Than	3.00	2 to 5	0.33	N/A	N/A	0.50	1.05	0.40	

* Indicates value outside of acceptable range

Exclusive State Funds - No. of Policies per Employee

	1986	1987	1988	1989	1990	Average
			Nevada			
No. of Active Policies	34,070	35,128	34,996	36,045	39,000	35,848
No. of Personnel	643	656	715	770	889	735
No. of Policies per Employee	53.0	53.5	48.9	46.8	43.9	48.8
			North Dakota			
No. of Active Policies	22,100	21,939	22,000	21,938	21,689	21,933
No. of Personnel	67	71	71	72	88	74
No. of Policies per Employee	329.9	309.0	309.9	304.7	246.5	297.2
			Ohio			
No. of Active Policies	250,000	251,000	249,023	256,358	257,221	252,720
No. of Personnel	1,357	1,485	1,528	1,716	2,795	1,776
No. of Policies per Employee	184.2	169.0	163.0	149.4	92.0	142.3
			Washington			
No. of Active Policies	NA	121,063	121,549	124,999	127,140	123,688
No. of Personnel	NA	1,443	1,477	1,150	1,200	1,318
No. of Policies per Employee	NA	83.9	82.3	108.7	106.0	93.9
			West Virginia			
No. of Active Policies	34,897	35,249	36,303	37,139	37,591	36,236
No. of Personnel	501	546	570	594	545	551
No. of Policies per Employee	69.7	64.6	63.7	62.5	69.0	65.7
			Wyoming			
No. of Active Policies	9,500	9,300	9,700	9,986	10,100	9,717
No. of Personnel	53	53	52	63	67	58
No. of Policies per Employee	179.2	175.5	186.5	158.5	150.7	168.7
			Total			
No. of Active Policies	350,567	473,679	473,571	486,465	492,741	455,405
No. of Personnel	2,621	4,254	4,413	4,365	5,584	4,247
No. of Policies per Employee	133.8	111.3	107.3	111.4	88.2	107.2

Competitive State Funds - No. of Policies per Employee

	1986	1987	1988	1989	1990	Average
			Arizona			
No. of Active Policies	36,168	38,797	40,670	41,519	41,857	39,802
No. of Personnel	606	630	637	640	693	641
No. of Policies per Employee	59.7	61.6	63.8	64.9	60.4	62.1
			California			
No. of Active Policies	207,076	232,211	244,956	253,035	262,655	239,987
No. of Personnel	2,363	3,216	3,732	5,010	5,062	3,877
No. of Policies per Employee	87.6	72.2	65.6	50.5	51.9	61.9
			Colorado			
No. of Active Policies	46,300	44,943	42,969	42,000	41,191	43,481
No. of Personnel	243	331	382	394	418	354
No. of Policies per Employee	190.5	135.8	112.5	106.6	98.5	123.0
			Idaho			
No. of Active Policies	7,710	9,000	9,466	10,450	12,084	9,742
No. of Personnel	56	75	80	110	114	87
No. of Policies per Employee	137.7	120.0	118.3	95.0	106.0	112.0
			Maryland			
No. of Active Policies	14,121	18,890	22,135	24,576	26,144	21,173
No. of Personnel	111	153	216	218	253	190
No. of Policies per Employee	127.2	123.5	102.5	112.7	103.3	111.3
			Michigan			
No. of Active Policies	NA	31,196	35,119	46,496	47,933	40,186
No. of Personnel	NA	408	464	470	502	461
No. of Policies per Employee	NA	76.5	75.7	98.9	95.5	87.2
			Minnesota			
No. of Active Policies	2,776	4,636	5,078	5,300	5,463	4,651
No. of Personnel	42	74	99	104	123	88
No. of Policies per Employee	66.1	62.6	51.3	51.0	44.4	52.6
			Montana			
No. of Active Policies	25,665	26,950	26,929	26,172	26,149	26,373
No. of Personnel	86	96	107	161	183	127
No. of Policies per Employee	298.4	280.7	251.7	162.6	142.9	208.3
			New York			
No. of Active Policies	181,781	191,007	192,797	190,957	192,066	189,722
No. of Personnel	2,284	2,424	2,516	2,643	3,073	2,588
No. of Policies per Employee	79.6	78.8	76.6	72.3	62.5	73.3
			Oklahoma			
No. of Active Policies	12,813	14,180	13,946	14,649	16,305	14,379
No. of Personnel	178	184	234	276	311	237
No. of Policies per Employee	72.0	77.1	59.6	53.1	52.4	60.8
			Oregon			
No. of Active Policies	42,603	46,903	47,841	35,645	34,147	41,428
No. of Personnel	1,028	1,089	1,112	1,168	1,114	1,102
No. of Policies per Employee	41.4	43.1	43.0	30.5	30.7	37.6
			Pennsylvania			
No. of Active Policies	16,512	17,818	20,286	20,609	24,798	20,005
No. of Personnel	152	184	201	216	227	196
No. of Policies per Employee	108.6	96.8	100.9	95.4	109.2	102.1
			Utah			
No. of Active Policies	21,120	21,258	22,000	22,557	NA	21,734
No. of Personnel	104	110	135	135	NA	121
No. of Policies per Employee	203.1	193.3	163.0	167.1	NA	179.6
			Total			
No. of Active Policies	614,645	697,789	724,192	733,965	730,792	700,277
No. of Personnel	7,253	8,974	9,915	11,545	12,073	9,952
No. of Policies per Employee	84.7	77.8	73.0	63.6	60.5	70.4

State Funds
Number of Policies per Employee

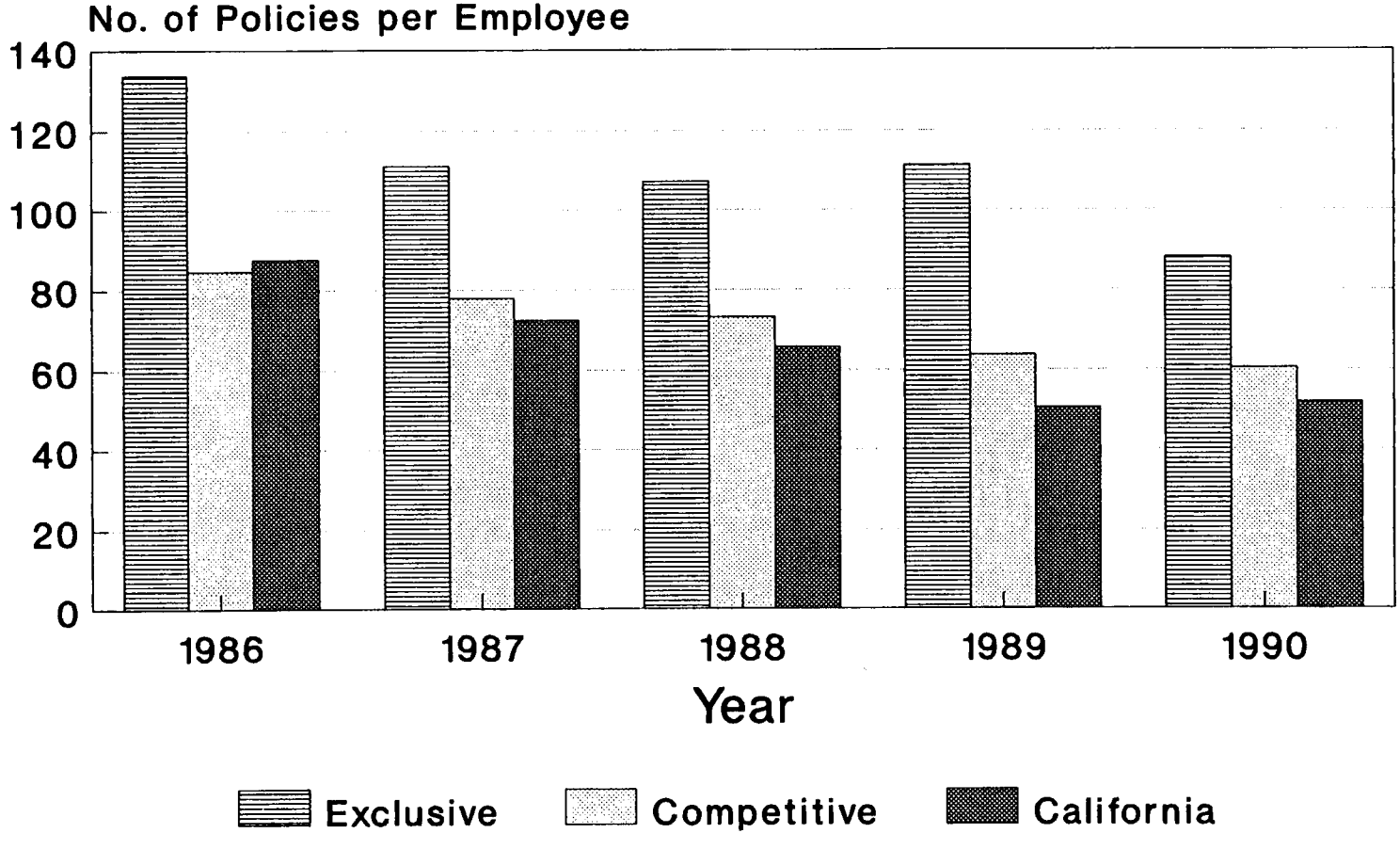


Exhibit AIS-15, Sheet 3

Exclusive State Funds
Number of Policies per Employee
Average 1986-1990

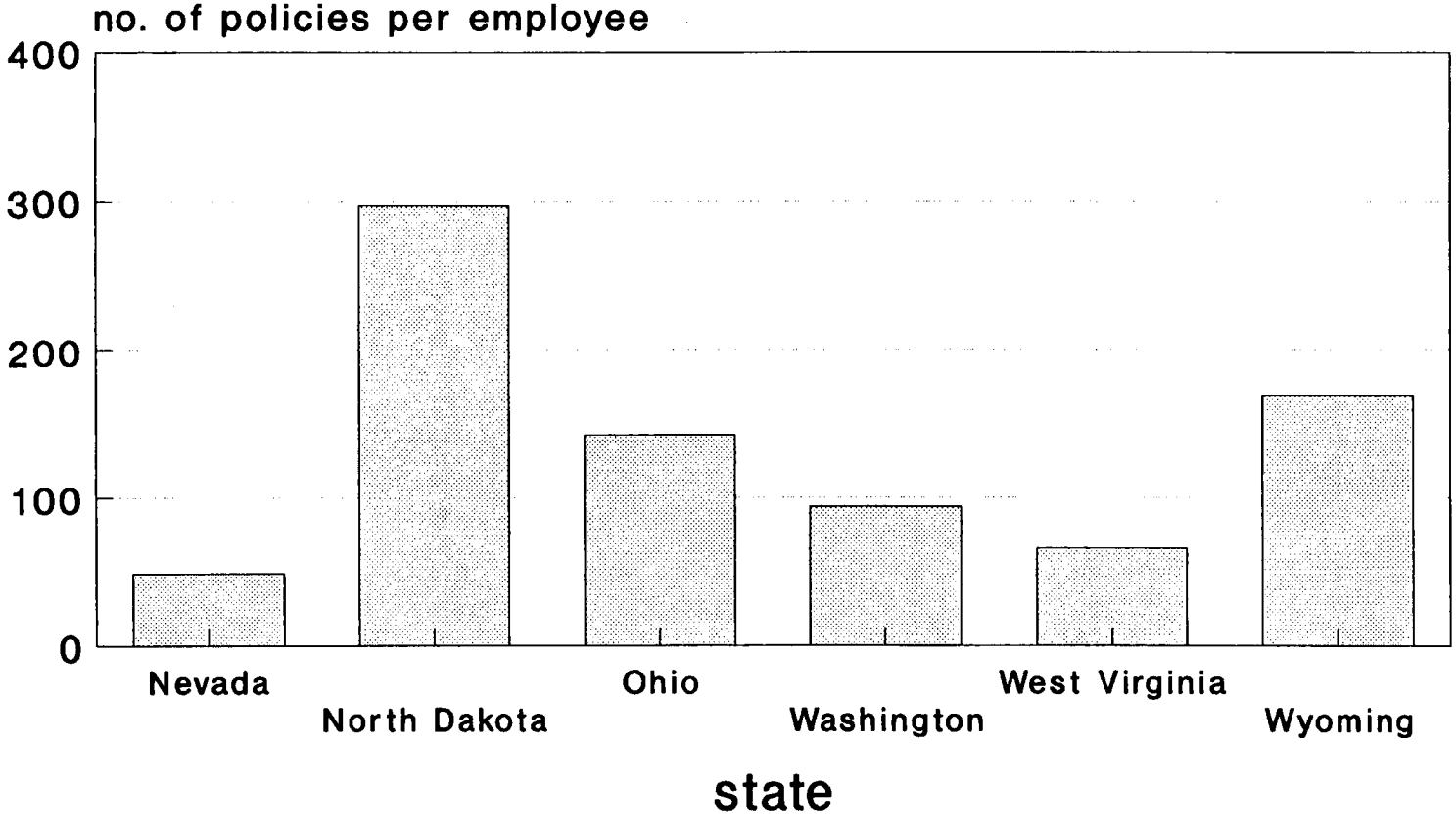


Exhibit AIS-15, Sheet 4

Exclusive State Funds - No. of Accidents per Employee

	1986	1987	1988	1989	1990	Average
			Nevada			
No. of Accidents Reported	61,850	64,644	73,530	79,536	83,256	72,563
No. of Personnel	643	656	715	770	889	735
No. of Accidents per Employee	96.2	98.5	102.8	103.3	93.7	98.8
			North Dakota			
No. of Accidents Reported	20,917	21,300	20,966	21,362	22,151	21,339
No. of Personnel	67	71	71	72	88	74
No. of Accidents per Employee	312.2	300.0	295.3	296.7	251.7	289.1
			Ohio			
No. of Accidents Reported	381,934	411,134	407,994	451,418	421,190	414,734
No. of Personnel	1,357	1,485	1,528	1,716	2,795	1,776
No. of Accidents per Employee	281.5	276.9	267.0	263.1	150.7	233.5
			Washington			
No. of Accidents Reported	NA	226,062	230,225	199,975	203,829	215,023
No. of Personnel	NA	1,443	1,477	1,150	1,200	1,318
No. of Accidents per Employee	NA	156.7	155.9	173.9	169.9	163.2
			West Virginia			
No. of Accidents Reported	75,967	71,973	70,827	69,773	71,229	71,954
No. of Personnel	501	546	570	594	545	551
No. of Accidents per Employee	151.6	131.8	124.3	117.5	130.7	130.5
			Wyoming			
No. of Accidents Reported	26,994	22,486	18,814	19,205	20,013	21,502
No. of Personnel	53	53	52	63	67	58
No. of Accidents per Employee	509.3	424.3	361.8	304.8	298.7	373.3
			Total			
No. of Accidents Reported	567,662	817,599	822,356	841,269	821,668	774,111
No. of Personnel	2,621	4,254	4,413	4,365	5,584	4,247
No. of Accidents per Employee	216.6	192.2	186.3	192.7	147.1	182.3

Competitive State Funds - No. of Accidents per Employee

	1986	1987	1988	1989	1990	Average
			Arizona			
No. of Accidents Reported	64,343	66,376	70,136	68,374	69,086	67,663
No. of Personnel	606	630	637	640	693	641
No. of Accidents per Employee	106.2	105.4	110.1	106.8	99.7	105.5
			California			
No. of Accidents Reported	234,757	266,869	279,439	263,287	271,397	263,150
No. of Personnel	2,363	3,216	3,732	5,010	5,062	3,877
No. of Accidents per Employee	99.3	83.0	74.9	52.6	53.6	67.9
			Colorado			
No. of Accidents Reported	60,596	58,612	56,345	53,720	48,049	55,464
No. of Personnel	243	331	382	394	418	354
No. of Accidents per Employee	249.4	177.1	147.5	136.3	114.9	156.9
			Idaho			
No. of Accidents Reported	9,956	10,417	12,084	13,938	15,684	12,416
No. of Personnel	56	75	80	110	114	87
No. of Accidents per Employee	177.8	138.9	151.1	126.7	137.6	142.7
			Maryland			
No. of Accidents Reported	32,696	37,816	42,281	42,254	42,694	39,548
No. of Personnel	111	153	216	218	253	190
No. of Accidents per Employee	294.6	247.2	195.7	193.8	168.8	207.9
			Michigan			
No. of Accidents Reported	NA	38,257	45,475	47,286	50,953	45,493
No. of Personnel	NA	408	464	470	502	461
No. of Accidents per Employee	NA	93.8	98.0	100.6	101.5	98.7
			Minnesota			
No. of Accidents Reported	6,100	7,319	7,359	9,602	10,400	8,156
No. of Personnel	42	74	99	104	123	88
No. of Accidents per Employee	145.2	98.9	74.3	92.3	84.6	92.3
			Montana			
No. of Accidents Reported	16,537	16,105	18,141	18,926	21,338	18,209
No. of Personnel	86	96	107	161	183	127
No. of Accidents per Employee	192.3	167.8	169.5	117.6	116.6	143.8
			New York			
No. of Accidents Reported	190,468	201,119	204,307	207,657	207,211	202,152
No. of Personnel	2,284	2,424	2,516	2,643	3,073	2,588
No. of Accidents per Employee	83.4	83.0	81.2	78.6	67.4	78.1
			Oklahoma			
No. of Accidents Reported	22,504	21,151	22,419	22,130	25,651	22,771
No. of Personnel	178	184	234	276	311	237
No. of Accidents per Employee	126.4	115.0	95.8	80.2	82.5	96.2
			Oregon			
No. of Accidents Reported	53,690	55,740	53,947	50,530	41,315	51,044
No. of Personnel	1,028	1,089	1,112	1,168	1,114	1,102
No. of Accidents per Employee	52.2	51.2	48.5	43.3	37.1	46.3
			Pennsylvania			
No. of Accidents Reported	31,666	35,903	40,323	44,769	49,976	40,527
No. of Personnel	152	184	201	216	227	196
No. of Accidents per Employee	208.3	195.1	200.6	207.3	220.2	206.8
			Utah			
No. of Accidents Reported	39,105	37,641	41,595	43,349	NA	40,423
No. of Personnel	104	110	135	135	NA	121
No. of Accidents per Employee	376.0	342.2	308.1	321.1	NA	334.1
			Total			
No. of Accidents Reported	762,418	853,325	893,851	885,822	853,754	849,834
No. of Personnel	7,253	8,974	9,915	11,545	12,073	9,952
No. of Accidents per Employee	105.1	95.1	90.2	76.7	70.7	85.4

State Funds
Number of Accidents per Employee

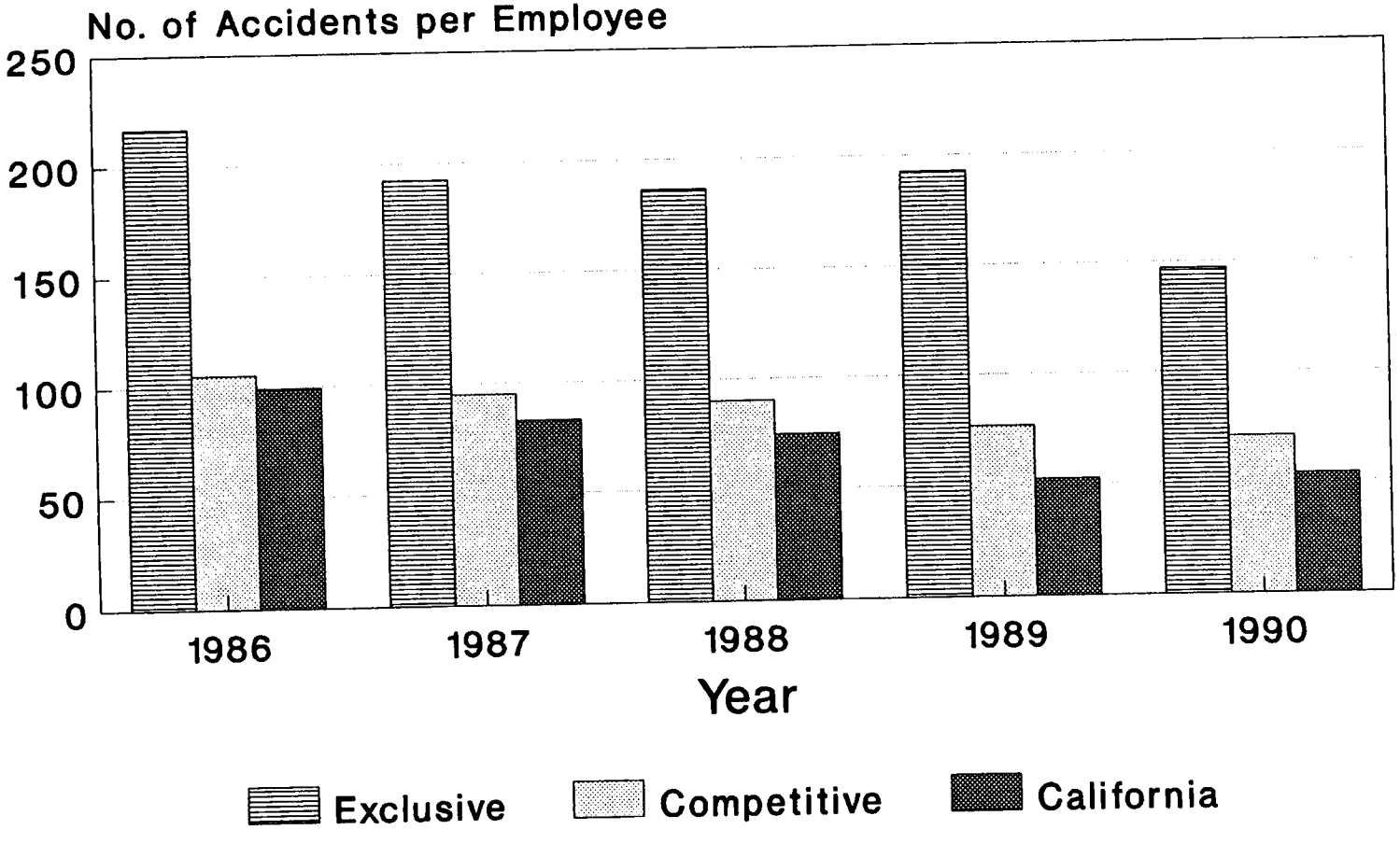


Exhibit AIS-16, Sheet 3

Exclusive State Funds
Number of Accidents per Employee
Average 1986-1990

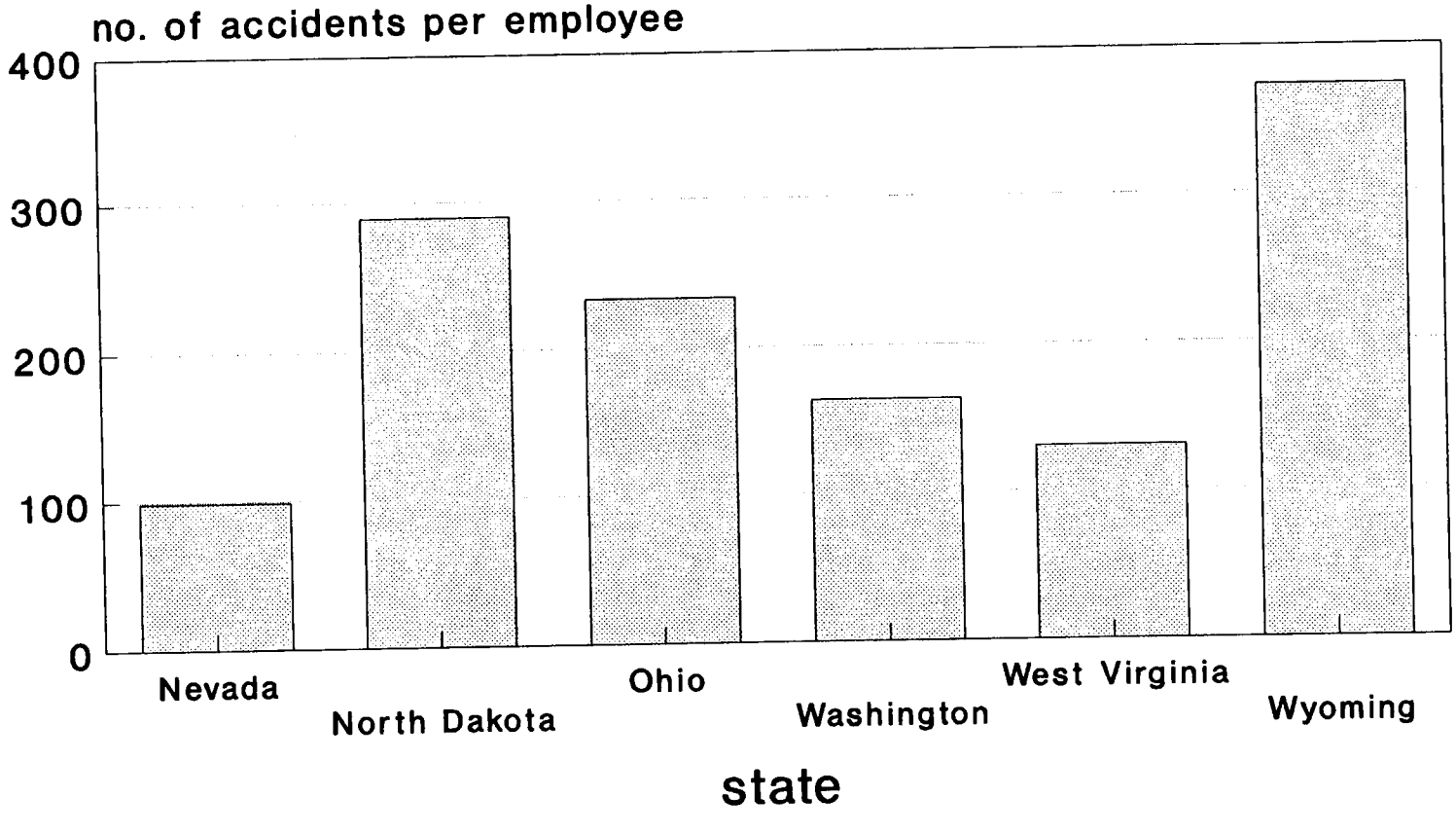


Exhibit AIS-16, Sheet 4

COMPARISON OF OVERALL RATING STRUCTURES USED BY STATE FUNDS

State Fund	Number of Rate Classes	Experience Rating	Eligibility Standard	Retrospective Rating	Number of Retro Plans	Dividends Allowed	Discounts Allowed
			Exclusive State Funds				
Nevada	937	Yes	Expected Losses =>$4,000	Yes	4 tabular, 1 flexible	Yes	No
North Dakota	139	Yes	Annual Premium =>$25			No	No
Ohio	225	Yes	Expected Losses =>$8,000	Yes	2 tabular	No	No
Washington		Yes	No minimum premium	Yes	5	Yes*	No
West Virginia	92	Yes	Exp. Period Prem. => $1,500	No		No	No
Wyoming		Yes				No	No
			Competitive State Funds				
Arizona	NCCI**	Yes	Annual Premium => $5,000	Yes	4 tabular, 1 flexible	Yes	Yes
California	437	Yes	Exp. Period Prem. => $20,600	Yes	1 tabular	Yes	No
Colorado	NCCI**	Yes	Annual Premium => $5,000	Yes	4 tabular	Yes	Yes
Idaho	NCCI**	Yes	Annual Premium => $5,500	No		Yes	Yes
Maryland	409	Yes	Exp. Period Prem. => $300			Yes	Yes
Michigan	392	Yes	Annual Premium => $4,000#	Yes*		Yes	Yes
Minnesota	529	Yes		Yes		Yes	Yes
Montana		Yes	Annual Premium => $2,500	Yes		Yes*	Yes
New York	739	Yes	Annual Premium => $5,000	Yes	4 tabular, 1 flexible	Yes	Yes
Oklahoma	NCCI**	Yes	NCCI Exp. Rating Plan	No		Yes	Yes
Oregon	NCCI**	Yes	Annual Premium => $2,500~	Yes		Yes	Yes
Pennsylvania	309	Yes	Exp. Period Prem. => $14,000	Yes		Yes	Yes
Utah	NCCI**	Yes	NCCI Exp. Rating Plan			Yes	Yes

* Allowed but not currently used
** The number of NCCI classes will vary somewhat between states, but will generally be in the range of 600.
# Merit rating based upon the frequency of lost time losses applies when the average annual manual premium is between $500 and $4,000 for the experience period.
~ Claim Rating Plan used for non-experience rated risks

Nevada

Average Workers' Compensation Rate

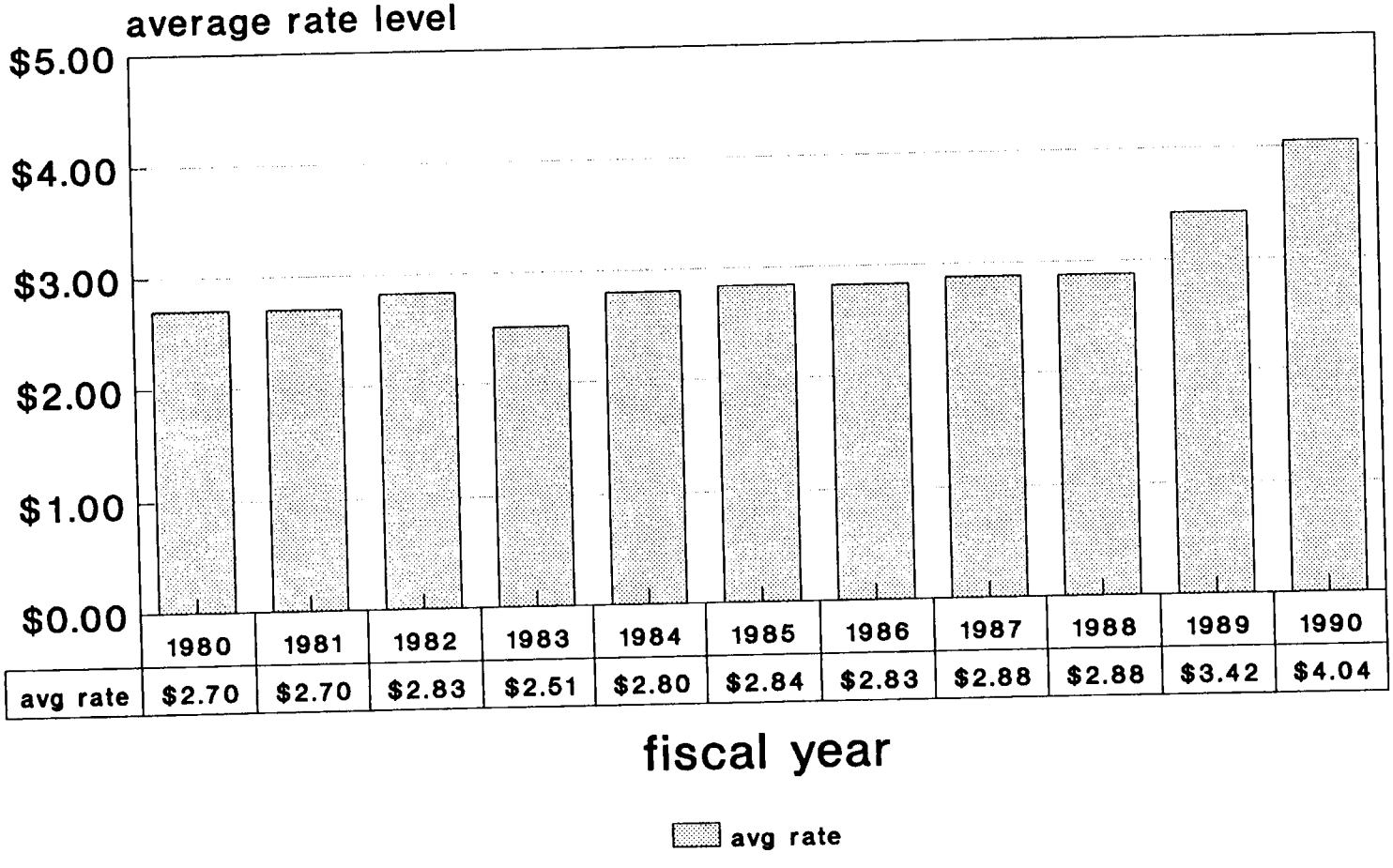


Exhibit AIS-18, Sheet 1

Ohio

Average Workers' Compensation Rate

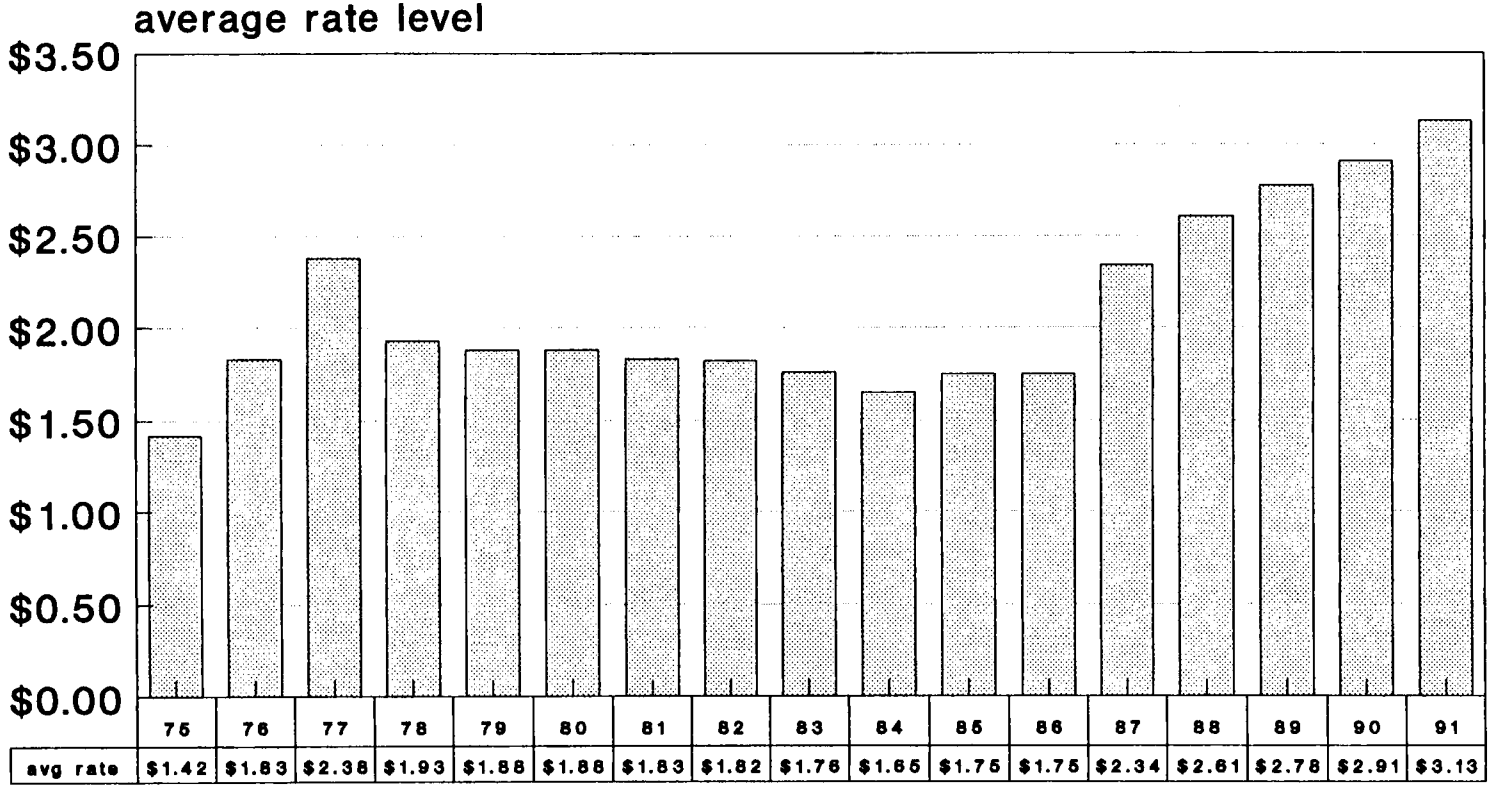


Exhibit AIS-18, Sheet 2

West Virginia

Average Workers' Compensation Rate

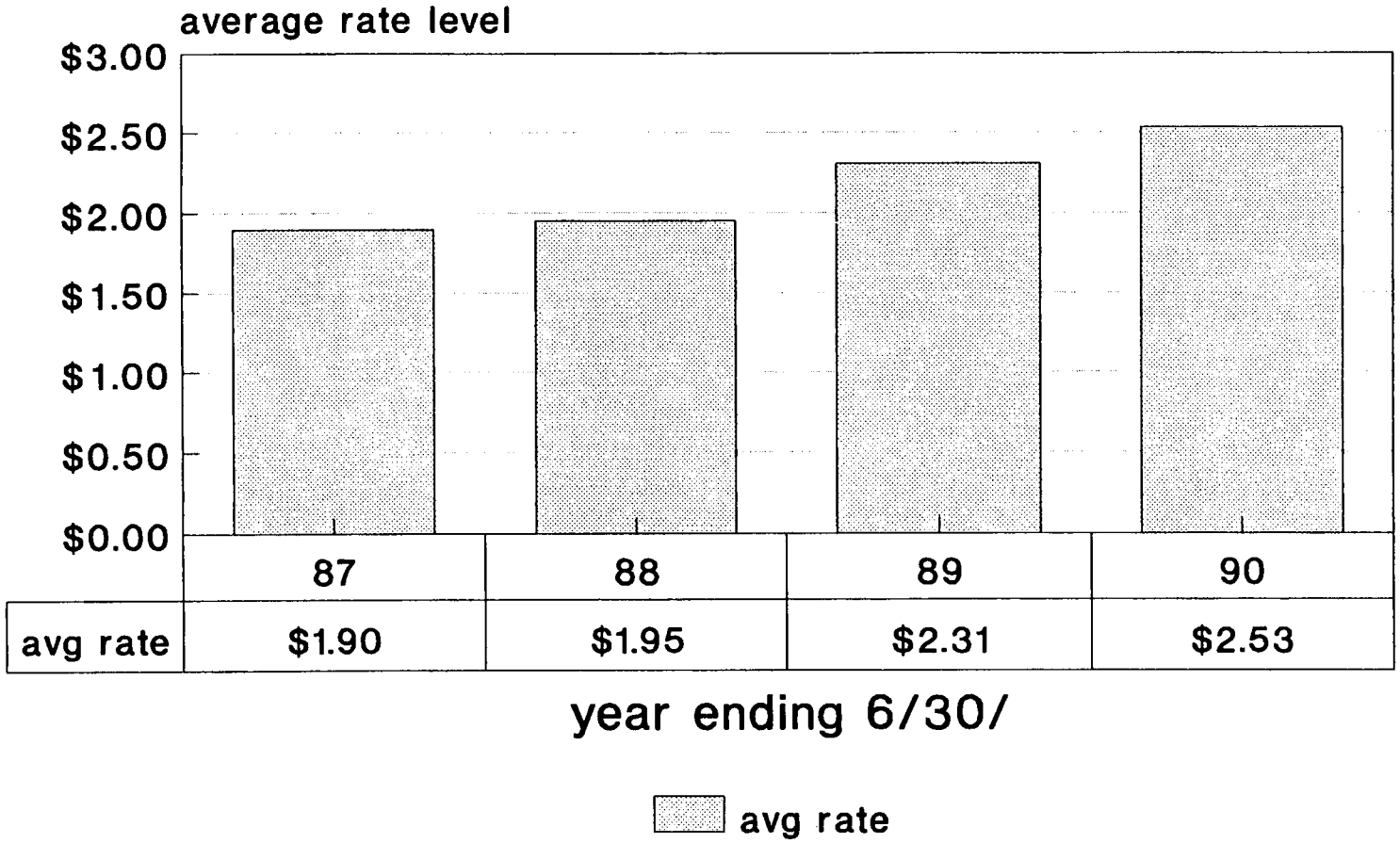


Exhibit AIS-18, Sheet 3

Nevada
Workers' Compensation
Rate Level Changes

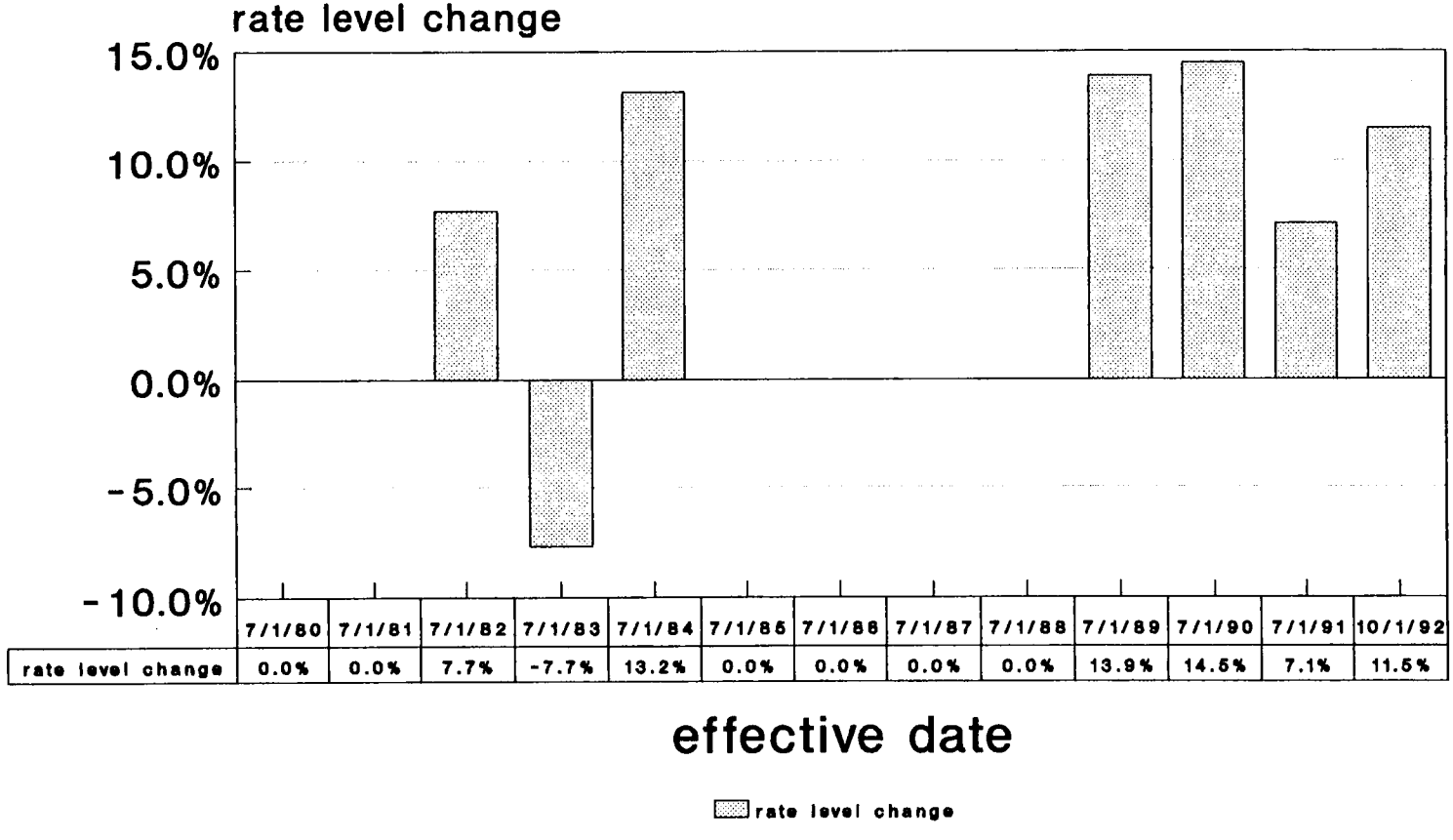


Exhibit AIS-19, Sheet 1

Ohio

Workers' Compensation

Rate Level Changes 1975-1991

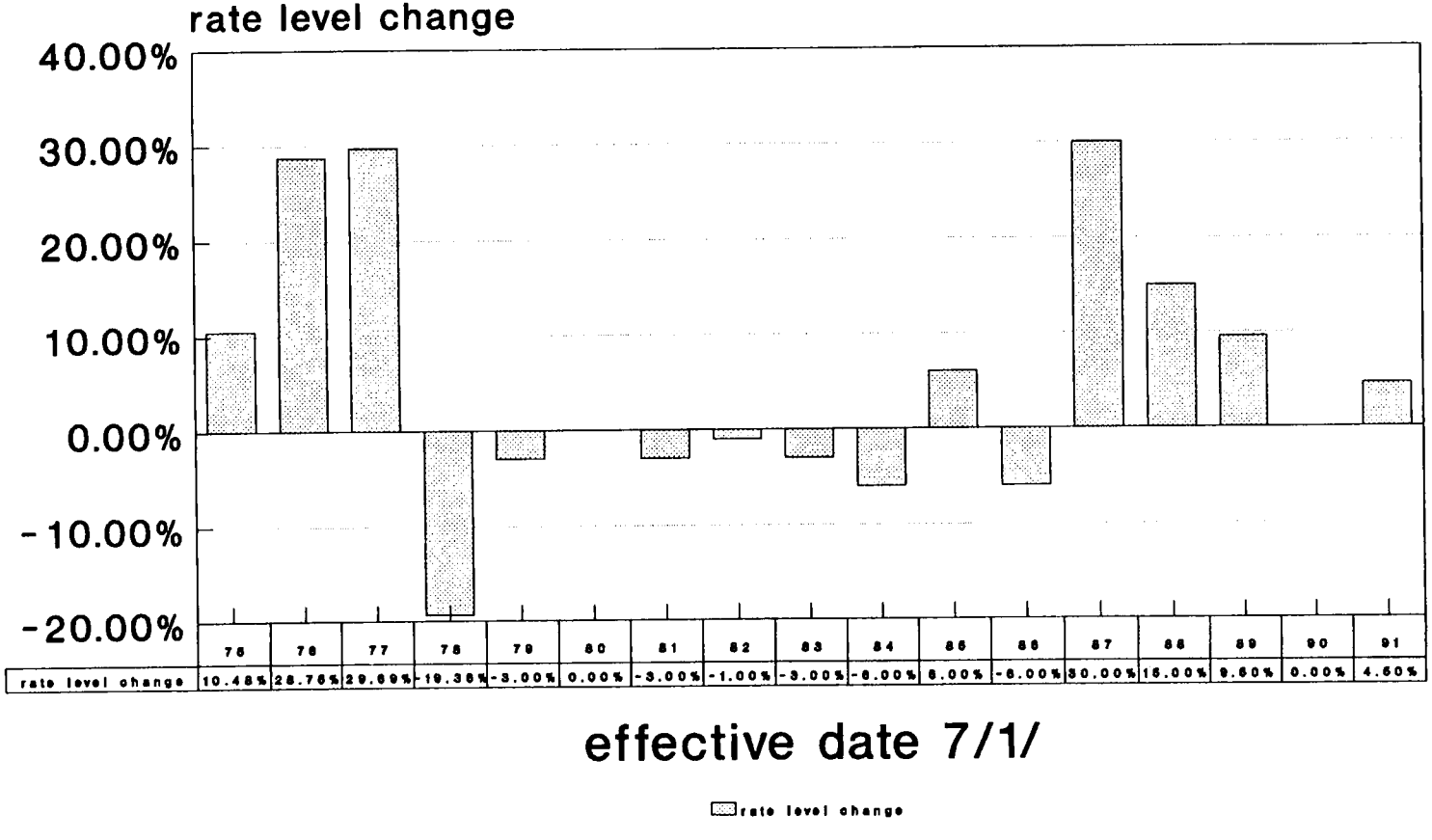


Exhibit AIS-19, Sheet 2

West Virginia
Workers' Compensation
Rate Level Changes

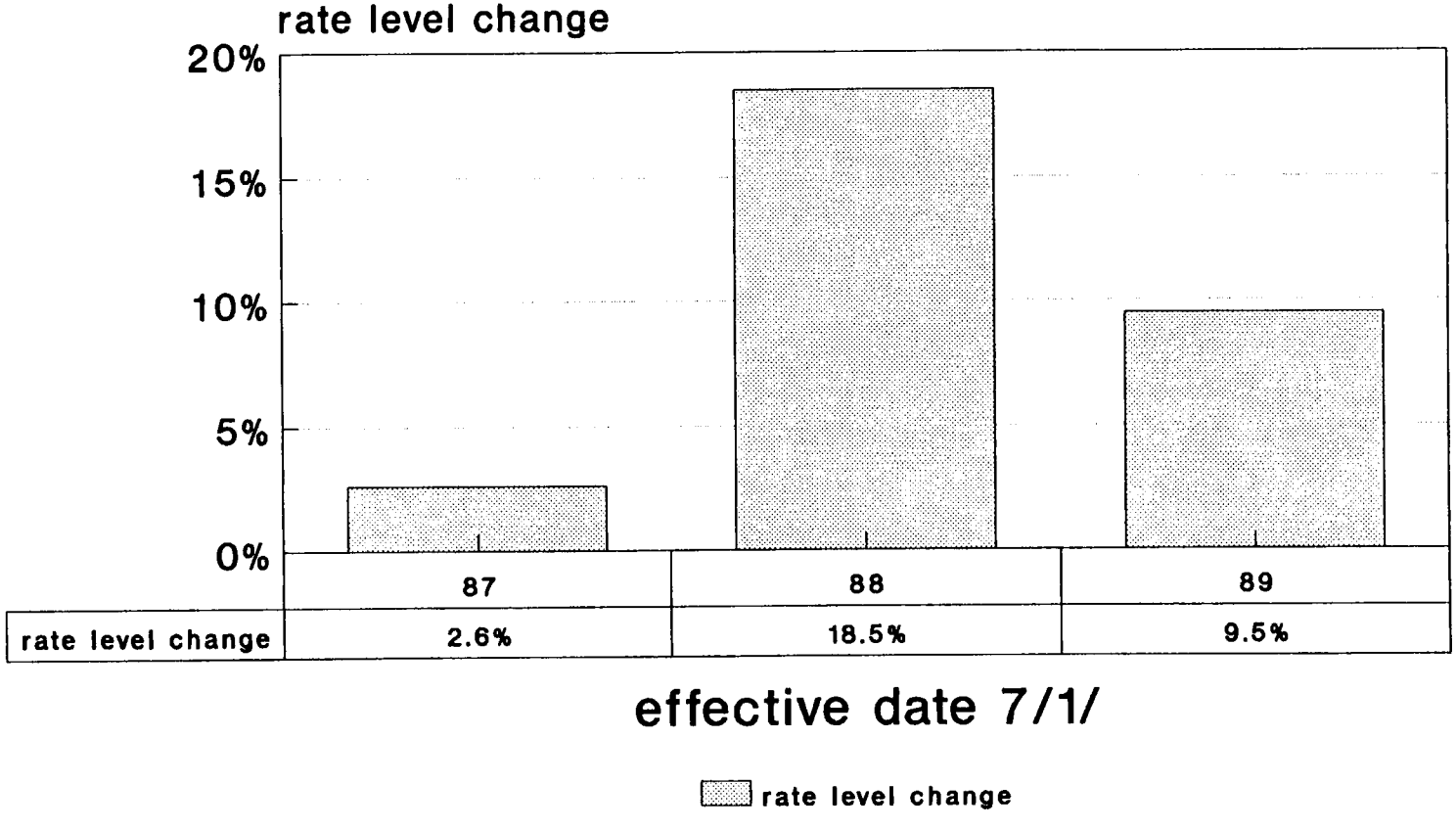
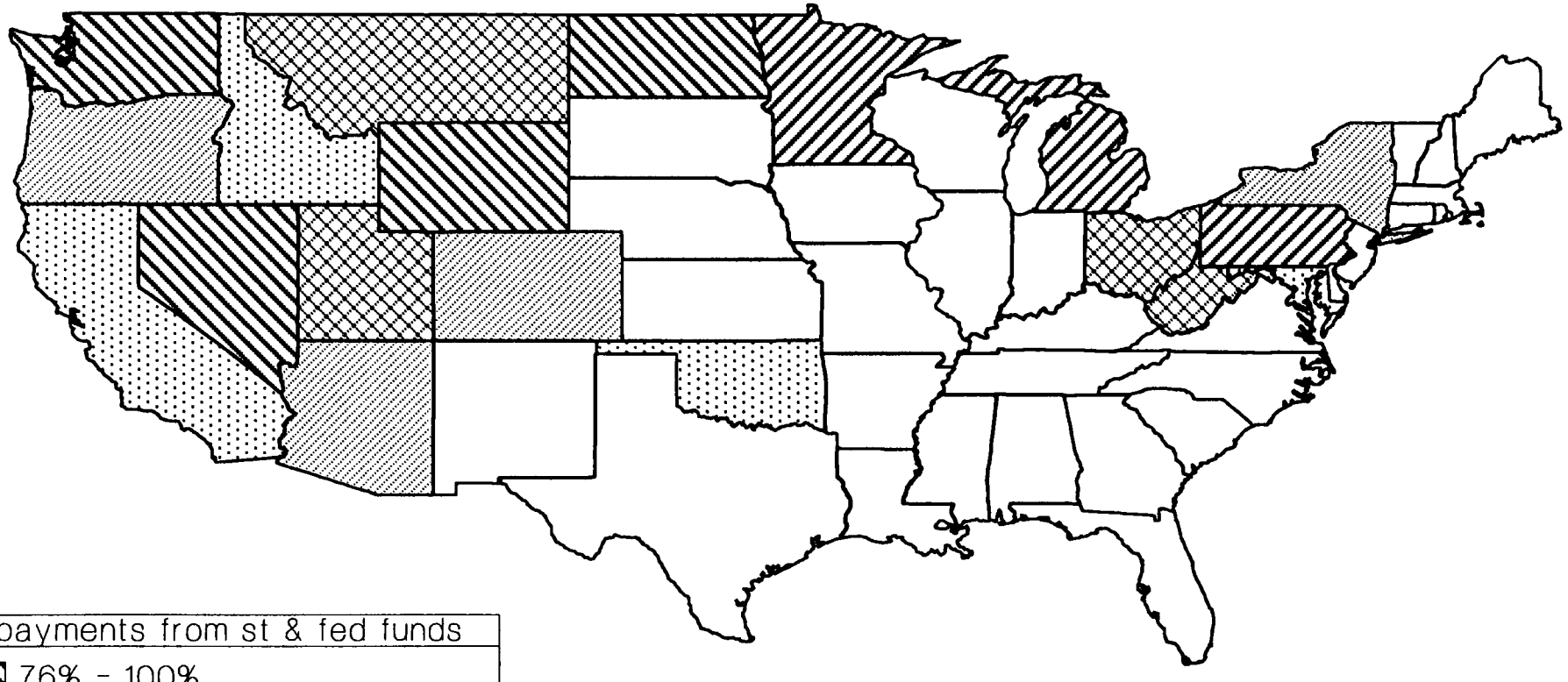


Exhibit AIS-19, Sheet 3

Workers' Compensation Payments - 1988
(In Thousands)

State	Total	Private Insurance	State & Fed. Funds	Self Insurance	Percent State & Fed. Funds
Arizona	$300,887	$126,670	$118,217	$56,000	39.3%
California	$4,810,305	$2,548,616	$817,689	$1,444,000	17.0%
Colorado	$474,482	$196,913	$205,869	$71,700	43.4%
Idaho	$84,983	$52,030	$24,753	$8,200	29.1%
Maryland	$396,734	$259,933	$76,801	$60,000	19.4%
Michigan	$1,010,014	$549,610	$70,404	$390,000	7.0%
Minnesota	$501,901	$369,454	$16,447	$116,000	3.3%
Montana	$150,436	$46,035	$91,101	$13,300	60.6%
Nevada	$236,861	$861	$200,000	$36,000	84.4%
New York	$1,344,539	$662,127	$432,412	$250,000	32.2%
North Dakota	$44,441	$124	$44,317	$0	99.7%
Ohio	$1,716,339	$6,339	$1,260,000	$450,000	73.4%
Oklahoma	$301,992	$166,992	$65,000	$70,000	21.5%
Oregon	$555,769	$217,505	$245,264	$93,000	44.1%
Pennsylvania	$1,499,049	$1,098,417	$100,632	$300,000	6.7%
Utah	$115,563	$29,201	$68,362	$18,000	59.2%
Washington	$705,478	$13,478	$550,000	$142,000	78.0%
West Virginia	$363,391	$735	$249,656	$113,000	68.7%
Wyoming	$45,594	$751	$44,843	$0	98.4%

Workers' Compensation - 1988
% Payments from State and Federal Funds

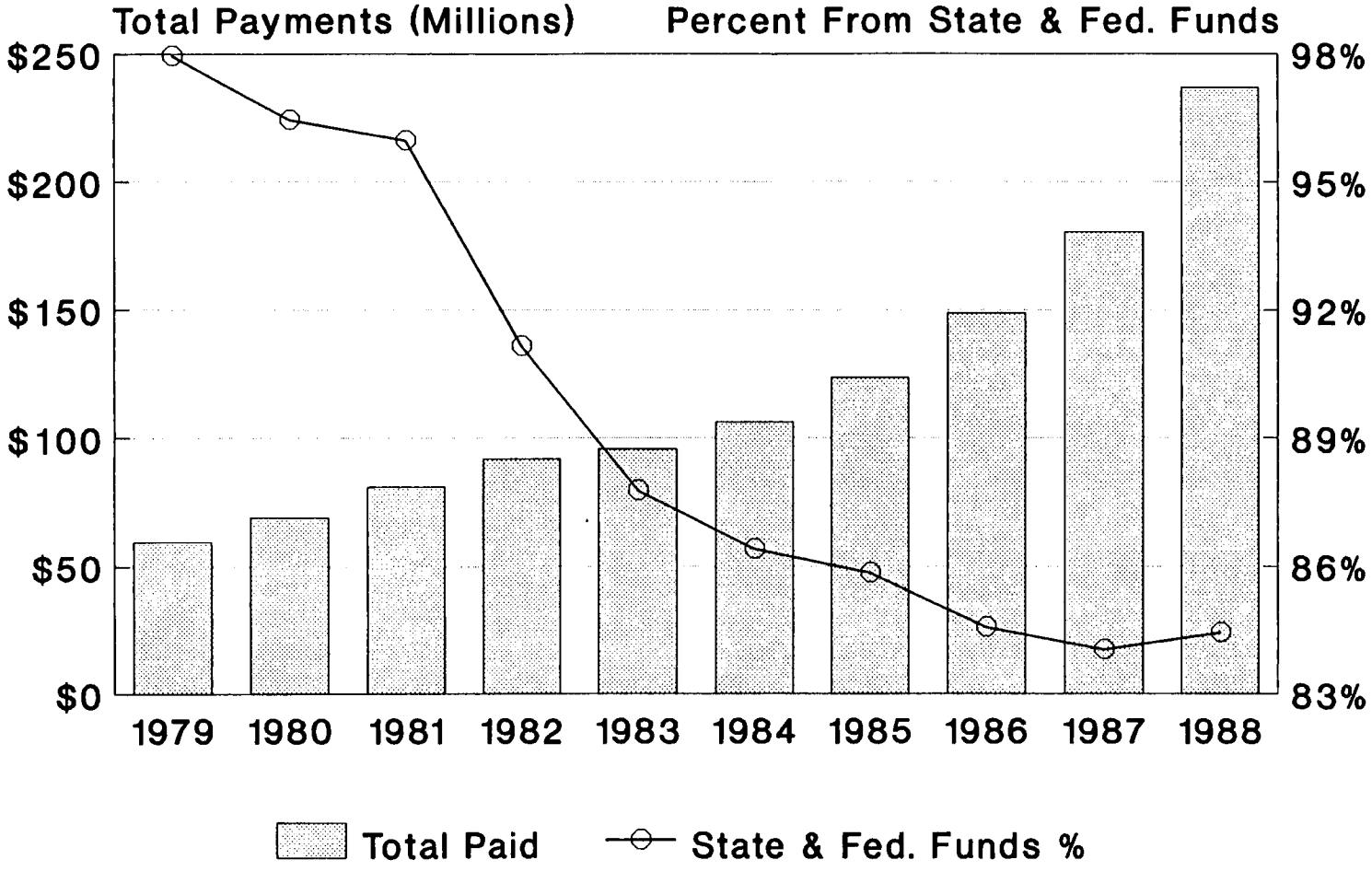


payments from st & fed funds

- 76% - 100%
- 51% - 75%
- 32% - 50%
- 16% - 30%
- 1% - 15%
- 0%

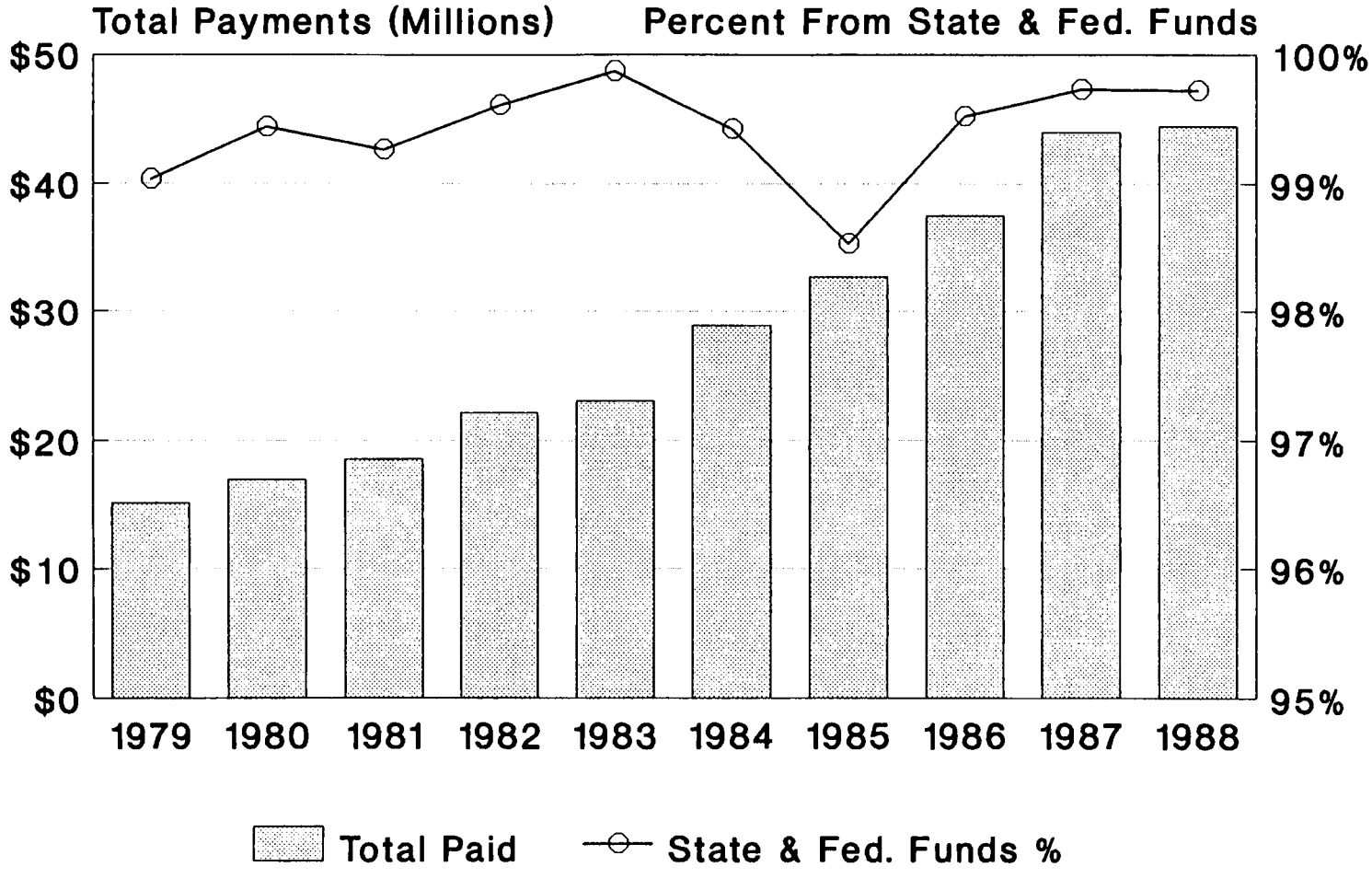
Appendix A, Sheet 2

NEVADA WORKERS' COMPENSATION
Payments From State & Federal Funds

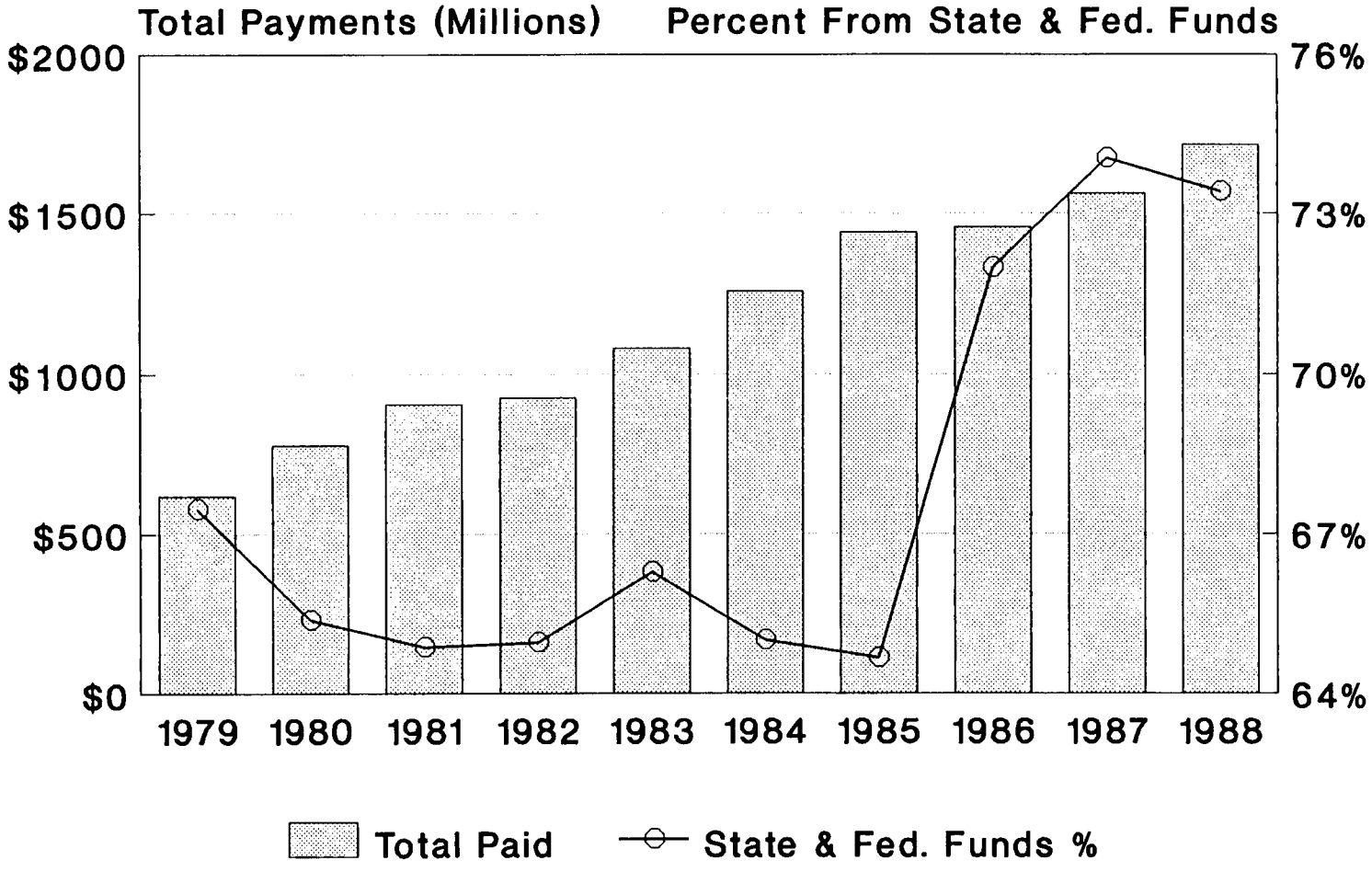


Appendix B, Sheet 1

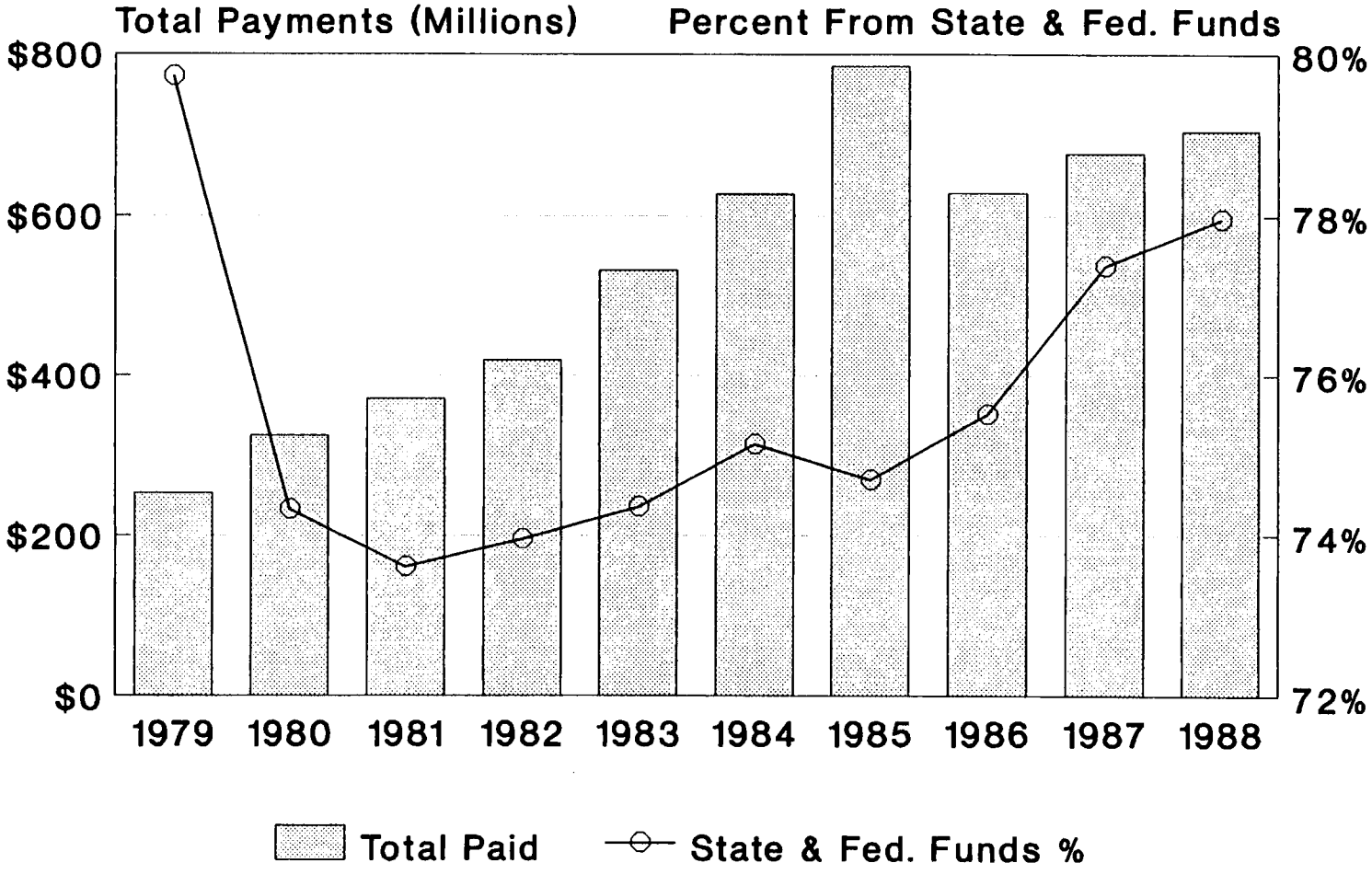
NORTH DAKOTA WORKERS' COMPENSATION
Payments From State & Federal Funds



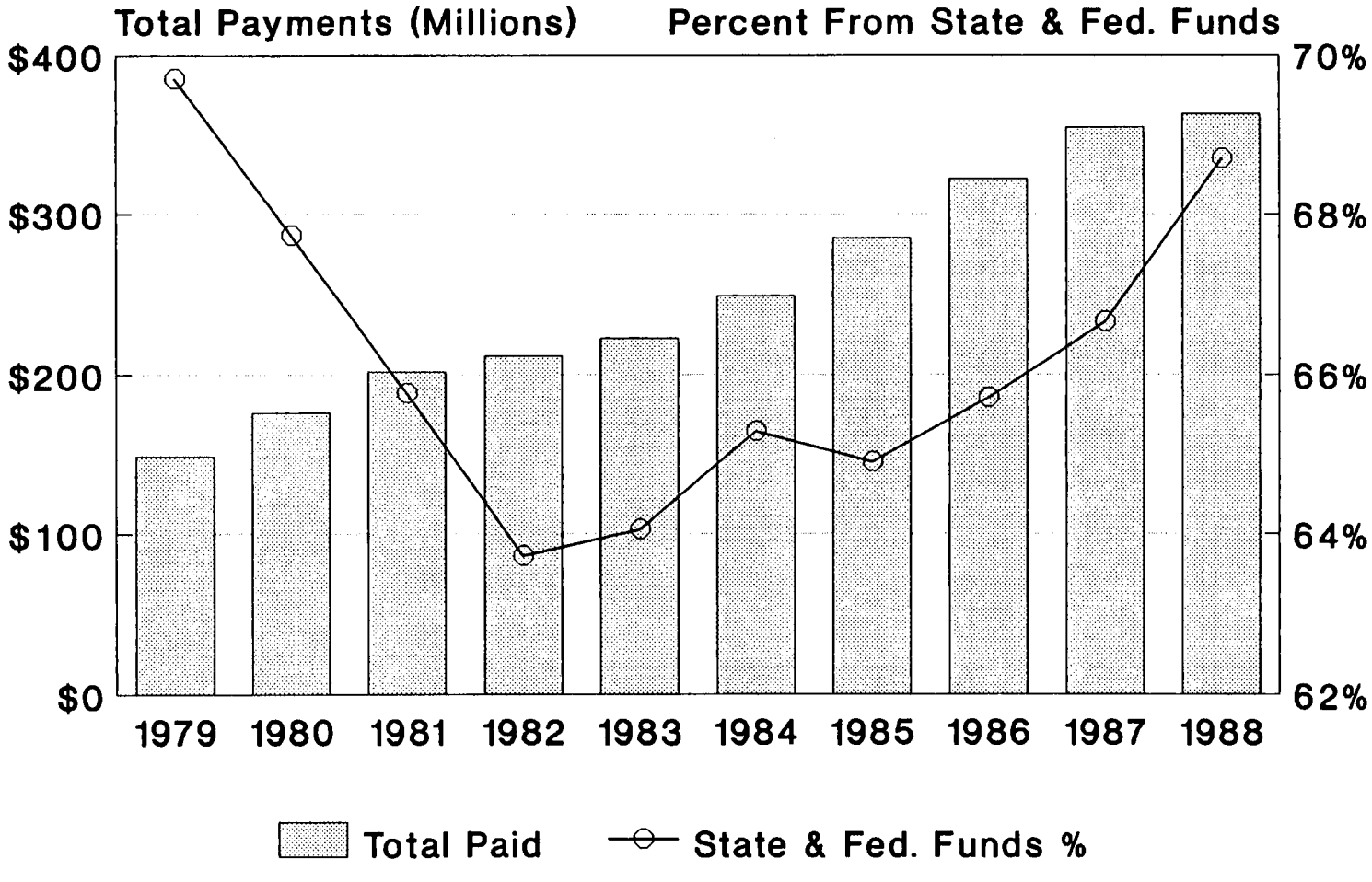
OHIO WORKERS' COMPENSATION
Payments From State & Federal Funds



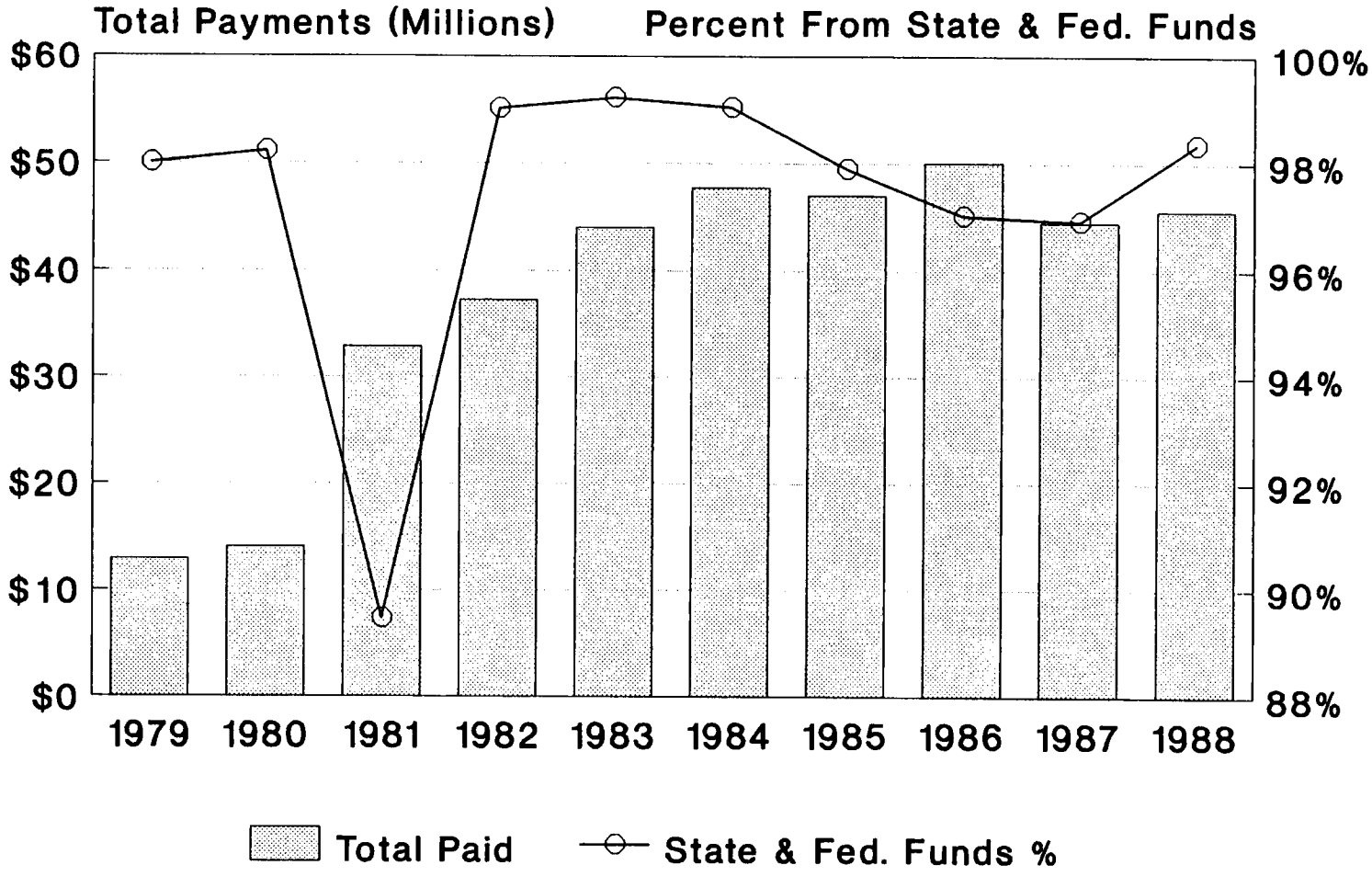
WASHINGTON WORKERS' COMPENSATION
Payments From State & Federal Funds



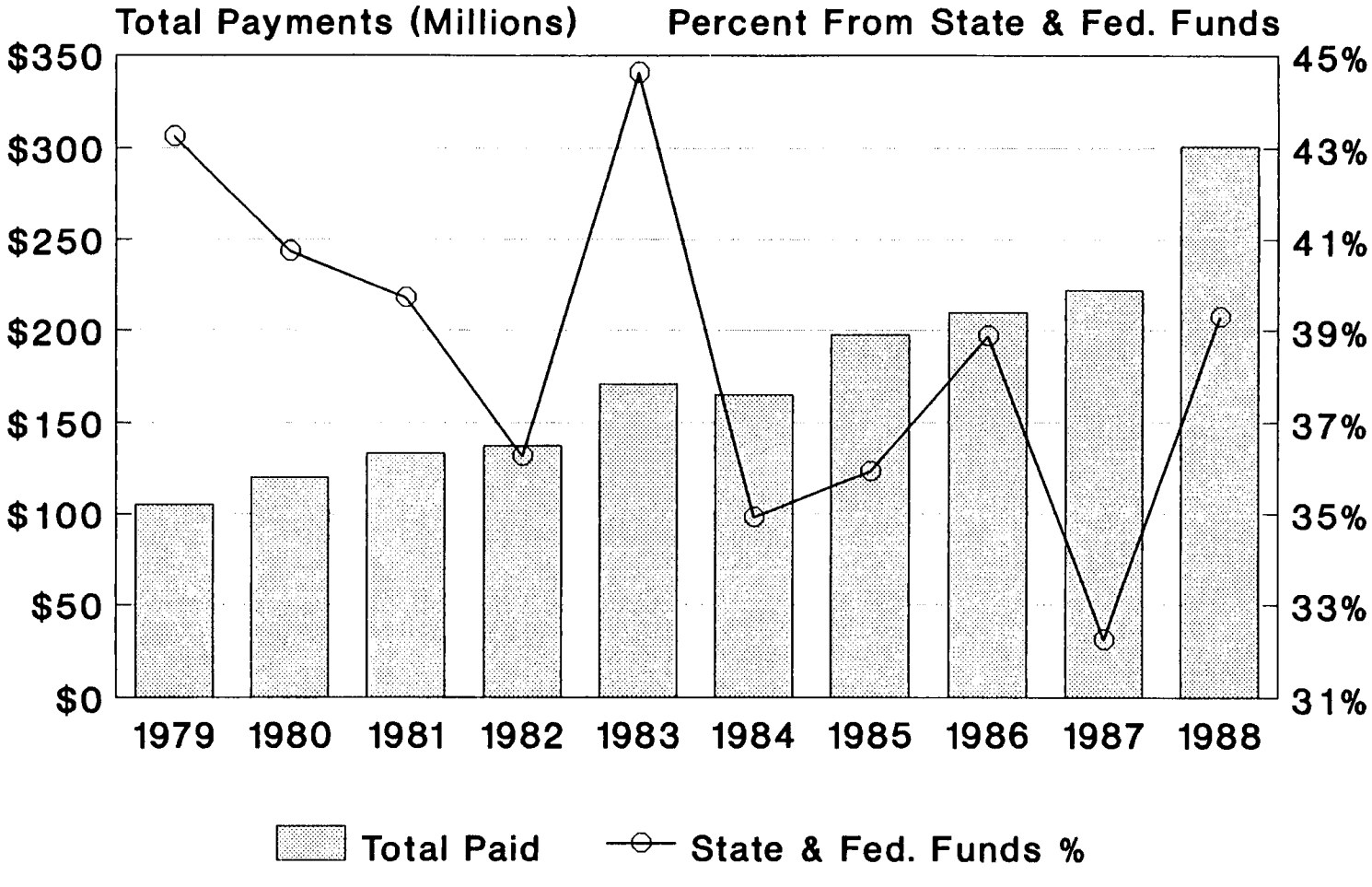
WEST VIRGINIA WORKERS' COMPENSATION
Payments From State & Federal Funds



WYOMING WORKERS' COMPENSATION
Payments From State & Federal Funds

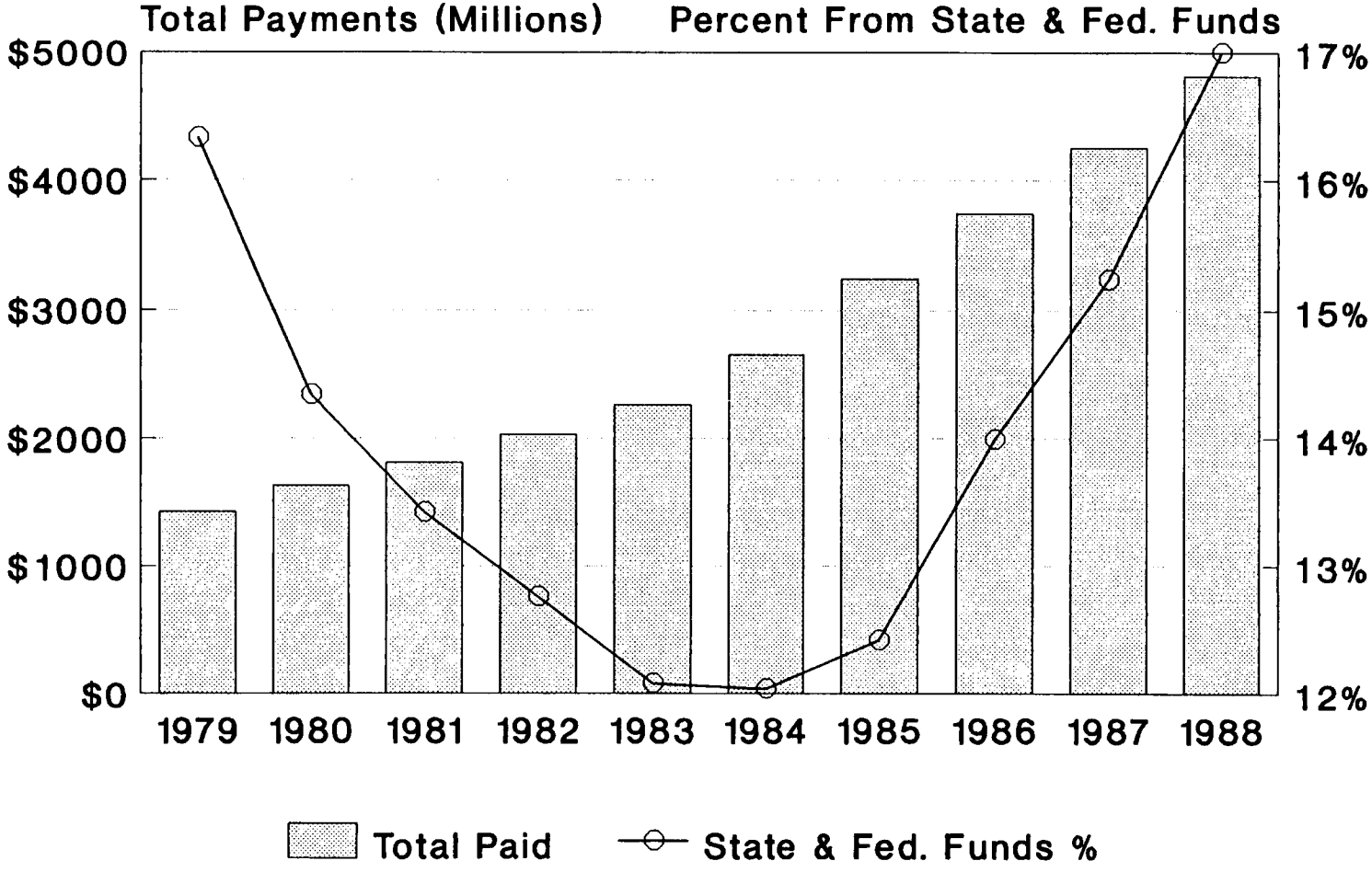


ARIZONA WORKERS' COMPENSATION
Payments From State & Federal Funds



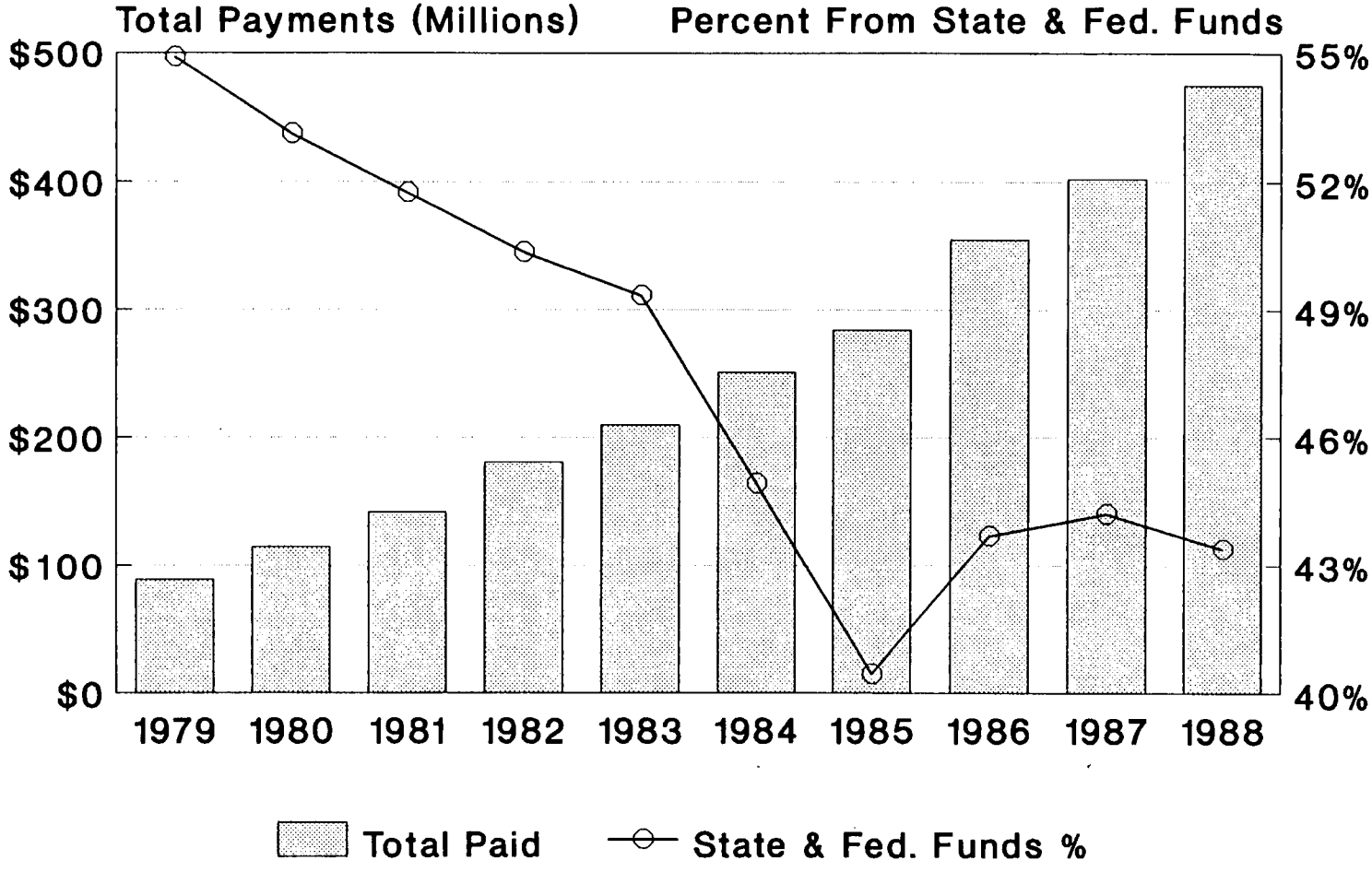
Appendix C, Sheet 1

CALIFORNIA WORKERS' COMPENSATION
Payments From State & Federal Funds



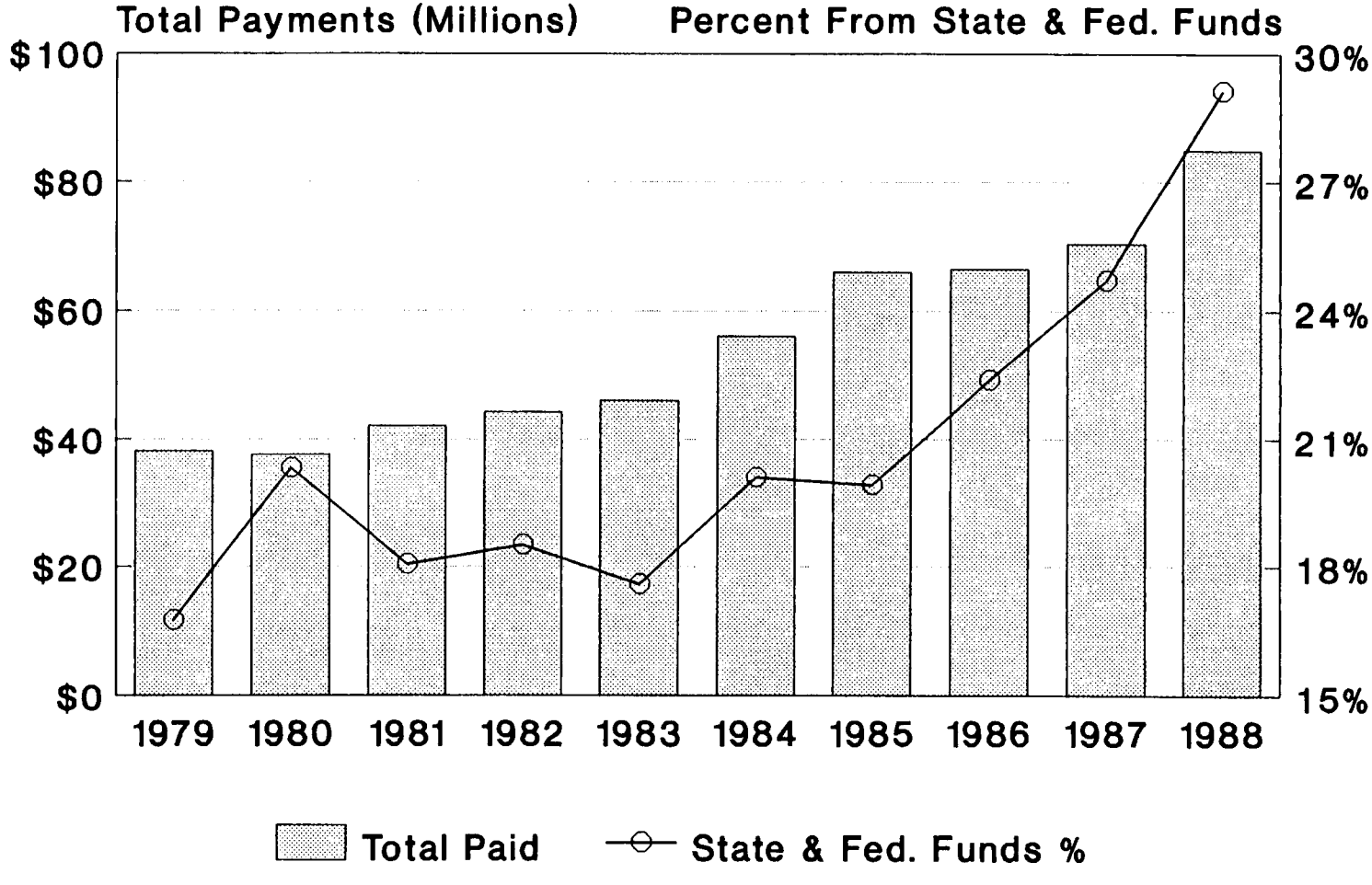
Appendix C, Sheet 2

COLORADO WORKERS' COMPENSATION
Payments From State & Federal Funds

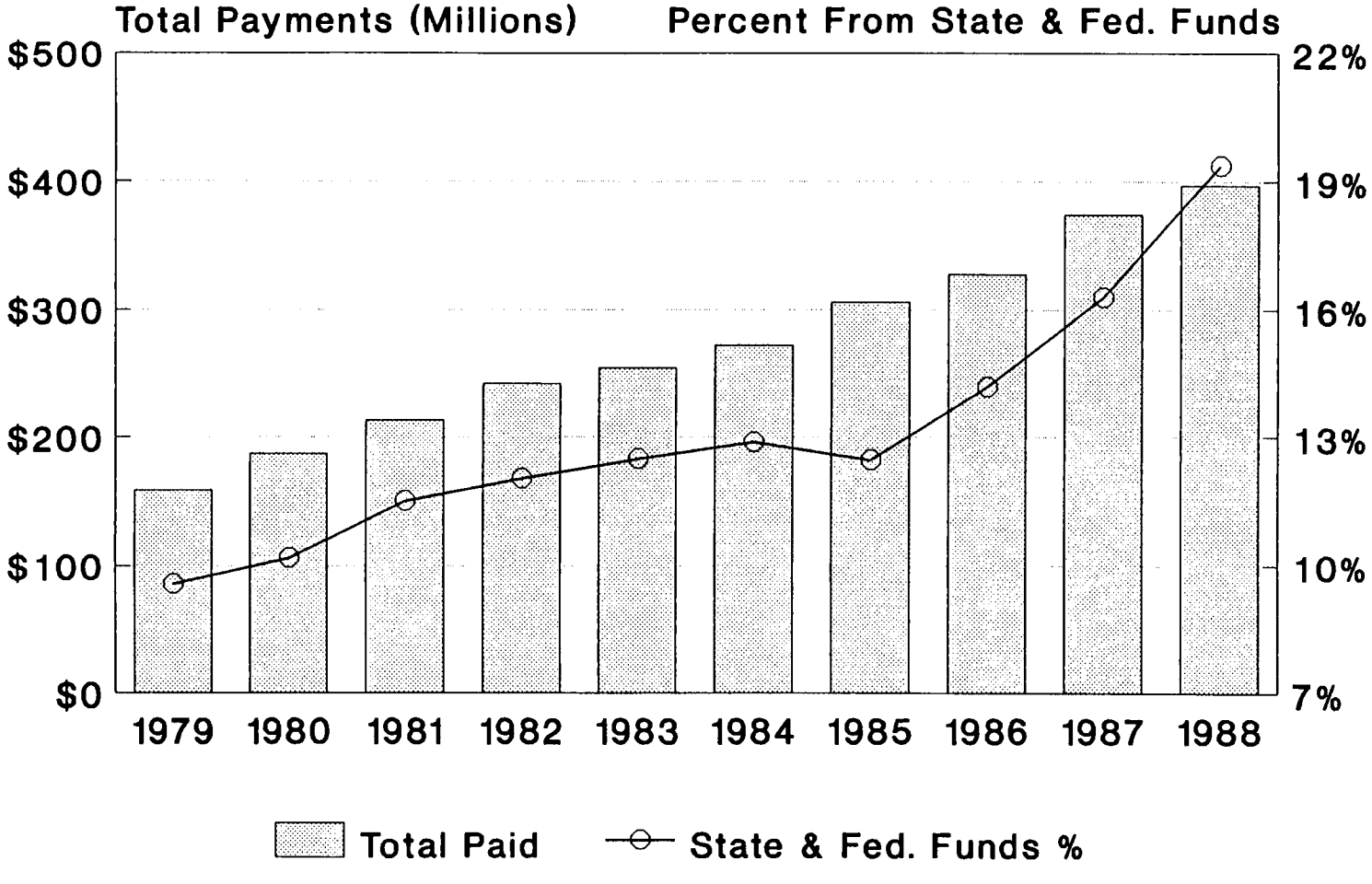


Appendix C, Sheet 3

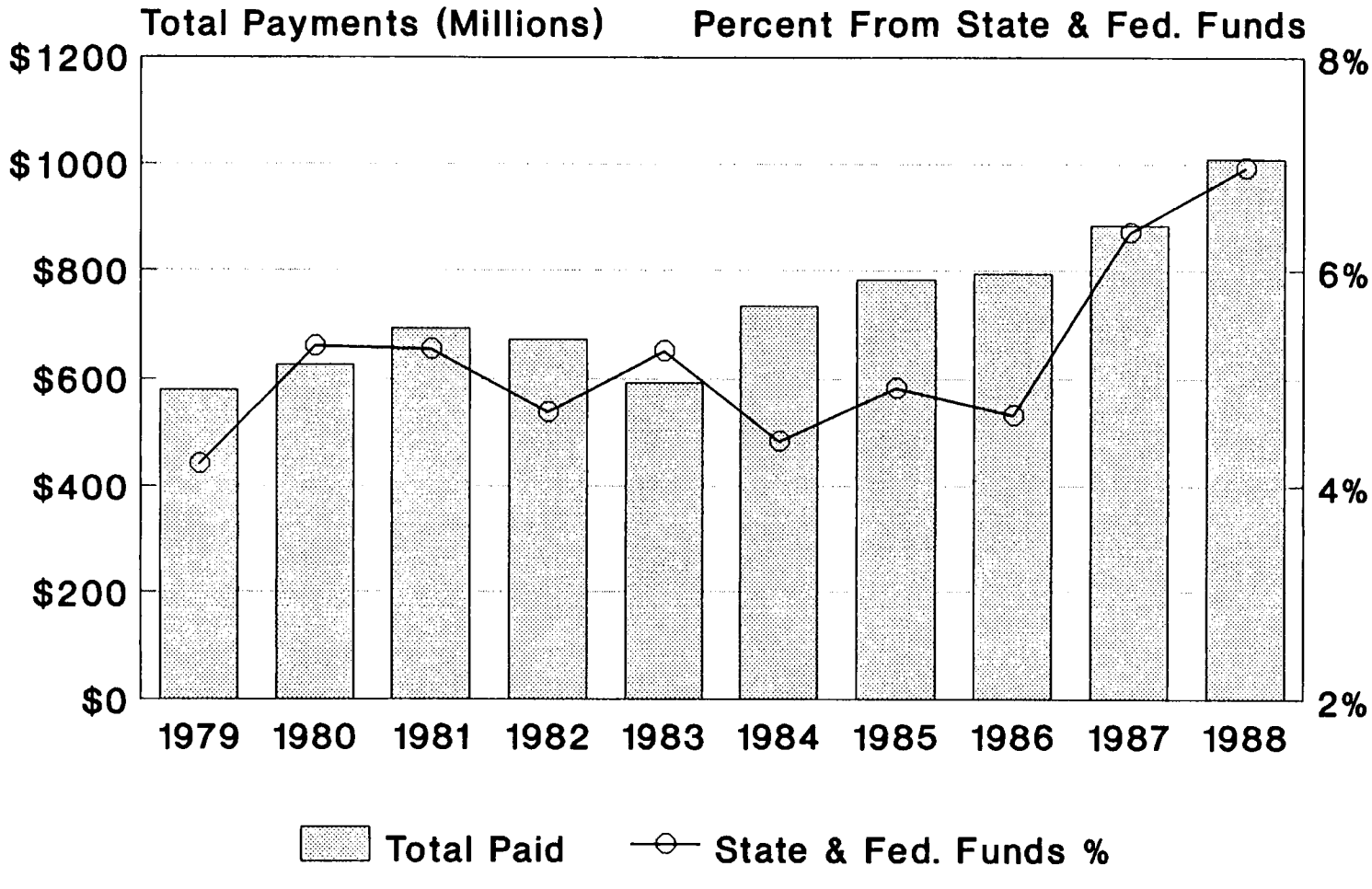
IDAHO WORKERS' COMPENSATION
Payments From State & Federal Funds



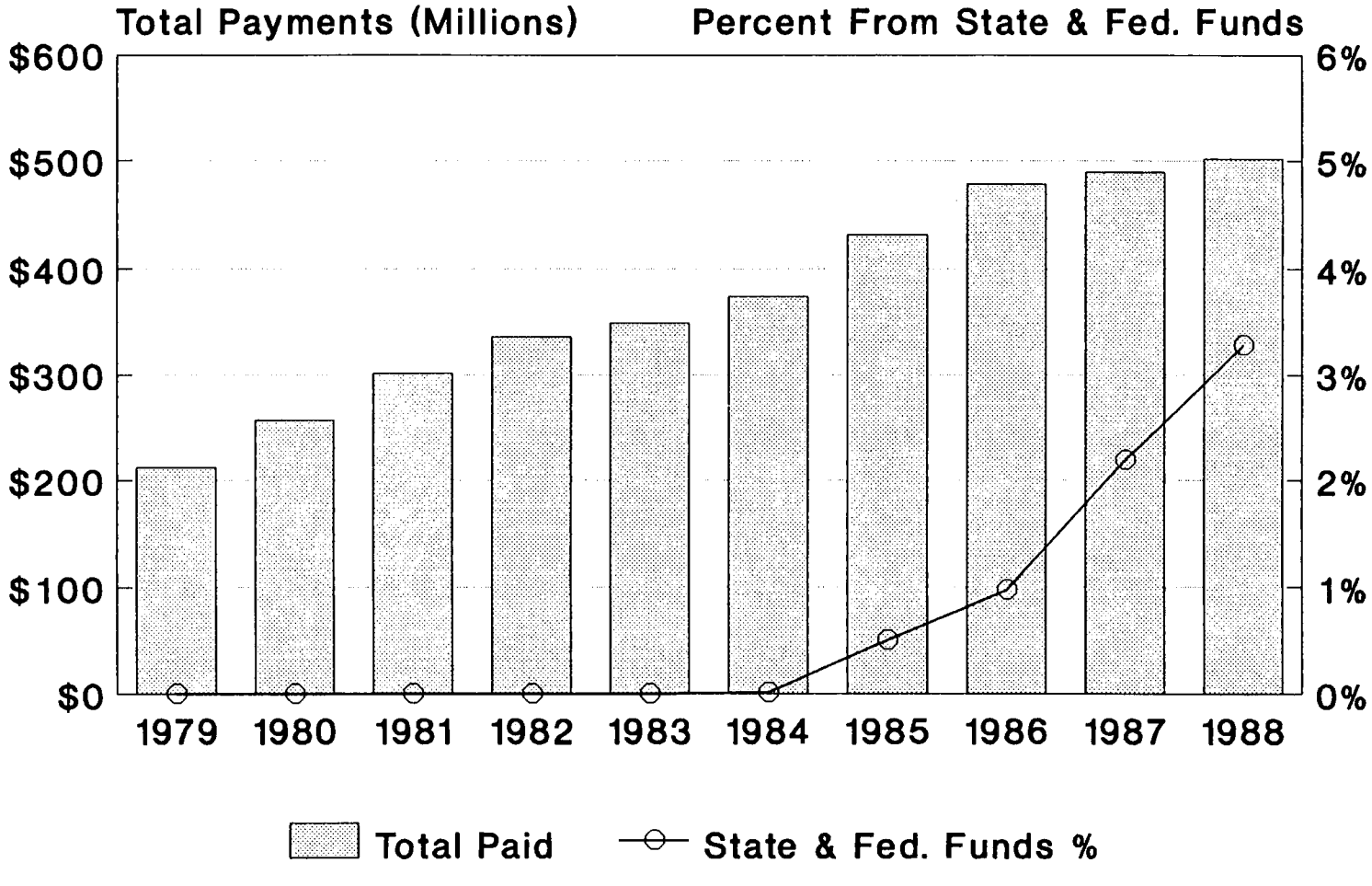
MARYLAND WORKERS' COMPENSATION
Payments From State & Federal Funds



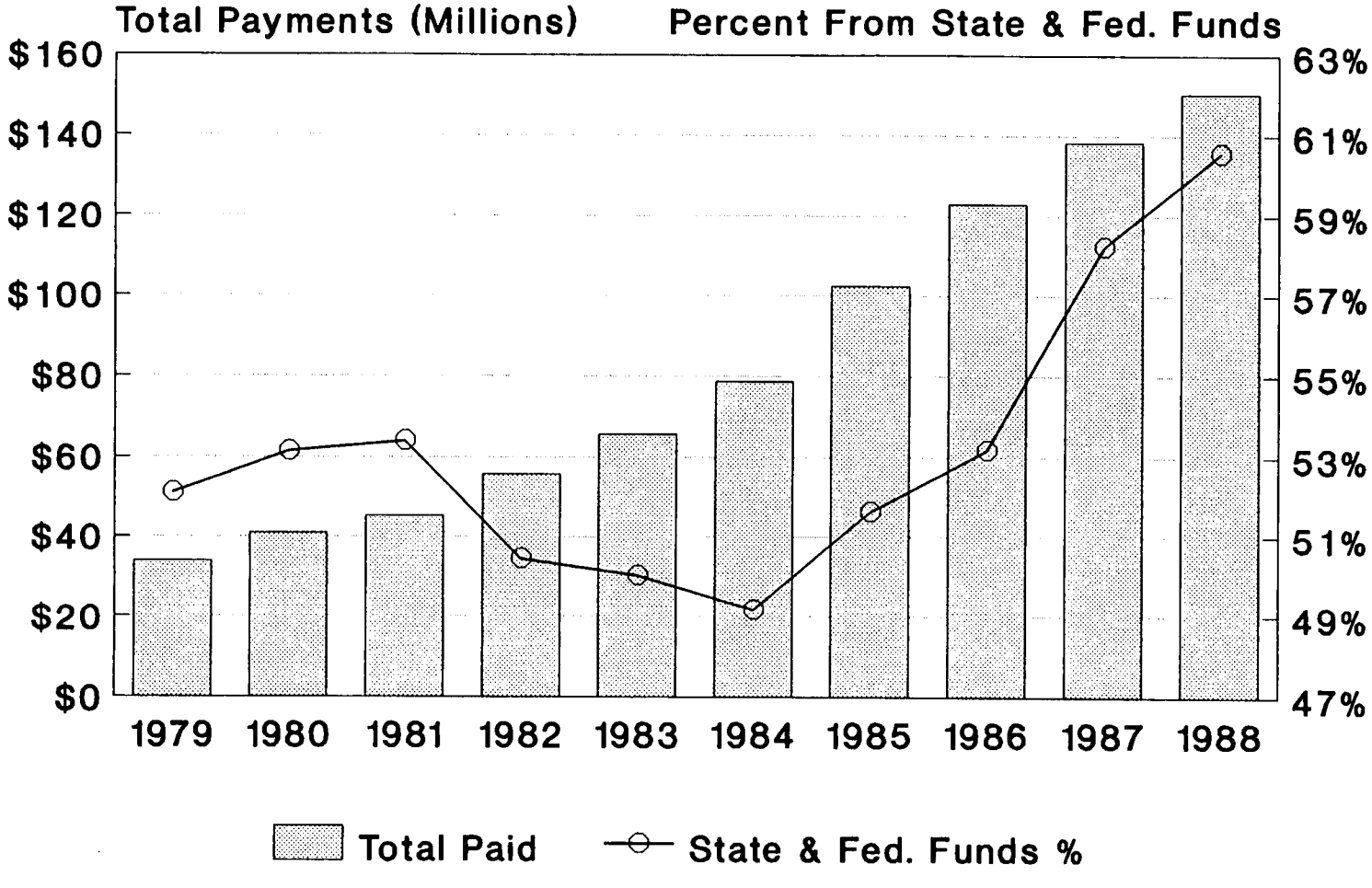
MICHIGAN WORKERS' COMPENSATION
Payments From State & Federal Funds



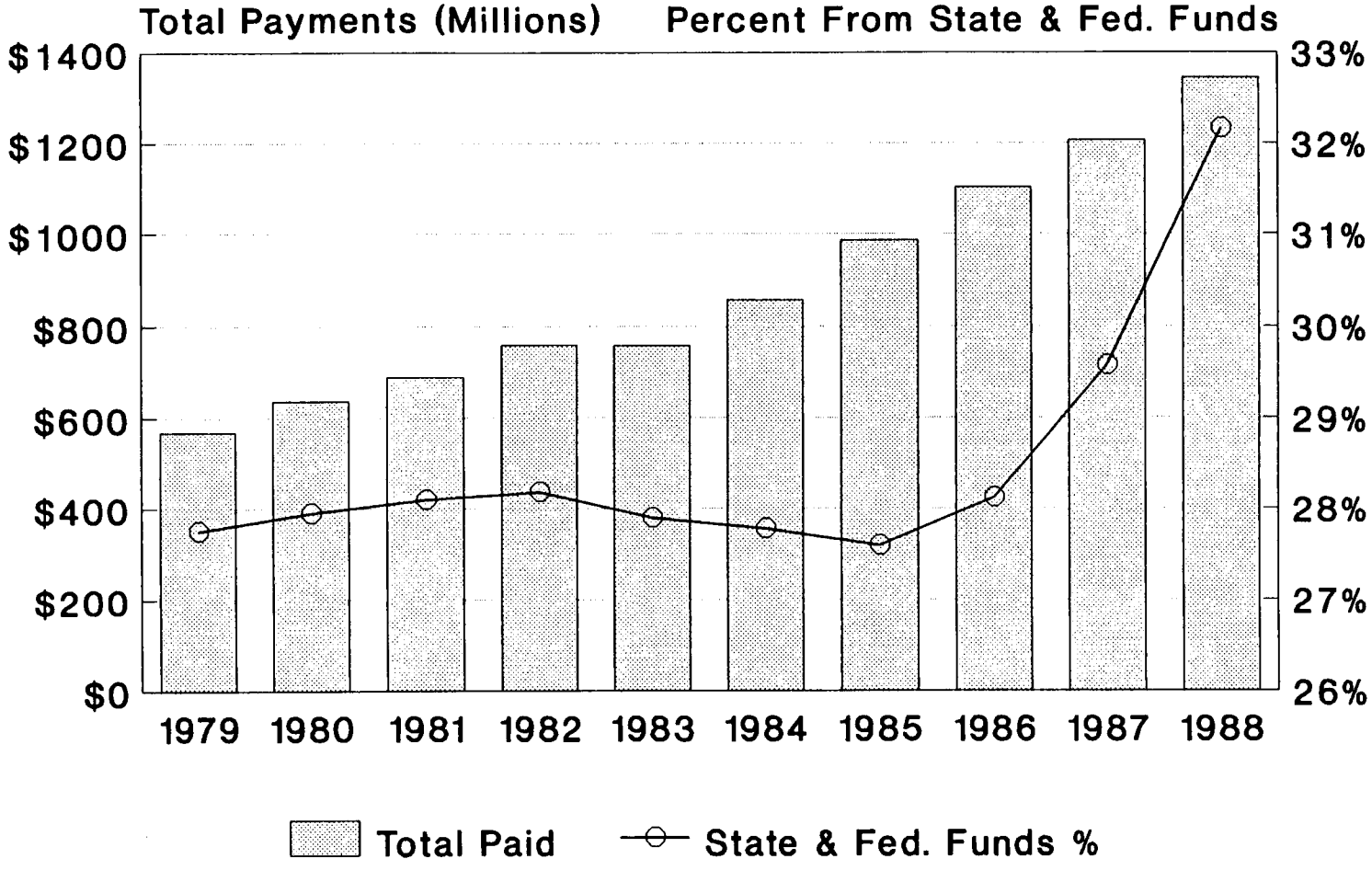
MINNESOTA WORKERS' COMPENSATION
Payments From State & Federal Funds



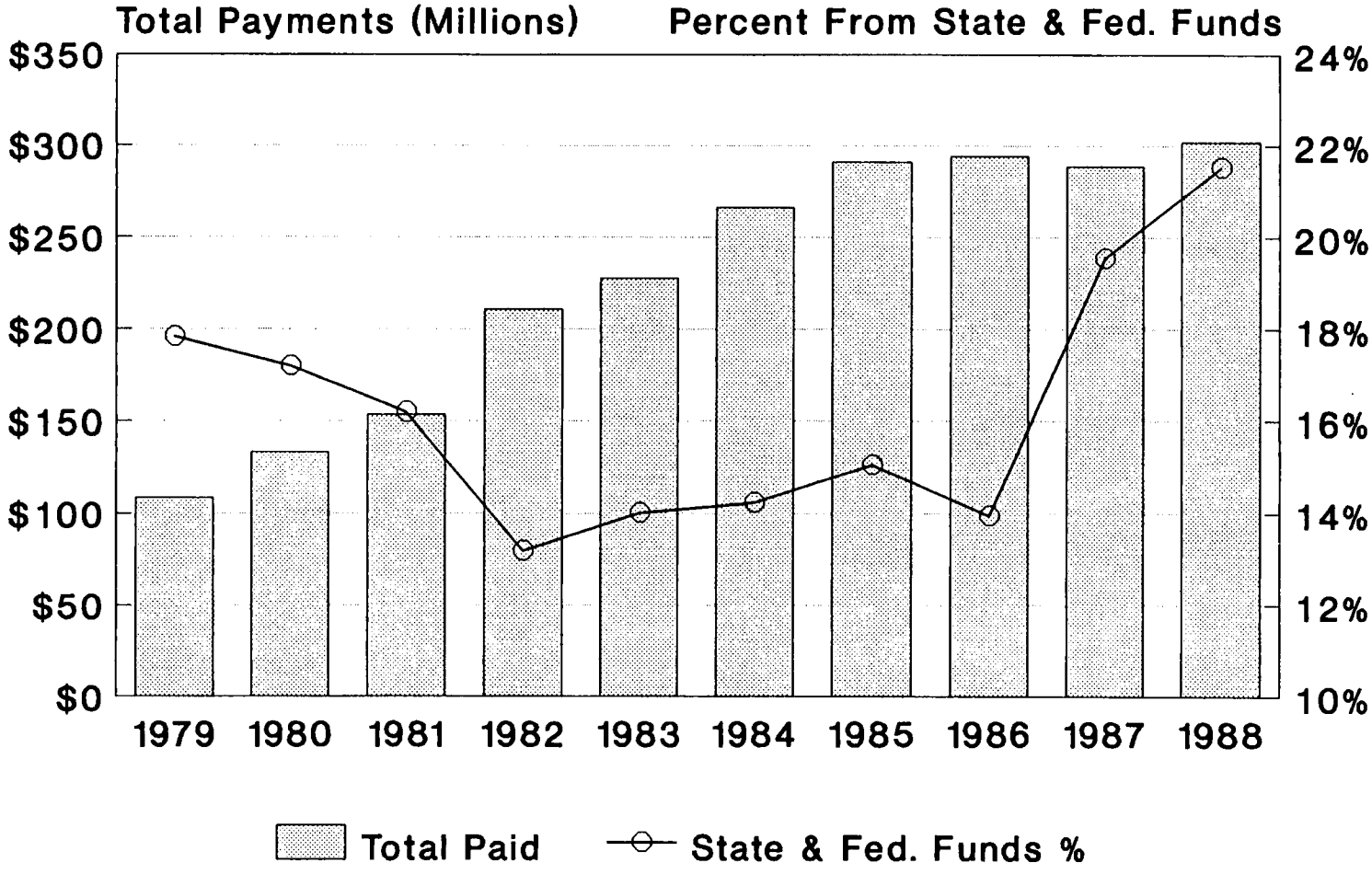
MONTANA WORKERS' COMPENSATION
Payments From State & Federal Funds



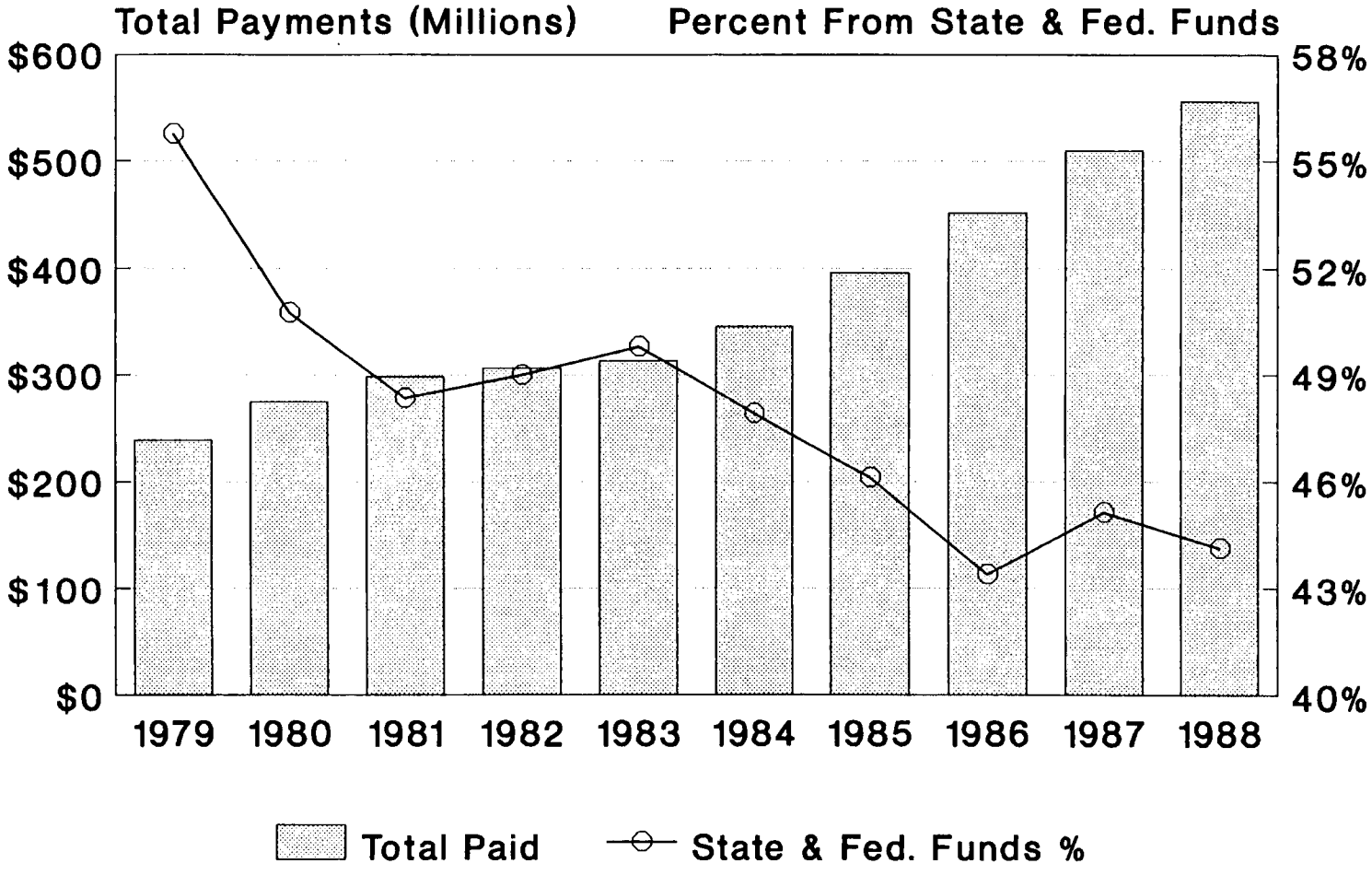
NEW YORK WORKERS' COMPENSATION
Payments From State & Federal Funds



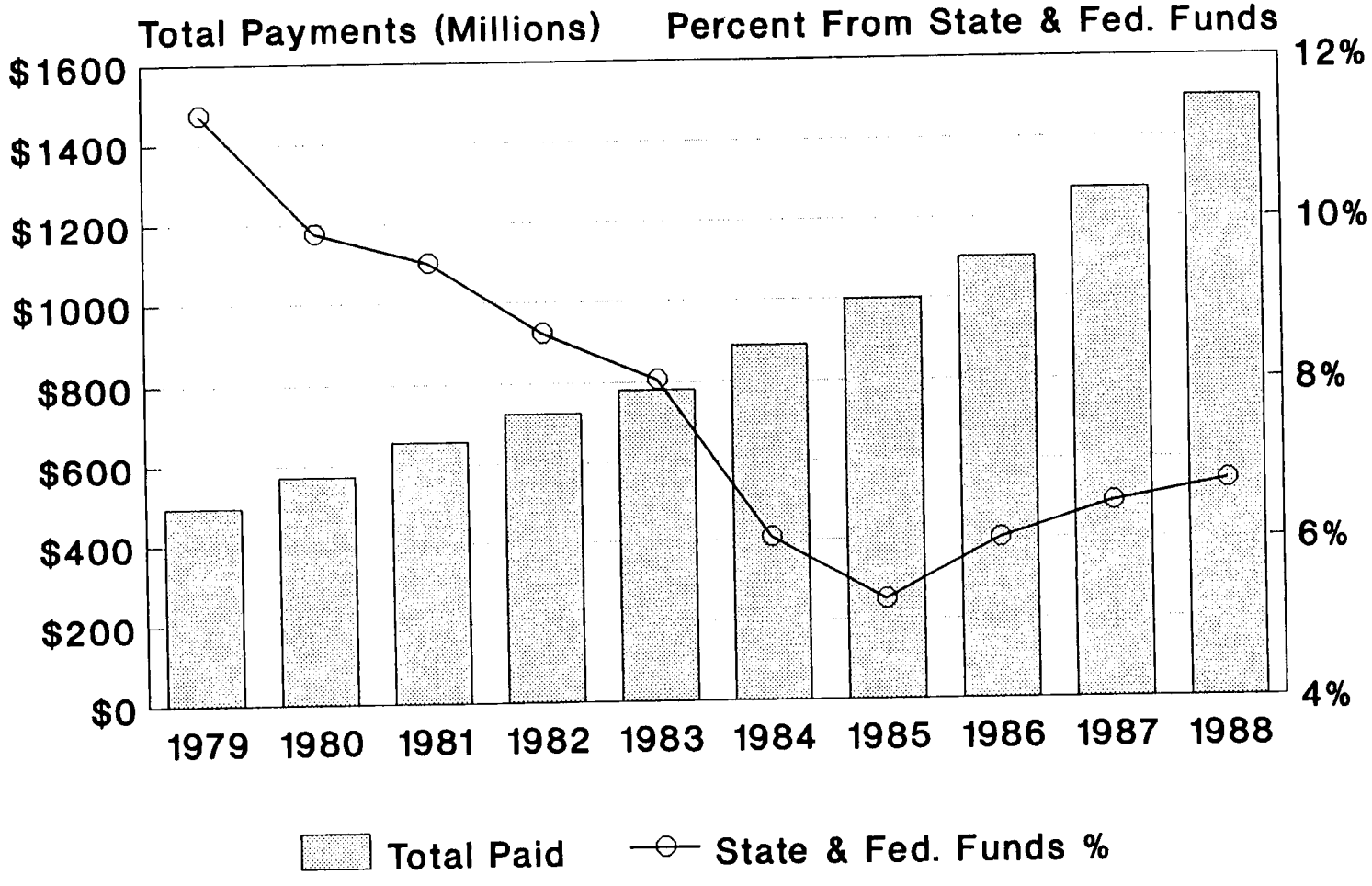
OKLAHOMA WORKERS' COMPENSATION
Payments From State & Federal Funds



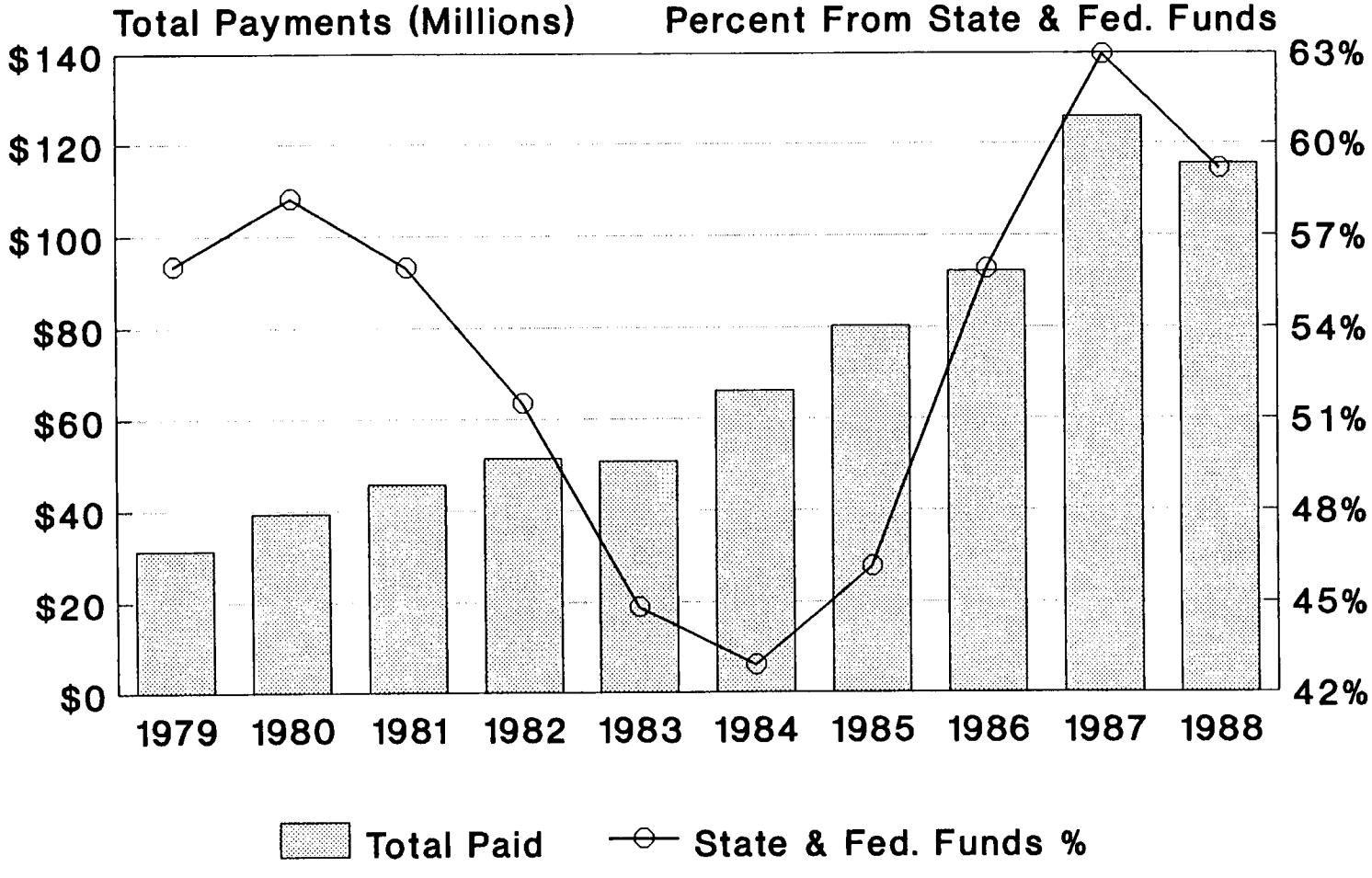
OREGON WORKERS' COMPENSATION
Payments From State & Federal Funds



PENNSYLVANIA WORKERS' COMPENSATION
Payments From State & Federal Funds



UTAH WORKERS' COMPENSATION
Payments From State & Federal Funds



D. THE RETROSPECTIVE PREMIUM FORMULA WHEN ADDITIONAL ELECTIVE PREMIUM ELEMENTS ARE INCLUDED

The retrospective premium for a risk which has elected either or both of the additional elective premium elements is determined by the following formula:

Retrospective Premium =

1. Basic Premium

   plus

2. Converted Losses

   plus

3. Excess Loss Premium

   plus

4. Retrospective Development Premium
5. Multiply the sum of 1 + 2 + 3 + 4 by the Tax Multiplier

Note: Include item 3 or 4 or both in the formula depending on whether such elective premium elements are in the retrospective agreement.

The result of this calculation is the retrospective premium when the risk has elected one or both of the elective premium elements. The retrospective premium shall not be less than the Minimum Retrospective Premium nor more than the Maximum Retrospective Premium.

II. RETROSPECTIVE RATING OPTIONS TO BE ELECTED BY THE RISK

A. EXPLANATION

This Plan includes five Retrospective Rating Options which control the premium which results from the Retrospective Premium Formula. When the insured and the insurance carrier agree that this Plan shall apply to a risk, one of the Retrospective Rating Options shall be designated in the agreement as the basis on which the retrospective premium will be determined.

The selection of a Retrospective Rating Option depends upon how the insured and the carrier evaluate the suitability of a specific option.

B. TYPES OF RETROSPECTIVE RATING OPTIONS

There are two types of Retrospective Rating Options:

1. The first type of Retrospective Rating Option is based upon factors in standard tables which are included in this Plan. Refer to Part Four—Premium Computation Tables. Such Retrospective Rating Options may be applied to the risk in a single state or, if the risk operates in more than one state, the designated option may apply on an interstate basis. Rating options I, II, III and IV are of this type and are described below:

   Retrospective Rating Option I: The Minimum Retrospective Premium will be less than the Standard Premium but the Maximum Retrospective Premium for the risk will be equal to the Standard Premium.

   Retrospective Rating Option II: The Minimum Retrospective Premium will be less than the Standard Premium and the Maximum Retrospective Premium will be more than the Standard Premium. By using this option, the insured ventures paying more than Standard Premium for the opportunity to obtain greater savings for controlled losses.

   Retrospective Rating Option III: The Minimum Retrospective Premium is not specified in the table for this option. It depends only on the result of the retrospective premium formulas in I-A and D of this Section of the Plan. The Maximum Premium will be more than the Standard Premium and will be the same as for Retrospective Rating Option II. Although the basic premium is higher than in Option II, there is a reward in Option III for unusually good loss results.

   Retrospective Rating Option IV: The Minimum Retrospective Premium will be less than the Standard Premium and the Maximum Retrospective Premium will be more than the Standard Premium. The difference between this option and options II and III is that option IV provides a narrower range of minimum and maximum retrospective premiums. Favorable losses result in savings and there is protection against poor experience producing higher maximum premiums provided by the other options.

2. The second type of Retrospective Rating Option is not based upon standard tables to determine the premium factors. Factors for this option are determined for each risk by agreement between the insured and the insurance

carrier, subject to the procedures described below:

Retrospective Rating Option V: The Basic Premium is determined by using the Table of Expense Ratios to determine the insurance carrier expenses and the Table of Insurance Charges for the remainder of the Basic Premium. The Loss Conversion Factor and Minimum and Maximum Retrospective Premium are subject tc agreement between the insured and the insurance carrier. The Tax Multiplier, Excess Loss Premium and Retrospective Development Premium are determined on the basis of the state or states included in this option.

(a) Retrospective Rating Option V may be applied to any of the following types of insurance alone or to any combination of such insurance:

Workers Compensation and Employers Liability

Third Party Liability Insurance for Commercial Lines

Commercial Automobile Physical Damage

Other Types of Insurance specified in the Retrospective Rating Plan Issued by the Insurance Services Office.

For illustrations and examples of combinations, refer to the Retrospective Rating Plan issued by the Insurance Services Office.

Note: When Rating Option V includes Workers Compensation and other commercial casualty insurance, the total retrospective premium, including the minimum and maximum retrospective premium, is determined on the basis of all insurance in the plan.

(b) For an interstate risk, an average of the specified state tax multipliers weighted by the state shall be used.

(c) The Loss Conversion Factor for Retrospective Rating Option V shall not be higher than 1.25 for stock insurance carriers nor higher than 1.47 for non-stock insurance carriers.

Refer to Appendix for explanations and examples on the use of Retrospective Rating Option V.

C. THREE YEAR PLAN—OPTIONAL

1. Retrospective Rating Options I, II, III and IV may also be applied to a risk for a period of three years. Refer to Part One-III-B for eligibility requirements. The factors for determining the retrospective premium for this option are in Part Four—Premium Computation Tables which includes tables designed for 3 year plans.
2. Retrospective Rating Option V may also be applied to a risk for a period of three years. Follow the procedure and examples cited in B-2 above, but determine the insurance carrier expenses on the basis of the annual Standard Premium and the remainder of the Basic Premium by use of the Standard Premium for the 3 year period of the Plan.

D. LONG TERM OR WRAP-UP CONSTRUCTION PROJECTS

1. Retrospective Rating Option V may be applied to such projects in the following manner:
   a. The project may be insured under a series of 1 year policies. Use Rule II-B above.
   b. The project may be insured under a series of 3 year policies. Use Rule II-C above.
   c. The Plan shall apply to such projects so that the Retrospective Premium is computed on the basis of the Standard Premium for the entire duration of the project.

Note: For determining retrospective premium for plans applied on a three year basis, or Long Term or Wrap-Up Construction Projects, any revision in Tax Multipliers and Excess Loss Premium Factors shall be applied to policies as of the first normal anniversary date of the risk, which is on or after the date of such revision, unless the revision is authorized for application to outstanding policies.

III. CANCELATION OF POLICY

A. EXPLANATION

While the Cancelation Condition of the Standard Policy permits cancelation by the insured or insurance carrier, the premium determination for a canceled policy is controlled by Rule X—Cancelation in the New York Manual for Workers Compensation and Employers Liability Insurance.

STATE FUND SERVICES

CLAIMS

The State Fund pays medical benefits and compensation to covered employees with work-related injuries. One claims representative manages all claims from a particular policy. This includes all actions from accepting the claim and determining the wage to setting up compensation and medical payments. This system has resulted in earlier and more frequent interaction between the claims professional, the employer and the injured employee.

REHABILITATION

The Fund's Rehabilitation Department provides intensive and individualized programs needed for those eligible claimants not physically able to return to the same line of work. These services are available to eligible Fund claimants throughout Arizona. Early contact with both the worker and the employer is emphasized and facilitated by a computerized rehabilitation alert system. Services include diagnostics, counseling, on-the-job training, formal training and placement. These are utilized as needed to resolve vocational problems and expedite returning the worker to a productive role within the community.

LEGAL

The State Fund has a legal staff to represent its policyholders in defending questionable claims and to see that compensation payments are fully supported by evidence and applicable laws.

LOSS PREVENTION

The State Fund has a Loss Prevention Department which provides safety services statewide to policyholders. Consultative services, posters, films, signs, folders, pamphlets and other safety materials are available to assist in injury control efforts.

MARKETING

The Marketing Department acquires and retains a fair share of accounts in order to maintain the Fund's position in the marketplace. Its field representatives also answer inquiries about workers' compensation insurance and assist policyholders in obtaining State Fund services.

AUDITING

Periodic service calls are made by Fund auditors. They assist policyholders in maintaining accurate records of all earnings and provide advice on reporting payroll classification under the correct code.

IMPORTANT PROVISIONS OF THE LAW

EMPLOYERS SUBJECT TO THE LAW

Arizona law requires all public and private employers who have one or more employees to carry workers' compensation insurance. This includes all employments, whether continuous throughout the year or for only a portion of the year.

EMPLOYMENT EXCEPTION

The law makes coverage for domestic servants optional, but employers can eliminate their potential liability by obtaining workers' compensation insurance to cover them.

METHODS OF INSURING

The law provides that employers may insure their workers' compensation liability in any one of three ways:

1. By insuring with the State Fund.
2. By insuring with another authorized insurance carrier.
3. By qualifying as a self-insurer under the rules and regulations of the Industrial Commission.

Claims Management. *continued*

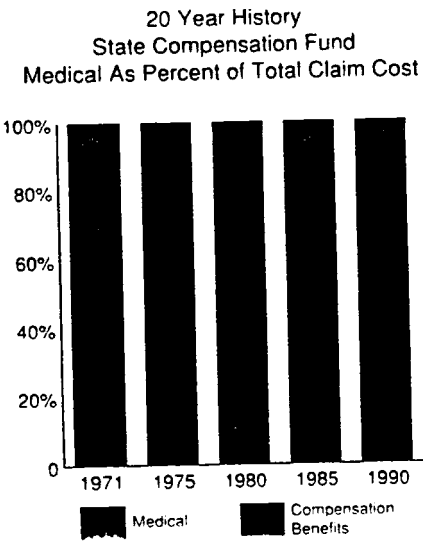
Where surgery is recommended by the attending physician, the State Fund audits costs and employs a staff of doctors and nurses to evaluate the proposed treatment. This process saved $1.1 million in 1990.

Just getting prescribed medicines can be an ordeal for an injured worker. We reduce costs through high volume discounts on prescriptions, while many State Fund claimants are given the option of having their prescriptions delivered to their homes, thereby improving service.

Once medical recovery has stabilized, claims representatives will encourage modified work or work rehabilitation programs where indicated.

Modified work programs are used when the claimant is likely to return to the same work and employer. In the meantime, the employer assigns jobs suited to the temporarily reduced capabilities of the injured worker. The claimant returns to the work routine, the amount charged for wage compensation is reduced, and recovery is shortened.

Vocational rehabilitation is used when the injury or potential for re-injury will not allow the claimant to return to the previous occupation. State Fund rehabilitation counselors review the aptitudes and skills of claimants, and work with them to develop new occupations. Through rehabilitation, disabled workers can regain the



Proper management of claims, like proper management of resources, ensures plenty even in times of hardship.

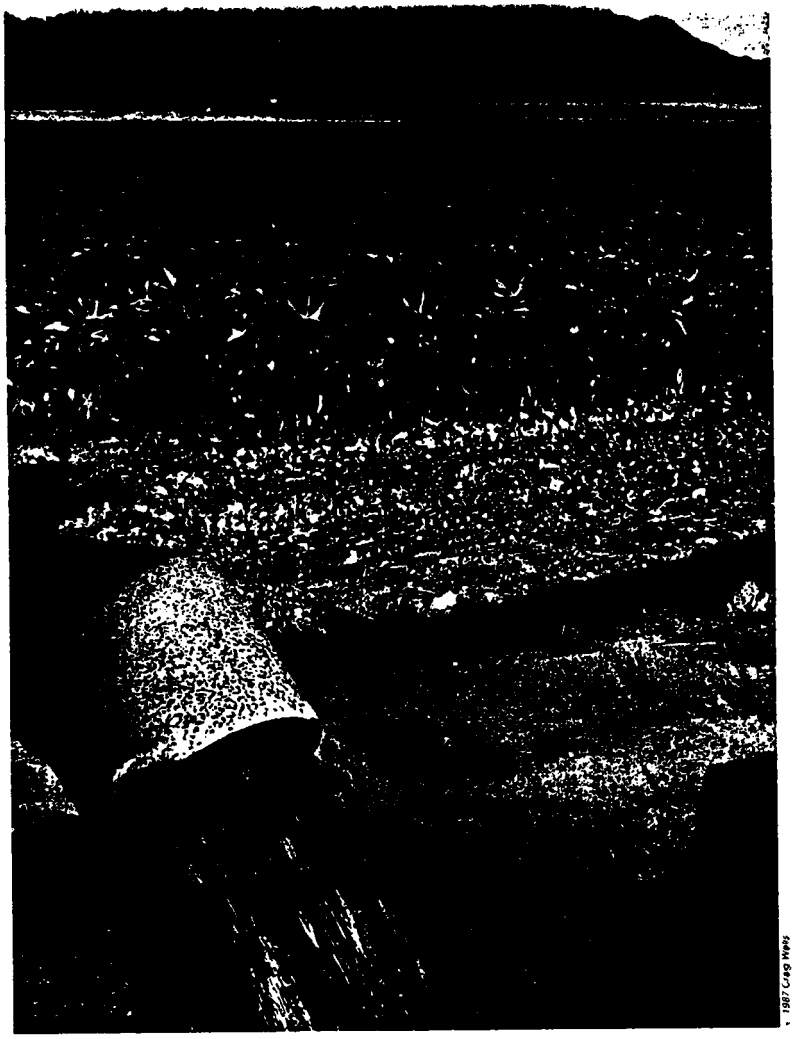
Claims Management

The Fund's claims management program balances prompt resolution of claims with stringent efforts to contain costs. Claims management strives to ensure:

- prompt, equitable claims administration, aimed at the earliest practical return to the work force,
- prudent management of recovery options and expenses.

State Fund claims representatives work hard to promptly determine claim coverage. In 1990, the coverage decision for all 69,000 State Fund claims averaged five days less than the time allowed by statute.

Every medical bill for State Fund claims is reviewed to establish relevance, and all medical charges are checked for compliance with the ICA fee schedule, or the Fund's own usual and customary charges for those services not covered by the fee schedule. In 1990, these audits reduced Fund claims costs by $16.7 million.



The Fund must conserve its financial resources to cover long-term commitments.

dignity of gainful employment. In addition to being a humanitarian commitment to injured workers, rehabilitation reduces claims costs.

At the State Fund, each employer is encouraged to work with their assigned claims representative. The mutual efforts of Fund claims representatives and employers result in quality claimant care, increased re-employment of injured workers and reduced claims costs.

Claims management. It's the service that helps everyone.

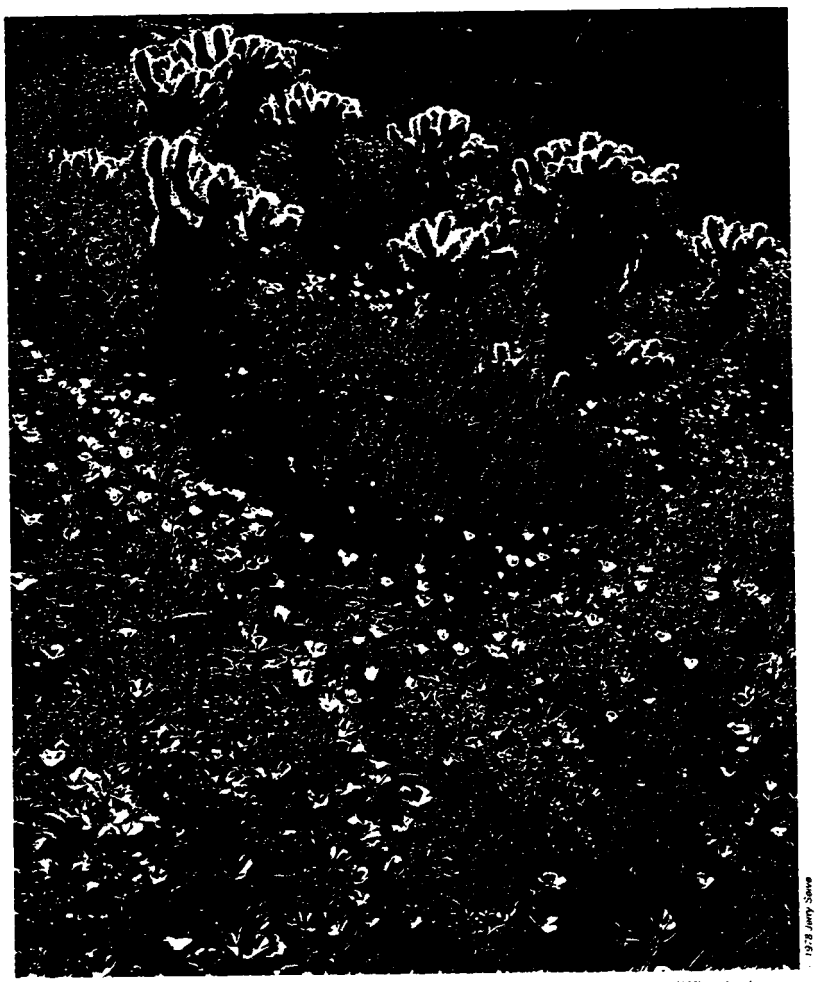
Workplace Safety Management: The Valuable Ounce

A quick review of the amount of effort required to manage work-injury claims underscores the axiom: an ounce of prevention is worth a pound of cure.

The State Fund offers the broadest range of safety services available throughout the state. Fund loss-prevention representatives support policyholder work-safety programs with hazard identification, accident reporting, safety training and injury record keeping assistance.

This safety management service is augmented by the State Fund's staff of industrial hygienists, who work with policyholders statewide. The Fund IH staff evaluates workplace health hazards from chemical, radiation, microwave, noise or ergonomic risks.

Every injury prevented is worth the safety efforts of the State Fund and our policyholders.



Many problems – and accidents – can be prevented by anticipating difficult times, and addressing situations before they develop into problems.

These, then, are the State Fund's major service efforts to help employers manage their workers' compensation challenges in the 1990s:

- available coverage at the lowest possible cost,
- full claims management services,
- statewide safety and health assistance.

The State Fund has developed many programs to fit each of these major services. In every aspect of workers' compensation, our programs are the most effective in the industry.

The State Fund Executive Staff. Standing from L to R; Chris Kamper, Pete Kilgard, Jerry LeCompte, Bill Novak and Greg Casadei. Seated; Harvey Taulton and Nolan Laughlin.

B. Public Awareness Division (Marketing)

The Marketing Division was established in 1990 to increase Fund awareness among Maryland employers. Marketing activities is being planned to include: direct sales force operation, contractual sales force, employer training sessions, make marketing presentations, establish a policyholder retention plan, develop contacts, attend trade shows and conferences, develop sales promotions, and provide help and guidance for policyholders, whether they are current, new or potential policyholders.

C. Underwriting Division

The Underwriting Division usually represents the initial contact between the Fund and the new policyholder. This Division provides many services, including the initial review and processing of applications for new policies, assigning proper job classifications and applicable rates, monitoring policyholder payroll reports and making policy changes as needed or requested. This Division also provides proof of insurance certificates upon request, issues annual rate letters and other correspondence to policyholders and serves as the liaison between the Fund and the policyholder.

The most important task is the assignment of job classifications to ensure that the premium rate is sufficient, but not excessive, so that the classification matches the actual work being performed as closely as possible. This responsibility explains the distinction between Underwriting and Marketing. Marketing tries to be as cooperative as possible in seeking business, but the Underwriters sometimes have the difficult and unpleasant task to assign risk classifications of a higher cost

than the policyholders were hoping to obtain.

D. Auditing Division

The Auditing and Field Services Division often provides the first personal contact with new policyholders by delivering the policies issued by the Fund (i.e. new policy applicants are generally handled in Underwriting via telephone and related paperwork is handled through the U.S. mail system). At the time of a new policy delivery, a payroll and classification review is conducted to ensure that deposits are adequate though not excessive. This Division is staffed by competent and technically trained professionals who are available to explain the Fund's policies, procedures and other areas of concern to policyholders. In addition, this Division performs routine audits of the policyholder's payroll on either an annual, biennial or triennial basis to determine if payrolls were properly reported.

E. Claims Division

The Claims Processing Division provides benefits to claimants for injuries, diseases or deaths which arise out of and occur in the course of employment with employers insured by the Fund. The major work responsibilities include:

(1) Review of accident and claim reports in order to accept or contest liability, by contacting employers/policyholders by telephone or field investigators. To estimate the cost of the future anticipated liability. This estimate, together with actual data as it becomes available, is used by the Fund's Actuary for financial statement purposes and is used in merit rating of the policy.

(2) Medical Case Management. There is on-going medical management in order to evaluate needed medical treatment and progress and to help control the cost of medical treatment.

(3) Provision of benefits. The payment of replacement wages for work time lost due to accidents and the payment of permanent partial, permanent total or fatal awards, if any, awarded by the Workers' Compensation Commission.

(4) Vocational rehabilitation referral. Cases of loss time from work on a long-term basis are reviewed for early vocational rehabilitation intervention and referral to contain costs. In July, 1988, House Bill 888 required that the insurer/employer be responsible for placing an injured worker in a best fit vocational rehabilitation program if he/she is unable to satisfactorily return to original work duties. Failure to comply results in fines levied by the Workers' Compensation Commission. Our staff is involved with returning the worker to the original job, modified job, or if not possible, making physical and mental evaluations, a work history, job opening surveys, re-training, and job placement.

(5) Stipulations and hearing preparation. When a claimant has reached maximum improvement after an accident, the case is prepared for a hearing, including updating medical evaluations for current status. The stipulation process is used to provide an avenue for the Fund and the claimant's attorney to settle a claim without the need for a full blown hearing at the Workers' Compensation Commission. The Commission encourages the stipulation process as a way to reduce the backlogged docket.

This Division processed 42,694 accident reports and paid more than $88 million in compensation and medical benefits last year.

F. Legal Division

The Legal Division is responsible for representing the Fund and its insureds in all litigation before the Workmen's Compensation Commission, all Courts in the State, and other offices having jurisdiction over Workers' Compensation cases. This Division drafts legislation for the Fund as requested, reviews legislation introduced in the General Assembly, and all other documents (such as contracts) for legal sufficiency and content. The Legal Division serves as the General Counsel for the Fund.

G. Accounting and Data Control Division

The Accounting and Data Control Division provides inter-divisional services for the various units of the Fund. The Division's duties include data input services, maintaining claim files on microfiche, processing benefit claims checks, processing

and depositing premium collections, incoming and out-going mail services and distribution, photo copying of documents, and maintaining a system of inventory control for the Fund's materials, supplies and equipment. A second major function of this division is to compile an automated statistics and data base for use by the independent Actuary. This responsibility includes maintaining data for the Fund's Loss Experience Modification Rating Plan, experience of losses by risk classification, claims paid on behalf of each State agency, etc.

Your Question #5 - Safety Inspections...

H. Risk Management Division

The Risk Management Division provides four basic services to employers, including management consultant services, which are on-site visits with Insurer's top management to review and evaluate needed Risk Management functions which the Fund feels are essential to assist the insured in the reduction and control of losses due to injuries in the workplace. Also provided to policyholders are occupational safety and health inspections to evaluate potential hazards existing in the employer's place of business. In addition, the Risk Management Division provides special education and training programs, complete costs analyses and review of losses, and explains cost containment procedures to policyholders. The purpose of these services is to reduce accidental injuries and job-related illnesses in the workplace.

By Executive Order, the State Employee Risk Management Administration (SERMA) was established and assigned the task of developing, implementing and monitoring the State Employee Risk Management Program. This unit was placed within the Risk

Management Division.

1991 Update:

The Risk Management Division conducts on-site reviews of private sector employers' facilities and advises them of unsafe conditions and practices that exist. The Division is also responsible for educating the employers in health, safety and loss prevention techniques. Personnel in this Division perform safety and engineering analyses at policyholders' places of business and, if required, perform an accident and injury analysis to determine the need for implementing a Loss Control Program.

ACCIDENT FUND OF MICHIGAN
INTER-OFFICE COMMUNICATION

DATE: December 18, 1991

TO: Barbara McLeod

FROM: Terry D. Burak

RE: AIS Risk Consultants, Inc.
Request for Information

You requested that I respond to items four and five of the AIS Risk Consultants, Inc. questionnaire.

Item # 4 requested a response regarding services provided such as safety inspections, risk management, loss control, claim management and rehabilitation provided by the state fund. The services that are provided by the Underwriting Department are the loss control safety surveys performed by our field personnel. At the present time the services provided are somewhat limited in that we have a very small staff to service a very large number of policyholders. They perform loss control surveys looking at both insurability and also make recommendations as to how the safety program can be improved by the policyholder. The loss control consultants do participate in the policyholder seminars which began in 1991 and will be continuing during 1992. We also provide news articles relating to specific type of accounts such as construction, restaurants, etc. whereby we target certain safety issues related to that type of operation.

Item # 5 requested a description of rating plans or other programs intended to encourage safety on the part of small and/or medium size insureds.

The Accident Fund does have an experience rating plan which is available to any risk whose annual premium at manual rates was $8,000.00 or more the last year or last two years of the experience period, or averaged at least $4,000.00 during an experience period of more than two years. The Accident Fund modified the experience rating plan on April 1, 1991 to more closely apply the experience of a specific insured's in the setting of their experience modification factor. This is a form that is developed by NCCI and is intended to be revenue neutral in that the increased debits will be offset by increased credits. The general rule is that most policyholders which would qualify for a credit will receive a larger credit and those policyholders who are debit rated will receive a larger debit.

The Accident Fund also has a merit rating plan which is available to any risk not eligible for the experience rating plan and whose average annual premium was between $500.00 and $4,000.00 during an experience period. The modification will be determined based upon the number of loss time claims paid or for which payment has been initiated in accordance with

the following schedule:

Number of Loss Time Claims	Merit Rating Modification
0 Claims	10% Credit
1 Claim	5% Credit
2 Claims	No Credit
3 or More	5% Debit

The Accident Fund also has a schedule rating plan which is applicable to policyholders whose estimated annual premium is $1,000.00 or more (in practice we use a minimum of $5,000.00) to reflect characteristics of the risks that are not reflected in it's experience. This adjustment is plus or minus 25%.

The Accident Fund does have a filing for a retrospective rating plan, however, the plan has not been used in recent years. We are developing a plan to be used beginning in 1992 and I believe the retrospective rating plan is self explanatory. Basically the premium is based on the actual losses of the insured. This plan is going to be intended for the larger size policyholder and may not be in line with the information requested as Mr. Schwartz has requested information on programs intended to encourage safety on the part of small and/or medium size insureds.

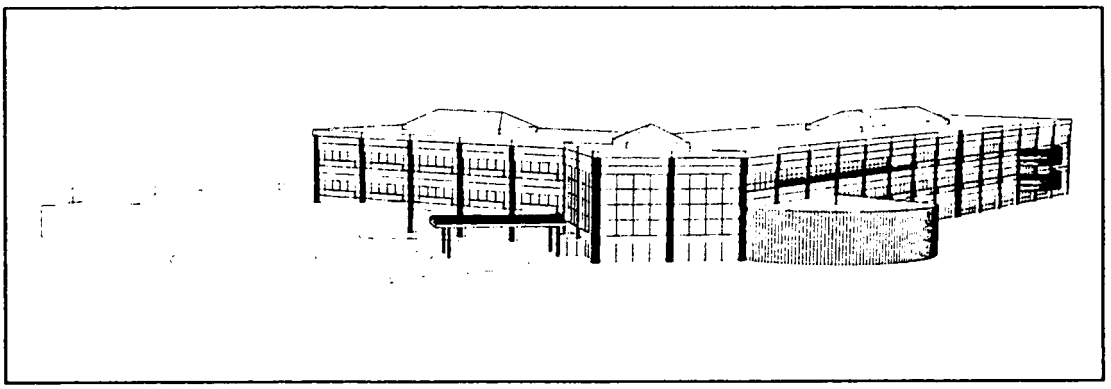
If I can be of any further assistance to you in responding to the inquiry, please do not hesitate to give me a call.

TDB:sjh

NEVADA STATE FUND

SIIS

State Industrial Insurance System of Nevada



Fiscal Year 1990 Annual Report

O-365

Cost Containment

In addition to the reviews made by its own staff, the System has found it cost-effective to contract with several companies to provide additional review, as well as vendors who provide services at a savings. As an example, Nevada Peer Review ensures the proper level of care is being rendered for all hospitalizations. The company performs continuous care monitoring, pre-admission screening and concurrent review. For the calendar year 1990, Nevada Peer Review saved the System approximately $1.4 million.

The System entered into a new agreement during the fiscal year that is designed to lessen the severity of orthopedic injuries. Health Care Excellence is a service that monitors orthopedic injuries and compares the ongoing treatment of these injuries to internationally developed standards of care. Cases deviating significantly receive a review by medical analysts. Where a potential problem is identified, the injured worker may be referred to an independent medical evaluator or may receive some other appropriate form of medical intervention in the case. This extra attention to orthopedic cases is designed to prevent complications which can lead to a claim that is costly to the claimant and employer in money and time.

To provide more cost-effective home health care, SIIS has signed with vendors to provide home health care throughout the state. These contracts, negotiated with a discount for the large number of patients served, have saved an average of 30 percent per treatment. Prior to contracts being signed with vendors, the average cost of treatment was $669.29. After the agreements were signed, the cost averaged $466.87. Another contributing reason for savings was the adoption of a fee schedule for home health care services.

Similar savings have also been obtained through a contract for durable medical goods. A 32 percent cost savings was obtained on items such as crutches, walkers, bottled oxygen, hospital beds and other medical equipment prescribed for System claimants. The average cost per item dropped from $135.12 to $91.92.

The System is also looking for a way to save money on prescription drugs. It is anticipated that during the next fiscal year a vendor will be chosen and a contract signed. It is likely the vendor will provide medication by mail for claimants with long-term medical conditions. Prescriptions can be refilled by mail on a routine basis, at a negotiated rate lower than the medical fee schedule.

Policyholder Services

For employers who want to take an active role in controlling losses, the System provides a wide range of services. Each employer's account is assigned to an account manager. The account manager is the employer's primary contact with the System for answering inquiries about claims, billings, rates, classifications and audits.

Another part of the System's effort to provide service to Nevada employers is the Loss Control department. It is staffed by professional loss control consultants and industrial hygienists. These consultants can help employers reduce accidents and industrial diseases.

Industrial insurance in Nevada is offered at very competitive rates. Between 1983 and 1990, the System has raised rates only twice. Independent comparisons and studies of workers' compensation insurance show Nevada has generally outperformed surrounding states in holding down rate increases.

Nevada ranks third out of ten states in the western United States in benefits for the injured worker, while, over the last seven years, Nevada experienced the smallest cumulative premium rate increase. These figures point to the overall efficiency of the System.

Financial Information

As Nevada continues to grow, so does the amount of premium paid by employers and the number of employees covered by industrial insurance. Premiums also grew because of an average 14.5 percent rate increase. Total premium rose from $250 million to $311 million. The System invests premiums to provide for future benefits. On June 30, 1990, the System had assets of $777 million, liabilities of $742 million and a provision for contingencies and surplus of $35 million. Investments comprise $658 million of the $777 million total assets.

Rate of return on the System's investment portfolio was 9.6 percent for fiscal year 1990.

Including dividends, income for the year was $372 million. Expenses for wage compensation, medical care for industrial accidents and occupational disease, administration, and interest required on actuarial liabilities totaled $377 million. The result was a net loss of five million dollars.

Rehabilitation Center

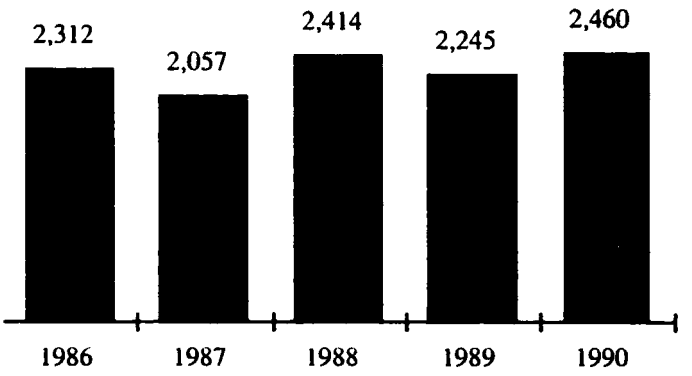
The Jean Hanna Clark Rehabilitation Center treated 2,460 patients in 1990. Eighty-four percent of those treated are System clients, the rest are employed by self-insureds and private patients. The fee schedule is uniform for all those who use the facility.

The Center is certified by the Commission on the Accreditation of Rehabilitation Facilities. CARF audits the programs and services to ascertain compliance with their standards. Though the Center receives many of the most difficult to treat industrial injuries, 85 percent of those who complete treatment at the Center are released to return to work in some capacity.

The Center was established 12 years ago with a total subsidy of operations. Over the years, as demand for the Center's services has grown, the need for subsidy has been reduced.

Shorter term treatments and diagnostic services have become more prevalent, although a wide range of services are offered. Physical, occupational, remedial and industrial therapy are provided as well as psychological services to help injured workers overcome the mental obstacles to a physical recovery.

Center staff include five physicians, including four with a speciality in physiatry (medical doctors who specialize in rehabilitative medicine), one orthopedic surgeon, psychologists, therapists and registered nurses. At times during the past two years the Center has been limited by a shortage of physicians and therapists, due to the nationwide demand for these specialties. However, at this time the Center staff is close to its authorized level.



Number of Patients Treated at JHC Rehabilitation Center

1990 Annual Report

REPORT OF SERVICES PROVIDED

	1990*
FIELD SERVICES	
Training Hours**	14,110
Service Hours***	125,184
ENGINEERING AND INDUSTRIAL HYGIENE	
Occupational Disease Investigations	266
Industrial Hygiene Surveys and Rechecks	1,348
ERGONOMICS SERVICES	
Ergonomics Consultations	288
CAMPAIGNS AND CONGRESS	
Safety Congress Attendance	3,531
Local Safety Councils	52
EDUCATION AND TRAINING - REGIONAL OFFICES	
Total Training Classes	2,631
Total Certificates Awarded	30,676
OHI0 CENTER FOR OCCUPATIONAL SAFETY AND HEALTH	
Total Training Classes	63
Total Certificates Awarded	1,218
PUBLICATIONS	
Pattern for Progress Participants	15,317
Ohio Monitor Monthly Circulation (avg.)	74,794
Ohio Monitor Readership (estimated)	298,928
FILM LIBRARY	
Number of Films Borrowed	8,105

* Calendar year

** Training hours are time spent training employers and their employees.

*** Service hours include time spent doing surveys, rechecks, accident investigations, safety meetings, and total statistical and cost analysis.

USES OF FUNDS

The following is a statement of expended funds for the fiscal year that ended June 30, 1990 and for the second half of the calendar year that ended December 31, 1990. Salaries for the entire division are reported as a single line item, followed by operating and equipment expenditures for each department within the division.

ACCOUNT	FY1990	JULY-DEC. 1990
Salaries/Payroll/ Personal Services	$12,017,627	$6,269,172
Administration	1,474,627	514,937
Support Services	57,828	14,792
Art Department	101,557	536
Film Library	57,219	7,147
Media Lab	25,364	7,989
Ohio Monitor	375,783	79,776
Pattern for Progress	275,767	198,447
General Publications	183,733	122,907
Research and Statistics	33,948	18,346
Resource Center	68,244	40,335
Safety Councils	257,906	133,515
Safety Congress	68,156	83,876
Training Center	66,132	17,110
Field Operations	609,666	235,941
Industrial Hygiene/Ergonomics	480,100	79,666
TOTAL EXPENDITURES	**$16,153,657**	**$7,824,492**

THE REHABILITATION DIVISION IN 1990

The Rehabilitation Division is charged with rehabilitating Ohio's industrially injured and disabled workers and preparing them for a return to gainful employment. In 1990, the division surpassed its previous efforts and assisted 2,913 injured or disabled workers return to work.

RETURNS TO WORK

The division follows a placement hierarchy in which the first priority is to return the injured worker to the same job with the same employer, as the most expeditious and cost-effective form of rehabilitation. The return-to-work figures are shown by category:

Return to Work

Rehabilitation Division		**Self-insured**
Same job, same employer	1,348	302
Different job, same employer	266	36
Same job, different employer	98	6
Different job, different employer	735	22
Self-employment	34	1
Unspecified		3
Walker Center (direct referral)	99	
Out-of-state	28	
Job Retention		
Same job, same employer	280	
Different job, same employer	25	
TOTAL	**2,543**	**370**

REFERRALS AND REHABILITATION PLANS

The number of injured or disabled workers referred to the Rehabilitation Division exceeded the 1989 figure by more than 2,000. Referrals and acceptance data are shown:

Claimant referrals	19,517
Accepted referrals	8,670
Referrals not accepted*	10,847
*Not Interested (NI)	6,602
Not Eligible (NE)	4,230

Almost all claimants not accepted are either not interested or not eligible. Since participation in rehabilitation is not mandatory, the injured worker may choose not to become involved. The "NI" number indicates those electing not to participate.

The "NE" number indicates those the division determined were not eligible for rehabilitation services, after careful review and consideration of each case.

An individual rehabilitation plan is prepared for each claimant accepted. During 1990, 6,514 plans were prepared by division case managers. (This number includes some plans for claimants accepted in 1989.)

The number of plans implemented during 1990 was 5,469. This indicates the plan was accepted by the claimant and services began. Plans completed during 1990 numbered 3,781. This indicates all services were provided; generally the result was a return to work. Because plan activities will overlap the calendar year, the number of plans prepared, implemented and completed, or the number of claimants returning to work, will not agree.

TIME INTERVALS

An important area of rehabilitation case management is the time spent in moving through the various phases of case development. The following chart highlights pertinent time frames for consecutive phases.

Mean Time	Phase of Development
103 days	Referral and acceptance of claimant
47 days	Acceptance and preparation of plan
202 days	Plan implementation and completion
4 days	Plan completion and return to work

REHABILITATION COSTS

The administrative costs of the Rehabilitation Division are shown for central office and field operations and for each industrial rehabilitation center:

Administration and field offices	$18,220,748.95
Camera Center	8,866,925.54
Walker Center	4,211,193.59
TOTAL	**$31,298,868.08**

These result in an average administrative cost (excluding risk and surplus fund expenditures) per claimant active in a division rehabilitation plan of $4,019.89. (Of 7,786 claimants in plan in 1990, 2,317 were carried over from 1989 and 5,469 were added.)

The average administrative cost for clients completing a program at the Camera Center was $1,700.27 and $1,175.65 for those at the Walker Center.

Surplus fund expenditures are shown by major expenditure category:

Living maintenance	$29,126,092.60
Living maintenance wage loss	1,003,715.37
Rehab services by other providers	13,626,301.70
Incentives to employers	899,935.54
Mobility grants and travel	1,230,478.32
Employer reimbursement (State fund SIs)	3,456,047.63
Rehabilitation Services Commission*	230,000.00
Self-insured employer reimbursements	17,750,771.00
Prior examinations	76,738.62
TOTAL	**$67,400,080.78**

*State match provided for federal grant program; funds are used primarily for training. This payment was made for FFY 91, beginning October 1, 1990.

The grand total of all costs was $98,698,948.86. This results in a cost per claimant active in a rehabilitation plan, including both division plans and self-insured provider plans, of $9,587. (This represents 7,786 division plans and 2,509 self-insured provider plans, for a total of claimants in plan of 10,295.)

REHABILITATION CENTERS

The W. O. Walker Center in Cleveland and the J. Leonard Camera Center in Columbus provide a variety of evaluation and treatment services for injured workers. Participation by program or service is shown here; numbers are not exclusive as a claimant may participate in more than one program or service.

	Camera	Walker	Total
Referrals for evaluation	**2,515**	**1,883**	**4,398**
Outpatient services	**389**	**477**	**866**
Treatment programs	**1,678**	**113**	**1,791**
General rehab	342		342
Pain and stress	1,315	113	1,428
Cognitive	21		21
Vocational programs	**629**	**1,109**	**1,738**
Career counseling	34	280	314
Vocational evaluation	201	456	657
Vocational services	29	147	176
Work simulation	365	226	591

Claimants returning to work in 1990 who received services at the J. Leonard Camera Industrial Rehabilitation Center (in 1990 or a prior year) numbered 500; those who received services at the W. 0. Walker Industrial Rehabilitation Center numbered 99.

The average time off work for a participant in services at one of the centers was 24 or more months. Demographic information is shown below:

		Camera	Walker
Male		70.59%	65.51%
Married		60.59%	46.05%
Grade(s) completed:			
	1-6	77.28%	5.62%
	7-9	4.79%	21.51%
	10-12	16.05%	65.15%
Age:	15-20	13.14%	6.1%
	21-30	9.32%	27.64%
	31-40	24.91%	22.92%
	41-50	36.28%	27.36%
	51-60	16.08%	15.79%

Overview

The Rehabilitation Division of the Industrial Commission of Ohio was created to help injured workers return to their jobs or lessen or remove any handicap from a work related injury.

The Division has rehabilitation case managers around the state who contact injured workers and do whatever is necessary to help them. These professionals work very closely with injured workers, their employers, doctors, and anyone else who may be concerned. All that is needed to get into the program is a claim number from the Bureau of Worker's Compensation and a willingness to return to work.

Today, Ohio has one of the finest programs of its kind in the country. The Rehabilitation Division has more than 100 professionals in 12 offices around the state, and two rehabilitation centers, the J. Leonard Camera Center in Columbus and the W. O. Walker Center in Cleveland. Also many doctors, private hospitals, clinics and other centers work with the Rehabilitation Division to help injured workers.

The Rehabilitation Program

Successful rehabilitation is dealing with any problem that keeps injured workers from getting back on the job. Because injuries and jobs are as different as the people who have them, rehabilitation plans are also different. A plan is made for each injured worker.

Rehabilitation case managers will talk with injured workers, their doctors, employers, families, and anyone who may be concerned about them. The teams will then put together a plan covering everything that is necessary to get injured workers back on the job.

The goal of the Rehabilitation Division is to return injured workers to their original job or to another job with the original employer. If for any reason this can not be done, the Division will help injured workers find the same type of job with a different employer. The last goal is to help injured workers get a different job with a different employer. Formal retraining is offered only when it proves to be necessary.

Rehabilitation Services

Services include general body conditioning, physical, occupational and/or psychological therapy. In some cases services could include weight loss, proper eating habits, or how to live with discomfort.

Many of these services deal with rebuilding strength to return to the job. In some cases, they help to deal with everyday problems.

Other services may include time at a supervised job site like the worker's regular job. This helps to get in shape for the real thing.

Some injured workers may have trouble because of the machinery they operate. A rehabilitation plan may include changes in the machinery or its operation. Or the plan may include new tools or machinery which are easier to operate.

Since the program is voluntary, the injured worker must agree to the plan. Most important is the approval of the injured worker's doctor and nothing can be done without his or her approval. When everyone agrees on the rehabilitation plan, it will be started and the injured worker is on the road back to work. But rehabilitation plans are flexible. They can be changed if conditions change.

Services outlined in the rehabilitation plan may be provided in the injured worker's town. In many cases, however, services may be more appropriate and effective at the Camera Center or the Walker Center.

These two centers are uniquely designed to deal with injured workers. They are equipped with the most up-to-date equipment and staffed by licensed professionals. Injured workers can live at the centers with other injured workers during treatment and return home to their families on weekends.

Compensation

There are no charges to injured workers taking part in this program. Nor is there any loss of benefits to injured workers during rehabilitation. Payments to injured workers in the rehabilitation program are called Living Maintenance. These are NEVER less than Temporary Total payments.

Going Back To Work

There are many other benefits for injured workers. Some may not be able to return to their original job. If this is the case, the Rehabilitation Division will work with the employer to find them another job in the company.

If an employer can not keep an injured worker after rehabilitation is completed, the Division will help that worker find another job. This is done through a series of tests to learn what types of jobs the rehabilitated worker can do. These tests are based on what the injured worker has done in the past and what they are able to do since their injury. Injured workers being treated at one of the Centers can try new jobs to see if the jobs are really what they expected them to be.

In a few cases, injured workers must find a new job with a new employer. The Rehabilitation Division can help them. Part of the rehabilitation program is showing injured workers how to hunt for a new job.

The Rehabilitation Division can, when necessary, help an injured worker get training for a new job. This is done at trade and technical schools. But the Rehabilitation Division helps with the cost of tuition, books and related items.

If an injured worker can not find a job in his home town, there are relocation grants to help with the cost of moving to a new job. But the worker must have a job before getting the grant.

Going back to work can be tough after being off several months because of an injury. The Rehabilitation Division can make this easier. Often injured workers may return to the job for a few hours a day. Then the time is increased gradually until they are able to work full time.

After Rehabilitation

The Rehabilitation Division's role does not stop after rehabilitated workers return to work. The case managers stay in contact with them to make sure they are getting along all right. If any problems do come up that are related to the injury, the case manager is still there to help.

Rehabilitation works, there is no question about it. But some things can make it work even better. The first is starting rehabilitation as soon as possible.

All it takes is a phone call to the nearest Rehabilitation Division Field Office with the injured worker's name, address, telephone number, Social Security number and Bureau of Worker's Compensation claim number. Here is a list of those Field Offices along with their phone numbers.

INFORMATION SERVICES

The Ohio Bureau of Workers' Compensation has many services to provide information to employees, employers, health care providers and other parties. These services include publications and speaking programs.

Speaking Programs

Members of the BWC Speakers Bureau are available to speak at no cost for community and professional (including employee and employer) groups. Speakers plan the subject matter of their talks according to the needs of their audience.

The BWC also has guided tours of its central office, which is located in Columbus. These tours explain the claims examining role of the BWC.

For more information about either program, call the Communications Department at (614) 466-1320 or complete the request form at the bottom of the publication order form.

Publications

The BWC provides a number of brochures and manuals to the public. These publications are written to assist specific groups, such as state fund and self-insured employers and employees. Most are provided at no cost. To order publications:

- Mark the number of each publication you want to receive in the space to the left of the publication's title.
- If only free items have been ordered, cut the order form on the dotted line, staple or seal with tape, stamp and mail.
- If there is a charge for any material ordered, send payment and the order form to: Ohio Bureau of Workers' Compensation, Office Services Department, 246 N. High St., Columbus, Ohio 43266-0581. Make checks payable to the Treasurer, state of Ohio.
- If you have any questions about the publications, call the Office Services Department at (614) 466-4781.

PUBLICATIONS AVAILABLE AT NO COST

Brochures

State Fund Employers

___PA200 The State Fund Employers' Guide to Workers' Compensation

___PA210 Obtaining Workers' Compensation Coverage

___PA220 Workers' Compensation for Volunteer Police and Firefighters

___PA240 Workers' Compensation for Sole Proprietors

___PA280 Workers' Compensation for Domestic Workers

___PA290 Workers' Compensation Rates

___PA300 The Retrospective Rating Plan

___PA330 Workers' Compensation for Churches

___PA340 Workers' Compensation for Farm Employees

Self-Insured Employers

___PA400 The Self-Insured Employers' Guide to Workers' Compensation

State Fund Employees

___PA510 Filing an Occupational Disease Claim

___PA540 Filing a Medical-Only Claim

___PA550 Filing a Lost-Time Claim

___PA560 Death Benefits

___PA570 Workers' Compensation Hearings

Self-Insured Employees

___PA700 Workers' Compensation Guide for Employees of Self-Insured Employers

___PA710 Filing an Occupational Disease Claim

___PA760 Death Benefits

___PA770 Workers' Compensation Hearings

Miscellaneous Publications

___PA810 Information Services

___PA850 Family Support and Workers' Compensation

Annual Reports

___1986 ___1985

Manuals

___PA960 The Workers' Compensation Law of Ohio

___PA970 The State Insurance Fund Manual

Newsletters

___ *Comprehension* - a quarterly publication for employers

___ *Health Care Communicator* - a bimonthly publication for health care providers

- Verify that all facts about an injury are accurately stated on the claims application.

- Work closely with injured employees and help process their claims so they can return to work as soon as possible.

- Try to get the disabled employee back to work as soon as recommended by the physician. In many instances employers can provide lighter duty jobs, sometimes at reduced pay, which the employee can perform before returning to his or her regular job.

- Closely examine statements and reports from the BWC or IC. Employers have the right to challenge a claim if they disagree with it.

- Establish a liaison with the BWC's Safety & Hygiene Department, which offers a range of safety materials, services and publications. Safety & Hygiene provides training programs to promote safety and identify and correct hazards.

Upon request, the BWC's Safety & Hygiene Department may assign a representative to serve as safety adviser or conduct a safety survey and advise the employer of conditions that violate safety codes and practices. A maximum of one percent of the premiums collected can be used to provide these services.

The bureau has a series of specific safety requirements, which may pertain to an employer's business. These requirements serve as excellent guidelines for developing a safe work environment. Should a work-related disability or death occur because the employer was in violation of a specific safety requirement (VSSR) or code endorsed by the BWC, the disabled employee or beneficiaries may qualify for increased compensation, the charges for which are directly assessed to the employer upon the finding of a VSSR.

(4) SAIF Corporation provides the same type of services as private insurers.

All insurers are required by statute to provide loss control consultative services. We have loss control consultants located throughout the state to provide assistance to employers. In addition, we have a team of industrial hygienists and laboratory facilities.

All claims management activities are performed in-house. Claims staff includes adjusters, investigators, nurses, medical consultants, early return-to-work specialists and vocational coordinators. In addition, legal defense is handled by house counsel except in conflict cases.

Vocational assistance is required by statute when a worker has a substantial handicap that prevents the return to suitable employment. Actual vocational services are provided by private rehabilitation organizations. Our early return-to-work specialists help employers to develop modified employment opportunities for workers with restricted work releases.

JAN · 0

Claims

One of the biggest factors in SAIF Corporation's turnaround has been the exceptional performance of our Claims Operations. In 1990, our improved handling of claims resulted in a savings of more than $40 million for SAIF's policyholders. Our improved claims performance was also recognized by an actuary for the international actuary and consulting firm of Milliman & Robertson, Inc., who called SAIF's Claims Department "the best I have seen." These results were achieved by following a straight-forward philosophy toward managing claims:

Theresa Hynes
Senior Claims Adjuster

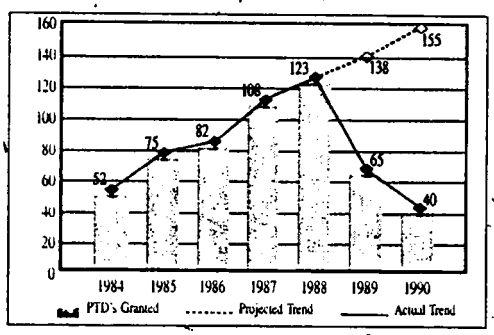
1. When the compensability of the claim is in question, adjusters will promptly evaluate, decide compensability, and communicate all decisions effectively to the worker and policyholder.
2. Claims Adjusters will accept compensable claims promptly.
3. The primary goals for claims employees regarding compensable claims are to facilitate the worker's early return to work and to close the claim promptly with no reserve.
4. All claims employees must protect the financial integrity of the Industrial Accident Fund.
5. Claims employees will keep our policyholders informed of all significant claim developments and will advise policyholders of all important decisions made by the worker's physician, by SAIF Corporation, or by legal authorities.

To implement this philosophy, we divided our Claims Division into three units. The Compensability Unit follows clear guidelines to determine whether an injury is work related. The Disabling Claims Unit is responsible for managing time-loss claims and closing those claims as fast as possible. A special claims unit employs adjusters trained to manage claims involving critical high-cost injuries and disabilities. Together, these three units

— and our entire Claims Operations, vocational experts, attorneys and other staff — produced extraordinary results in 1990:

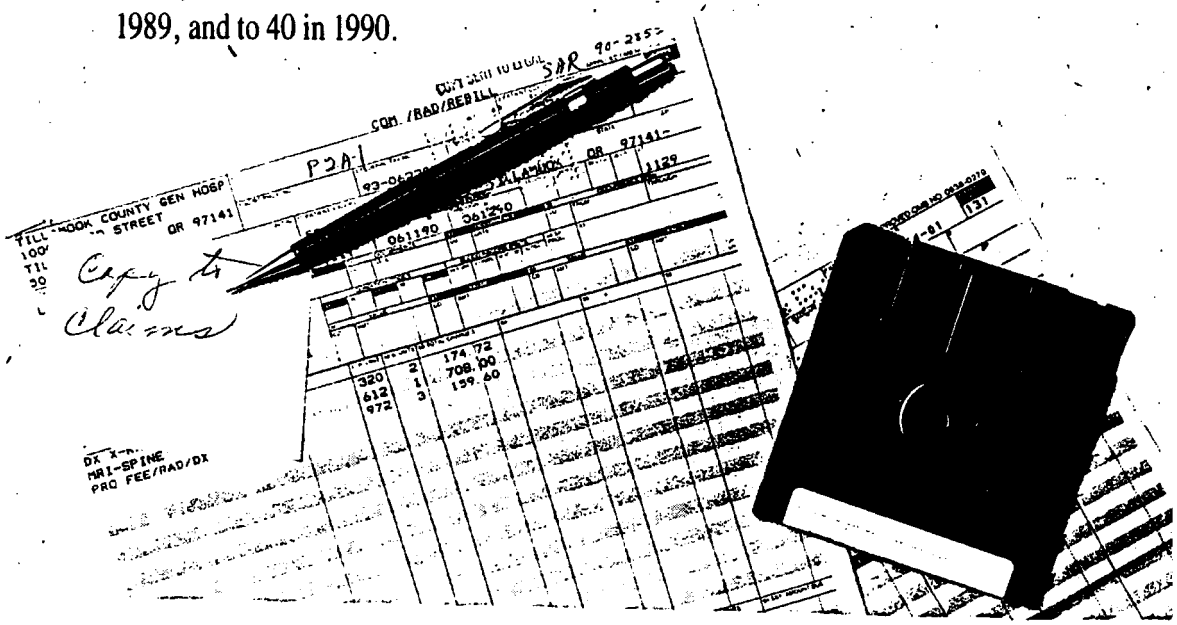
- Over 93 percent of all claims denied by SAIF in 1990 have stayed denied.
- The number of claims filed with SAIF declined 18 percent in 1990 versus 1989.
- The number of time-loss days paid by SAIF declined 32.5 percent in 1990 versus 1989.
- 66 percent of all time-loss claims compensability decisions by SAIF in 1990 were made within the first 14 days.
- The number of new permanent total disability awards paid by SAIF has declined from 123 in 1988, to 65 in 1989, and to 40 in 1990.

Number of Permanent Total Disabilities



"Risk management is like forest management. You have to work long term and participate actively to maximize results. In the forest safety is a way of life. With SAIF, accidents are down; and so are our premiums."

Lynn Herbert
General Manager
Herbert Lumber Co.
Riddle, Oregon



Early Return-to-Work

Work-related injuries affect more than injured employees themselves. Much more. They affect families, friends, fellow employees and the daily operations of entire companies. That's why SAIF's commitment to early return-to-work is so important.

Dave Jordan
Early Return-to-Work Specialist

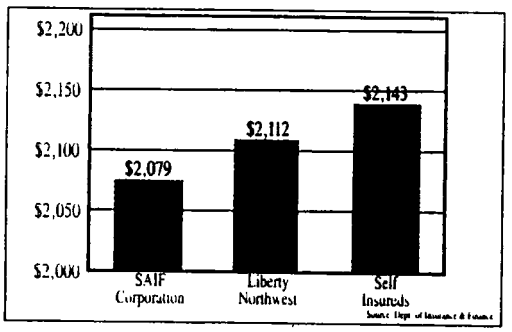
Studies have shown that the sooner injured employees return to work, the better their chances of making a full recovery instead of remaining dependent on the workers' compensation system. Our team of highly trained early return-to-work specialists consults with employers, workers and physicians to develop modified jobs that can be performed by injured workers while they recover from an injury.

Through our early return-to-work programs, workers can return to productive employment sooner than expected and they can recover from their injuries faster. Employers who provide their injured workers with modified work while they are recovering can lower the cost of workers' compensation claims an average $3,500 per claim. In addition, workers-placed in modified jobs generally receive lower permanent disability awards.

Our commitment to early return-to-work is another example of SAIF's efforts to control claim costs. We are the only workers' compensation insurance company in Oregon to make such a substantial commitment to early return-to-work programs. These programs can help employers reduce the cost of workers' compensation claims, retain valuable and skilled employees, and avoid the cost of recruiting and training new employees.

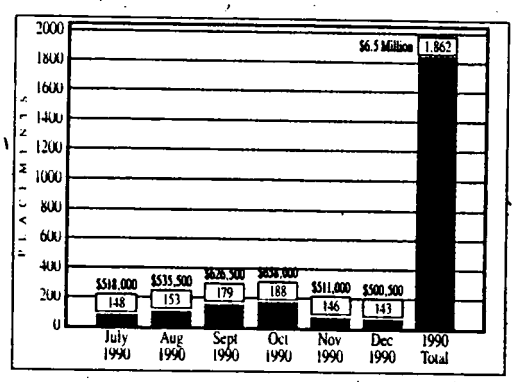
Average Closure Costs

Comparison of the Average Closure Costs on All 1989 Disabling Claims First Closed in 1989



Early Return-To-Work

Placements/Estimated Savings Monthly and Cumulative Totals



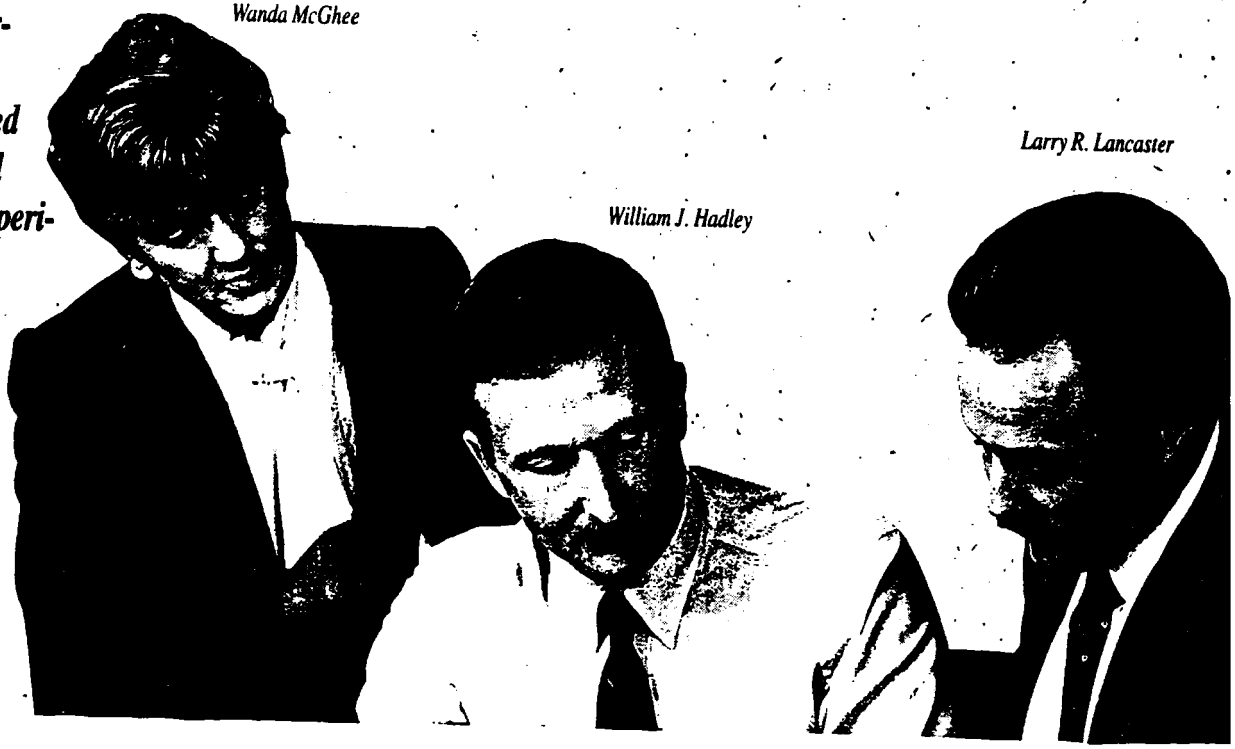
"With 100 employees, we can't afford accidents or down time. So we've invested in safety — and in SAIF Corporation. With their help, we've controlled accidents, increased productivity, and experienced rapid growth worldwide."

Phil Edin
Vice President
Climax Portable Machine Tools

Wanda McGhee

William J. Hadley

Larry R. Lancaster



Fraud and Investigations

Most insurance companies accept fraud as part of the price of doing business. Unfortunately, they pass the cost of fraud along to their customers through higher rates. SAIF Corporation and our Fraud/Investigations Division find that attitude unacceptable.

Since its inception in January 1989, the Fraud/Investigations Division has spearheaded the most comprehensive crackdown on workers' compensation fraud in Oregon history. With more than 50 trained investigators and staff specialists, the Division gathers evidence and information in cases of suspected fraud. This information has been forwarded to the proper state and local authorities, often resulting in criminal convictions or civil judgments.

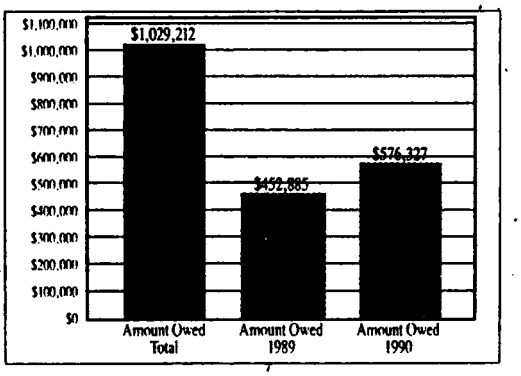
Jeff Maldonado
Deputy Director, Fraud/Investigations Division

In less than two years, our Fraud/Investigations Division has received more than 2,100 complaints of workers' compensation fraud. By the end of 1990, these cases pushed total convictions to more than 65 and increased total awards above $1 million. Many of these cases involve medical providers who cheated our policyholders and the workers' compensation system. Many of these providers are now prohibited from treating the injured workers employed by our policyholders.

By aggressively pursuing cheaters, we are able to save the system money, lower premiums for our customers, improve the care provided to injured workers, and reduce the number of fraudulent claims.

Fraud Recoveries 1989-1990

As of December 31, 1990



Medical Services

SAIF's Medical Services Division is the largest and most comprehensive division of its kind in Oregon. Each year, this Division audits more than 400,000 bills submitted by medical care providers who treat injured workers. These audits ensure policyholders that we are paying the correct amount for the medical care provided to their injured employees. Nothing more, nothing less.

In 1990, the Division's system of verifying and correcting medical bills saved our policyholders more than $12 million in unnecessary medical costs and treatments. These efforts have helped reduce workers' compensation costs.

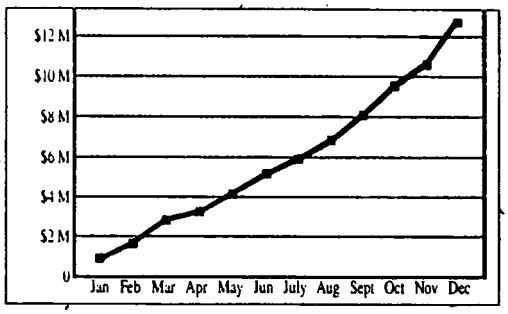
Besides verifying and correcting medical bills, our automated auditing process makes accurate and appropriate payment of medical bills. It's just one more way our Medical Services Division is contributing to SAIF's goal of providing the best workers' compensation coverage at the lowest possible price.

"Thousands of people ride our buses every day. People depend on us to be efficient, reliable, and there when they need us. We depend upon SAIF Corporation to be our partner in ensuring that our employees work safely, maintain their health, and when necessary, receive the benefits provided under the law."

Phyllis Loobey
General Manager
Lane Transit District
Eugene, Oregon

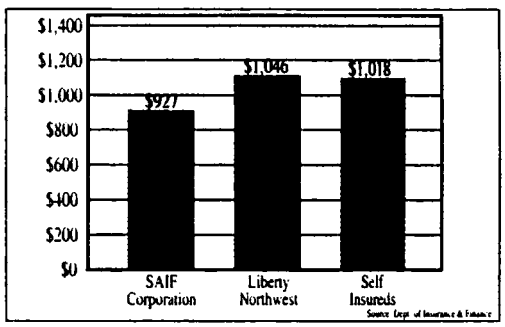
Medical Services Division

Bill Reductions - 1990



Medical Cost Per Claim

Comparison of the Average Medical Cost per Claim On 1989 Disabling Injuries First Closed in 1989



Appendix J, Sheet 7

Loss Control

Workplace accidents cost employers millions of dollars each year. That is why SAIF Corporation developed a comprehensive approach to loss control.

Ted Jean
Risk Manager

Bonnie Robbins
Early Return-to-Work Specialist

Ken Carpenter
Loss Control Specialist

Chuck Jekabsons
Senior Group Representative

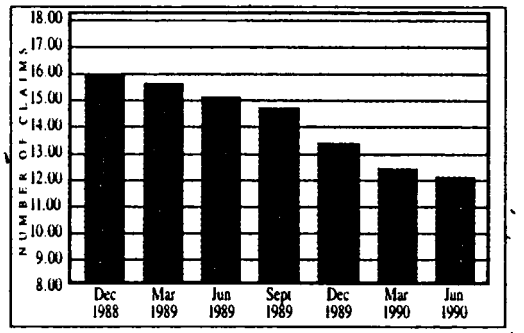
SAIF's loss control consultants work with our customers to prevent job-related injuries or illnesses by helping tailor programs to the needs of individual businesses. They work with employers to determine what kinds of claims have occurred. They identify patterns and trends in claims, and find solutions that reduce or eliminate claims.

SAIF has the largest industrial hygiene staff of any workers' compensation insurance company in Oregon. These professionals help reduce occurrences of occupational diseases by identifying, evaluating, and controlling hazards caused by chemicals, fumes or noise.

The result of SAIF's commitment to loss control has been a significant decrease in the frequency of claims filed by the employees of our policyholders.

Claims Frequency Rate

Rate per 200,000 manhours worked



STATE WORKMEN'S INSURANCE FUND
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY

"SAFETY PAYS"

December 30, 1991

RE: **AIS RISK CONSULTANTS INC.**
Request for information on competitive State Funds

(1) **Annual statements** for the years 1986, 1987, 1988, 1989 and 1990 are included with this reply.

(2) **Statutes and regulations** governing this State Fund are included with this reply. A green booklet entitled **Pennsylvania Workmen's Compensation Law,** 1990 edition.

(3) A description of the operation of this State Fund is included under the title, **"SWIF Facts."**

(4) SWIF contracts with professional organizations to provide the following services: **Safety inspections, medical bill audit, medical case management, investigative surveillance, policyholder payroll audit.**

SWIF provides a managed care program, known as **SWIFcare,** to 5,000 policyholders in the Greater Pittsburgh area. This is a pilot program, utilizing a specific network of providers. A case coordinator is assigned to the "lost time indemnity" claim and is responsible for establishing continual communication with the injured worker, employer, provider and SWIF claim representative. The objective is to develop a safe return-to-work plan with the assistance and cooperation of all participants at the earliest possible time in managing the claim.

SWIF is pleased with the rate of savings identified in the pilot program and plans to expand **SWIFcare** to other areas of the state.

Professional services which SWIF contracts for at no cost to the policyholder:

(4) A. **Safety inspections** are provided to policyholders who have injury records showing they would benefit from this service. Most large policyholders receive the service as do others requesting a safety inspection.

B. **Medical Management** is performed on all claims of significant injury and those selected by SWIF claim reviewers due to type of injury.

100 LACKAWANNA AVENUE, P.O. BOX 5100, SCRANTON, PA 18505-5100

C. **Medical Bill Audits** are performed on all bills in excess of $1,000.00 and on selected ones over $500.00.

D. **Surveillance** services are used when appropriate.

E. **Policyholder Payroll Audit** on-site reviews are conducted for all policies with an annual estimated premium in excess of $2,000.00. An in-house mail audit is used for policies with premiums less than $2,000.00.

F. **Attorneys,** contracted through law firms, are used to augment SWIF's legal staff.

5. SWIF has no rating plan to encourage safety on the part of small and/or medium size insureds. However, we plan to develop one in the near future.

   We currently include safety literature as a "stuffer" with our bills to policyholders.

6. Rates, established by the **Pennsylvania Compensation Rating Bureau,** are listed by classification for the years **1981** and **1990** and are included with this reply.

7. Average rate level is not available.

8. The most recent actuarial report evaluating the rate level and rate structure of SWIF is not available.

9. Same as No. 8.

10. Same as No. 8.

11. None.

JOB/emk#1 misc

STATE WORKMEN'S INSURANCE FUND
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY

RECEIVED
JAN

"SAFETY PAYS"

SWIF FACTS

SWIF - the **State Workmen's Insurance Fund** - was established by the Pennsylvania State Legislature in 1915 as an Enterprise Fund within the Department of Labor and Industry. SWIF issues Worker's Compensation insurance policies to employers in Pennsylvania and serves as the **"insurer of last resort"** for any employer unable to obtain this type of coverage through private insurance companies.

SWIF's operating structure is similar to private insurance companies in that its operations staff is accountable to the **SWIF Board** which is comprised of the **Secretary of Labor and Industry**, the **Insurance Commissioner** and the **State Treasurer.** Oversight responsibility lies with the **Deputy Secretary** for **Collections** and **Compensations.** As with private insurance companies, SWIF must adhere to the state insurance laws and rules of the Pennsylvania Compensation Rating and Coal Mine Rating Bureaus. SWIF uses the basic rate tables established by these Bureaus to calculate the annual premium amount to be charged for each policy issued.

The policy provides medical coverage and weekly compensation benefits to employees of the policyholder, who incur work-related injuries. It protects the worker against financial crises and the employer against extensive legal costs. Physical rehabilitation and vocational rehabilitation are included in the schedule of coverages. SWIF coordinates the efforts of the treating provider, employer and injured employee to develop a safe return-to-work plan.

The primary functional areas of SWIF are: **Underwriting, Claims, Accounting, Legal, Data Processing** and **Administration.** Policyholder and claimant services are provided by SWIF's Home Office in Scranton and eight (8) District Offices located in **Philadelphia, Harrisburg, Pottsville, Sunbury, Pittsburgh, Scranton, Erie** and **Johnstown.** All offices are connected on-line to SWIF's state-of-the-art, integrated data base computer system known as PICS (Pennsylvania Insurance Compensation System). PICS was installed in October, 1988, and is considered to be one of the most advanced, comprehensive systems designed to process worker's compensation insurance policies and claimant data.

PICS begins by rating the estimated annual premium and printing the information sheets and endorsements for a policy. Injured worker reports are recorded and monitored to provide payment of medical bills and compensation benefits. Check data is transmitted to the Treasury Department for printing and mailing. Monthly invoices for premium are printed and mailed to policyholders. PICS, under the direction of the Accounting Division, monitors the collection of premium and prints past due and cancellation notices when necessary.

As of October 31, 1991, SWIF insured 28,041 employers at an estimated annual premium of $287 million. These policyholders employ approximately 295,000 people and generate an estimated $6.4 billion annual payroll within the Commonwealth.

100 LACKAWANNA AVENUE, P.O. BOX 5100, SCRANTON, PA 18505-5100

STATE WORKMEN'S INSURANCE FUND

RECAP OF SWIF'S GROWTH FROM 1988 TO 1991

UNDERWRITING:	1988	1991	INCREASE	%
NO. OF POLICIES INFORCE	20,286	28,041	7,755	38%
NO. OF NEW POLICIES WRITTEN	7,276	11,178	3,902	54%
NO. OF PAYROLL AUDITS	17,996	25,300	7,304	41%
NO. OF 'LOSS PREVENTION SURVEYS COMPLETED'	75	500	425	176%
$ PREMIUM WRITTEN (THOUSANDS)	$127,888	286,941	$159,053	124%

STATE WORKMEN'S INSURANCE FUND
UNDERWRITING STATISTICS AS OF 10/31/91

1,131	POLICIES WITH ANNUAL PREMIUM IN EXCESS OF $50,000.00
48	**NEW** POLICIES BEING ADDED EACH DAY
1,666	POLICIES **RENEWED** EACH MONTH
19,000	PREMIUM **INVOICES** MAILED EACH MONTH

PICS GROWTH STATISTICS (AVERAGE)

	1989	AS OF 10/31/91	INCREASE	
DAILY TRANSACTIONS	62,333	110,200	47,867	77%
RESPONSE TIME (SECONDS)	.430	.431		
NUMBER OF USERS PER DAY	114	236	122	107%
NUMBER OF INDEMNITY CHECKS PER CYCLE	7,999	10,757	2,758	34%

STATE WORKMEN'S INSURANCE FUND

RECAP OF SWIF'S GROWTH FROM 1988 TO 1991

CLAIMS ($ IN THOUSANDS)

	1988	1991	INCREASE	%
$ CLAIMS PAYMENTS (INDEMNITY AND MEDICAL BILLS)	$ 95,102	195,000	99,898,000	105%
NO. OF MEDICAL BILLS PAID	128,890	344,000	215,110	167%
NO. OF CHECKS ISSUED	301,891	641,000	339,109	112%
NO. OF ARISING CLAIMS MEDICAL AND LOST TIME	32,935	46,000	13,065	40%
NO. OF CLAIM PETITIONS	1,086	1,774	688	63%
NO. OF SWIF PETITIONS	1,194	2,392	1,198	100%
$ SUBROGATION RECOVERED	$ 1,401	3,665	$ 2,264,000	162%

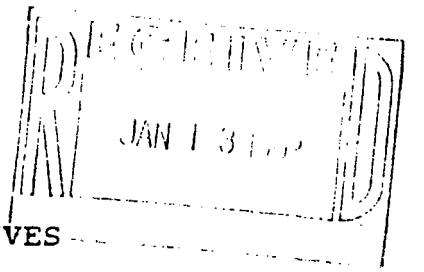
CLAIMS STATISTICS AS OF 10/31/91

203	NEW CLAIMS PER DAY 51 ARE 'LOST TIME' 152 ARE 'MEDICAL ONLY'
42	'LOST TIME' CLAIMS CLOSED PER DAY
1,450	MEDICAL BILLS PAID PER DAY
3,350	CLAIMS IN LITIGATION
1,700	CLAIMS IN SUBROGATION
21	DAYS AVERAGE TO PRODUCE FIRST INDEMNITY PAYMENT
92%	OF BILLS PAID WERE RECEIVED IN CURRENT AND PRIOR MONTH
527,681	CHECKS ISSUED FOR MEDICAL AND INDEMNITY JAN. - OCT. 1991

COST REDUCTION PROGRAMS UTILIZED BY SWIF GENERATED FOLLOWING SAVING FOR JAN. - OCT. 1991.

$ 4,800,000.00	SUBROGATION - COLLECTED & FUTURE CREDIT
3,869,000.00	MEDICAL MANAGEMENT
21,069,000.00	COMMUTATIONS
$29,738,000.00	TOTAL

WORKERS COMPENSATION FUND OF UTAH
1990 OPERATING PERFORMANCE PLAN



CORPORATE PURPOSE AND PRIMARY OBJECTIVES

PURPOSE: The Workers Compensation Fund exists to offer low cost workers compensation insurance to Utah employers in fulfillment of their legal obligation to their employees, while maintaining an actuarially sound reserve fund.

Since Utah employers can voluntarily insure their workers compensation risk with the Workers Compensation Fund or insure with another carrier, the Fund will adopt business objectives and strategies which will allow it to remain a viable, competitive, yet actuarially sound insurance business.

OBJECTIVES: In support of the mission of the Workers Compensation Fund, the following objectives are established. The Fund will:

1. Maintain current market share
2. Retain current policyholders
3. Increase employer awareness of Fund services
4. Provide effective accident prevention advice to policyholders
5. Provide timely policy information to prospective policyholders
6. Provide timely claims adjudication services to claimants
7. Adjudicate claims effectively to deny unjustified claims
8. Adopt a pricing strategy, including premiums, deposits and dividends which will offer insurance at a low cost sufficient to support an actuarially sound fund
9. Pay health care providers on a timely, accurate basis
10. Minimize the administrative burden on employers in providing payroll and other information to the Fund
11. Audit the payroll records of employers to insure the proper payment of premiums
12. Provide legal assistance to employers as claims are denied and appealed to the State Industrial Commission

13. Provide leadership in the Utah workers compensation area

14. Monitor trends and issues in the workers compensation field and make appropriate recommendations to the Industrial Commission and the Legislature

15. Provide appropriate incentives to health care providers to moderate their prices in return for expedited claims management and payment

16. Pursuant to the maintenance of an actuarially sound fund, effectively manage, report, and protect these funds while realizing a high return from investments

WORKERS COMPENSATION FUND OF UTAH
1990 OPERATING PERFORMANCE PLAN

POLICYHOLDER SERVICES DIVISION
DIVISION PURPOSE AND PRIMARY OBJECTIVES

PURPOSE: To provide Workers Compensation Fund of Utah policyholders with professional underwriting services, industrial safety expertise, timely and accurate payroll audits, and appropriate properly prepared policy contact documents.

OBJECTIVES:

1. Develop fully trained and knowledgeable division employees through the use of selected educational training courses and seminars, in-house training programs, and continued on the job training.

2. Coordinate all policyholder services activities to provide effective communications with insured employers.

3. Improve our ability to attract and retain profitable accounts by developing and implementing a dividend plan whereby dividends would be based on each individual policyholder's premium size and loss ratio.

4. Continue to provide information brochures to policyholders on the following:

   a. Workers Compensation Fund information
   b. Payroll audits

5. Develop and distribute brochures on the following:

   a. Industrial safety
   b. Experience modifications

6. Maintain service levels to our policyholders that clearly represent a customer oriented organization.

WORKERS COMPENSATION FUND OF UTAH
1990 OPERATING PERFORMANCE PLAN

BENEFITS ADMINISTRATION DIVISION
DIVISION PURPOSE AND PRIMARY OBJECTIVES

PURPOSE:The purpose of the Benefits Administration Division is to provide payment of workers compensation benefits to entitled individuals in a manner which produces the greatest contribution to the Fund's ability to accomplish its overall mission of providing workers compensation insurance to policyholders at the lowest possible cost.

OBJECTIVES:To perform its mission, the Benefits Administration Division must develop, implement and maintain an operating plan and system with supporting policies and procedures which meet the following objectives:

1. Provide efficient and highly professional claims service. This will be assured through:

   a. Organizational structure and technology designed to enhance quality control and minimize response time.

   b. Sufficient management information to thoroughly analyze and evaluate department performance.

   c. Continuous and in-depth training for professional and clerical staff in the most cost effective manner.

   d. Maintenance of a work environment, performance appraisal system, salary/benefits structure which attracts and retains competent and highly productive personnel.

   e. The highest level of cooperation with policyholders in the investigation, processing and management of claims.

2. Utilize proven, cost effective disability management programs and concepts in order to return injured workers to gainful employment as soon as possible, thus reducing medical and indemnity costs.

3. Utilize effective medical cost containment programs, and services to control utilization of medical treatment and equipment.

4. Generate and maintain adequate, fair, and defensible claim reserves through sound reserving methodology and practices.

APPENDICES

VOLUME V

A. ANALYSIS OF THE PROFITABILITY OF WORKERS' COMPENSATION INSURANCE V-APPENDIX-1

APPENDICES
VOLUME V

APPENDIX A

ANALYSIS OF THE PROFITABILITY OF WORKERS' COMPENSATION INSURANCE

SPECIAL NOTE:
This is supplemental data to the original report requested by the Commissioners.

AIS RISK CONSULTANTS, INC.

Consulting Actuaries • Insurance Advisers

4400 Route 9 South • Freehold, NJ 07728 • (908) 303-7470

February 3, 1992

Dr. Dennis J. Aigner, Dean
Graduate School of Management
University of California, Irvine
Irvine, California 92717

Dear Dr. Aigner:

I am writing in regard to your request for additional analysis of the profitability of workers' compensation insurance.

In the study of workers' compensation profitability by insurance group in California, I performed a regression of each cost component (i.e., losses, expenses, dividends and investment income) against the overall operating ratio. You requested that a multiple regression be performed for all the cost variables simultaneously. This would take the form:

OPERATING RATIO = A + B * LOSSES + C * EXPENSES + D * DIVIDENDS - E * INVESTMENT INCOME

However, this equation is by definition an equality when A = 0 and B = C = D = E = 1. Hence, a multiple regression would result, within rounding, in infinite T-statistics and an R-Squared of 1. This is why the regressions were done one at a time instead of simultaneously. The correlation matrix for these variables is shown in the attached Exhibit AIS-1.

You also requested a comparison of the workers' compensation rate of return by state with the difference between the requested and approved rate changes. This is displayed in Exhibit AIS-2. This linear regression shows that the rate difference is significant in explaining the return (T-Statistic = -3.00). However, only a small portion of the return is explained by the rate difference (R-Squared = 19%).

A plot of the return on net worth versus the rate difference for the 40 states analyzed is shown in Exhibit AIS-3. The significance of the rate difference in explaining the return is strongly influenced by five states with both low returns and a large difference between the filed and approved rate. These five states are Florida, Louisiana, Maine, Rhode Island and Texas. These states are commonly regarded as "problem" states for workers' compensation for reasons in addition to the difference between filed and approved rates. If these five states are excluded from the regression, the T-Statistic becomes 1.14 and the R-Squared is 4%. This could indicate that for most states the difference between the filed and approved rates does not strongly influence profitability, and that for these five states, other factors in addition to rates are impacting profitability.

In performing this analysis, data from 40 states was used. The six states with monopolistic funds were excluded. In addition, for five other jurisdictions (including DC) there was not sufficient information available regarding the difference between the filed and approved rates. Of these five jurisdictions, one had a high profit (about 21%), three had moderate profits (in the range of 10% to 14%) and one had a loss (about -4%).

Some of the other considerations that should be kept in mind are:

(1) Many states do not allow insurers to build a provision for rate deviations or policyholder dividends into the rate level. However, the profit figures published by insurers include a deduction for deviations and dividends. It is questionable whether rates that do not include a provision for these items should be compared to profits which subtract these items out.

(2) The profit figures are based upon insurance company estimates of reserves, including both case reserves on known claims and incurred but not reported (IBNR) reserves. Many states, and even the National Council on Compensation Insurance, have concluded in recent years that insurance companies have increased their reserves, and hence understated profits. A correction for this can be made in the ratemaking process, but it is not included in the profit figures that insurance companies publish.

(3) State specific situations need to be accounted for in a more complete analysis. For instance, in Maine since policy year 1988 insureds are financially responsible for at least 50% of any deficit in the assigned risk plan, which makes up about 80% to 90% of the total market. While insurers include the deficit from the residual market in their profit figures, they do not include future assessments on policyholders to fund this deficit as revenue. Another special circumstance would be Texas. The major difference between the filed and approved rates has been the targeted underwriting profit value. However, the operating loss in Texas is mostly attributable to losses escalating far faster than anyone, including the NCCI, predicted. Hence while Texas shows both an operating loss and a large difference between filed and approved rates, the correlation is at least somewhat spurious.

(4) Many factors other than the approved rates have an influence on insurance company profits. Some of the possible explanatory variables could be the existence of a state fund, the extent of self insurance, the difference between expected and actual loss development, shifts in loss trends and variations in interest rates.

This quick analysis which you requested provides some indication that a weak correlation exists between profits and rate approvals. However, much more work would need to be performed to reach a more definite conclusion.

Sincerely,

Allan I. Schwartz
FCAS,ASA,MAAA,FCA
President

AIS/mc

Enclosure

cc: Dr. Patricia A. Cheshier
Dr. Stewart L. Long
Dr. William E. Neeley
Dr. Melchior D. Powell
Dr. Susan D. Schaefer
Dr. James C. Van Horne
Richard Soper
Glenn Shor

CALIFORNIA WORKERS' COMPENSATION
ANALYSIS OF PROFITABILITY BY COMPANY
PEARSON CORRELATION MATRIX

	OPERATING RESULT	LOSSES	EXPENSES	INVESTMENT INCOME	DIVIDENDS
OPER RESULT	1.000				
LOSSES	0.457	1.000			
EXPENSES	0.254	-0.219	1.000		
INVEST INC	-0.224	0.384	0.008	1.000	
DIVIDENDS	0.220	-0.066	-0.432	0.201	1.000

NUMBER OF OBSERVATIONS: 33

Exhibit AIS-1

WORKERS' COMPENSATION

Regression of Return on Net Worth on the
Difference Between Filed & Approved Rate Changes

State	1985-1990 Workers' Compensation Return on Net Worth	Difference In Annual Rate Rate Change Between Filed And Approved
Alabama	-0.8%	4.5%
Alaska	18.5%	0.0%
Arizona	11.4%	0.0%
Arkansas	7.1%	4.8%
Colorado	-15.9%	0.0%
Connecticut	11.6%	2.7%
D.C.	31.7%	2.9%
Florida	-6.5%	15.2%
Georgia	0.4%	0.5%
Hawaii	25.7%	10.0%
Idaho	9.1%	0.9%
Illinois	15.5%	2.6%
Indiana	7.5%	0.1%
Iowa	11.6%	4.4%
Kansas	5.9%	4.2%
Kentucky	14.6%	1.7%
Louisiana	-6.1%	16.6%
Maine	-18.6%	19.1%
Maryland	22.1%	4.9%
Michigan	14.2%	0.4%
Mississippi	2.6%	3.6%
Missouri	5.4%	2.6%
Montana	-4.1%	0.0%
Nebraska	6.9%	3.8%
New Hampshire	7.8%	5.8%
New Jersey	14.1%	0.4%
New Mexico	-5.7%	5.1%
New York	18.7%	5.8%
North Carolina	1.4%	3.6%
Oklahoma	7.7%	10.0%
Oregon	10.2%	3.4%
Rhode Island	-14.2%	13.8%
South Carolina	9.5%	6.9%
South Dakota	5.0%	2.2%
Tennessee	-0.4%	4.0%
Texas	-13.2%	10.8%
Utah	14.3%	1.6%
Vermont	8.0%	2.0%
Virginia	10.4%	9.7%
Wisconsin	14.3%	3.4%

Regression Output:

Constant		0.113
Std Err of Y Est		0.101
R Squared		0.192
No. of Observations		40
Degrees of Freedom		38
X Coefficient(s)	-1.008	
Std Err of Coef.	0.336	
T statistic	-3.001	

WORKERS' COMPENSATION INSURANCE

PROFIT VS. RATE APPROVALS

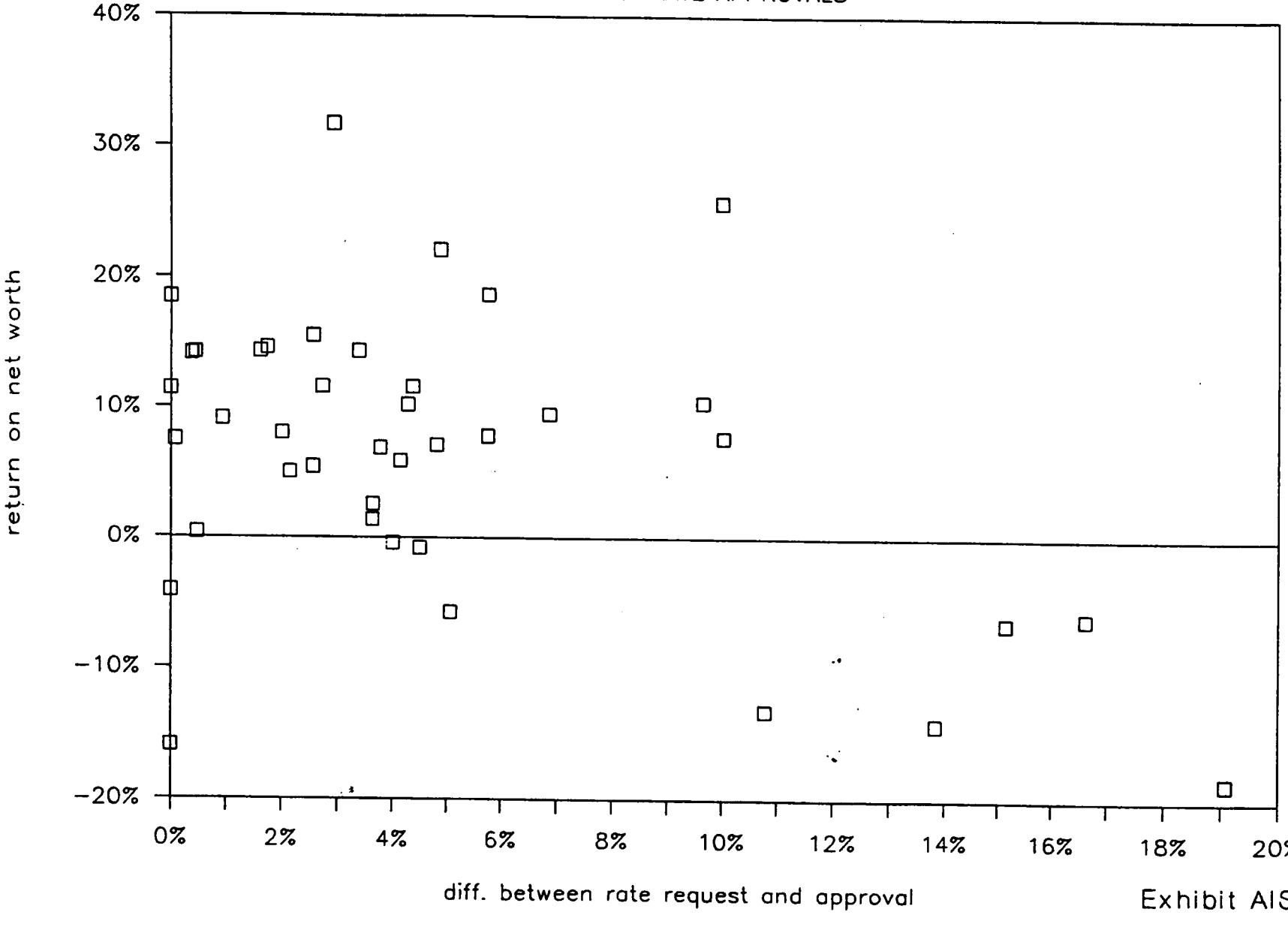


Exhibit AIS-3

- NOTES -

STATE OF CALIFORNIA
WORKERS' COMPENSATION RATE STUDY COMMISSION

- NOTES -

- NOTES -

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Volume II Commission Staff Report Soper & Associates	426	15	197
Volume III Commission Staff Report Soper & Associates	426	4	17
Volume IV Sub-Contract Resource Report Milliman & Robertson, Inc.	256	7	71
Volume V Sub-Contract Resource Report AIS Risk Consultants, Inc.	524	10	269
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Richard H. Soper, CMC, Executive Director
Workers' Compensation Rate Study Commission
Soper & Associates
P. O. Box 3727
Palos Verdes Peninsula, CA 90274

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