A REPORT TO THE
MINNESOTA LEGISLATURE
AND GOVERNOR

MINNESOTA WORKERS' COMPENSATION: STATE FUND LEGISLATIVE STUDY COMMISSION

S.F. 75

DECEMBER 1980

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Senate

State of Minnesota

January 1, 1981

The Honorable Albert H. Quie
Governor, State of Minnesota

The Honorable Jack Davies
President, Minnesota Senate

The Honorable Harry. A. Sieben
Speaker, Minnesota House of Representatives

Gentlemen:

Pursuant to Laws of Minnesota 1979 Extra Session, Chapter 3, the accompanying report of the Study Commission on State Workers' Compensation Funds is submitted to you. Beginning March 24, 1980 and ending December 9, 1980, the Study Commission held twelve hearings in which it explored all aspects of the differences between state workers' compensation funds and the private insurance industry.

This report contains the recommendations of the Commission along with detailed exhibits of the testimony which led to our conclusions. Although there are other issues that must be addressed in the field of workers' compensation, our charge limited us to examining this aspect of the system. We believe that the adoption of these recommendations will guarantee a more efficient and lower cost workers' compensation delivery system in Minnesota.

Respectfully submitted,

Steve Keefe

Steve Keefe, Chairman
Workers' Compensation Study Commission

SK/bc

ACKNOWLEDGMENTS

Many individuals have contributed to this study. Any attempt to name other than those most closely involved would result in an extensive list that may omit an important contributor. Laura Lindorfer and Joanne Blockey are due special credit for the many long hours of typing and arranging the final manuscripts and transcriptions. We are indebted to Betsy Chesebrough for serving as secretary to the Commission, and especially for transcribing the original tapes of witnesses appearing before the Commission. We are pleased to express thanks to all the secretaries of Senate Counsel, as well as Diane Ruppert, Sandy Wendt and Peggy Kormendy. For the research assistance of Robert Kaplan and the administrative work of Steve Goff we are also very grateful.

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MAJORITY REPORT

RECOMMENDATION: THE UNDERSIGNED MAJORITY OF THE MEMBERS OF THE STUDY COMMISSION RECOMMEND THAT THE MINNESOTA LEGISLATURE SHOULD ESTABLISH A COMPETITIVE STATE COMPENSATION INSURANCE FUND WHICH WOULD BEGIN SELLING INSURANCE TO PRIVATE EMPLOYERS IN MINNESOTA ON JULY 1, 1984. TO PREPARE FOR ENTERING THE MARKET THE STATE FUND SHOULD BE DEVELOPED AS AN INDEPENDENT STATE AGENCY, COMMENCING JANUARY 1, 1982, TO ADMINISTER THE WORKERS' COMPENSATION CLAIMS OF THE EMPLOYEES OF THE STATE OF MINNESOTA, AND THAT FUNCTION SHOULD BE REMOVED FROM THE DEPARTMENT OF LABOR AND INDUSTRY. THE NEW INDEPENDENT AGENCY SHOULD MAKE FULL USE OF MODERN INNOVATIONS IN CLAIMS HANDLING TECHNIQUES AND SHOULD IMMEDIATELY COMMENCE A STUDY TO DETERMINE (A) WHAT THE ACTUARIALLY SOUND PREMIUMS SHOULD BE FOR THE STATE OF MINNESOTA AS A CLIENT OF THE STATE COMPENSATION INSURANCE FUND AND (B) WHAT UNFUNDED LIABILITIES HAVE BEEN INCURRED IN THE PAST AS A RESULT OF WORKERS' COMPENSATION CLAIMS ON CASES THAT ARE STILL OPEN, OR WHICH MAY BE REOPENED.

FUNDS FOR ESTABLISHING THE INDEPENDENT STATE AGENCY TO ADMINISTER THE STATE OF MINNESOTA WORKERS' COMPENSATION CLAIMS SHOULD BE PROVIDED BY THE MINNESOTA LEGISLATURE AS PART OF ITS RESPONSIBILITY TO REFORM THE STATE'S SELF INSURANCE SYSTEM. FUNDS TO PROVIDE ADEQUATE SURPLUS TO FUND THE STATE COMPENSATION INSURANCE FUND WHEN IT BEGINS SELLING INSURANCE TO PRIVATE INTERESTS IN 1984 SHOULD BE LOANED TO THE STATE COMPENSATION INSURANCE FUND BY THE MINNESOTA LEGISLATURE AT THE RATE OF INTEREST THE STATE CURRENTLY OBTAINS ON OTHER INVESTMENTS OF THIS NATURE. THE STATE FUND SHOULD PRESENT A REPORT TO THE 1983 LEGISLATURE WITH A DETAILED PLAN FOR FUNDING THE UNFUNDED LIABILITY FOR PAST WORKERS' COMPENSATION CLAIMS. THE STATE FUND SHOULD NEGOTIATE

WITH THE STATE OF MINNESOTA A FAIR AND EQUITABLE PREMIUM RATE FOR INSURING THE STATE'S WORKERS' COMPENSATION LIABILITY IN THE FUTURE. THE STATE OF MINNESOTA SHOULD GUARANTEE THE SOLVENCY OF THE FUND ONLY TO THE EXTENT REQUIRED BY ITS OWN PREMIUM VOLUME, BUT NOT BEYOND THAT. THE STATE OF MINNESOTA SHOULD BE REQUIRED TO PURCHASE WORKERS' COMPENSATION INSURANCE FROM THE STATE FUND AFTER JANUARY 1, 1984, UNTIL THE STATE FUND HAS HAD ADEQUATE TIME TO DEVELOP SUFFICIENT PREMIUM VOLUME TO SUPPORT ITS ACTIVITIES AS AN EFFICIENT, COMPETITIVE INSURANCE AGENCY.

THE MAJORITY OF THE MEMBERS OF THE STUDY COMMISSION RECOMMEND THAT, IN CONJUNCTION WITH THE ESTABLISHMENT OF A STATE COMPENSATION INSURANCE FUND, THE LEGISLATURE SHOULD REPEAL THE EXISTING REGULATED RATE SYSTEM FOR WORKERS' COMPENSATION INSURANCE AND IMPLEMENT A COMPETITIVE RATE SYSTEM SIMILAR TO THE FILE AND USE RATE PROCEDURES USED IN OTHER CASUALTY AND LIABILITY INSURANCE LINES.

THE COMPETITIVE RATE SYSTEM FOR WORKERS' COMPENSATION INSURANCE, IN ITS FINAL FORM, SHOULD EMBODY THE FOLLOWING FEATURES:

1. THE WORKERS' COMPENSATION RATING ASSOCIATION OF MINNESOTA SHOULD BE LIMITED TO THE FUNCTIONS OF DETERMINING WORKERS' COMPENSATION RISK CLASSIFICATIONS (FOR DATA PURPOSES ONLY) AND OF COLLECTING, EVALUATING AND DISSEMINATING DATA ON THE ACTUAL WORKERS' COMPENSATION LOSS EXPERIENCE OF SUCH CLASSES, TOGETHER WITH RELATED FUNCTIONS, BUT SHALL NOT COLLECT OR DISSEMINATE DATA, ESTIMATES OR PROJECTIONS RELATING TO TREND FACTORS OR EXPENSE FACTORS AND SHALL NOT DEVELOP, DISSEMINATE OR PROPOSE

RATES FOR ANY WORKERS' COMPENSATION RISK CLASSIFICATION. THESE DATA SHOULD BE TREATED AS PUBLIC RECORDS SUBJECT TO DATA PRIVACY LIMITATIONS. A WORKERS' COMPENSATION INSURER SHOULD BE REQUIRED TO MAINTAIN MEMBERSHIP IN A WORKERS' COMPENSATION RATING SERVICE, BUT NOT NECESSARILY THE CURRENT MINNESOTA WORKERS' COMPENSATION RATING ASSOCIATION.

2. INDIVIDUAL WORKERS' COMPENSATION INSURERS SHOULD BE PERMITTED TO CHARGE WORKERS' COMPENSATION PREMIUM RATES DETERMINED BY THEM, SO LONG AS THESE RATES ARE FILED WITH THE COMMISSIONER OF INSURANCE AND ARE NOT CLEARLY EXCESSIVE, INADEQUATE OR DISCRIMINATORY. INDIVIDUAL INSURERS SHOULD ALSO BE ABLE TO DETERMINE AN EMPLOYER'S RISK CLASSIFICATIONS FOR PREMIUM PURPOSES AND MODIFY, FOR THOSE PURPOSES, THE CLASSIFICATIONS ESTABLISHED BY THE RATING ASSOCIATION. INDIVIDUAL INSURERS SHOULD ALSO BE AUTHORIZED TO OFFER EXPERIENCE, DIVIDEND, MERIT AND RETROACTIVE PLANS AND PREMIUM DISCOUNTS AS DETERMINED BY THEM.

3. WORKERS' COMPENSATION INSURERS AND THE WORKERS' COMPENSATION RATING ASSOCIATION OF MINNESOTA SHOULD BE MADE SUBJECT TO STATE LAW EQUIVALENT TO THE APPROPRIATE PROVISIONS OF THE SHERMAN, CLAYTON AND FEDERAL TRADE COMMISSION ACTS SO AS TO ASSURE COMPETITIVE BEHAVIOR.

4. EXISTING REQUIREMENTS FOR INSURER DATA REPORTING AND LICENSING AND EMPLOYER ACCESS TO DATA SHOULD BE MAINTAINED.

5. THE ASSIGNED RISK POOL SHOULD BE RETAINED, BUT THE PREMIUM RATES APPLICABLE TO ASSIGNED RISKS SHOULD BE DETERMINED BY THE COMMISSIONER OF INSURANCE IN SUCH A WAY AS TO AVOID ANY ARTIFICIAL INCENTIVE TO INSURER REJECTION OF RISKS.

6. THE EXISTING REINSURANCE ASSOCIATION, SPECIAL FUND AND REOPENED CASE FUND SHOULD BE RETAINED.

7. EXISTING PROVISIONS REQUIRING ASSESSMENTS AGAINST OTHER WORKERS' COMPENSATION INSURERS IN CASE OF INSURER INSOLVENCY SHOULD BE RETAINED. A SIMILAR REQUIREMENT SHOULD BE IMPOSED ON SELF-INSURERS WITH RESPECT TO SELF-INSURER INSOLVENCY.

THE TRANSITION TO FULLY COMPETITIVE PREMIUM RATES IN WORKERS' COMPENSATION SHOULD BE STRUCTURED AS FOLLOWS:

1. THE PROVISIONS ABOVE SHOULD BE ENACTED TO TAKE FULL EFFECT AS OF JANUARY 1, 1988.

2. THE COMMISSIONER OF INSURANCE SHOULD BE FULLY EMPOWERED TO MAKE RULES, TO TAKE EFFECT JANUARY 1, 1983, WHICH WILL GOVERN A FIVE-YEAR TRANSITION TO FULLY COMPETITIVE WORKERS' COMPENSATION PREMIUM RATES.

3. THESE RULES SHALL SEEK TO REMOVE REGULATION OF WORKERS' COMPENSATION PREMIUM RATES IN SUCH A WAY AS TO PROVIDE EMPLOYERS WITH THE ADVANTAGES OF ECONOMIC COMPETITION, PRESERVE NECESSARY DATA DEVELOPMENT AND OTHER JOINT INSURER SERVICES, GUARD AGAINST INSOLVENCY AND UNPAID BENEFITS, AND DETER ANY INSURER OVERREACHING OR UNFAIR EXPLOITATION OF THE EMERGING MARKET SITUATION.

4. THESE RULES SHOULD CONTEMPLATE THE JANUARY 1, 1983, CONVERSION OF THE EXISTING REGULATED WORKERS' COMPENSATION PREMIUM RATES INTO ADVISORY RATES, WITH DEVIATION UPWARD OR DOWNWARD PERMISSIBLE WITHIN SPECIFIED LIMITS.

5. THE COMMISSIONER SHOULD MAKE REGULAR REPORTS TO THE APPROPRIATE LEGISLATIVE COMMITTEES BEFORE JANUARY 1, 1983, ON THE DEVELOPMENT OF THE RULES AND ON THE IMPLEMENTATION AND MODIFICATION OF THOSE RULES AFTER JANUARY 1, 1983. THE COMMISSIONER SHOULD INCLUDE RECOMMENDATIONS FOR ADDITIONAL LEGISLATION, INCLUDING ANTI-TRUST LIABILITY PRIOR TO 1988, IF SUCH LEGISLATION SEEMS NECESSARY TO ACCOMPLISH A FULLY COMPETITIVE WORKERS' COMPENSATION INSURANCE MARKET BY JANUARY 1, 1988.

6. THE COMMISSIONER SHOULD UNDERTAKE A MAJOR EDUCATIONAL EFFORT TO ACQUAINT EMPLOYERS WITH THE IMPLICATIONS OF COMPETITIVE WORKERS' COMPENSATION PREMIUM RATES AND WITH THE SPECIFIC TRANSITION RULES.

The Workers' Compensation State Fund Legislative Study Commission was created by the Laws of Minnesota 1979 Extra Session, Chapter 3, Section 67, to study and report on the feasibility of a state competitive fund to provide workers' compensation insurance. Following a thorough investigation of the public policy of workers' compensation in Minnesota, the conclusion of the majority of the members of the Study Commission is that the Minnesota Legislature should establish a competitive state workers' compensation insurance fund to begin underwriting workers' compensation insurance to private employers in Minnesota on July 1, 1984.

In addition, the Legislature should repeal the existing regulated rate system for workers' compensation insurance as of a future date certain and authorize the Commissioner of Insurance to take the appropriate steps, during the transition period, to phase in a competitive rate system similar to the file and use rate procedure used in other casualty insurance lines. The introduction of the Minnesota State Workers' Compensation Insurance Fund into the market in 1984 as recommended by the Study Commission will provide additional insurance capacity at the same time that competitive rates are being implemented in the Minnesota workers' compensation rating system. In the event that the deregulation of rates results in a rapid increase in rates in the private insurance market,

the Minnesota State Workers' Compensation Insurance Fund will assure the availability of coverage, as well as providing a control and counter-balancing force in the market as did the competitive state fund in Montana when that state introduced open rating.

To prepare for entering the market the state fund should be developed as an independent state agency commencing January 1, 1982, to administer the workers' compensation claims of the employees of the State of Minnesota, and that function should be removed from the Department of Labor and Industry. That new independent agency should make full use of modern innovations in claims handling techniques and should immediately commence a study to determine (a) what the actuarially sound premium should be for the State of Minnesota as a client of the State Compensation Insurance Fund and (b) what unfunded liabilities have been incurred in the past as a result of workers' compensation claims on cases that are still open or which may be reopened.

Funds for establishing the independent state agency to administer the State of Minnesota workers' compensation claims should be provided by the Minnesota Legislature as part of its responsibility to reform the state's self-insurance system. Funds to provide adequate surplus to fund the state compensation insurance fund when it begins selling insurance privately in 1984 should be loaned to the state compensation insurance fund by the Minnesota Legislature at the rate of interest the state currently obtains on other investments of this nature. The

state fund should present a report to the 1983 Legislature with a detailed plan for funding the unfunded liability for past workers' compensation claims. The state fund should negotiate with the State of Minnesota a fair and equitable premium rate for insuring the state's workers' compensation liability in the future. The State of Minnesota should guarantee the solvency of the fund only to the extent required by its own premium volume, but not beyond that. The State of Minnesota should be required to purchase workers' compensation insurance from the state fund after January 1, 1984, until the state fund has had adequate time to develop sufficient premium volume to support its activities as an efficient, competitive insurance agency.

I. MINNESOTA STATE WORKERS' COMPENSATION INSURANCE FUND

The primary consideration in the creation of this study commission was the diversity of opinions held by legislators, employers, labor and insurers regarding whether or not the State of Minnesota should establish a state fund to underwrite workers' compensation insurance policies in competition with the current private insurance providers. The majority of the members of the Study Commission is of the opinion that, given the historical problems associated with this line of insurance and the accompanying cost problems currently imposed on Minnesota employers, the state should provide such an option to Minnesota employers. A state fund would provide a competitive market mechanism which would ultimately benefit employees, employers,

insurers, and the comprehensive public policy of workers' compensation in the State of Minnesota. It would also provide a means of eliminating the unnecessary administrative expenses associated with private insurance to those employers who would find such an option desirable.

With the detailed experience of private insurers, the eighteen state funds in the United States, and the provincial funds in every province of Canada to draw from, there is no significant obstacle to the State of Minnesota establishing a fund which would equal the performance of the most effective and cost efficient workers' compensation insurer, whether state fund or private insurer. The success of state funds, in terms of claims management and lowest possible workers' compensation costs to employers, has repeatedly proven successful beyond doubt.

This is not the first time that the issue has been considered in Minnesota. The minority report of Senate Document No. 1* of the Minnesota Senate of 1921, advocated the creation of a state fund to compete with mutual insurance companies not operating for profit:

> "The two main parties to workmen's compensation are the employer who pays, and the injured workman who receives the benefits. The general public, or society, is only indirectly interested. It is self evident that if unnecessary cost for administration can be eliminated the injured workman may receive increased compensation without additional cost to the employer, or else that the employer will pay less for his insurance. The state fund, so called, is not insurance by the state, but

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* 1921 Minnesota House of Representatives Journal, p. 1787.

> merely state administration, at cost and without profit, of a mutual insurance company. The liability of workmen's compensation is a collective liability for all industry in the state coming under the scope of the act, and the insurance for such liability should be collectively administered, under the supervision of the state. This is a proper function of government, and differs in all essential respects from the project of state ownership and operation of business in general. The state, through the industrial commission, merely acts as a trustee to this collective fund, and administers it in accordance with the law, and takes no profit therefrom. The basic principle is 'that the compensation law is a workmen's compensation law, and not an employer's compensation law, nor an insurance company's compensation law.' It is enacted for the benefit of the injured workman, and the interests of every other person should be subordinated."

The problems addressed by this study commission have gone beyond the concern for adequate benefit payments to injured workers, to the current cost crisis encountered by the employers who pay premiums which are disbursed as benefits, administrative expenses and profits. The level of benefits for industrially injured workers in Minnesota now represent a reasoned response to living costs incurred by industrially impaired or handicapped workers in today's economy. This was not always the case in Minnesota. As recently as 1973 the maximum weekly benefit in this state was $80, and for the ten years from 1957 to 1967 the maximum weekly benefit remained at $45.

The establishment of the National Commission on State Workmen's Compensation Laws by the Occupational Safety and Health Act of 1970 created significant activity on the state level to increase the benefit structure and administration of state compensation programs, to avoid federal intervention. Of the 84 federal commission recommendations presented in 1973,

19 were considered "essential" benefit guidelines. The Minnesota Legislature took an aggressive stance toward benefit improvements during the mid 1970's, culminating in the passage of the 1979 workers' compensation act (Laws of Minnesota 1979 Extra Session, Chapter 3). Minnesota now complies with 16 of the 19 essential recommendations. More generous benefits have meant increased costs for Minnesota employers. The current cost problem is highlighted by comparisons to costs in our neighboring states.

Benefit levels in Minnesota were held at unrealistically low levels for too many years. The adoption of the essential recommendations and increased benefits were expected to result in increased costs. However, little indication was given that costs would escalate so rapidly. In 1970 direct written premium in Minnesota was under $80 million. By 1980 this figure had escalated over 500 percent to exceed $400 million. This dramatic increase in workers' compensation costs far exceeded the amount predicted by the Minnesota Workers' Compensation Rating Association (Bureau) when the benefit improvement bills were being considered by the Legislature. Having attained adequate benefit levels, the concern of recent legislative sessions has been how to deal with the unanticipated increases in costs now facing Minnesota employers. The initial step taken in 1977 was to create the Workers' Compensation Study Commission which reported in 1979 and initiated major reform. Subsequently, the intermediary insurance delivery system, which absorbs a significant portion of the workers' compensation

dollar, has been examined in greater detail by the current Study Commission.

Employers perceive workers' compensation insurance as a mandatory form of payroll-based taxation. Workers' compensation insurance premium payments now exceed the total Minnesota corporate income tax by more than $50 million per year, despite the fact that most of the largest corporations self insure their workers' compensation liability.

It is obvious that a significant "burden of proof" lies with those who advocate change from the present system. In Insurance Arrangements Under Workmen's Compensation, C. Arthur Williams, Jr., stated in 1969:

> "The Achilles heel of private workmen's compensation insurers is their expense ratio relative to that charged by the best State funds. Although this expense ratio is lower than that incurred in any other line of insurance except group disability income insurance, it is still higher than most observers, including many private insurance representatives, believe is desirable. Private insurers should, with a sense of urgency, investigate more efficient ways of marketing their product, particularly to smaller employers." (p. 207)

Williams also said, "(B)ecause workmen's compensation insurance is social insurance, private insurers should be expected to meet some special standards not imposed on them in other lines." (p. 210) It is at least arguable that with a 500 percent increase in costs over ten years, the industry should realize certain economies of scale in terms of the administrative expense of this line of insurance. This has not been the case. The fact that the 37 percent allowable expense ratio in workers' compensation is based on the experience

of the least efficient stock insurer provides a perverse method of reinforcing inefficient insurer operations. The insurance industry appears to have no incentive to hold down costs. Higher costs translate to higher profits and significantly higher investment return to the benefit of the insurance industry and to the detriment of Minnesota employers and employees. Increased competition in the workers' compensation market through the introduction of a state fund could provide the incentive to the private companies to implement "more efficient ways of marketing their product".

Testimony before the Study Commission by Norman Grosfield, a private attorney and former administrator of the Montana state fund, indicated that a major strength of a competitive state fund is its ability to act as a control on workers' compensation insurance costs. He stated that, "...the state fund acts as a control device in keeping the private carriers alert to the fact that somebody is watching and if they (private insurance rates) get too high, they (private insurers) are just not going to sell any insurance." This is exactly what occurred in Montana. The lower-cost insurance available from the competitive state fund forced private insurers, upon the insistence of the insurance agents, to review the rate structure established by the National Council on Compensation Insurance (NCCI). Within a period of a few years, private insurance rates for workers' compensation were reduced to a range more competitive with less expensive rates offered by the Montana

competitive state fund.

The primary advantage of the state fund systems is the surprisingly low expense ratio relative to benefits paid, or the cost of operation of such a fund. The expense ratio of stock insurance companies is roughly 37 percent. This means that in excess of one-third of every dollar collected in premiums goes for expense and profit. The expense ratio of mutual companies is approximately 22 percent. Comparable expense ratios for state funds typically run between eight and 21 percent, with the average for the competitive funds at 14.2 percent. A competitive workers' compensation insurance market, based solely on the disparities revealed in these expense ratios, could save Minnesota employers tens of millions of dollars annually.

In several of the competitive state funds investment income on loss reserves exceeds total expenses incurred, including loss adjustment expense. In such instances, the state fund can (1) pay a dollar (or more) in benefits for each premium dollar earned, (2) lower the employer's subsequent premium payments, (3) pay dividends, or (4) any combination thereof. As a result of the 1979 law, investment income is being considered in the current rate hearing proceedings for the first time in Minnesota history. With today's interest rates, the amount of investment income realized by an insurance company or state fund is indeed significant.

Testimony before the Study Commission indicated that an

insurer could realize a 90 percent investment return on a permanent total case reserve over the life of the claim. In state fund states such investment income is returned directly to the system to the benefit of employers' premium payments.

Many legislators and employers believe that the employers should be afforded a "no-frills, low cost option" of workers' compensation insurance. This will only occur with increased competition in the market through the creation of a non-profit state fund utilizing investment income to reduce premiums.

An example of the competitive low-cost insurance available from state funds is provided by a five-year comparison (1972-1976) (p. 78) of the experience of nine competitive state funds, private insurers which directly compete with those funds, and Minnesota private insurers. Earned premiums, incurred losses, dividends paid and retention were compared over the five-year period. Retention figures over a period of years provides a good indication of the relative overhead costs of this form of insurance, particularly from an employer's point of view.

Incurred losses represent losses paid and reserves established to pay future benefits. The loss ratio (incurred losses relative to premiums earned) of state funds averaged 83.3 percent for the five-year period. The average loss ratio of private insurers which compete directly with state funds was 68.2 percent. The loss ratio of Minnesota private carriers during this same time period was 60.9 percent. The consistently higher loss

ratio of private carriers in state fund states, as opposed to private carriers without such competition, appears to represent a benefit to employers directly attributable to increased competition.

While state funds were experiencing the highest loss ratio of the three systems, they also paid out the largest dividends. State funds, private carriers in state fund states, and Minnesota private carriers paid dividends of 12 percent, 7.9 percent and 7.4 percent, respectively for the five-year period studied.

By deducting the incurred losses and dividends paid from the premiums earned, the amount of money retained by the insurer (whether public or private) for profit and expenses represents an employer's view of the overhead costs of the insurance policy. Retention of state funds provides a dramatic example of why they offer lower cost insurance than private carriers. It also reinforces the opinion that state funds provide a competitive market mechanism to improve the efficiency of the private insurance sector.

Retention as a percent of earned premium was 4.7 percent for state funds for the five-year period. The private insurers in those states retained 23.9 percent of earned premium. During the same five-year period Minnesota insurers retained 31.7 percent of earned premium or $248.5 million. Assuming that the state funds affect the market behavior of private insurers within the same jurisdiction, employers and employees may benefit significantly

because a slight percentage change in retention could mean millions of dollars in savings.

A study examining the feasibility of establishing a state fund which was prepared for the Alaska Legislature reported that statewide savings from a state competitive fund might be 3 percent of total state premium. If such savings were to be realized in Minnesota, the state could benefit by as much as $15 million. Part of this savings is readily understood in terms of benefit ratios. C. Arthur Williams indicated that workers' compensation benefits relative to premiums earned less dividends on the average varied from $.64 on the dollar for the least efficient stock carriers to $.90 on the dollar for competitive state funds (p. 199). With the creation of a new state fund, this would not occur immediately, but the long-term effect of a state fund would ultimately offer Minnesota employers lower cost insurance.

The operation and administration of state funds is well beyond an experimental state. It is a proven method of delivering workers' compensation security in 18 states, Puerto Rico, the Virgin Islands, and all the provinces and territories in Canada. These funds are, in fact, specialists in the delivery of workers' compensation insurance and have developed efficiencies of specialization that are not found in multi-line, multi-state private insurers. The United States is the only modern industrialized country which provides for compensation security through a private insurance mechanism.

Frequent discussions surround the question of whether a state fund offers superior, equal or inferior service to that of private insurers. The insurance industry vociferously claims to provide superior service, but then offers the caveat that such service is often dependent on the size of the risk. On the other hand, in state fund states, employers are often the biggest defenders of the state fund system. In terms of promptness of payment and security of payment there appears to be little distinction between state fund and private insurer operations. In the areas of accident prevention and safety, private insurers devote more resources and have the benefit of nationwide experience. The superior service they can offer is primarily available to medium and larger policyholders. The shortcomings of certain state fund safety services are not a function of any inherent defect in the system. The best state funds do compete favorably with the best private insurers in this area. The role of safety services and accident prevention is logically a significant part of the whole theory and system of workers' compensation, and there is no reason why any such deficiencies would exist in the establishment of a state fund in Minnesota.

There have been no new state funds created since the Oklahoma fund in 1933. The creation of this fund was due to private insurer insolvencies during the depression. The Oregon fund has been the only state fund to change its essential nature, going from exclusive to competitive status in 1966.

Why have no state funds been created since 1933? Although the insurance industry claims that this is a reflection of the disregard held for state funds, the primary reason is that cost of workers' compensation insurance was not a significant problem until the recommended benefit increases of the National Commission on State Workmen's Compensation Laws were enacted. The cost crisis in compensation insurance has led the legislatures in Alaska, Georgia, Illinois, Kansas, Kentucky, and Minnesota to seriously consider establishing state funds.

During the 1979 session when the issue of establishing a state competitive workers' compensation fund was considered by the Minnesota Legislature, the most powerful argument in opposition to that proposal was the need for large amounts of money to be invested by the state for start-up costs. The proposal being presented by this Study Commission eliminates that problem. It comes about as a result of a consensus of a majority of the members of the commission that the current state administration of its own workers' compensation program is not the example to the other employers of the state that it ought to be. The State of Minnesota is the only employer of its size either insured or self insured which operates on a "pay as you go" basis without adequate reserves established for paying the liabilities being incurred as a result of employees' injuries. The unfunded liability of the state may exceed $5 million. In addition, the claims handling techniques of the state are characterized by the worst kinds of delay and inefficiency.

Regardless of what decision the Legislature makes on the

question of whether or not to establish a state fund, the State of Minnesota has a responsibility to correct this problem. Although there are many ways in which a solution may be sought, we suggest setting up an independent agency to take over the claims handling function of the State of Minnesota in order to introduce all the modern innovations in claims handling and rehabilitation techniques that we have been recommending to other Minnesota employers. In addition, this independent agency should go back to all the still open case files and establish proper reserving procedures so that the State of Minnesota will not have the massive unfunded liability that it has had up to now. This will be a large job and will require the hiring of experienced, well-trained claims adjustment staff and the establishment of modern electronic information systems. Once the job is completed, this independent agency will have excess capacity and valuable experience which it can turn to making insurance available to private employers in Minnesota on the same basis as the most efficient and successful state funds.

In the 1921 Legislative Study Commission report, a primary reason cited for opposing the creation of a state fund was the anticipated premium volume which such a fund could reasonably expect. At the time the total workers' compensation insurance premiums in Minnesota were approximately $2 million. Based on the market shares of the state funds at that time, a competitive Minnesota fund would realize between $80,000 and $980,000 in premium, or if an average degree of success were attained,

$260,000 in premium. The conclusion drawn by the majority of that Study Commission was that such a fund would not "have a sufficient premium income to operate economically". The commission therefore concluded that competition between stock and mutual insurers "ought to safeguard the public interests for the present, at least" (emphasis added). They went on to state, "...should experience demonstrate that the practices of insurance companies (have) become such as seriously to affect the interests of the employee or employer, as by unreasonably postponing payment of compensation or by charging excessive premiums, the state would be justified in entering the insurance field." (MN Senate Document No. 1, 1920, p. 1773) The majority of the current Study Commission is of the opinion that the public interest of the state would be better served by a comprehensive workers' compensation policy that provided an option to employers in the choice of insurance.

It is reasonable to question the ability of state government to operate more efficiently and effectively than the private sector. The few studies that have been completed indicate that state funds do compete favorably with all aspects of private insurance in the area of workers' compensation, and that state funds can do so at lower cost. The majority of the Study Commission finds that the goals of competitive funds - to provide maximum service to claimants and policyholders at minimal administrative expense, while also paying out the maximum benefits in relation to premiums - is an option Minnesota employers demand and deserve.

The majority of the Study Commission concludes that increased competition in workers' compensation insurance is inherently desirable and that such competition could be effectuated by the creation of a competitive state workers' compensation insurance fund. The market incentives resulting from state and private insurance competing for business would minimize the danger of complacency, promote higher standards, better service, reduce administrative expense, and, as a result, lower cost.

II. DEREGULATION OF WORKERS' COMPENSATION PREMIUM RATES

Workers' compensation insurance premium rates are the only insurance rates which continue to be regulated in Minnesota and in most other states. Other lines of insurance in which premiums were once fixed by a mandatory rate order, such as automobile insurance, have all been deregulated. Premiums (and services) in these lines are determined by the individual insurer in response to market pressures, subject to sanctions against clearly discriminatory, excessive or inadequate rates. Automobile insurance deregulation has generally resulted in more competition, lower premium rates and greater flexibility by insurers in meeting the varying needs of insureds. It has not resulted in any serious profitability or insolvency problems and loss prevention has not suffered. The same has been true of other deregulated insurance lines. Product liability and medical malpractice insurance,

two lines which have had recent "crises" in premium rates and availability far more serious than that in workers' compensation, are also deregulated. In these lines, too, pricing, service, availability and profit problems have been much alleviated through competition.

There is every reason to believe that the same advantages will result from deregulation of premium rates in workers' compensation insurance. Indeed, the U. S. Justice Department, in a report on the pricing and marketing of insurance, has concluded that there are many features of workers' compensation insurance which make it an even better candidate for deregulation than most of the other casualty insurance lines. This report concluded that "workers' compensation appears to be one line of (property-casualty) insurance which is perhaps most conducive to total state deregulation and full exposure to market controls." Three states, Illinois, California and Montana, have successfully introduced elements of competition in workers' compensation rates without ill effects.

The Commission recommends that Minnesota adopt the deregulation plan detailed at the outset of this report. This plan should introduce the advantages of competition to workers' compensation insurance while retaining sufficient regulatory authority during the transition period to prevent uncertainty or unfair exploitation of the new situation before market conditions and pressures are fully in place. The final competitive rate structure would also retain the important data

functions of the Rating Association and preserve the significant protections to employees and employers embodied in mandatory insurer participation in the Reinsurance Association, Reopened Case Fund, Assigned Risk Pool and Insolvency Guaranty Fund, while guaranteeing a free and competitive market in workers' compensation insurance rates and services.

Workers' compensation insurance rates have been regulated in Minnesota since workers' compensation was introduced as a system of industrial accident compensation in 1913. The central purpose of rate regulation has always been to avoid insurer insolvency by requiring "adequate" rates and in this fashion to guarantee that benefits would be paid. The admitted anticompetitive and monopolistic implications of regulated rates were thought to be acceptable given the dangers of insolvency. There were many good reasons why insolvency and thus "adequate" rates were the major public policy concern in workers' compensation insurance in the early twentieth century. Workers' compensation was an entirely new system of compensation, the first statutory entitlement plan in American history. How it would work and what financial burden it would impose on insurers was entirely problematical. Apart from the newness of the system, there were operational deficiencies among insurers which were not adequately monitored apart from the rate regulation apparatus. Companies were often under-capitalized; some wrote only workers' compensation insurance; some were badly managed; and professional and financial standards in some cases

were not very high. The rate regulation system thus served as a means to guard against the effects of poor insurer practices. In addition, apart from rudimentary reinsurance, a workers' compensation insurer in the early period assumed all liability. Since this liability was not diffused as it is under the current structure of secondary funds, mandatory reinsurance and insolvency assessments, the rate structure had to serve the main purpose of guaranteeing against insolvency by setting rates as high as necessary to do so.

The workers' compensation insurance business has changed a great deal since 1913 and those changes have all reduced the need for a rate regulation system geared to assuring "adequate" rates. The main outlines of the workers' compensation system, the basic rules of liability, are now well established. Though there are points of uncertainty and expanding liability, such as the occupational disease area, there is nothing like the wholesale unpredictability of a brand new system. Serious problem areas (such as black lung disease) seem certain to be addressed by separate legislation. Insurers, too, have overcome the earlier deficiencies which caused policy makers such concern. They are now highly capitalized and generally well managed. Actuarial and investment personnel in the industry have both attained high levels of professional competence and predictability. In addition, all companies are now multi-line companies, which greatly diminishes the potential impact of workers' compensation losses on a given firm. The Insurance Division, through data and financial requirements, licensing

and other regulatory tools, now has the means, without rate regulation, to assure that all insurers meet the general standards of the industry. Another significant change since the inception of rate regulation is the development of several loss distribution mechanisms which cushion the liability of individual insurers. These include the second injury fund and mandatory insurer assessments in case of insolvency. Most recently the risk assumed by individual insurers was dramatically reduced through the creation of the mandatory Reinsurance Association and the Reopened Case Fund. The potentially serious burden of workers' compensation liability is therefore made much more manageable and predictable. The need for an additional margin of safety by means of regulated "adequate" rates is therefore greatly diminished.

These changes in the workers' compensation insurance system have had the effect of transferring all of the original functions of the regulated rate system to other more appropriate vehicles in the workers' compensation system. These purposes, guarding against unpredictability, providing for the financial integrity of the system, assuring benefit payments, guaranteeing proper management and professional practices and protecting against extraordinary losses, would thus be more than adequately promoted under a competitive rate system. They are already being served by more effective means than rate regulation. All of those means - relative stability in the workers' compensation system, insurer reserves and professionalism, non-rate related

regulatory authority and extensive loss distribution mechanisms - would all be retained or enhanced under a competitive rate system. Together with the retained power of the Insurance Commissioner under a "file and use" rate system to disallow clearly inadequate rates, these safeguards will continue to assure that workers' compensation benefits are paid and that liability is manageable, without the excessive costs, delays, politicization and inflexibility of the regulated rate system.

The antiquated character of the regulated rate system has, in fact, been recognized by all concerned. In 1979 the Workers' Compensation Study Commission noted that annual workers' compensation premium volume was approaching $500,000,000 and that this premium represented the second greatest expense, after wages, in several lines of business. That Commission concluded that the rating process ought to be reformed so that those paying the premiums could be assured that the rates were not more than necessary. The Commission proposed and the Insurance Commissioner refined a plan for the transformation of the rate hearing into an adversary process in which the rate proposals had to be justified and could be challenged by interested parties, including the Insurance Division staff, and in which the Commissioner made an independent decision based upon all the testimony. It is no reflection upon the efforts of the Insurance Division and all the parties to say that this process has fallen far short of meeting expectations.

Rate regulation, as we have said, was designed to assure

that rates were high enough to avoid insolvencies and guard against unpredictability, deficient practices and unlimited liability. The way to do this is to decide what a comfortable rate would be and then add a margin of safety. There is no need in such a system to be terribly precise. Indeed, the very essence of the system is to deviate upward from whatever a precise analysis would indicate. This type of rate regulation, as we have said, is no longer necessary given the other institutional safeguards in the workers' compensation system. But it is at least technically possible to make rates in this way without insurmountable problems. The 1979 reforms were an attempt to make the rate system do something which was necessary, i.e., reduce rates to what a competitive market would generate, but was impossible to accomplish by means of the regulated rate system. This was an effort which had to be made and it should result in rates which are closer to those competition would yield. But we believe it is now apparent to all concerned that the regulated rate hearings are not conducive to the goal of developing rates which are equivalent to what competitive rates would be if we had competition. The only way to actually do this is to have competition.

The inability of the regulated rate process to accomplish the result sought in 1979 is essentially the problem of seeking competitive results through monopoly, though this is aggravated by the massive amounts of data and the limited resources which can be allocated to the process by most parties and also by the

Insurance Division, and by the politicization inherent in regualted rates. The result sought is rates which are no higher and no lower than necessary. This is a very precise goal, when compared to the "high enough and then some" goal of the earlier form of anti-insolvency rate making. Thus, the kinds and the volume of detail called for in the post-1979 rate process has grown enormously, as have the theoretical decisions which have to be made. The result has been a volume of testimony and detail which threaten to overwhelm the process and have certainly strained the resources of all concerned. The delays since the original filing have also been considerable. In addition, we must frankly say that there is great political pressure inherent in the regulated rate process. There is thus always the danger that rates may in some respects reflect the political clout of the parties rather than economic reality and thus cause either unnecessary costs or unnecessary reductions of services or denials of benefits.

However, the major reason why the regulated rate system, even as amended in 1979, cannot "fine tune" rates to competitive levels is simply that as long as there are regulated rates, we have monopoly rather than competition and the rates necessarily will be higher than they would be under a competitive regime. The reason for this is that, depsite all the data generated in rate making, the figures used are always averages of the efficient and the inefficient. The rates promulgated will necessarily provide higher than necessary profits to the most

efficient and "unearned" profits to the least efficient. The more efficient cannot (or at any rate have little incentive to) reduce their rates and the less efficient have little incentive to become more efficient. Thus, no matter how "low" the regulated rates, they remain higher than they would be if rates were determined in a free market in which the most efficient would reduce rates and force the less efficient to duplicate their efficiency, thus reducing average rates. Perhaps equally important, employers who were efficient in reducing losses would presumably be much better rewarded under competitive rates, thus reducing their own premiums as well as the overall cost of the system. Thus, the regulated rate system necessarily produces higher premium rates than would a competitive workers' compensation insurance market.

This form of state authorized monopoly has significant implications for other aspects of the workers' compensation system as well. An insurance company which insures for workers' compensation as well as other risks (as almost all do) will find that it has far more flexibility in the other lines. There it can reduce premiums to increase business, increase them where losses are higher than predicted and vary the level of services depending on the needs of insureds and their willingness to pay for those services. Since this flexibility is notably absent in workers' compensation, the effect is that more talented personnel and greater resources are allocated to other lines where they will have more impact. The result is far less innovative thinking and far less aggressive marketing

in the workers' compensation line.

The same problem is felt in the services insurers provide to employers in the areas of loss prevention and claims control. Though it is quite possible for competition to occur in services even though rates are regulated, the actual tendency is for services to become uniform - and sometimes perfunctory - throughout the workers' compensation insurance industry. Since no one is likely to attempt to bid an insurer's business away, the major incentive to a high level of service is absent. These tendencies are especially aggravated for smaller employers. In addition, the incentive to the employer himself to reduce losses and monitor claims is considerably reduced under a regulated system since he receives far less return for these efforts than he would under a competitive system, which would reward better risks more fully.

Why should competitive rates be adopted? The foregoing description of the deficiencies of the regulated rate system suggests most of the answers to that question. First, it is an unchallengeable economic fact that competition in a non-oligopoly market will result in lower costs for the same unit of production than oligopoly, and much less than absolute monopoly, which is what exists in workers' compensation. We tolerate regulated monopoly rates for telephone and power service, since these are natural monopolies which might otherwise abuse their position. But there are in excess of 200 workers' compensation insurers active in Minnesota, none of which has a market share greater than 8 percent. If competition

would cause some of these insurers to withdraw from Minnesota, it is likely to draw others to our state. The number of insurers and the $500,000,000 market at stake are sufficient to guarantee the cost advantages of competition to the employers and the employees of the state.

A second reason for adopting a competitive rate system is equity for small and medium-sized employers. Competition would simply extend advantages to smaller and medium-sized employers which larger businesses already enjoy. The largest firms in Minnesota currently may self-insure their workers' compensation liability. The fact that this option exists, together with the sheer volume of their business, results in competition for their premiums, through retroactive and dividend plans and in the service area, even in the context of regulated rates. The absence of competitive features in the market generally and the difficulty of self insurance, however, saddle the small and medium-sized employer with monopoly workers' compensation prices and service, without any alternative. The adoption of competitive workers' compensation premium rates would thus merely extend to hard-pressed small and medium-sized businesses some portion of the market leverage already enjoyed by the largest firms.

A third reason for adopting competitive rates is that competition will encourage - indeed require - that insurers improve, and vary, the services which they offer to employers in reducing losses and controlling and adjusting claims. Some

employers need more of these services than others. Some need some services, but not others. All complain about the current quality of these insurer services. Competition will result in more variation in the service packages which insurers offer because it will be a means to obtain business and because it will be possible to vary premiums depending on the services needed. Thus, competition should result in more innovations in services, higher quality of performance, more tailoring of services to employer needs, and a more equitable distribution of the cost of these services.

A fourth reason for adopting competitive workers' compensation rates is that they will result in more incentives to employers to reduce risks and control claims. Currently many employers feel that such efforts have little prospect of actually reducing their premiums. Competition for better risks will have the effect of increasing the premium reductions which result from better loss control. This will reduce the costs of those employers who reduce losses and provide appropriate responses to claims, thus encouraging safety and rehabilitation and reducing the overall cost of the workers' compensation system.

A number of arguments are raised against the deregulation of workers' compensation insurance rates, but we are persuaded that there are satisfactory responses to these criticisms. It is said that workers' compensation insurance rates should be regulated because workers' compensation insurance is required. Since the ultimate option available in the usual competitive

market - not buying the product at all - is not available to employers, it is argued that regulation of rates is necessary to protect employers. Several responses to this argument should be made. First, as we have seen, regulated rates do not appear to result in many advantages to employers, or at any rate the disadvantages far outweigh the advantages. Second, auto insurance is also legally required and several other forms of insurance (product liability and malpractice insurance, for example) are in practice obligatory, yet the premium rates in these lines are determined by competition without ill effects due to the mandatory character of the insurance. In auto insurance the existence of an assigned risk pool, rather than regulated rates, guarantees coverage to the insured. The assigned risk pool in workers' compensation serves the same function, quite apart from regulated rates.

Another argument put forward against competitive workers' compensation rates is that regulation is somehow necessary to protect the common data base and the common risk classification system. In response to this argument it should be noted that rating services, risk classifications and shared loss data are common in deregulated insurance lines and do not, in themselves, pose anti-competitive dangers. These systems would be preserved in our competitive rate recommendation, though individual insurers could modify an employer's risk classification or subdivide the classification for premium purposes.

A third criticism made of competitive workers' compensation premium rates is that they would reduce loss prevention efforts by

insurers. We believe this criticism is in error. Competition should, in fact, result in improved and more varied services to insured employers who need them (and less to those who don't) at commensurate premiums. As we have indicated, most employers complain that insurer loss control efforts are not currently very helpful. Competitive rates might have had the effect predicted if they had been introduced in 1913, but at current levels of insurer sophistication cost effective loss prevention efforts should be encouraged by competition. Since insurers will not be able to depend on regulated rates (and rate increases) to offset losses, the value of their own loss control efforts will appreciably increase. These efforts will both augment profits and increase the salability of the firm's insurance/service package. At the same time, uneconomic "courtesy" services will tend to be abandoned to everyone's advantage.

The major argument offered against rate deregulation is that regulation for "adequate" rates is necessary to provide against insolvency and unpaid benefits. As we have noted, this was the reason regulated rates were adopted in the workers' compensation system. However, since that time alternative and more effective means have been developed to provide against insolvency and extraordinary liability in the workers' compensation system. The second injury fund, mandatory insurer assessments in case of insolvency, the Reopened Case Fund, the Assigned Risk Pool and the Reinsurance Association all serve to distribute and cushion the effect of extraordinary losses and insolvencies

among workers' compensation insurers. These structures accomplish this result in a far more direct way than regulated rates. They permit us to abandon rate regulation and create significant cost savings and improvements in services and loss levels, while effectively guaranteeing that all benefits will be paid as due. The protection afforded by these back-up systems is augmented by the internal strength developed by the insurance industry since 1913. The capital reserves, management skills and professional competence of the 1980 insurance industry, reinforced and monitored by improved Insurance Division licensing and non-rate regulatory efforts, is a further safeguard against insolvency. To the degree that insolvencies are nonetheless unavoidable, it is far better for competitive pressures to bring about an orderly liquidation - with no unpaid benefits - than for the inefficiency of some insurers to be subsidized through higher premium rates for all employers than are otherwise necessary.

There are two further reasons why competitive pricing of workers' compensation insurance rates is likely to work very well. One is that workers' compensation is a statutory system. Unlike product liability rules, for example, which are court-determined and in continual upheaval, workers' compensation benefits and liability rules are largely statutory. Despite the criticisms of judicial "liberality" in workers' compensation, the fact remains that liability is largely predictable on the basis of specific legislative benefits. Thus, workers' compensation liability should be far more predictable than product

liability, malpractice or even simple negligence liability. The competitive pricing of workers' compensation insurance should therefore be at least as workable as the competitive pricing of those forms of insurance.

A final reason why competitive workers' compensation rates should afford ample advantages to the consumers of workers' compensation insurance has to do with the relative sophistication of those consumers. They are all employers. They are all accustomed to competition. They practice it themselves. They expect to find it among those who provide them with goods and services. The lack of competition in workers' compensation insurance has been the major cause of their dissatisfaction with the system. There is thus little reason to fear for the consumers of workers' compensation insurance under a competitive price system. If they are provided with adequate safeguards and information in the transition period, most employers ask for nothing less and nothing more than competitive prices for the workers' compensation insurance they must buy. Once they have competition, there is no reason to doubt that most of them will soon be able to use it to reduce their workers' compensation costs. Because of the panoply of new safeguards against unpredictability, extraordinary liability, insolvency and poor insurer practices, these competitive advantages can be introduced with the assurance that workers' compensation benefits will not be endangered in the slightest.

Respectfully submitted,

Senator Steve Keefe

Senator Jim Nichols

Senator Conrad Vega

Senator William Luther

Representative Wayne Simoneau

Representative Leo Reding

Representative Joseph Begich

PROPOSED LEGISLATION

A bill for an act

relating to workers' compensation; creating the Minnesota workers' compensation insurance corporation as a nonprofit public corporation; changing the procedure for the administration of compensation claims of state employees; appropriating money; amending Minnesota Statutes 1980, Chapter 176, Section 176.591, Subdivisions 1 and 3; proposing new law coded in Minnesota Statutes 1980, Chapter 176A; repealing Minnesota Statutes 1980, Sections 176.061, Subdivisions 8 and 9; 176.541, Subdivisions 2, 3, 4, 5, 6 and 8; 176.551; 176.561; 176.571; 176.603 and 176.611.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [176A.01] [DEFINITIONS.]

Subdivision 1. [APPLICATION.] For the purpose of sections 1 to 14 the terms defined in this section have the meanings given them.

Subd. 2. [BOARD.] "Board" means the board of directors of the Minnesota workers' compensation insurance corporation.

Subd. 3. [CORPORATION.] "Corporation" means the Minnesota workers' compensation insurance corporation.

Subd. 4. [FUND.] "Fund" means the workers' compensation insurance fund established pursuant to section 11.

Subd. 5. [MANAGER.] "Manager" means the chief executive officer of the Minnesota workers' compensation insurance corporation.

Sec. 2. [176A.02] [CREATION OF CORPORATION; BOARD OF DIRECTORS.]

Subdivision 1. [CREATION.] The Minnesota workers' compensation insurance corporation is created as a non-profit, public corporation.

Subd. 2. [BOARD OF DIRECTORS.] The corporation shall be administered and controlled by a board of directors consisting of six members appointed by the governor with the advice and consent of the senate. Each board member shall serve for a term of six years and shall hold office until a successor is appointed and qualifies.

The first members appointed shall serve terms which shall expire as follows: two on January 3, 1983; two on January 4, 1985; and two on January 6, 1987.

The board shall annually elect a chairman from among its members and may elect other officers as it deems necessary.

Compensation of board members, removal of members and filling of vacancies shall be as provided for state boards in section 15.0575.

Neither the board, any of its members, nor any officer or employee of the fund shall be held liable in a personal capacity for any act performed or obligation incurred in connection with the administration, management or operation of the corporation.

Sec. 3. [176A.03] [GENERAL POWERS.]

For the purpose of carrying out the specific powers granted to the board pursuant to sections 1 to 14 the board may exercise the following powers:

(a) It may sue and be sued;

(b) It may have a seal and alter it at will;

(c) It may adopt, amend and repeal bylaws, rules and procedures relating to its operation;

(d) It may enter into contracts;

(e) It may in its own name rent, lease, buy or sell property or construct or repair buildings necessary to provide space for its operations; and

(f) It may hire employees and set their compensation.

Sec. 4. [176A.04] [MEMBER OF RATING AND REINSURANCE ASSOCIATIONS.] Effective July 1, 1983, the board shall be a member of the workers' compensation rating association and the

workers' compensation reinsurance association.

Sec. 5. [176A.05] [TREATMENT AS STATE AGENCY.]

Subdivision 1. [EXEMPTIONS.] The corporation and the board are exempt from the following provisions applicable to other state agencies and boards:

(a) Rulemaking and contested case procedures pursuant to sections 15.041 to 15.051;

(b) Civil service and public employee bargaining provisions of chapters 43 and 179; and

(c) All provisions of chapters 16 and 16A.

Subd. 2. [ECONOMIC INTEREST DISCLOSURE.] Members of the board and the manager shall file statements of economic interest with the ethical practices board as provided in section 10A.09.

Sec. 6. [176A.06] [MANAGER.]

Subdivision 1. [APPOINTMENT.] The board shall appoint a chief executive officer, called the manager, who shall be responsible for the day-to-day operation of the corporation. The manager shall have proven successful experience as an executive at the general management level. The compensation of the manager shall be set by the board. The manager may be removed at the pleasure of the board.

Subd. 2. [BOND.] Before beginning the duties of the office, the manager shall qualify by giving an official bond in an amount and with sureties as approved by the board. The manager shall file the bond with the secretary of state. The premium for the bond shall be paid out of the fund.

Subd. 3. [POWERS.] The board may delegate any of its general or specific powers to the manager who shall exercise those powers subject to the direction and approval of the board.

Sec. 7. [176A.07] [ADMINISTRATION OF STATE CLAIMS.]

Subdivision 1. [PAYMENT BY BOARD.] Beginning January 1, 1982, the board shall administer all claims for compensation of state employees under chapter 176, including claims in which the loss was incurred or reported before January 1, 1982. The provisions of chapter 176 apply to claims administered under this subdivision. For the purpose of chapter 176 the board shall be treated as the insurer of state employees and the state

agency or department employing a claimant shall be considered the employer. Compensation due on state claims administered pursuant to this subdivision shall be paid from the state compensation revolving account upon warrants prepared by the board and submitted to the state treasurer.

Subd. 2. [REIMBURSEMENT BY AGENCIES.] The agencies and departments of the state shall reimburse the board for all claims paid to their employees pursuant to subdivision 1. At the end of each calendar quarter, the board shall notify each agency and department of the total amount due under this subdivision. The agency or department shall pay the amount due within 14 days of receipt of this notice. All amounts paid to the board shall be deposited in the state compensation revolving account.

Sec. 8. [176A.08] [INSURANCE OF STATE LIABILITY.]

Subdivision 1. [POWERS AND DUTIES.] Beginning July 1, 1983, the board shall insure the liability of the state to pay workers' compensation claims under chapter 176 for all losses incurred on and after July 1, 1983. The board may exercise all powers necessary and convenient to carry out the duties of an insurer under chapter 176 with respect to state claims. Not later than January 1, 1983, the board shall adopt bylaws and procedures for its operation including the form of policies of insurance which will be issued to state agencies and departments.

Subd. 2. [PREMIUMS; DETERMINATION AND PAYMENT.] Not later than January 1 of each year, beginning on January 1, 1983, the board shall determine an annual insurance premium for all state departments and agencies which is adequate to insure the workers' compensation losses incurred by the agencies and departments during the next fiscal year. The premium shall be calculated in accordance with workers' compensation insurance rates allowed under chapter 79 or rates otherwise established according to law. The premium shall be sufficient to pay the operating expenses of the board during the fiscal year and to establish adequate reserves for the full payment of losses incurred during the fiscal year as payment becomes due in the future. The premiums shall include an experience rating or

retrospective rating plan which is approved by the workers' compensation rating association for use by its members and which is approved by the board and the commissioner of administration.

The premium for each department or agency shall be separately calculated if the premium is credible. In order to provide for continuous accountability of claims experience for each agency and department, the board shall, for those agencies and departments without a separately calculated premium, devise a method for allocating the cost of the annual premium among those agencies and departments. Each state agency and department shall pay its annual premium or allocation of premium in advance to the board within 14 days after the beginning of the fiscal year to which the premium applies. Premiums paid pursuant to this subdivision shall be deposited in a separate state claims account in the workers' compensation insurance fund.

Subd. 3. [PAYMENT OF INSURED CLAIMS.] All claims insured under this section which the board determines to be due under chapter 176 or which it agrees or is ordered to pay pursuant to any proceeding under that chapter shall be paid from the separate state claims account in the workers' compensation insurance fund and may not be paid from any other assets of the fund.

Subd. 4. [PAYMENT OF OUTSTANDING STATE CLAIMS.] The board shall continue payment of state workers' compensation losses incurred before July 1, 1983, pursuant to the provisions of section 7.

Subd. 5. [LIABILITY OF STATE.] In the event that funds are insufficient to pay any workers' compensation claim which is due to a state employee as provided in sections 7 and 8 the board shall prepare a warrant for the amount due and present it to the commissioner of finance who shall pay the amount from any unencumbered balance in the general fund.

Sec. 9. [176A.09] [STUDY OF STATE CLAIMS EXPERIENCE.]

The board shall analyze the workers' compensation claims experience of state agencies and departments during the five fiscal years ending July 1, 1982 in order to determine actuarially sound premiums for insurance policies issued to

state agencies and departments pursuant to section 8, subdivisions 1 to 3.

The board shall also determine the total estimated incurred workers' compensation losses of the state that are outstanding as of July 1, 1983, and shall formulate a plan for the full funding of reserves necessary to pay those losses. Not later than February 1, 1983, the board shall submit this plan to the legislature for its consideration.

This section is repealed July 1, 1983.

Sec. 10. [176A.10] [AUTHORITY TO INSURE OTHER EMPLOYERS.]

Subdivision 1. [POWERS.] Beginning July 1, 1984, and subject to the provisions of this section, the board may insure any public or private employer against liability for workers' compensation claims of their employees under chapter 176. Subject to the provisions of this section, the board may exercise all powers necessary and convenient to conduct a workers' compensation insurance operation. The board shall adopt bylaws and operating procedures for the conduct of its insurance operation.

Subd. 2. [SUBJECT TO LICENSING AND REGULATION.] The board shall not begin operations as an insurer under this section until it has met the requirements of chapter 60A for licensing of a stock company writing workers' compensation insurance. Sections 1 to 14 shall be considered the certificate of incorporation of the board. Except as provided in section 12, subdivision 1, the insurance operations of the board are subject to all of the provisions of chapters 60A and 60B. The commissioner of insurance has the same powers with respect to the board as he has with respect to a private workers' compensation insurer under chapters 60A and 60B. The board shall be considered an insurer for the purposes of chapters 79 and 176. With respect to the operation and procedures relating to state claims pursuant to sections 7 and 8, the regulatory provisions of chapters 60A and 60B, and sections 79.28 to 79.32 shall not apply.

Subd. 3. [PREMIUMS.] The board shall charge the lowest insurance premiums possible, including any dividend plans, which

are consistent with the maintenance of adequate reserves, the solvency of the fund and the ability of the fund to meet the anticipated demand from employers for insurance coverage.

Subd. 4. [STATE LIABILITY.] The insurance operation of the board shall be supported entirely out of the assets of the fund. Except as otherwise provided for state claims pursuant to section 8, subdivision 5, the state is not liable for any obligations of the board.

Sec. 11. [176A.11] [WORKERS' COMPENSATION INSURANCE FUND.]

Subdivision 1. [CONTENTS OF FUND; EXPENDITURES.] The workers' compensation insurance fund consists of all insurance premiums paid to the board, all money, securities and property owned by the board and all interest and investment income earned on money, securities and property owned by the board. All claims paid pursuant to policies of insurance written by the board shall be paid from the fund. All expenses of administration related to the insurance operations of the board, including taxes and fees payable by the board and the expense of audits, surveys and reports required by law, shall be paid from the fund. Except as provided in this subdivision, no other expenditures shall be made from the fund.

Subd. 2. [CUSTODIAN.] The board shall be the custodian of the fund. No assets belonging to the fund shall be required to be deposited in any fund in the state treasury.

Subd. 3. [INVESTMENT.] The board may invest and reinvest the assets of the fund which are in excess of current operating requirements in the same manner and to the same extent as provided in chapter 60A for a stock company writing workers' compensation insurance.

Subd. 4. [DEPOSITS.] Any money in the fund which is in excess of current operating requirements and not otherwise invested, may be deposited by the board from time to time in financial institutions authorized by law to accept deposit of public money.

Sec. 12. [176A.12] [FEES AND TAXES.]

Subdivision 1. [FEE IN LIEU OF PREMIUM TAX.] The board shall pay a fee in the amount that would have been due if the

board were subject to the tax imposed in section 60A.15. The fee shall be paid in the same manner as the tax imposed in section 60A.15 is paid by a domestic stock insurance company.

Subd. 2. [PROPERTY TAX.] The board shall not rent, lease or otherwise locate in any property which is not subject to local property taxation. Any real property owned by the board is subject to local property taxation.

Subd. 3. [TAX EXEMPTION.] Except as provided in subdivision 2, the board and the corporation are exempt from all state and local taxes.

Subd. 4. [FEDERAL TAXES.] The board shall take all steps necessary and proper to qualify the corporation for exemption from federal taxation.

Sec. 13. [176A.13] [REPAYMENT TO GENERAL FUND.]

The board shall repay, over a period of five years beginning July 1, 1984, to the general fund in equal installments, the amount appropriated to it in section 18, subdivision 3. The first payment shall be due on July 1, 1985. The amount to be repaid shall include interest at the average rate as is earned by the state board of investment for all investments.

Sec. 14. [176A.14] [AUDIT, SURVEY AND REPORTS.]

Subdivision 1. [AUDIT AND SURVEY.] The financial affairs of the corporation shall be audited annually by an independent auditor selected by the commissioner of insurance. An actuarial survey shall be conducted annually on the insurance operations of the corporation by an independent actuary selected by the commissioner of insurance.

Subd. 2. [REPORTS.] The board shall prepare and submit an annual report to the governor and the legislature not later than November 15 of each year, beginning November 15, 1982, concerning the financial status of the corporation, progress in implementing the legal powers and duties of the board and recommendations for legislative action.

Sec. 15. Minnesota Statutes 1980, Section 176.591, Subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT.] To facilitate the

discharge by the state of its obligations under this chapter, there is established a revolving fund to be known as the state compensation revolving fund.

This fund is comprised of the unexpended balance in the fund on ~~July 1, 1935~~ January 1, 1982, and the sums which the ~~several~~ departments of the state pay to the fund.

Sec. 16. Minnesota Statutes 1980, Section 176.591, Subdivision 3, is amended to read:

Subd. 3. [COMPENSATION PAYMENTS UPON WARRANTS.] The state treasurer shall make compensation payments from the fund only as authorized by this chapter upon warrants of the ~~commissioner of the department of labor and industry~~ workers' compensation insurance board.

Sec. 17. [IMPLEMENTATION.]

The first members of the board of directors of the workers' compensation insurance corporation shall be appointed not later than August 1, 1981. The board shall act promptly to select a manager, hire necessary employees and acquire necessary facilities and supplies to begin operation as required by section 7 on January 1, 1982. The board shall begin the study required under section 9 not later than January 1, 1981.

Sec. 18. [APPROPRIATION.]

Subdivision 1. The sum of $1,500,000 is appropriated from the general fund to the board of directors of the Minnnsota workers' compensation insurance corporation for expenditures necessary to implement the provisions of sections 1 to 9, 14 and 17. This appropriation is available until July 1, 1983.

Subd. 2. The sum of $1,000,000 is appropriated from the general fund to the board of directors of the Minnesota workers' compensation insurance corporation for expenditures necessary to implement the provisions of section 9. This appropriation is available until July 1, 1983.

Subd. 3. Effective July 1, 1984, the sum of $1,500,000 is appropriated to the board of directors of the workers' compensation insurance corporation for use as capital and surplus in the insurance operations of the corporation authorized by section 10.

Subd. 4. In accordance with the transfer of the operation of state workers' compensation claims from the department of labor and industry to the board of directors of the Minnesota workers' compensation insurance corporation there shall be a reduction by ten of the approved complement of personnel for the department of labor and industry.

It is intended that these positions be taken from the functions related to state employee workers' compensation claims of the audit and claims processing activity of the department of labor and industry.

Appropriations for salaries, supplies and expenses required for these positions are cancelled to the general fund.

Sec. 19. [REPEALER.]

Minnesota Statutes 1980, Sections 176.061, Subdivisions 8 and 9; 176.541, Subdivisions 2, 3, 4, 5, 6 and 8; 176.551; 176.5661; 176.571; 176.603 and 176.611 are repealed.

Sec. 20. [EFFECTIVE DATE.]

Sections 15, 16 and 19 are effective January 1, 1982. Sections 1 to 14, 17 and 18 are effective July 1, 1981.

MINORITY REPORTS

MAINTAINING THE CURRENT WORKERS' COMPENSATION INSURANCE DELIVERY SYSTEM

The creation of this study commission resulted from the diverse views of the members of the 1979 Legislature as to whether or not the state should engage in the business of selling workers' compensation insurance in competition with private stock and mutual insurance companies. It is the opinion of the undersigned members of the commission that the interests of Minnesota employers and workers would not be well served by the intrusion of the state into a commercial enterprise of this nature.

There are three basic reasons for reaching this decision. First, other factors are more important in creating the high workers' compensation costs in Minnesota. These problems should be addressed before undertaking any experimental venture with a state fund. Second, the need for and benefits expected to be derived from a state fund have not been demonstrated. Third, an examination of the operation of state funds clearly demonstrates that they are not the solution. Instead, they have a tendency not only to create additional problems, but a potential to add costs to the system.

Since its inception in 1913, the workers' compensation system in Minnesota has been periodically reformed. The impact of such reform has not always been adequately reviewed to determine cost impact, particularly during the last decade. The current attempt to create a state insurance fund is being made at the expense of Minnesota employers by delaying an in-depth examination of the actual reasons behind the high costs associated with this line of insurance in Minnesota.

Although a state fund is being offered as a panacea to the ills of the Minnesota workers' compensation system, the actual maladies of the system were addressed in a much more direct fashion by Mr. Hugh Russell of the Wisconsin Department of Labor and Industries and Human Relations before the previous Workers' Compensation Study Commission:

> "Many things can technically be said about setting insurance rates. Basically, insurance rates are a reflection of what is actually going on within the system -- what it costs, what the injuries cost, how much it costs to administer them. There are basically about five different ways in which you can directly affect the cost of the operation of the system and have that reflected in the insurance rates. That's in the area of safety, the injury that does not happen does not cost anything. You can affect it by reduction of benefits, overall or selectively. You can affect it by the evaluation of disabilities under the system. You can affect it by the prompt re-employment or rehabilitation of the people who are injured. You can affect it by dealing with the cost of litigation and litigation is the expensive part of the process." (Emphasis added)

A comprehensive review of the five specific subject areas presented by Mr. Russell could have a more dramatic and lasting effect on the workers' compensation system of this state than the establishment of a state-operated insurance facility. Safety, benefits, evaluation of disability, rehabilitation and litigation are five areas of the compensation system that have a direct affect on costs in the Minnesota system. The Legislature should conduct a comprehensive review of these five areas in terms of current costs to determine what changes in the system could most effectively reduce those costs. Implementing reform in these areas would again make the cost of workers' compensation insurance in Minnesota

comparable to our neighboring states, whose industries experience considerably lower workers' compensation costs. The Workers' Compensation Study Commission Report to the Legislature in 1979 recommended several changes in these specific areas which were enacted into law. Their effort should be commended, but it is generally felt that they did not go far enough. It is the Minnesota law which is reflected in the high costs of workers' compensation in this state. The insurance delivery system is not responsible for the excessive statutory provisions enacted by the Legislature. This is exemplified by the fact that, for all practical purposes, the same private insurers are underwriting workers' compensation in Minnesota and in Wisconsin. To assume that the private insurers behave differently once they approach the St. Croix or Mississippi River Valleys can only be explained by their response to statutory provisions which mirror the jurisdictional differences in cost.

The state should not enter the arena of private enterprise unless a demonstrable and compelling need for the intervention is firmly established. The need has not been established by this commission. If the security of payments to compensation beneficiaries were jeopardized due to the absence of financially secure private insurance carriers, the state might be justified in establishing a security measure, such as a state fund, to guarantee the payments.

The security of workers' compensation payments in Minnesota has never been in question because insurer insolvency has never been a problem in workers' compensation insurance in Minnesota. Even one insolvency could cause severe problems and hardships for employers and injured workers. The excellent solvency record of

Minnesota insurers is attributable to the statutory provisions enacted by the Legislature and implemented by the Division of Insurance.

In this era of fiscal restraint, budget deficits and demands for less government, it would be imprudent to burden the taxpayers of this state with the costs and potential problems associated with the establishment of another department in the state bureaucracy unless the need for it and benefits to be derived are clearly established.

This point of view regarding a change in the workers' compensation insurance delivery system was persuasively articulated by C. Arthur Williams, Jr., in Insurance Arrangements Under Workmen's Compensation. He stated, "With the high cost of making a change, however, and other matters in more urgent need of attention, unless the State's population is philosophically disturbed by its present arrangement, no compelling case can be made for changing an existing system." (p. 207)

Creating a state fund would, by implication, accuse the insurance industry of being responsible for the high workers' compensation costs in this state, while ignoring other more important problems. In the debate over the establishment of a state fund, little or no documentation has been provided regarding the actual benefits of such a change. Significant amendments agreed upon blindly could compound the current workers' compensation problems of Minnesota employers. Serious questions have been raised regarding the potential benefit to be gained through the creation of a state fund. For instance, the cost of establishing a state fund is unknown.

The danger of relying on the vague cost projections which could potentially accompany the establishment of a state fund was provided as recently as 1979. The Minnesota Workers' Compensation Reinsurance Association (MWCRA) (M.S. 1979 Supplement, Chapter 79.34) requires that all workers' compensation insurers and self-insurers in Minnesota be members of the MWCRA for the purposes of reinsuring any claim in excess of $300,000, or $100,000 at the option of the insurer or self-insured employer. The MWCRA is prohibited from funding a reserve in excess of $500,000. A simulation model that the MWCRA uses for rate-making purposes indicates that they may be operating with an unfunded liability (over the $500,000 reserve limitation) of $50-$75 million on an undiscounted basis. This is, of course, a preliminary estimate that could be subject to considerable statistical error, but the ability of the system in the future to meet the obligation created by this liability has not been fully considered.

The claimed cost savings to be realized from a newly established fund are also suspect. The Reinsurance Association has effectively removed the "long tail" or extended payout period and large case reserves previously maintained by individual private insurers. Questions regarding the reserving practices of insurers and the amount of investment income realized on those reserves were the basis for the establishment of this reinsurance mechanism. It must be understood that if a state competitive fund is required to be a member of the Reinsurance Association, the amount of investment income realized on case reserves would be significantly

less than any other state fund has realized. Investment income would also be much smaller in comparison to other state funds because a new state fund would not have 60 years of investment experience upon which to draw. Thus, lower cost insurance to Minnesota employers would only apply to the possible elimination of acquisition costs, and that would be solely at the expense of Minnesota's salaried or independent insurance agents.

Several other cost questions remain unanswered. What start-up funds would be necessary to establish a capital account? How much for a surplus account? Would this money be repaid, and if so, at what interest rate, or would the fund be subsidized by all state taxpayers? What is the potential benefit to employers of such a fund in dollar terms?

Another of the goals state fund proponents hope to achieve is increased competition in the workers' compensation insurance market. Increased competition may be a desirable goal, but creating a state fund is not the sole method of achieving that goal. Workers' compensation rates have been under an existing regulatory mechanism for 60 years. A separate proposal to establish open price competition, as opposed to regulated rates, is now receiving considerable support from some groups and individuals. Prior to the establishment of any state insurance fund, market competition based on price should be afforded every opportunity to develop between those private companies that already have experience marketing and servicing such a highly specialized product. Significant competition currently exists in the market through such mechanisms as dividends, retrospective rating, and experience

rating to those employers who qualify. The Legislature should examine methods of introducing even more competition into the market through traditional methods of market incentives.

In addition, no facts currently exist which would warrant the establishment of a state insurance fund specifically writing a single line of insurance within a single state. This conclusion has been recognized by other states. The last state to enact such legislation was Oklahoma during the height of the depression, 47 years ago in 1933. If Minnesota were to begin to underwrite this form of "mandatory" insurance, some individuals would find good reason for the state to underwrite other mandatory lines as well, such as automobile insurance.

A review of the operation of the existing state funds in several instances has displayed weaknesses inherent to the operation of government in business.

The primary concern in the operation of any workers' compensation insurance mechanism, whether private or state-operated, is the security of payment to the industrially injured. In several instances, both competitive and monopolistic state funds have been criticized for operating in a less than financially responsible manner and, in some instances, failing to adhere to proven actuarial standards. As recently as October, 1979, the Pennsylvania Commissioner of Insurance testified that the competitive State Workmen's Insurance Fund (SWIF) was in "...precarious financial condition...", "...operating on the brink of insolvency...", and "...in dire need of improved management based on sound actuarial methods". C. Arthur Williams, Jr., reported that "two competitive state funds

were technically insolvent in 1966 with a negative policyholders' surplus ratio...".

The most dramatic example of financial mismanagement was the 1978 report that the monopolistic Ohio state fund had incurred an actuarial deficit of $1,300,000,000. During this time the Ohio fund was also subject to extensive fraud and mismanagement. A study conducted by Arthur Anderson and Company indicated that an attempt to audit the records of the Ohio fund with generally accepted auditing principles could not be completed for the years as recently as 1977 and 1978.

In explaining why the rates of the monopolistic fund in the State of Washington had risen so dramatically during the period of 1975 to 1978, a labor leader from that state explained that "we had a political manipulation, which is possibly one of the unfortunate attributes of a state fund operation".

It is in the area of service to policyholders that state funds are most commonly criticized for not delivering the quality of service available through private insurance. The private insurance industry places strong emphasis on service to its policyholders. In the specific instance of workers' compensation insurance, the services provided by private insurance to employers and injured workers alike have proven superior in the areas of claims management and administration, timeliness of benefit payments, safety services, medical care, and rehabilitation. Private insurance companies play a leading role in developing industrial safety standards. Nationwide experience of the insurance industry provides a broad base of specialization in technical areas such as industrial hygiene and occupational health. The ability to

implement innovations in claims administration, claims management and claims adjusting is another advantage not available to a single-line insurer. The broad expertise and innovative services provided by private insurers are not economically feasible for a governmental insurance fund operating within the boundaries of a single state.

The monopolistic funds are commonly and severely criticized for providing minimal service to policyholders. Since these funds are statutory monopolies and lack competition, they have no fear of losing business. They also have no incentive to improve their services. Such systems often force employers to hire professional administrative service organizations at extra cost to the employer.

In many instances the competitive state funds fare no better. The Colorado fund has experienced dramatic premium growth. At the same time it has had an extremely difficult time convincing the Colorado Legislature to increase its staff complement. The result has been the establishment of a "claims mill" which may approve illegitimate claims or refuse legitimate claims due to insufficient staffing and claims investigation. This provides slight reassurance to employers and even less to those individuals with legitimate claims who may be subject to long delays or no compensation payments whatsoever. The potential impact of the whims of the Legislature or the potential liability involved in an irresponsible Legislative mandate could have a serious negative impact on the operation of a state insurance facility.

State funds are not a viable alternative for multi-state employers. These employers can be afforded the option of a multi-state or all-states endorsement by private insurers who provide coverage under one policy regardless of where the employee may be located.

Furthermore, several state funds do not offer employers' liability insurance to protect employers against claims from third parties which result from work-related injuries. Given this situation, an employer must purchase additional insurance from a private carrier. A similar situation may occur with regard to workers covered by the federal Longshoremen's and Harbor Workers' Act. In instances such as these, private insurance provides the employer with the sole alternative to unnecessary and duplicative paperwork.

A definitive comparison of state versus private workers' compensation insurance is virtually impossible due to the diverse jurisdictional requirements imposed on this form of insurance in terms of benefits and administration of the laws. There is, however, in some state fund jurisdictions an indication that the state fund may actually increase real costs, provide inequities in the distribution of cost, and require taxpayer subsidization. For example:

- Ohio employers must pay 8¢ per $100 of covered payroll to finance the Disabled Workers Relief Fund and the administrative cost of the state fund.
- Employers in Ohio must pay 90 percent of the administrative cost of the fund and general tax revenues provide the remaining 10 percent.

- Employers in many state fund jurisdictions must hire professional service organizations (incurring costs in addition to their workers' compensation insurance premium) to provide services not available from the fund.
- The medical aid fund in the state of Washington is paid equally by employers and employees. This violates the basic concept of workers' compensation which provides that industrial injury costs are part of the cost of production.
- The largest portion of the savings which may be realized by the establishment of a state fund is in acquisition costs. This perceived savings is achieved at the expense of independent agents and sales personnel. This is, in effect, a transfer of certain dollars and elimination of dollars and jobs in the private sector, including the subsequent decline in tax revenue.
- The absence of the services provided by agents may further substantiate the need for an employer to hire a professional service organization at extra cost.
- Many state funds do not pay premium taxes.
- Many state funds do not pay real estate taxes.
- No state funds pay federal or state income taxes.
- The fact that a state fund may not pay taxes implies a general population subsidy because the loss of tax revenue must be compensated by additional tax revenue or reduced state service.

- If the establishment of a state fund caused any insurers to leave the state, the tax base would erode further.
- Any jobs created by the establishment of a fund would be at the expense of private employment with commercial insurers and independent insurance agents.
- The argument that a state fund could affect rates significantly is unconvincing in view of the fact that rates are regulated by the State Insurance Division to assure that they are not excessive, inadequate or unfairly discriminatory.

Although a variety of specific reasons exist for opposing the creation of a state compensation insurance fund, the principal reason is financial. There have been no specific figures provided that would document the start-up costs necessary to establish and finance such a fund. More importantly, the undersigned members of the Commission strongly disagree with the conclusion of the majority of the Commission, that the financial implications of the establishment of a state fund would provide any benefit whatsoever to the employers and workers in the State of Minnesota.

The workers' compensation system in Minnesota is in need of serious review and revision. The emphasis of such a study should concentrate on industrial safety, the benefit structure, the evaluation of disability, reemployment and rehabilitation, and litigation. If the Legislature is to reduce the costs of workers' compensation in Minnesota, the costs represented by these specific areas need to be determined. Only the Legislature can affect the workers' compensation costs borne by Minnesota employers. This can only be done through a comprehensive review and revision of the

previously enacted statutory provisions of workers' compensation in Minnesota which have proven so costly. That some individuals now propose a cosmetic approach to the costs of the system, will serve no constructive purpose other than to delay the inevitable revision suggested above.

The history of mismanagement and questionable financial practices of several state funds makes such a state operation very circumspect. To enact such a significant law amendment with no documentation of benefit to the system, is an arbitrary and capricious approach to a problem in need of definitive analysis and constructive change. A comprehensive review, as suggested above, would ultimately benefit Minnesota employers and workers to a much greater degree than the establishment of a state fund. The costs involved in establishment of a state fund, benefits in terms of workers' compensation costs, have not been established. Such determinations should logically precede a fundamental restructuring of an established and proven insurance delivery system.

Respectfully submitted,

Representative John R. Kaley

Representative O. J. Heinitz

Representative Tony E. Stadum

Senator Nancy Brataas

Senator Roger Laufenburger

MINORITY RECOMMENDATION: THE MINNESOTA LEGISLATURE SHOULD REPEAL THE EXISTING REGULATED RATE SYSTEM FOR WORKERS' COMPENSATION INSURANCE AND IMPLEMENT A COMPETITIVE RATE SYSTEM SIMILAR TO THE FILE AND USE RATE PROCEDURES USED IN OTHER CASUALTY AND LIABILITY INSURANCE LINES, BUT SHOULD NOT ESTABLISH A STATE COMPETITIVE INSURANCE FUND TO PROVIDE WORKERS' COMPENSATION INSURANCE TO PRIVATE EMPLOYERS.

The majority of the members of the Study Commission have recommended that the Legislature deregulate workers' compensation insurance rates and that it create a state workers' compensation insurance fund in the private market. The undersigned believes strongly that competitive rates in workers' compensation, with appropriate limitations, will serve to reduce prices, improve services and increase options for employers, without endangering the payment of benefits. I therefore join in that portion of the majority report which recommends the deregulation of workers' compensation insurance rates. I strongly oppose, however, the creation of a state workers' compensation insurance fund. Such a state fund would represent an unwarranted government intrusion into the private sector and would be altogether unlikely to have any significant impact on prices. A state fund would certainly provide worse services than a private insurer and would be unlikely to scrutinize claims adequately. Such a fund would be subsidized by taxpayers and would represent standing temptation to tamper politically with rates and benefits or to operate without adequate reserves to pay benefits. I

therefore strongly oppose the creation of a state workers' compensation insurance fund and join in the minority recommendation that such a fund not be created.

The means to implement competitive rates in workers' compensation insurance and the arguments for doing so are addressed at length in part II of the majority report and I will not attempt to recapitulate them. I will say, however, that since I began seriously to work on the issue of workers' compensation two years ago I have been convinced that competitive rates are the only reform which can hope to streamline the workers' compensation delivery system and reduce costs. I introduced a bill to begin discussion on this issue during the 1979 session. Much additional research has since been done and many constructive comments have been made by the insurance commissioner and others concerned about workers' compensation rates. I am now confident that deregulation of workers' compensation rates can be accomplished, perhaps even more quickly than the majority report contemplates, and that the results will be lower prices and better services for all employers.

All other insurance lines have long been deregulated in most states and Illinois, Montana and California have successfully introduced elements of competition in workers' compensation rates. The U.S. Justice Department has concluded that workers' compensation rates are more "conducive" to deregulation than most other insurance lines. The National Association of Commissioners of Insurance has been interested in deregulation of workers' compensation insurance rates for

some time. A major Governor's Task Force in Oregon has recently recommended deregulation of workers' compensation rates there.

Competition and deregulation are clearly the direction which workers' compensation rate reform is taking across the country. The majority report clearly indicates that fears about insolvency, unpaid benefits or increased rates under a competitive system are unfounded. Our workers' compensation system will continue to provide ample guarantees against insolvencies and unpaid benefits. Careful review of insurer practices, including bans on rates which are inadequate, excessive or discriminatory, will also continue. Competitive rates will reduce prices just as they do in every other type of business. Expanded state anti-trust liability will protect against monopoly practices after deregulation and the forces of competition will thus assure that prices go down for most employers. A careful, staged transition will assure that everyone enters competition with their eyes open and that no unfair exploitation of changed conditions occurs. With rates removed from the regulatory and political arena they will be determined by the market and will thus reflect the genuine cost of providing scheduled workers' compensation benefits. If costs still seem high we will know that the benefit structure itself, not the delivery system, is the reason and the way will be clear to make hard decisions about which benefits we can and which we cannot afford to provide.

In contrast to the nationwide movement toward deregulation of rates, no state has created a state competitive fund since

1933. In 1966 Oregon reduced its state workers' compensation fund from a monopoly to a competitive fund. The existing state competitive funds are plagued by poor services, bad management, fiscal problems, questionable rate and claims practices and outright fraud. Their sometimes lower rates reflect these factors, together with significant subsidies from the taxpayers. In addition, some state funds rates are artificially lower because of investment income on reserves which most of them have been accumulated for more than 50 years. Obviously, a Minnesota competitive fund would have no such reserves to draw on.

The creation of a state workers' compensation insurance fund in Minnesota would involve untold millions in "start-up" costs and additional taxpayer subsidies in the form of forgone tax revenues. It would involve the state, whose own workers' compensation claims record is notoriously bad, in handling private employers' workers' compensation liability. It would mean the creation of a new, underfunded, untried insurance company at the same time that rates are being deregulated, with very likely ominous results. Such a state fund would not mean lower prices, unless they were paid for through poor services, fiscal irresponsibility or political meddling.

It would be a grave mistake to create a state workers' compensation insurance fund in Minnesota and a bad precedent for other independent businesses who might soon be faced with a state competitive truck company or state competitive farms.

Creating a state fund at the same time that we undertake a more promising change, introduction of competitive workers' compensation rates, is likely to complicate and undermine deregulation reform. Since competitive rates are the only real solution and since the state fund is both a bad idea in itself and a threat to the success of deregulation, I oppose the creation of a state competitive fund.

Respectfully submitted,

Representative Tony Stadum

EXHIBITS:

STAFF PAPERS

THE ENACTMENT OF WORKERS' COMPENSATION LEGISLATION

Workers' compensation was originally designed as a no-fault system of providing benefits in the form of wage replacement and medical care to the victims of industrial-related injuries. The financing of the system is provided by employers' insurance premium payments which are ultimately included in the price of a finished product and eventually borne by the consumers of that product.

Germany established the first modern compensation system in 1884. Maryland was the first state to adopt the principles of workers' compensation in this country in 1902. The scope of this act was very restrictive, and it was declared unconstitutional within three years. In 1908 Massachusetts authorized private plans of compensation which had no practical significance. In 1908 Congress passed a very limited compensation act covering certain federal employees. This was to be the first compensation act of practical application in this country. In 1909 Montana enacted compensation legislation applying to mining, which was also to be declared unconstitutional. In 1910 New York became the first state to enact a compensation law, followed in 1911 by ten states - California, Illinois, Kansas, Massachusetts, Nevada, New Hampshire, New Jersey, Ohio, Washington, and Wisconsin.

In 1913 Minnesota passed its first workers' compensation law (Laws of Minnesota 1913, Chapter 467). Prior to that time, industrially injured workers had four options: (1) sue the employer for damages, (2) hope the employer would offer financial assistance, (3) fall back on an insurance policy if one was available, or (4) turn to private or governmental agencies for assistance.

As Robert Asher described in his article "The Origins of Workmen's Compensation in Minnesota",[1] "The first option (#1 above) involved great uncertainty. Even if the courts did not interpose the formidable common law doctrines* which protected employers against tort action by injured employees, the employee had to face the vicissitudes of a jury trial, the long delays in accompanying legal action, the prospect that his attorney's fees and payments to expert witnesses would eat up a substantial part of any award for damages."

Several employers did aid injured workers (#2), but this was extremely arbitrary and often dependent on the employer's opinion of the value of the employee. Insurance policies (#3) inevitably provided only minimal emergency benefits and were generally adequate to cover the funeral expenses of fatalities, and the dependents then had to find other sources of income. Public or private assistance (#4), when it was available, was usually minimal and temporary.

Concurrently, Minnesota employers were becoming thoroughly disenchanted with these conditions and the mounting volume of accident litigation. They were disturbed by the continual harassment of legal actions instituted by unscrupulous attorneys and even more

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[1] Asher, Robert, Minnesota History, Minnesota Historical Society, Winter 1974, p. 142.

* a) fellow-servant doctrine - prohibited recovery if a fellow worker's negligence was a contributing cause of injury,
b) contributory negligence - prohibited recovery if an individual's negligence had been even partly responsible for the injury,
c) assumption of risk- prohibited any award if the injury resulted from an inherent hazard of that employment which the worker was, or should have been, aware. Also, in a perfectly competitive labor market, wages would reflect the advantages and disadvantages of each occupation, including allowances for potential injuries.

concerned with the time and costs involved in the liability-litigation system.

United States Steel reported that in 1908 less than half the money paid its Minnesota employees in court or in out-of-court settlements ever reached the disabled. George M. Gillette, President of the Minnesota Employers Association (predecessor to the Minnesota Association of Commerce and Industry - MACI) and one of the three members of the original Minnesota Employees Compensation Commission, reported paying $18,000 for employers liability insurance in 1907, but injured employees received only $3,000 in settlements.

Gillette and other employers were aware that a significant portion of employers' liability insurance premiums paid to casualty companies went to cover the cost of contesting litigation. At the time insurers perceived their interests, on behalf of employers, to be to minimize payments to the victims of industrial injury. In some instances, insurance policy provisions of this period prohibited employers from settling such cases directly with the injured worker.

Employers were becoming more sophisticated in terms of industrial accidents. They realized that without some form of compensation a strong negative reaction was elicited from the families, friends and coworkers of the employee, as well as society at large. Simultaneously, employers were concerned with the deterioration of employer-employee relations and increased employer liability insurance premiums due to a more liberal judicial view.

Thus, in 1909, the Minnesota Employers' Association joined with

the Minnesota State Federation of Labor and the Minnesota State Bar Association and approached Governor John A. Johnson to create a special commission to investigate the feasibility of establishing a compensation system based on the "risk of the industry" rather than the then current system based on negligence.

Membership of the Minnesota Employees' Compensation Commission was comprised of Gillette representing the employers, William E. McEwen, secretary of the Federation of Labor and state Commissioner of Labor, and Hugh V. Mercer, representing the Bar and serving as the chairman and neutral mediator between the interests of labor and capital.

As in the present debate over the establishment of a state workers' compensation insurance fund, George M. Gillette was very concerned with the socialistic overtones involved in the establishment of a workers' compensation system. He was insistent upon employee contributions to a workers' compensation system, stating that they were "the greatest influence which is at work to prevent accidents" and because sharing some of the cost removed "much of the sting of socialism from any system of this kind".

Employee contributions and the low benefits proposed by Gillette were unacceptable to both Mercer and McEwen. A concensus was not reached by the commission and eventually two bills were presented to the Legislature in 1911. The Gillette bill represented employers and emphasized cost and a system that was elective in nature. The Mercer-McEwen bill which represented a slightly higher benefit structure and was a compulsory system with few exceptions.

Where did the special interests stand with respect to the passage of the initial workers' compensation legislation in Minnesota?

Most employers initially opposed workers' compensation based on cost and principle. It was thought that such a compensation plan could potentially place the operation of Minnesota business at a competitive disadvantage, specifically those companies that competed in multi-state markets. Other employers supported the concept expecting it to reduce litigation, eliminate waste, improve employer-employee relations, and preempt generous judicial awards without dramatic cost increases. Although there was not a particularly sophisticated approach to employer-employee relations, this was undergoing rapid change.

Organized labor was reluctant to support the Mercer-McEwen legislation, viewing even those benefits as inadequate. The Federation of Labor finally did support the bill, but the railroad unions balked and successfully pursued a more generous employers' liability bill.

Casualty insurance companies opposed the Gillette workers' compensation proposal based on its elective nature. Unless an overwhelming majority of employers were forced to accept such a system, the industry would have great difficulty in establishing sufficient experience upon which to base accurate rates for such a diverse clientele - some buying workers' compensation insurance and others employers' liability policies.

The compulsory Mercer-McEwen bill was opposed on constitutional grounds. If such a bill was enacted and later declared unconstitutional, insurance companies would have to rewrite employers' liability policies at great expense.

Casualty insurance company agents opposed workers' compensation even if their companies endorsed it. They felt that elective as well as compulsory workers' compensation forced employers into a compensatory plan. If the purchase of workers' compensation insurance were to become necessary for employers, insurance companies would be forced to keep the cost of such mandatory insurance as low as possible. The low rate-high volume perception suggested to the agents that commissions on such policies would be minimal.

Prior to the passage of the original workers' compensation act, the stock insurance companies had additional concerns. According to Asher, "The stock companies also were apprehensive that the inevitable increase in insurance rates under workmen's compensation would make employers more receptive to proposals for state insurance, give many employers an incentive to form employer mutual insurance companies, and create demands for barring profit-oriented insurance companies from writing these insurance policies." Furthermore, it was felt that increases in compensation insurance costs might also lead to state regulation of rates, which would severely limit casualty insurance company profits.

Even though rate regulation became reality within a decade, it obviously did not have a dramatic effect on casualty company profits over the years, but rather established a regulatory system responsive to the needs of the industry.

The fears of the stock insurance industry were also borne out in the development of a number of very successful mutual companies. Wisconsin employers responded to excessive casualty insurance rates by establishing the Employers Mutual Liability Insurance Company

(Employers of Wausau). Other states responded by establishing competitive or exclusive state workers' compensation insurance funds. Of the 18 jurisdictions to establish state funds, 12 funds compete directly with private insurers and 6 funds prohibit private insurers entirely.

Action on workers' compensation legislation was delayed during the 1911 Legislative Session due to the factionalism and complexities involved in restructuring the Minnesota system. An interim committee of the Senate was appointed to draft a bill for consideration in 1913. By 1913, several states, including Wisconsin and Illinois, had enacted compensation legislation and removed the potential of a "competitive disadvantage" to Minnesota employers.

The workers' compensation legislation finally enacted in 1913 was a compromise between labor and employers, neither of which achieved their full objectives. The Employers' Association lost its demand for employee contributions and the medical benefit maximum was doubled. The Federation of Labor did not achieve the objectives of a higher benefit scale or the implementation of a state compensation insurance fund.

The state fund debate was to remain a primary issue before the Minnesota Legislature in several subsequent legislative sessions. Casualty insurance companies came to the brink of being eliminated from the workers' compensation insurance market in Minnesota in 1919. A bill to create a monopolistic state insurance fund was passed by the Minnesota House of Representatives on March 12, 1919, by a 78-48 vote. The strength of the arguments in opposition to pure monopolistic state insurance forced state fund proponents to

accept an amendment which would provide for competition from mutual insurance companies, to the sole exclusion of stock carriers. Even with this amendment, the state fund bill was defeated in the Minnesota Senate on a tie vote, 33-33, on April 2, 1919.

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MEMORANDUM May 12, 1980

TO: Senator Steve Keefe

FROM: Paul Hyduke

RE: Workers' Compensation

Attached is the latest National Council on Compensation Insurance Average Earned Rate Exhibit issued on March 19, 1980.

I have also included a 5-year comparison of premiums, losses, dividends, and retention of state funds, private insurers in state fund states, and Minnesota private carriers. These figures may lend some credence to the "yardstick" concept of state funds competing directly with private carriers. For the five years examined: 1) retention as a percent of earned premium for Minnesota private insurers consistently exceeded the retention percentage of private carriers in state fund states in every year except 1976; 2) the loss ratio of Minnesota private carriers was well below the average established by private carriers in state fund states; and 3) the dividends paid (as a percent of earned premium) by Minnesota insurers was lower than their counterparts in every year except 1976.

Also enclosed is a copy of the Conning & Company report of February 1, 1980, which examines the California Workers' Compensation market and lauds the existence of the competitive fund.

PH:lkl
Enc

5 YEAR COMPARISON

Premiums - Losses - Dividends - Retention (000 omitted)

Competitive State Funds v. Private Carriers v. Minnesota Private Carriers

STATE FUNDS

Year	(1) Earned Premium	(2) Incurred Losses	(3) Loss Ratio %	(4) Dividend Paid	(5) %	(6) (1)-(2)-(4) Retention	(7) Retention as a % of Earned Premium	(8) Retentio as a % o Incurre Losses
1972	354,327	268,979	75.91	59,558	16.81	25,790	7.28	9.59
1973	393,838	305,658	77.61	63,526	16.13	24,654	6.26	8.07
1974	457,558	370,042	80.87	63,472	13.87	24,044	5.25	6.50
1975	520,379	468,397	90.01	51,284	9.86	698	0.13	0.15
1976	637,753	555,815	87.15	46,733	7.33	35,205	5.52	5.97
Totals	2,363,855	1,968,891	83.291	284,573	12.038	110,391	4.67	5.61

PRIVATE CARRIERS

1972	1,100,080	740,194	67.29	104,294	9.48	255,592	23.23	34.53
1973	1,319,243	846,155	64.14	121,802	9.23	351,286	26.63	41.52
1974	1,499,972	1,005,642	67.04	136,089	9.07	358,241	23.88	35.62
1975	1,655,832	1,152,818	69.62	125,669	7.59	377,345	22.79	32.73
1976	2,050,142	1,452,287	70.84	116,529	5.68	481,326	23.48	33.14
Totals	7,625,269	5,197,096	68.16	604,383	7.93	1,823,790	23.92	35.09

MINNESOTA PRIVATE CARRIERS

1972	109,633	67,900	61.9	8,151	7.4	33,581	30.6	49.5
1973	125,506	72,757	57.9	10,050	8.0	42,700	34.0	58.7
1974	151,986	84,043	55.2	12,160	8.0	55,783	36.7	66.4
1975	178,782	100,066	55.9	13,111	7.3	65,605	36.6	65.6
1976	217,835	152,441	69.9	14,588	6.6	50,806	23.3	33.3
Totals	783,741	477,207	60.8	58,059	7.4	248,475	31.7	52.1

Sources: State Fund data provided by the American Association of State Compensation Insurance Funds.*

Private Carrier data from A. M. Best Company.

Minnesota Private Carrier Data provided by the Minnesota Insurance Division.

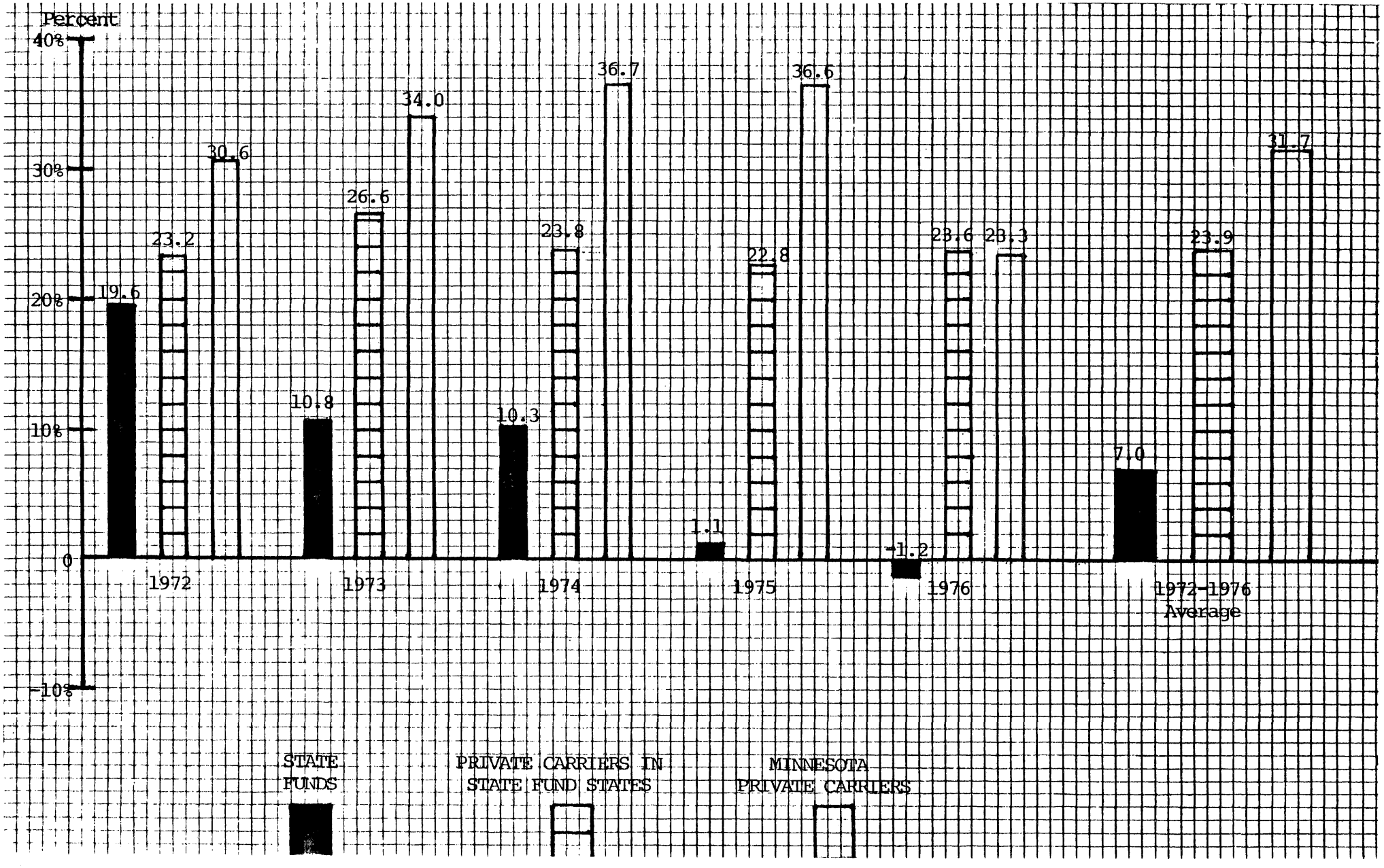
*Nine state funds included: Arizona, California, Colorado, Idaho, Maryland, Michigan, Montana, Oklahoma and Oregon. Information incomplete or not available for three state funds: New York, Pennsylvania and Utah.

PH:lkl
7-3-80

5 Year Comparison

Retention as a Percent of Earned Premium

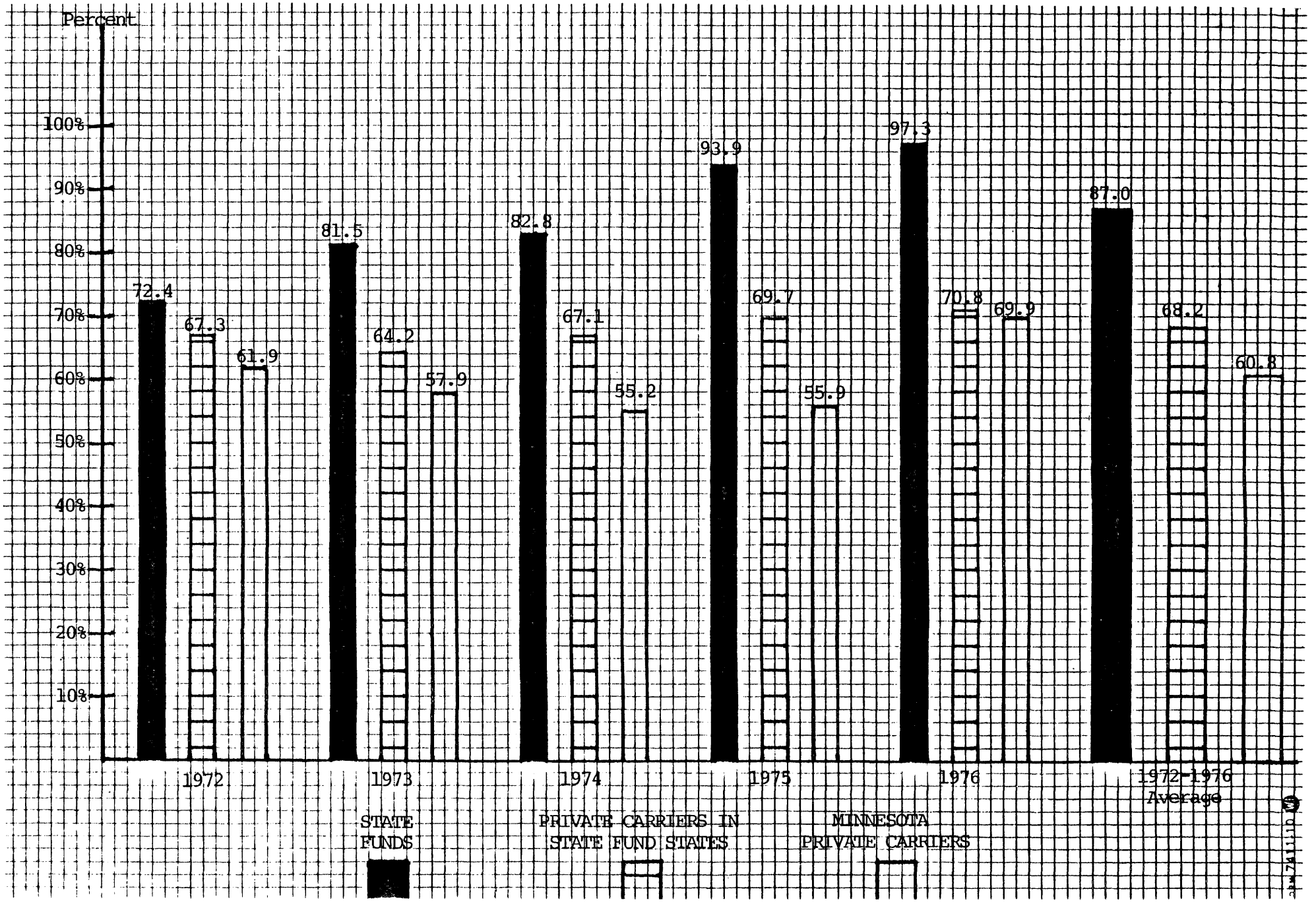
State Funds v. Private Carriers v. Minnesota Private Carriers



5 Year Comparison

Loss Ratio

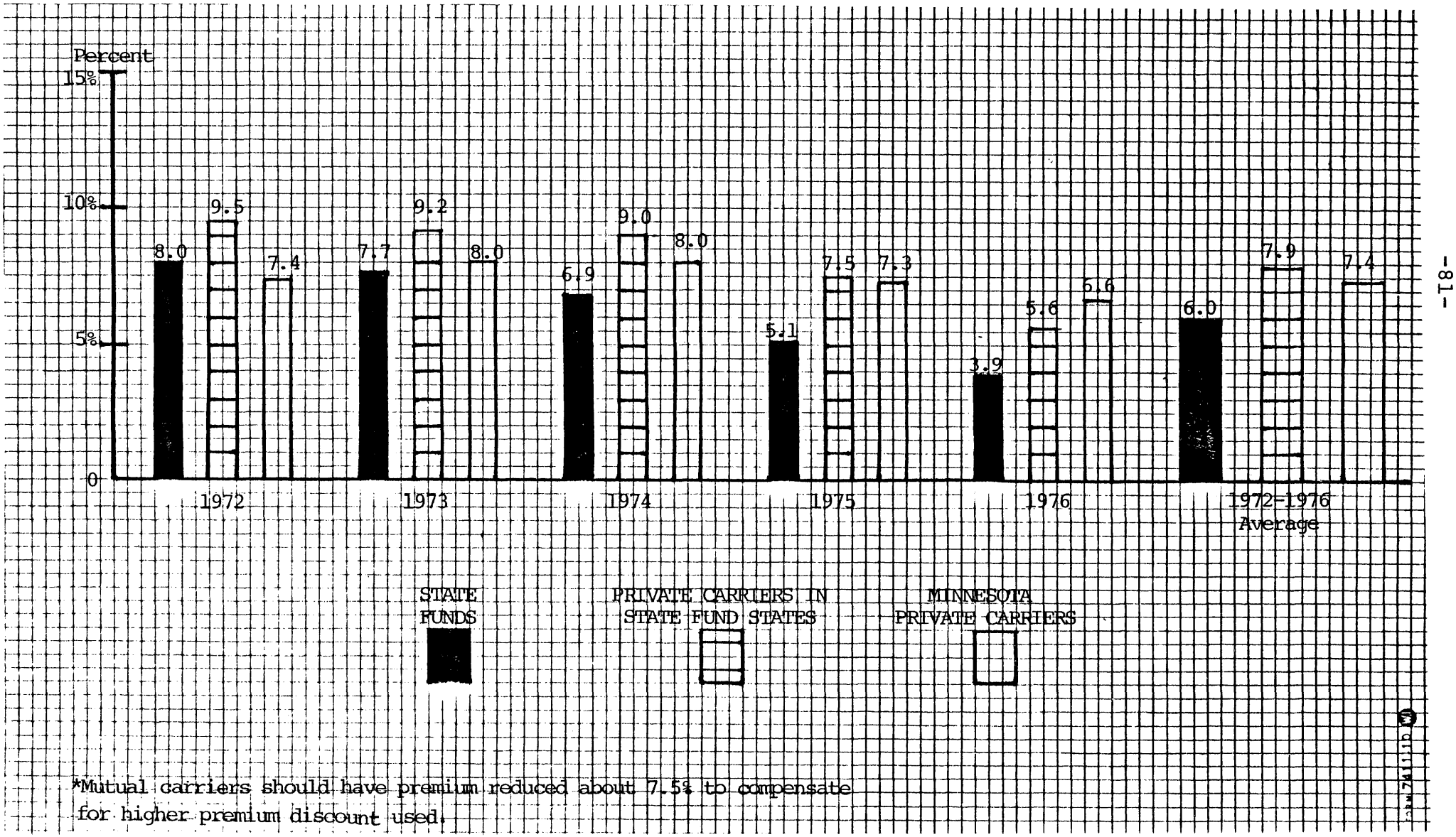
State Funds v. Private Carriers v. Minnesota Private Carriers



5 Year Comparison

Dividends Paid as a Percent of Earned Premium

State Funds v. Private Carriers* v. Minnesota Private Carriers



*Mutual carriers should have premium reduced about 7.5% to compensate for higher premium discount used.

Minnesota

House of Representatives

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October 20, 1980

TO: Members, Workers' Compensation State Fund Study Commission

FROM: Douglas P. Seaton, Legislative Analyst

RE: "Subsidies" to the State Competitive Workers' Compensation Funds

I. Introduction

Several members of the Commission have raised the issue of possible "subsidies" to the state competitive funds as obstacles in any comparison between the state funds and private workers' compensation insurance carriers. Construed broadly this issue involves any direct or indirect subsidy to the state funds, any exemption from taxes or insurance regulations and any condition or requirement of doing business faced by private insurers but not by the state funds. This memorandum provides information on the various forms of "subsidy" enjoyed by each of the competitive state funds and estimates on the dollar significance of the more important "subsidies."

II. Subsidies Generally

A direct legislative appropriation to a state fund or an exemption from certain taxes or fees not available to a private insurer will clearly allow the state fund to operate at lower premium rates than the private insurer. The lower cost to the employer purchasing insurance does not represent greater efficiency under those conditions, however, since the difference in cost is borne by the taxpayers in the form of direct outlays or for gone revenues. Thus, employer workers' compensation insurance rates would reflect a taxpayer subsidy.

Another type of "subsidy" involves costs of doing business which affect the private insurer but which are not costs to the state fund. Exemption from regulatory compliance would be such an indirect "subsidy," but profits and agent commissions are the two most significant costs necessarily faced by private insurers which most state funds do not incur.

The analysis of this second type of "subsidy" is not as simple as that for a direct subsidy in the form of an appropriation to the state fund or an exemption from taxes. Clearly, if a state fund does not have to make profits or pay commissions to remain in business, while a private carrier does, the costs of doing business are different and, other things being equal, employers would pay lower premiums to the state fund. Some of this "savings" would be reflected in lessened services to the employer and the injured employee. Some of it, however, would be a genuine "savings" in the sense that the state fund premiums may be reduced by an amount greater than any reduced value to employers or injured employees because of the loss of services which are supplied by a private carrier-agent system but not be a state fund.

In other words, it is not easy to say what proportion of the commission and profit "cost" to private insurers is necessary to deliver important workers' compensation insurance services and what proportion is extraneous. These important differences between state funds and private carriers in the cost of doing business must be considered in evaluating their relative performance, but it is difficult to fix the dollar significance of these differences. The alternative approaches range from adding the total amount of agent commission (and other acquisition costs) and profits to state fund costs before evaluating relative performance, since private carriers must bear these costs while most state funds do not, to discounting these amounts entirely as unnecessary costs since most state funds apparently can provide workers' compensation insurance consistent with law without them. The truth clearly lies somewhere between, but the data do not tell us exactly where.

Table I provides an overview of the twelve state competitive workers' compensation funds with respect to the significant issues in an assessment of state fund "subsidies." This information is based on a review of state statutes and AASCIF data and a telephone survey of state fund personnel, corroborated in many cases by additional information from state insurance and revenue departments. The "subsidy" issues are presented in roughly the order of increasing cost significance.

III. Direct Subsidies

The first ten items of Table I illustrate that very few state funds are provided with direct subsidies in the form of money or services from the state. No state fund is provided with office space, computer or legal services or funds by a state agency. One state fund, however, has received a state loan which was ultimately forgiven. Investment or personnel services are provided without charge by state agencies in Maryland, Montana, New York, Pennsylvania and Utah. The Maryland fund has employee retirement benefits paid by the state. Some of these direct subsidies may involve significant dollar amounts. The cost of retirement benefits can amount to a substantial percentage of total employee compensation costs, a not insignificant item in a labor-intensive industry. Seven of the state funds have none of this type of subsidy, however. Only New York and Maryland enjoy more than one such form of subsidy. Many of the others

receive only trivial subsidies. Direct subsidies are therefore not very important for the state funds as a whole.

IV. Indirect Non-Tax Subsidies

Item eleven indicates that Maryland's state fund is exempt from insurance regulations, alone of the state funds. This may be a significant indirect subsidy to this state fund, but others are apparently subject to regulation on the same terms as the private carriers.

The twelfth item of Table I represents the first significant "subsidy" enjoyed by most (all but two) state funds: state agencies must insure with the state fund. Local subdivisions are also required to insure with the state fund in Colorado and Idaho. The size of this "locked in" customer varies from state to state, but this provision provides all of these state funds with an advantage over private carriers in the struggle to attain an optimum scale of operation for purposes of loss-distribution. Since self-insurance usually costs a large employer less than traditional insurance, the required premium payments from state agencies to the state workers' compensation fund may also reflect a taxpayer subsidy to the state fund. It is difficult to place a dollar value on this "subsidy," but it is clearly significant.

V. Tax Exemptions

Items thirteen through seventeen involve the most significant of the unambiguous "subsidies" to state funds: many of them are exempt from some or all of the taxes, fees and assessments paid by private workers' compensation carriers. Four of the state funds are exempt from paying assessments (usually a percentage of premium volume) to insurance departments, rating agencies, or certain special funds which require payments from private carriers. Eight of the funds are exempt from premium taxes, while six funds are exempt from privilege fees paid by private carriers who insure in the state. All of the state funds are exempt from federal and state income taxes. Five of the twelve funds are exempt from property taxes as well. These exemptions represent a considerable advantage to the state funds. They are certainly one of the most important factors in the differential between state fund and private insurer premiums. The tax exemptions, however, are less significant than they appear at first to be and they do not account for all the differences in state fund and private carrier rates.

Table II provides data on taxes, fees and assessments attributable to workers' compensation paid by insurers operating in Minnesota during fiscal year 1979. The premium volume indicated is written premiums for calendar year 1979 (thus the tax rates given are not exact). This information is derived from the National Association of Insurance Commissioners' data base, courtesy of the Minnesota Insurance Division, except that state income tax data was provided by the Minnesota Department of Revenue.

Some of the figures in Table II require explanation. The state premium tax figure reflects the 2 percent Minnesota premium tax rate. The state income tax figure is very low largely because the premium tax is a direct credit against the state income tax and also because workers' compensation insurance suffered underwriting losses of 6.9 percent of total premium in 1979. (It may be of interest that "investment gain" attributable to workers' compensation in 1979 was 8.94 percent of total premium.) The federal income tax figure is negative in part for the same reasons. Workers' compensation insurance has paid no federal income taxes since at least 1976. In fact, significant losses were reported in each of these years. The total taxes attributable to workers' compensation insurance in 1979 amount to 3.42 percent of total premium.

Though one might suppose a more "normal" tax rate than these 1979 figures should be sought for the purposes of determining the value of the state fund exemption from taxes, the percentage of total prmeium paid in taxes by workers' compensation insurers has in fact remained roughly the same since 1976. This 3.42 percent of premium is clearly significant. A state fund would be entirely free of this cost and of the record-keeping and reporting requirement that accompany taxable status. From the point of view of public revenues, a state fund which was exempt from all taxes and attained a 20 percent market share would cause a diminution of $2,893,000 in state and local tax collections at current premium levels. Nonetheless, the effect of the state fund tax exemptions is less than one might have assumed.

VI. Profits and Acquisition Costs

To return to Table I, items 18, 19 and 20 indicate that the costs borne by private workers' compensation carriers, but not by most state funds, also include profits and most acquisition costs (agent commissions and "solicitation" expenses). No state fund need show a profit. Only the Arizona, California & New York funds pay commissions to agents and eight of the twelve funds refrain from any solicitation of business. Both of these items have to be considered carefully in an evaluation of state fund performance, since they are "costs" to private carriers from which the state funds are exempt. The numbers are certainly significant if the 20 percent allocated for acquisition costs and profits in the last rate hearing is accurate. At least in part, these expenses represent significant workers' compensation services and the cost of capital. At the same time, as indicated above, a portion of these costs may be "extraneous" for purposes of this evaluation in the sense that a state fund may be able to offer adequate workers' compensation services without them. This portion may therefore represent efficiencies in state fund operation.

Profits are very difficult to evaluate as a "subsidy" issue. The previous Minnesota rate allocation for profits was 2.5 percent, or $10,069,000

at current premium volume, but this includes no provision for investment income. The NAIC data indicate an 8.94 percent investment return on premium volume in 1979 or $37,796,710. Nonetheless, after underwriting losses are considered (and excluding 4.5 percent for dividends) the operating profit for the year is given as 0. The dispute over workers' compensation insurance profitability is beyond the scope of this paper. It suffices to say for these purposes that profit, a cost to private insurers not borne by state funds, conservatively estimated, must be at least 4.5 percent (dividends to policyholders) and could be more. This is clearly a significant difference between state funds and private carriers, but it is possible that this percentage should be reduced to reflect only that proportion of profits which provide additional insurance services.

Commissions and other acquisition costs (items 19 and 20 in Table I) are more easily calculated than profits, though it is similarly difficult to determine what proportion of these costs reflect additional services and what proportion are "extraneous." Total "sales expenses" are indicated as 8.9 percent of premium or $37,627,598 in the NAIC data for Minnesota, though 13.9 percent of premium or $58,766,698 was allocated to agent commissions in the last rate filing. Even at the lowest of these figures (and even assuming a substantial reduction for "extraneous" costs) the "exemption" from agent commission of most state funds is probably the most significant item in the premium differential between state funds and private insurers. The last rate hearing also allocated 3.6 percent or $15,220,150 to other acquisition costs and it seems likely that the largest part of this amount would not be a cost to the "non-soliciting" state funds.

VII. Risk Rejection

Item 21 of Table I reflects another issue related to state fund "subsidies:" the ability of a state fund to reject risks. Four of the state funds can reject risks just as private carriers can, but the other eight cannot reject risks. In addition, three of the six which can reject risks in practice do not. In five of the states in which the state fund cannot reject risks there is no assigned risk pool, either. The likely result in all six of these states, and particularly in those with no assigned risk plan, is that the state fund receives a greater share of poorer risks than the private carriers do. This is borne out at least in the size of risks since state fund insureds do tend to be smaller than the average private insured. The issue here, of course, is one of a state fund subsidy to private insueres, rather than the reverse. The private insurers are spared the presumably higher losses and greater administrative and service demands of high risk employers, who they would otherwise have to apportion among themselves through an assigned risk plan. The state fund in these situations functions as an assigned risk pool without cost to the private insurers. The value of this reverse "subsidy" is difficult to determine, but it is certainly significant and must be considered as an offset in any tally of state fund subsidies.

VIII. Conclusion

Any evaluation of the magnitude of state fund "subsidies" will be inexact. The types of subsidies vary from state to state and the costing of several of the most significant items is almost pure guess work. Several items discussed in this memorandum will not be viewed as "subsidies" at all by some observers. Broad ranges are probably the best numbers which can be provided on this issue. These ranges represent the average advantage to a state fund, expressed as a percentage of premium value, of each type of "subsidy." Thus the value of a free service provided to only a few state funds is pro-rated to give figures for state funds generally. In order to make meaningful comparisons between state fund premium rates and private insurer rates the state fund rates should be increased by a proportion somewhere within this range.

Direct Subsidies (Items 1 - 10 in Table I)	.25 - 1%
Indirect Subsidies (Items 11 and 12)	1 - 2%
Tax Exemptions[1] (Items 13 - 17)	3.42%
Profits (Item 18)	4.5 - 10%
Acquisition Costs (Items 19 and 20)	8.9 - 17%
Inability to Reject Risks (Item 21)	[1 - 2%]
Total[2]	16 - 32%

[1] Reflects Minnesota data only.

[2] The lower figure would be further reduced if it were assumed that part of the cost of profits and acquisition expenses did not reflect measurable workers' compensation services and thus are somehow "extraneous" to this calculation even though they represent costs to private insurers.

DPS/dlr

TABLE I

	Ariz.	Cal.	Colo.	Idaho	Md.	Mich.	Mont.	N.Y.	Okla.	Ore.	Penn.	Utah
1. State fund exempt from court filing fees	---	---	---	---	---	---	---	Yes	---	---	---	---
2. State civil service system handles hiring without charge	---	---	Yes	---	---	---	Yes	Yes	---	---	---	Yes
3. Investment services provided to state fund without charge	---	---	---	---	Yes	---	Yes	---	---	---	---	Yes
4. Legal services provided to state fund without charge	---	---	---	---	---	---	---	---	---	---	---	---
5. State job-service provides employment assistance without charge	---	---	---	---	---	---	---	---	---	---	---	---
6. Retirement benefits of state fund employees paid by state	---	---	---	---	Yes	---	---	---	---	---	---	---
7. Space provided to state fund without charge by state	---	---	---	---	---	---	---	---	---	---	---	---
8. Data processing or other services provided to state fund without charge	---	---	---	---	---	---	---	---	---	---	---	---
9. Direct legislative appropriations to state fund	---	---	---	---	---	---	---	---	---	---	---	---
10. State loans to state fund which have been forgiven	---	---	---	---	---	---	---	---	---	Yes	---	---
11. State fund exempt from insurance regulation	---	---	---	---	Yes	---	---	---	---	---	---	---
12. Locked-in "customers" of state fund: state agencies	Yes	Yes	Yes	Yes	Yes	---[1]	Yes	Yes	Yes	Yes	---	Yes
other subdivisions	---	---	Yes	Yes	---	---	---	---	---	---	---	---

[1] But administers state self-insurance programs.

(Continued)

TABLE I - Page 2

	Ariz.	Cal.	Colo.	Idaho	Md.	Mich.	Mont.	N.Y.	Okla.	Ore.	Penn.	Utah
13. State fund exempt from assessments	---	Yes	---	---	---	---	---	Yes	---	---	Yes	Yes
14. State fund exempt from privilege fees	---	Yes	---	---	Yes	---	---	Yes	Yes	---	Yes	Yes
15. State fund exempt from premium taxes	---	---	Yes	Yes	Yes	Yes	Yes	Yes	Yes	---	Yes	---
16. State fund exempt from state and federal income taxes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17. State fund exempt from property taxes	Yes	---	---	---	---	---	---	Yes	Yes	---	Yes	Yes
18. State fund not obliged to show profit	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
19. State fund pays no agent commissions	---	---	Yes	Yes	Yes	---	---	---	Yes	---	Yes	Yes
20. State fund does not solicit business	---	---	Yes	Yes	Yes	Yes	Yes	---	Yes	---	Yes	Yes
21. State fund cannot reject risks	---	---	---	---	Yes	---	Yes	---	---	---	Yes	Yes

TABLE II

Minnesota Workers' Compensation Insurance Premium Volume[1]	State Premium Tax[2]	State Income Tax[2]	Federal Income Tax[2]	Other Taxes, Fees And Assessments (State & Local)[2]	Total Taxes Attributable To Workers' Compensation	Taxes Attributable To Workers' Compensation As Percentage Of Premium
$422,782,000	$8,307,000	$185,000	0 [-$14,096,810]	$5,976,000	$14,468,000	3.42%

[1] Calendar Year 1979

[2] Fiscal Year 1979

STATE OF MINNESOTA

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November 18, 1980

TO: Workers' Compensation Study Commission

FROM: Jay Y. BenAnav, Senate Counsel

SUBJ: State Claims Handling

Although the statutory charge of the Study Commission was to make a study of systems used to finance and purchase workers' compensation insurance, there are other problems within the system which cannot be ignored and which will continue to exist whether or not a state fund is established. One of the most serious problems is the state's handling of workers' compensation claims made by its own employees. The state's operation is inefficient and notorious for its delay of medical and compensation payments.

There are approximately 36,000 state employees. According to departmental reports, during fiscal year 1980 the Department of Labor and Industry (DLI) made 16,509 workers' compensation payments for workers' compensation claims made by state employees. The Department, which is responsible for handling state employee claims, has an assigned complement of ten employees handling such claims. Of these ten employees, two are departmental attorneys, two investigators, two account technicians, three analysts, and one is a clerk typist.

Currently the state is nine months behind in medical payments to providers of health care to injured employees. In addition, a 60 day delay in making the initial payment on an uncontested compensation claim following an injury is typical. The present workers' compensation statute (M. S. 176.221) allows an employer 30 days following an injury within which to begin compensation payments. As a result of the state's inability to meet this statutory directive, the state routinely requests and is granted an extension.

The following steps should be considered in order to improve the state's performance in the area of workers' compensation claims by state employees.

(1) The state should take into account the findings and conclusions of the 1979 Workers' Compensation Study Commission Report concerning its handling of workers' compensation claims made by state employees. One of the findings of that report is the need to return injured employees to work as soon as they are physically able, or to determine, as soon as possible after an injury, whether an employee will require retraining and rehabilitation. In addition, the 1979 report stressed the importance of employee participation in and knowledge of the workers' compensation system. This and the other recommendations of the 1979 commission report were designed to encourage early intervention in the claim of an injured employee and to reduce litigation and in turn reduce the costs to the system. These recommendations remain valid considerations today.

(2) Each state department should be required to pay into the state compensation revolving fund on a quarterly basis. (This fund pays workers' compensation claims by state employees.) Currently state statute (M. S. 176.611) provides that each self-sustaining department, except the Department of Transportation, reimburse the fund at the end of each fiscal year in the same amount that was paid by the fund to the department's injured employees. Departments which are not self-sustaining are not required to pay into the fund until the end of the biennium. This delay in payment serves no useful purpose and may only result in the fund occasionally having insufficient money to pay claims as they come due. In addition, a delay in payments by the departments results in the departments sometimes being unaware of or concerned about the amount of money that is actually needed to pay injured employees. In order to assure that the fund has the money to pay claims, and to alert each department as to the money that is being used to pay injured employees, payment on a quarterly basis should be required.

(3) Each department and division should be required to monitor the progress and status of each injured employee. Currently, the individual departments have little or nothing to do with an employee once the employee files an injury report with the DLI, which handles the claim from the filing of the report on. The DLI makes the decision regarding return to work, retraining, etc. This system has not functioned well since the DLI has been unable to handle payment of benefits let alone assure proper retraining and the like. Therefore, each department and division

should be responsible for working with and monitoring injured employees to assure that each employee is properly served, returned to work, retrained or whatever else is necessary.

(4) Each department should be required to include workers' compensation as a specific item in its budget request and the budget request should be accompanied by the department's workers' compensation expenditures for each fiscal year during the last biennium. A department that does not spend its entire workers' compensation appropriation should be permitted to use whatever remains for other purposes. This procedure would require each department to better justify and analyze its request to the governor and legislature and to take a closer look at its injured employees. Together with other changes in the method of claims handling, this closer look should result in each department becoming actively involved with its injured employees with respect to return to work, rehabilitation, etc. In addition, each division within a department should be held accountable by the department for the injured employees in that division by charging to that division's account the benefits paid to its employees. This decentralization should further encourage each division to assure that an injured employee is returned to work as soon as the employee is capable or, if necessary, see that retraining or reemployment with another employer takes place.

(5) The legislature should make an appropriation that would be used to hire a consultant to study and make recommendations to the DLI, the governor and legislature. These recommendations

would assist the state in improving its claim handling procedures by making the system more efficient, reliable, and better able to serve the best interests of the employee and state. The DLI itself is unable to study the state's claim handling system since it is too enmeshed in the current system to objectively evaluate its own performance.

would assist the state in improving its claim handling procedures by making the system more efficient, reliable, and better able to serve the best interests of the employee and state. The DLI itself is unable to study the state's claim handling system since it is too enmeshed in the current system to objectively evaluate its own performance.

EXHIBITS:

TESTIMONY

Workers' Compensation State Fund Study Commission - June 24, 1980

OVERVIEW OF STATE FUND OPERATIONS IN THE UNITED STATES

Glenn Adams - Manager, Colorado State Compensation Insurance Fund

Our guest this morning is Glenn Adams who is the Director of the Colorado State Workers' Compensation Fund which I think may be the most successful competitive state fund in the country. They have about 70 percent of the market now and they have been growing dramatically over the years. I think they have increased their number of policies by 70 to 75 percent over the last three years and they offer a 30 percent up front discount over the rates the private insurance companies charge in the State of Colorado. At the same time, Glenn is the President of the American Association of State Compensation Insurance Funds. He probably is the leading national authority on state funds, particularly on state competitive funds. He's going to talk to us for a little bit and then we're really planning on having sort of an informal meeting where we can talk to him about our questions, fears and worries about state funds and with his broad experience, I thought it was a good way to start us off. Although some of us have looked into state funds a little bit in the past, others are fairly new to this area and this is a good way for us all to start. Glenn, if you will just come up here, we're getting all of your golden words right down on tape here so if you will talk into the microphone, it won't help us hear you but it will help us transcribe the tape.

(Adams) Thank you Senator Keefe. Lady and Gentlemen of the Committee. First, I'd like to say I'm very pleased to be here and discuss with you what I consider to be my most favorite subject and that is State Compensation Insurance Funds. To qualify myself to speak to you, I'd like to tell you a little bit about my background. I've been employed for over 30 years now by the Colorado State Compensation Insurance Fund. I've held most management positions in that fund and for the last eight years I've been the manager and the chief executive officer. In 1970 and 1971 I was selected to go to the country of Thailand by the United States Government to establish a state fund for that country. That state fund started to operate on January 1, 1974. I'm going back later this year in October or November for the United States Government to study that fund, if I can free up the time, to study that fund and make a report as to how it's doing. There are many who say in this day and age you cannot start a state fund. If you see the difficulties and roadblocks that existed in a country like Thailand, who had no expertise, didn't know what a claims adjuster is, didn't know what an underwriter was, didn't know what a typewriter was, had absolutely no statistics, and yet they did it. We built a rating system that apparently works because the last I knew they were quite solvent, so it can be done. I'm also the President of the American Association of State Compensation Insurance Funds which is an organization dedicated to the improvement of our other state compensation insurance funds of all of our members and also dedicated to getting other states to go into the state fund concept because we believe in it.

Now, why state funds? All of the state funds except one were started in this country between 1913 and 1919. There are

a total of 18 of them. One in Oklahoma was started in 1933. It's interesting to note that 12 of those state funds are competitive state funds and by competitive they range all the way from very aggressive competitiveness to very passive depending on what their legislatures have told them they want their state funds to be. Six of those state funds are exclusive state funds, meaning that you buy your workers' compensation insurance from only the state comp fund. Private carriers are not allowed. It's interesting that 11 of those 18 state funds are in the West. The State of New Mexico is the only state in the western United States that does not have a state fund. Now, there's a reason for that and I guess the reason is that back in the 1913's and 1915's when workers' comp laws were being enacted, legislators in the west felt that the private carriers would not want to write business in this wild, untamed country, so legislatures established their own insurance mechanism which has held forth for the last 65 years or so and is doing very well.

Now, you hear a lot of pros and cons about a state fund. Things that are good about them. You also hear things that are bad about them. I'd like to take just a few minutes to go into those pros and cons and you'll have to understand right off the top I'm for them and I'm going to do my best to tell you and show you that it is a concept whose day has come.

Number one. Insurance by a state fund is less costly than by a commercial insurer and later I will present you figures that will show you beyond any doubt that in Colorado it is less costly to insure with the state compensation insurance fund.

Two. The ability to make the choice is desirable in itself. In Colorado you can make a choice. You don't have to insure with

the state fund but you can voluntarily do so. And that's a complete free choice, with the exception of public employers who must insure with the state fund.

Three. The existence of a state fund creates a source of insurance for small employers and employers with high risk exposure. In Colorado we do not have an assigned risk plan. The state fund will insure any employer who comes to us for insurance. In other words, we have no second class citizens. They all buy first class insurance from a first class insurance carrier.

Four. To the extent that premium payments are made to a state fund rather than to a private company based out of state, capital is retained in the home state, a very important point. There are large amounts of investments the state funds and insurance carriers hold now. We like to hold as much as possible of it in Colorado rather than letting it go back east or wherever. We buy mortgages guaranteed by the United States Government, FHA, and VA mortgages, which provide jobs for our citizens. These employers turn around and insure with the state fund. From our viewpoint, it's just plain good business and it is a benefit to the state.

Five. A state fund is less likely to be concerned only with the bottom line and there is a bottom line in workers compensation insurance. I want to cite you some examples. In 1971, our legislature decided that all farm and ranch employees should be covered under the workers' comp act. Previous to that, it had been employers of four or more. In 1971, they changed it to one or more. Now the farmers quite frankly found this quite a tramatic jolt because we use the National Council on Compensation Insurance Rating System and that system basically had only one

classification for farmer and ranch labor and that classification was high, quite high. So, our legislators told us, not the private insurance industry, told the state fund to study the problem and devise a classification and rating system for farmers and ranchers that was equitable to the risk. We did that and put our plan into effect August 1, 1973, even though we did not have experience with the various five different classifications we came up with, we did assign rates based on our own best judgment. Surprisingly, today we're still using that rating plan for farmers and ranchers. The National Council has, in turn, adopted a plan very similar to ours (it is amazingly similar to ours) for the whole country. The thing is, seven years later they still cannot assign rates to that plan--something we were able to do in 1973; and as it turned out, with a great deal of validity. As it turns out, these are the only five classifications that we don't use of the National Council plan.

Our rates average on these five classifications 60 percent less than rates charged by private insurance carriers; which means that we have virtually all of the farm and ranch coverage in the state. Let me give you another example. In 1973, the National Council recommended that the minimum premium formula be changed for small employers. Now the minimum premium in workers' comp is the least amount that a policy can be written for in an entire year. The formula previous to that time was 15 times the rate plus the $10 or $15 expense constant. So if you had a classification that had a $2 rate, to figure the minimum premium, you would take 15 times $2 or $30 plus either a $10 or $15 expense constant. That charge would make your minimum premium then $40. They then suggested a change to take place and be implemented

in about four stages to go from 15 times the rate; 25 times the rate; 35 times the rate; 45 times the rate to currently 55 times the rate. You can see what that has done to the cost for a small employer. Well, the state fund looked at our data in Colorado and said, "We don't see that the small employer needs to be charged in that manner." Because our data did not show that they were that bad a risk and that we were not losing; so we are still today using 15 times the rate for calculating the minimum premium. Just now, countrywide (I understand it hasn't gone into effect in Minnesota) they've come up with another proposal to change the expense allocation in the rates. What this means when you get right down to that bottom line, is that they reduced the rates for the larger employers (which is business that they want, obviously) and charged that expense part of it to the smaller employers. Let me tell you what that would mean in Colorado. And this was to be also implemented over a two-year stage because the bite the first year was thought to cause too much of a ruckus. For a small employer who paid $65 previously, on April 1 his premium went to $82, which is a 26 percent increase. Next April 1 it will go to $112 which is a 72 percent increase. 72 percent over a two-year period based on the same payroll and very little difference in the cost. Now, we didn't go along with this. The State Fund said, "No, this is not right, this is an imposition on the small business community." I should point out that there's nothing in our statute that governs the state compensation insurance fund that says we are supposed to protect the small employer but if we look back on this as our philosophy, if we look back on why the state compensation insurance fund was established

and that was to provide coverage for employers who couldn't buy it anyplace else or preferred to insure with the state. As we had no financial problems, we couldn't see going clear out of our way to actually persecute the small businessman so we stayed just exactly where we were, which is where we're at and which is where we're going to stay.

Six. State fund competition improves the regulation of insurance companies. I understand you have a lot of problems with that. We don't have that much of a problem in Colorado. Whenever the National Council, which is the equivalent of your rating bureau, recommends a rate change, invariably the insurance commissioner and his analysts call the state fund to get our position in spite of the fact that the insurance commissioner does not approve rates for the state comp fund. So, there's that measuring device that you have when you have a state fund. We are a guide and we are listened to. Even more important, your legislators, there's never ever any kind of legislation that affects workers' comp in any regard in Colorado that's introduced that the state fund isn't called upon to testify. That is because the state fund has integrity in our state and the state fund has credibility and besides that, I'm a state employee and I do not get at a table before one of my committees and tell a lie. I may not tell them what they want, but I tell them the truth and that's very much appreciated.

Finally, on the pros -- state funds can offer specialized service which is a thing you might think is quite strange because how can a government agency provide a better service than a private industry situation? Well, you have to remember that in Colorado we have 70 percent of the business. We write more business

than all the private carriers combined and quite frankly, we have all the expertise in the state at work for the state fund, at least the bulk of the expertise, and that has not only to do with the policyholders but the collecting of the premiums and so forth. That also applies to the claim adjustment and legal end of it.

Now the cons -- what's against the state funds. These are the common arguments. The state fund is government in business. It's socialism and if it is, we've got it in Colorado but I'll tell you this, anybody that would introduce a bill to abolish the fund or dramatically hurt it would find they would have a march in front of the capitol because the state fund is too important to the citizens in Colorado, socialism or not. I don't think it's socialism.

State funds are government agencies, inherently inefficient bureaucracies and susceptible to the ills of political influence. Take that in two parts. Inefficient--inherently inefficient bureaucracies. Well, I have to say to that, who says state government's got a monopoly on that or federal government, or local government, or whatever. I'm going to show you figures later on I think will show you that state funds are extremely efficient and therefore get the job done. So far as political influence, if you allow political influence in your law, then you have written a bad law. I'll just read you a short quote from the statute that governs our fund. This talks about the authority of the manager.

> "The manager is hereby vested with full power, authority and jurisdiction over the administration of the state compensation insurance fund and may do and perform any and all things whether herein specifically designated or in addition thereto which are necessary or convenient in the exercise of any power, authority or jurisdiction over said fund in the administration thereof under the

provisions of this article as fully and completely as the governing body of a private insurance company might or could do."

Now that provision tells me to act like a private insurance company and I have never been subject to political influence. So, if it happens in Minnesota, if you decide to establish a fund, it's your own fault you've written a bad law.

Three. State funds are not needed. Commercial insurers are doing the job. Well, if that's so, and I've said this a couple of other times since I've been here and at other meetings that I've attended, if that's so, why am I here? And, are you sure commercial insurers are doing the job or doing a job on you. I don't know.

Four. The employer will lose the services of an agent or broker if he insures with the state fund. If that's important to you, having an agent or broker, then you will lose those services although we have field offices very conveniently located around the state to handle our policyholders.

Five. To the extent that a state fund is exempt from taxation or receives full services from other state agencies, the fund is subsidized and the state loses income. Well, in Colorado we are not subsidized in any way by other agencies of state government. Any services we get from other agencies of state government, we pay for. In my opinion, if I was able to go out for those services on the open market, I could probably buy them cheaper but we are not subsidized and the state loses no income. Well, the state fund does not pay income taxes, it does not pay the insurance taxes or premium taxes that the private insurance companies do. That's true but look at it another way. The taxable amount or the deductible amount for

insurance premiums with the state is less, so therefore, there is somewhat of an income tax increase because of that so very possibly it's a washout. Who knows?

And finally, unlike a mutual company, a state fund is not controlled by its policyholders. Well, I don't know how much control policyholders have over a mutual company but I have a statutory advisory council that consists of 8 employers, appointed by the governor, 8 employers insured by the state fund, 2 employees of employers insured by the state fund, a member of the state senate, a member of the state house of representatives, and the insurance commissioner, ex officio. I would guess that this advisory council has every bit as much control of the fund as the policyholders of a mutual insurance company.

Now, about the Colorado fund specifically. It was created in 1915 which is 65 years ago and went into effect the same day as our workers' compensation act. We have a three-way law meaning that you can insure with the state compensation insurance fund, you can insure with a private carrier, any private carrier that is authorized to write in the state or if you can qualify, you can be self-insured. In 1979 we insured 70 to 75 percent of all employers and wrote 60 percent of the premium. The difference in those two figures will become clearer later on. Our premium volume in 1979 was $93,700,000 and included in that was $40,000,000 of advance rate discounts never charged employers. Now that is our 30 percent off the top rate discount over private carrier rates. It's $40,000,000 that we never took out of the pockets of our employers and it's very important. In addition to that, we declared $20,000,000 as a dividend which is about 21 percent of the premium we actually

collected. Therefore, making workers' comp cost in Colorado to those employers insured with us at least 50 percent cheaper, we insured 38,000 employers and last year processed about 77,000 accident reports. Now, how are we organized? We're organized like any insurance company. We're also a state agency so we have obligations as a state agency in addition to our insurance company operations. We have a claims department. This claims department is a full-service claims department. We have a large staff of adjusters. We have claims investigators both in house and private investigators that we use. We provide vocational rehab services which we contract for from eleven different vendors in Colorado. We have the ability to provide any services necessary on any claim, whether we have it in house or not. We have a full underwriting department to service the calls, etc. of the policyholders. Now this is an underwriting department in that they assign rates, classifications, etc. They do not determine whether they can issue the coverage or not, whether it's a good risk or not. If they come to us and want insurance, we determine what their classification is, assign a rate, collect a premium and put their policy in effect. Our underwriters do not make a judgment whether we want to insure you or not. We have a payroll-audit department which is quite large and this is, of course, to protect the integrity of the classification system. We have a total of 35 in that department. We have a legal department and the state fund has the only legal counsel in the State of Colorado (and there is something like 14) and at the same time it is not under the control and jurisdiction of the state attorney general. The reason for that is that there is a conflict of interest frequently between the state fund and the appeals board who is represented by the attorney general and the division of labor, etc. so we're recognized

as having to have our own legal counsel. We have an accident prevention division which is the largest accident prevention effort in the State of Colorado, even including OSHA. As an example, we were able to convince our Legislature that we just had to do something about accidents, particularly when they abolished what we had which was COSH which was a Colorado Occupational Safety and Health Act and threw it all back under OSHA. It left the state practically bare of any organized state effort in accident prevention. In 1976 we had cut that to 2.06 accidents per policyholder. By the end of 1980 we hope to be down to about an even two accidents per policyholder. Now that's cutting out of 38,000 employers one-half accident off of each one and when you consider an average accident cost of $1,000 on an average, you're talking about one heck of a lot of money. We have a full data processing department. Nobody can operate today without computers. We have an accounting department, we have an administrative department that oversees all of the other functions. We additionally operate three field offices, besides the main office in Denver, three locations located strategically around the state to provide services where necessary. All of our employees are under the civil service system, including me as the manager. We have a departmental form of government in Colorado. Our department is called the Department of Labor and Employment. The three divisions in that department are the State Comp Fund, the Division of Labor which is the regulatory agency and the Division of Employment and Training. We have full status as a division in that department.

Now, how do we operate? Side by side and in harmony with the private insurance industry which we have been doing as I

said for sixty-five years. We report all of our experience as do all of the private insurance companies to the National Council, the rating organization who make and recommend rate changes from time to time based on the data that's reported to them. We use the same experience rating plan as the private insurance carriers do. We use the same retrospective rating plans. The only difference is in the bottom line and we use exactly the same rates with a few exceptions with the farmers that I mentioned. The bottom line is the state fund discount, 30 percent, just knock 30 percent off the total bill. We do that to remind them which is much more impressive than reducing our rates because they see it rather than a reduced rate, they see it as reduced dollars which they know never come out of their pocket.

I guess the proof of the whole thing is in the figures and I have two sets of figures; one I asked to be set out for you and I'll explain that. I just want to briefly touch on what I think is the proof. Now, I've got two sets of figures here. One is for the private carriers (and this is all performance in Colorado) and one set of the state compensation insurance fund. Now this analysis covers 1974 to 1978. The other set I will show will include 1979 for the state comp fund but I couldn't get it from the private carriers at this point so I will have to wait until later.

Private carriers in that five-year period had premiums of $203,200,000, incurred losses of $137,875,000, or a loss ratio of 67.8 percent. The point I was going to make here is the retention from the private carriers for this five-year period was 32.2 percent meaning that they kept $65,000,000 as retention. Now relate that to the $137,000,000 losses paid. It cost them

$1 to administer $2 worth of benefits. I expect that is very much like the experience that you have here in Minnesota.

On the other hand the state fund, and this is the discounted premium, amounted to $226,200,000 with incurred losses of $201,900,000 or a loss ratio of 89.3 percent or retention percentage of 10.7 percent or $24,000,000. Basically, it took the state fund $1 to disburse $9 in benefits. Seems to me there's a tremendous difference in that. Now, if you want to make copies of these--

Now the one that you did get handed out to you, this is an up-to-date, five-year spread for the State Compensation Fund for the period 1975 through 1979. There are about 9 columns here and these 9 columns, if you pay attention and get the message I would like to get across, tells you what the bottom line is in workers' compensation insurance. I'd like to suggest if you get the same information from the private insurance industry you would solve some of the mysteries that there are. For that five-year period our premium volume was $293,396,000. Now that's with the 30 percent discount off. If we elevated that to manual premium level, that would be something like $405,000,000, so there alone we saved the employers of the state $122,000,000. However, we gave dividends in that period of $40,000,000 to come to a net premium then of $253,400,000. We incurred losses during that five-year period of $245,667,000 and if you divide that out, we paid out 96.9 percent of the net premium dollar collected in losses. Almost 97¢ out of every dollar. However, it costs us to operate. The next column there is our operating expenses for that five year period which is some $24,000,000. Now figure that as a percent of the manual premium level of $405,000,000 had we collected that much or collected

at the full manual rate. Our expense ratio, the ratio of premium to expenses, 5.9 percent. If you figure on the basis of what we actually billed and collected prior to dividends, it's 8.2 percent or if you figured after dividends had been returned, it's 9.7 percent, less than 10 percent. Now again compare that with what an employer in Minnesota must pay.

The next column then is retention and you'll notice in our case, it's a negative retention. In losses, and after paying losses and expenses, we spent $16,319,000 more than we took in. And, here's where you have to get down to the real nitty-gritty. How did we do it. Look in the next column that is our investment income which is $44,784,000 and, you note, just growing like wild-fire. So, we paid that deficit, if you will, of $16,000,000 and added another $28,000,000 to our surplus. Now, our surplus is currently at (this is as of December 31) $47,658,000. Now that is 51 percent of our 1979 annual premium. Now, the insurance industry tells you that and most commissioners will tell you that, in surplus you should have a minimum of one-third of annual premium or a maximum of two-thirds. Alright, we're sitting right at 51 percent. It's possibly higher than we need. I would have to acknowledge that; but on the other hand, it's a safe, conservative level of surplus.

Now finally, I just want to note in this connection there has been so much said about state funds bordering on the brink of insolvency etc. If you are going to have a state fund, just some of the safeguards you may want to put in your law to see that that doesn't happen and one is through examinations. One examination, this is an annual examination, an examination the state fund must have every year is an examination by a qualified certified public accounting firm, and get this--hired by the

legislative state auditor. I do not hire this certified public accounting firm. The Legislature hires him. I pay for him but the legislative auditor hires the auditor. That, of course, is the guarantee that the state fund stays in a good financial position. Additionally, we have an actuarial examination that is required on an annual basis by a consulting, outside actuary. He's hired by the executive director of the Department of Labor and Employment. Again, so that the administration in this state will be sure that the state fund is in a solvent condition. Thirdly, every three years we have to have a tri-annual examination by the insurance commissioner of our state and the statute says we are to be examined like any other insurance company. Now, with these kinds of safeguards, I think we of course have a much better and much more solvent fund, at least everybody is more comfortable with the kinds of reports that we give.

In closing, I'd just like to say that if there is anything that our association can do, the American Association of State Funds, can do to help you in giving you any more information or helping you write a statute, or whatever, I would like to, as President of the Association, offer that help. With that, I'll close and thank you for your kind attention.

STATE COMPENSATION INSURANCE FUND

FIVE YEAR HISTORY

Year	Premium	Dividends	Net Premium	Losses	Expenses	Retention	Investment Income	Surplus Change
1975	$ 28,402,240	$ 2,000,000	$ 26,402,240	$ 27,880,662	$ 3,300,221	$ (4,778,643)	$ 5,320,091	$ 541,448
1976	35,744,464	---	35,744,464	41,579,538	3,683,683	(9,518,757)	5,996,057	(3,522,700)
1977	57,608,089	3,000,000	54,608,089	49,754,029	4,706,586	147,474	7,377,290	7,524,764
1978	77,985,667	15,000,000	62,985,667	56,903,868	5,273,716	808,083	10,477,425	11,285,508
1979	93,655,956	20,000,000	73,655,956	69,549,485	7,083,792	(2,977,321)	15,613,187	12,635,866
5 Years	$293,396,416	$40,000,000	$253,396,416	$245,667,582	$24,047,998	$(16,319,164)	$44,784,050	$28,464,886

COLORADO WORKMEN'S COMPENSATION INSURANCE

MANUAL RATE LEVEL
(Prior to Discount)

Year	Premium Earned	Elevated to Manual Level	Incurred Losses	Loss Ratio
		*State Compensation Insurance Fund (Factor 1.38)		
1974	$ 26,491,902	$ 36,558,825	$ 25,797,058	70.6
1975	28,402,240	39,195,091	27,880,662	71.1
1976	35,744,464	49,327,360	41,579,538	84.3
1977	57,608,089	79,499,163	49,754,029	62.6
1978	77,985,667	107,620,220	56,903,868	52.9
5 Years	$226,232,362	312,200,659	201,915,155	64.7
1979	$ 93,655,956	$133,459,737	$ 69,549,485	52.1
		*Private Carriers (Factor 1.08)		
1974	$ 28,144,751	$ 30,396,331	$ 16,701,701	54.9
1975	29,802,299	32,186,483	21,672,881	67.3
1976	33,823,065	36,528,910	27,279,974	74.7
1977	48,571,923	52,457,677	30,862,581	58.8
1978	62,873,720	67,903,617	41,357,984	60.9
5 Years	$203,215,758	219,473,018	137,875,121	62.8

The State Compensation Insurance Fund average discount of 27.5%, and the Private Carriers average discount of 7.6% have been used to elevate the Earned Premiums to Standard or Manual Premium Level, so that loss ratios may be reviewed on a comparative basis.

Workers' Compensation State Fund Study Commission - July 8, 1980

COMPARATIVE ANALYSIS OF INSURER OPERATIONS

Dr. Jerry Weber - Teknekron, Inc.

I will highlight some of the things that I think will be of greatest interest. I do want to thank you for inviting me here. It was so hot here yesterday that I walked around three of the ten thousand lakes in Minnesota and was tempted to jump in but wasn't appropriately dressed. But, I do appreciate the invitation and the kind words you have said about our study.

We were pleased with the response we got from the study. It was a self-administered questionnaire which was sent out to the private carriers, to state funds and to self-insurers. Our response rate for the private carriers included 90 percent of the earned premium of all private carriers and I want to put it that way because of the fact that the numbers, in term of the proportion of carriers, were not quite as impressive as the earned premium which was covered by the respondents. Another way of putting that is that most of the large carriers were included in the responses. We did not get the same response rate from small carriers. In fact, 24 of the 25 largest stock companies and 12 of the 15 largest mutual companies were included in the responses and I am talking about companies being included in the responses because there is another thing I want to say about the data. We refer to groups and we refer to individuals when we talk about carriers. The reason we refer to groups is that most of the responses for large carriers come from a group which included a number of carriers. So that you might have, for instance, the Crum and Forster group which would include a number of insurance carriers and our response came from the group itself

and not the individual carriers. Most of the premium, you will notice, came from the group respondents. We also received data from 16 of the 18 state funds. That included about 98 percent of the earned premium of the state funds. Thirty-seven of the private carrier respondents, these groups, represented 80 percent of the aggregate earned premium. That would give you another feeling for the market in general in comp. That there are large numbers of carriers but compared to the large number of carriers, a relative small number of groups write a large percentage, a very large percentage, of compensation.

Now what was the purpose of our survey. We were supposed to develop a portrayal of insurers and it was supposed to be for the most part a descriptive study. We have, in a number of places in the study, particularly the next to the last chapter, tried to introduce some analysis in that we tried to actually relate outcome to either certain types of carriers or to certain activities by the carriers. But for the most part, we were not able to do that. It became a descriptive study and the focus was on a number of items. Those items were the overall activity level, that is we wanted to get some idea of what was really the activity in workers' comp, we wanted to get some idea of money flow, where did the money go to. We wanted to get some idea of personnel resource allocations. One thing you will notice is that in all our discussions of personnel allocations where the private carriers were studied, we used total property and casualty personnel allocations, not only workers' comp allocations, because that was the only format in which the carriers would give us the data or could give us the data. When we talk about actual personnel, it is for all property and

casualty insurers. We wanted to get an idea of resources allocated to safety, of resources that were allocated to claim management and of resources that were allocated to rehabilitation. Finally, we wanted to get some idea of how much focus was oriented toward process outcome.

After I go over my discussion of the report, I will talk a little bit about some of the other experiences which either I have been involved in or my company has been involved in which has led us to some opinions. I will state it as some opinions that may impact cost. I know that the impact on cost is something that you are interested in.

Let me go to an overview of the findings now. I have prepared a copy of some of the major tables which I think are most useful for us to go over and we will just go through them. I will make some comments and after I have done that, I will leave it open for questions either on the tables which I have prepared or on the report which I guess all of you have and some of you may have had a chance to review in it's entirety.

The first table I have, Table IA, gives you some picture of the distribution of activity among the private carriers and the state funds. For instance, in terms of claims you see that state funds have about 1/7th of the total number of claims handled by the private carriers. For lost time claims, they have a little bit larger percentage. In terms of policies, you see that the state funds actually have almost a third of policies even though their other activity is somewhat lower and that is because state funds will frequently have the lower premium employers, the smaller employers, so that the differences between let's say a comparison of earned premiums among the two kinds of insurers and comparisons

of policies give you a different picture of perhaps the relative importance, if you want to use that word. Once again, the first table gives you a picture of the total aggregate activity as we estimate it for the different kinds of insurers.

Page VI-2 presents a summary table that we have prepared because I thought it would be a good idea to review or have an overall view of the data we collected, and then we will go into some more detail on some of the issues involved. We have prepared the summary table to make it somewhat easier to look at our findings across the various groups and across the various activities. Immediately you see one of the major factors, let's say one of the major factors if not the major factor in the differential in the apparent cost of writing for the state fund and the private insurers and that is the marketing activity. You see there that from our findings the private insurers expended about nine percent, or the ratio of marketing cost to net earned premium, was about nine percent for the private carriers. For the state funds who reported those costs, it came to about two percent of their earned premium. That was acquisition cost. Of the twelve competitive state funds, six reported acquisition costs and one of the four exclusive funds showed acquisition costs.

Next, we looked at underwriting costs and there we had the percentage of total personnel which were allocated to underwriting. Our definition of underwriting included actuarial staff, payroll auditors, and direct underwriting staff as indicated by the carrier. I repeat once again everything was self-reported. The differential was not great there as you can see, the percentage of personnel going to underwriting appeared pretty similar across the different

kinds of insurers. Now, we also indicated that there were some definition problems and that it is possible that certain underwriting costs could be included in acquisition costs. One of the things we did was to ask the insurers to indicate where they allocated various kinds of costs in an accounting framework. I won't go into that in detail other than to say that there is considerable variability. So, sometimes safety people can be included in some claims activity of some sort and claims people may be doing safety activity and marketing people may be doing safety activity, so it is pretty difficult to get an exact accounting definition for the carriers. The third item we looked at was claims adjustment. We have claims adjustment as a percentage of premium. Again, you see that the differential is not terribly great. It is eight percent for groups, nine percent for individual private carriers and seven percent for competitive state funds. Our estimate of six percent to ten percent for self-insurers was purely an estimate based on some information from some self-insurers about how much they would pay a private adjusting firm for their doing their claims adjustment and the estimate came out in that range. That was just a rough estimate. In terms of safety, we again looked at the percent of total personnel and we see that as a percentage of total personnel we have eight percent for the groups, ten percent for individual carriers and ten percent for the competitive funds.

The next item we have are the payments for medical bills. Now, one of the things we did collect in our survey was the actual medical payments and actual indemnity payments as compared to incurred losses. Incurred losses include

reserves for those projected costs into the future so we both collected actual medical payments and actual indemnity payments and the incurred losses provided by the insurers. This item here is actual medical bills paid as a percentage of premium and that came or ranged from 13% for the individual insurers to 19% for the state funds. We really had no estimate on a quantitative basis of resources allocated for vocational rehab. We see that state funds indicated a ratio of 43% in indemnity paid to earned premium which was compared here to 34% for the group insurers and 25% for the individual private carriers. The incurred losses are used more often in discussing and comparing insurers. You see a parallel ratio in a sense that the state funds have an 86% rate, the group insurers had a 71% rate and the individual insurers had a 67% rate.

One thing I will say now just to indicate where my thoughts come from as an analyst is that there is no reason--this is my opinion now--there is no reason to believe that lower expense ratios are better than higher expense ratios. Just abstractly as an analyst I can argue that more administrative costs may be a preferable way to go for the overall efficient operation of a social service system. It is at least possible that small is not better even though I do come from California. You will notice that the one outstanding feature of this table is the difference in marketing activity. It really stands out as a major differential between the types of insurers.

The next table (I-B) is an overview of the characteristics of the private workers' compensation insurance carriers. There you see that we have divided the carriers into four different categories or the groups and the individual carriers into different categories depending on their total earned premium. The things I will point out here are the average number of states in which

the carriers write. You see with the larger groups that they are writing in most of the states.

The largest group category averages 46 states in which they write and their focus as you can tell declines rapidly. The largest group carriers only had 33% of their premium in the top three states whereas the smallest group carriers had 90% of their premium in the top three states. So the picture that one gets there is the private carriers, particularly the large private carriers, have their activity pretty well spread out among the 50 states. You see the average number of offices, now these are total number of offices in all the states which range from 4 offices for the smallest individual carriers to over 100 offices for the larger group carriers. I think one of the real issues in providing good claim service is whether the claims people are available or not. Some of the state funds only have one office. Of course, their states are quite small frequently and they have one office which will handle claims. I don't know in this state whether the claims by the private insurers are handled in a number of centers or whether most of them are handled out of this area or exactly how that works. But I think the number of offices and the availability of claims people can be very important. That gives you an overall quantitative introduction to what private insurance carriers are like.

The next page I-11 goes into more detail particularly with the sales practices of the private carriers. There we looked at whether or not those carriers depended primarily or exclusively on independent agents or primarily on their own employees and then we looked at the personnel distribution for all casualty insurance by the private carriers. First looking at the sales practices you see that most of the carriers depend upon independent agents or brokers. Relatively small numbers depended primarily on their own

employees or exclusively on their own employees. So, it is mainly an agency system which is being used. When you go over to Table I-E, you see there the percentage of companies which have the percent of personnel listed on the left hand column. We have the percent of all personnel in the left hand column and we have less than 10%. So you see that 48% of group insurers had less than 10% of the personnel in sales. 10% of the group insurers had over 30% of their personnel by the carriers. You see for example that 78% of carriers indicated that they had less than 10% of all personnel in loss control. It may well be that we had a problem there too with general attorneys and where they would be. Some of the companies probably included the attorneys who are active in litigation in the general category. You see that the largest grouping is really underwriting where 38% of the carriers had over 30% of their personnel in just general underwrite. Again, the picture is that of considerable variation among the companies in terms of their allocation.

The next Table, I-F, presents an overview of the characteristics of state funds. Here where you bring up oranges and apples and mixtures and so forth, you really see the difference in terms of size. We have the four exclusive funds and the 12 responding competitive funds. You see that the number of policies just varies tremendously ranging from the 1600 for Oklahoma to 245,000 policies for Ohio. You see that there is the considerable variation in the number of offices handling workers' comp claims and in the amounts of indemnity and medical paid. Finally, in the percent of earned premium in the state. I know that you have reviewed this data before in your '79 study which I found to be a very good, competent study, I really have to praise you for that. I noticed that the data

on earned premium by state fund was in that study.

The next table (I-J) presents similar information for the state funds that we had presented for the private carriers dealing with their market and acquisition allocations and general personnel allocations. You see the way that we have presented this now is that we have the number of personnel on the left and the percentage distribution going across. For instance, in Nevada the total personnel were 125 people allocated 34% to claims, 23% to underwriting 12% to loss control, 14% to general and 17% to other. Again, you get this considerable differential. It is somewhat unfortunate that we didn't have the opportunity to go back and question each of the state funds in some detail about some of these items here. There are considerable differences and the one thing I would say is that in thinking about the potential for state funds, it is tremendously important to remember that a state fund can become any one of a number of kinds of institutions. The definition of a state fund and the implementation of a state fund, the organization of the state fund, the people who run the state fund and how they operate, all will have a tremendous impact on what a state fund might accomplish and what its impact will have within the state. There are large differences in the activities and the actual operation of the state funds according to the data that we received. Also associated with the development of a state fund is the initial investment and capital which might go into that. We have on page II-9, the distribution of earning assets by the various state funds and the ratio of earning assets to earned premium for the state fund. One of our findings which we will reference directly was that the state funds did receive a substantial amount of investment income relative to their earned premium as compared to private

carriers. So that their basic earning assets provided a substantial amount of monies. We tried to indicate how that varied among the state funds by taking the ratio of earning assets to earned premium in this table and you see that again there is tremendous variability. If you wanted to sit down and say how much in the way of earning assets would be required in order to start off with some level of earned premium which I know is one of the things you have to do when you are thinking about how much a state fund would cost, at least in terms of the current state of state funds, you would have a great variability in terms of what that ratio is.

All of that information is presented as background to the next table or the next few tables which look at the allocation of expenditures by the private carriers and by the state funds. These are the more typical data which is presented in looking at the experience of carriers. Table II-C is the allocation of expenditures and is the ratio of each of the expenditures to net earned premium. Again, we have done it by groups of carriers depending upon their size with the size getting larger going from Group I to Group 4. Group 4 is the largest group of carriers. You see there that the incurred losses relative to net earned premium came to about 66% for all group carriers. Their loss adjustment expense which is related to their claims activity on an average was 9% of earned premium. Net commissions were about 9%. Other acquisition expense as about 4%. Board expenses of various sort was about 6% and taxes about 4% and total expenses came to 31%.

The next table (II-E) presents the ratio of incurred losses to earned premium for the state funds. The first column and the last column may be the two to first look at. You get the picture that incurred losses relative to earned premium are substantially

greater for the state funds than they were for the private carriers and total expenses relative to earned premium are considerably lower. The loss adjustment expenses really vary considerably. In terms of the question of why or how can the insurers handle their marketing activity with such low reported resource allocations, the same thing would have to be asked about some of the loss adjustment expenses (because they are very low to handle claims) in this area. A large number of the state funds do not have any indication of tax expenditures getting back to what had been discussed before. It looks as if half of the state funds do not have any listed expenditures on taxes and very few had expenditures for the various participating boards that they might have to belong to.

The next table which is on page II-15 shows you two things. One of them is the ratio of losses paid to incurred losses. That gives you some idea of the so-called development costs in comp. That is, what are the costs on the tail? Payouts for any premium year policy will continue for a number of years. We have compared the incurred losses with the actual paid losses and that just gives you some idea of what the development costs might be. What we have indicated here is that on the average the carriers' actual losses paid were about 69% of what was reported to be incurred losses. Also what we have done is taken the ratio of loss adjustment expense incurred losses. You see that the average for the groups came to 14% and it came to 16% for the individual carriers. The next table which is on page II-20 shows the same thing for the state funds, losses paid to incurred losses and loss adjustment expense to incurred losses. In the next three tables (II-K, II-L, II-M) we try to look at which is the ratio of expense to loss time claims or to total claims. Again it is just an attempt to have some base on which

to look at the expense figures. When you look at these expenditure items, everybody says is that enough, is it too much, how do we compare one group of insurers to another group of insurers and frequently you use earned premium as the denominator to use for comparison purposes. We also asked what is the ratio of acquisition expenditures to total claims, how much does that come to? What is the ratio of acquisition expenditures to policies? As an example, for the group private carriers, acquisition expenditures come to $236 per policy. That is a fact that we have laid out. Whether that is an adequate amount or too much is up to people to discuss. We did want to provide some other basis for looking at the data we have on total expenses. So the next three tables as I say indicate for the state funds and the private carriers something about what their expenses were like relative to various measures of activity, either total claims or policies.

Why don't we move to page II-29? This table presents what we call the underwriting profit rate, the investment income rate, and the dividend rate. Now all of these rates are taken relative to net earned income. For the underwriting profit rate, we merely subtracted expenses and incurred losses from earned premium and then took the ratio. What you see there is that for all the carriers the sum of investment income rate and the underwriting profit rate is positive. Even though some of the carriers did have an underwriting profit loss, their investment income as a proportion or as a ratio to net earned income was such that the sum of the two would lead to a positive number. You see that the dividend rates were about 6% for the group carriers, about 9% for the individual carriers. Also you see for the state funds, if you look at the

state funds, you see that substantial investment income accrued relative to earned premium.

Let me conclude by looking at a couple of process tables. Look at page V-9. This was data that we put together using another study that had been done for the Inter-Departmental Workers' Compensation Task Force. That was a study of closed claims done by Cooper and Company. Over a period of several weeks they obtained data on claims which were closed by cooperating insurers. One of the tables which we were able to put together dealt with the time between notice and first check by disability category. You see there is a comparison of a few states where you have private carriers and state funds. Once again, you really have somewhat of a mixed bag in terms of the results. In some cases, the state funds appeared to be responding quicker and in other cases the private carriers appeared to be responding more rapidly. We have done a lot of closed claim analysis and the variability is considerable because of cases out on the tail. At the same time, in order to control high costs, the tail cases are frequently terribly important. They are important to learn something about. In Table V-G, which is the next table, we again took some states where we could make some comparisons and looked at the percentage of controverted cases comparing stock and non-stock and state funds carriers. There again, taking account of the relatively small samples, there appears to be a difference in the percentage of controversion, but once again there is a whole variety of factors that goes into determining the outcome such as the litigation.

Let me conclude now with an overview of really where we came out from this study. First of all, we suggested that as financing

mechanisms in general or organizations purely handling the collecting of funds, and then the passing through of the funds, that we did not find much difference between the state funds and the private carriers. They seemed to be organized fairly effectively in that regard. We came to that conclusion because it appeared to us that underwriting losses could be offset by investment income, and furthermore carriers can control their exposure to some extent through their marketing efforts and their underwriting efforts. Also, the pure financing activity in terms of solvency of the system is regulated by the insurance commissioners. So the financing mechanism represented by the industry didn't appear to be faced with a catastrophe. This finding was of great relevance when we did the study because at the time we did the study there were some bad years that had just occurred in the casualty industry and the workers' comp industry. We also suggested that from some of the outcome analysis that we had done, some of the process analysis using the Cooper study and some other surveys that had been done by the workers' comp task force that the system was pretty efficient in handling simple cases, but it didn't appear to be that efficient in addressing the process of complex claims, and that gets back to the issue of litigation. What we found was that the more costly, more complex claims did have a large percent of cases litigated. That varied by state, but a general comment was that there was a large amount of litigation when you got to the complex cases.

The state funds appeared to vary considerably among each other in many respects, although the allocation of resources appeared to be relatively similar other than for acquisition

costs. The real need we felt, in looking at the data, was to develop systems which would allocate more of the resources which are collected to claims management and safety services than were currently being provided by any type of insurer, either private or state fund. As I indicated to start with, the study was basically a descriptive study and a fact-finding study. Our ability to get behind this first layer of facts was quite limited. I think I will stop there.

TABLE I-A

ESTIMATED[a] ACTIVITY OF WORKERS' COMPENSATION CARRIERS, 1974

Private Carriers

Total Claims (millions)	7.0
Lost Time Claims (millions)	1.7
Indemnity Payments ($billions)	1.96
Medical Payments ($billions)	1.00
Safety Inspections (millions)	1.5
Policies (millions)	2.4

State Funds

Total Claims (millions)	1.3
Lost Time Claims (millions)	.33
Indemnity Payments ($billions)	.53
Medical Payments ($billions)	.24
Safety Inspections	b
Policies (millions)	.7

a. The aggregate amounts were estimated in the following manner: We first divided the aggregate earned premium of the respondents to the relevant question by the total earned premium of all private carriers or state funds as applicable. Then the inverse of that ratio was multiplied by the value for the activity category reported by those respondents.

b. We received estimates of safety inspections from ten state funds with less than 40% of aggregate state fund earned premium. Their response summed to slightly more than 75,000 inspections for each of the years.

TABLE I-B

AN OVERVIEW OF THE CHARACTERISTICS OF PRIVATE WORKERS' COMPENSATION INSURANCE CARRIERS

Private Insurer Category	Average Earned Premium (1975) (millions)	Percent of Earned Premium in Sample (1975)	Average Number of Claims (1974)	Average Number of Policies (1974)	Average Number of Offices (WC)	Average Number of Offices (WC Claims)	Average Number of States in Which Write	Percent of Earned Premium in Top Three States (1974)	Average Indemnity Paid (1974) (000)	Average Medical Paid (1974) (000)	Ratio of* WC Earned Premium to PC Earned Premium (1975)
Groups-Earned Premium											
1. < $5 million (6)	$1.6	0.2	594 (3)	2,354 (5)	7	7	5	90	$778	NA	.00
2. $5 million to $24.99 million (14)	15.0	4.0	6,765 (13)	13,243 (13)	29 (12)	29 (12)	38	55	4,162	$2,604	.12
3. $25 million to $99.99 million (15)	54.6	15.6	13,900 (13)	27,597 (13)	44	39	45	45	16,794 (12)	8,699 (12)	.15
4. $100 million+ (15)	229.0	65.6	66,612	74,316 (14)	110*	101*	46	33	83,170 (13)	41,895 (13)	.14
Individual											
1. <$1 million (30)	.4	0.2	96 (17)	1,224 (24)	14 (28)	4 (26)	6 (29)	88	$ 66	$ 45	.02
2. $1 million to $4.99 million (30)	2.4	1.4	663 (21)	2,138 (25)	13 (29)	12 (29)	9	82	525	322	.05
3. $5 million to $24.99 million (16)	11.1	3.4	7,222 (12)	10,151 (13)	12	12	17	71	3,246	1,936	.10
4. $25 million+ (7)	71.1	9.5	16,995	10,784 (6)	35*	23	19 (6)	74	16,160 (6)	8,730 (6)	.15

The numbers to the side of the categories in parentheses refer to the number of cases which were in each category.

The numbers in parentheses beneath some values refer to the number of responses used in the calculation if less than those in the original sample.

*In these cells, there were some observations above 160 offices, which were computed as 160 so that the means are slightly understated.

TABLE I-D

SALES PRACTICES OF PRIVATE CARRIERS

Description	Individual					Group				
	1	2	3	4	Total	1	2	3	4	Total
Exclusively by Independent Agents or Brokers	14 (47)*	15 (52)	11 (69)	1 (14)	41 (50)	6 (100)	11 (79)	10 (67)	12 (80)	39 (78)
Primarily by Independent Agents or Brokers	5 (17)	6 (21)	1 (6)	2 (29)	14 (17)	0	1 (7)	2 (13)	1 (7)	4 (8)
Primarily by Own Employees	1 (3)	2 (7)	1 (6)	4 (57)	8 (10)	0	1 (7)	2 (13)	1 (7)	4 (8)
Exclusively by Full-Time Employees	7 (23)	5 (17)	2 (13)	0	14 (17)	0	1 (7)	1 (7)	1 (7)	3 (6)
Other	3 (10)	1 (3)	1 (6)	0	5 (6)					

*Numbers in parentheses are percentages within the size class.

TABLE I-E

PERSONNEL DISTRIBUTION FOR ALL CASUALTY INSURANCE, PRIVATE CARRIERS

(Percentages*)

Percent of All Personnel	Sales	Claims	Underwriting	Loss Control	General
			(Group)		
<10%	48	21	4	78	22
10% - 19%	27	31	15	22	41
20% - 29%	13	29	25		15
30% - 39%	10	15	38		15
40% - 49%		2	13		4
50% +	2	2	6		2
Total Responses	(48)	(48)	(48)	(45)	(46)
			(Individual)		
< 10%	20	30	13	64	35
10% - 19%	29	29	31	25	41
20% - 29%	19	25	28	8	19
30% - 39%	6	5	13	2	4
40% - 49%	6	4	12		
50% +	21	6	4	2	
Total Responses	(70)	(79)	(78)	(53)	(68)

*Percentages were for those carriers who indicate that they made use of at least one person in the category.

TABLE I-F

AN OVERVIEW OF THE CHARACTERISTICS OF STATE FUNDS

	Earned Premium 1975 (millions)	Number of Claims (1974)	Number of Policies (1974)	Number of Offices (WC)	Number of Offices WC Claims	Indemnity Paid (1974)	Medical Paid (1974)	% of Earned Premium in State (1974)
Exclusive Funds								
1. North Dakota	4.7	17,727	18,581	1	1	1.3	2.4	--
2. Nevada	43.1	38,195	14,828	4	2	26.2	10.3	--
3. Washington	137.9	166,000	86,500	16	1	92.5	28.8	--
4. Ohio	309.0	400,000	245,000	16	16	NA	NA	--
Competitive Funds								
5. Maryland[a]	5.3	13,134	4,662	1	1	2.7	1.3	5
6. Idaho[a]	6.5	5,209	3,490	4	1	NA	NA	19
7. Oklahoma[a]	8.7	6,106	1,647	1	1	3.3	1.5	10
8. Utah[a]	10.7	34,582	13,823	1	1	5.9	5.1	56
9. Montana[b]	15.7	9,735	16,701	1	1	4.0	1.5	
10. Michigan[b]	17.9	12,385	11,840	2	2	8.5	2.6	5
11. Pennsylvania[b]	22.0	27,500	13,950	8	8	6.3	3.0	
12. Colorado[b]	28.4	54,392	20,851	4	1	11.6	7.3	47
13. Arizona[b]	39.6	35,410	18,423	10	1	20.8	8.0	36
14. Oregon[c]	122.0	71,116	39,602	17	1	35.6	17.5	61
15. New York[c]	139.2	147,951	77,061	5	5	62.9	23.2	23
16. California[c]	252.7	231,470	105,000	19	19	88.1	50.9	23

a) In some of the following tables this fund will be included in the small competitive category.
b) In some of the following tables this fund will be included in the medium competitive category.
c) In some of the following tables this fund will be included in the large competitive category.

Table I-G State Funds

Description of Workers' Compensation Market

Description	Exclusive	Competitive			Total
		Small	Medium	Large	
Exclusive	4				
Comp. - State and Local		4	5	2	11
Comp. - All Risks		2	3	1	6
Comp. - May Reject		1	2	2	5
Comp. - All Risks Rejected		1	1	1	3

Table I-H State Funds

Description of Acquisition Practice

Description	Exclusive	Competitive			Total
		Small	Medium	Large	
Do Not Actively Solicit	4	3	4		11
Advertise - No Commissions			2	2	4
Actively Solicit		1			1
Other					

Table I-I State Funds

Marketing Workers' Compensation

Type	Exclusive	Competitive			Total
		Small	Medium	Large	
Ind. Agents			1		1
Ind. Agents Supplemented					
Primarily Own Employees		2			2
Full-Time Employees	3	2	5	3	13
Other	1				1

Table I-J - State Funds

Personnel Allocation

(Percentage)

Respondent	Number	Sales[1]	Claims[2]	Under-Writing[3]	Loss Control[4]	General[5]	Other
Exclusive							
Nevada	125	0	34	23	12	14	17
North Dakota	31	0	16	25	29	10	19
Washington	591	0	38	21	21	5	15
Ohio	406	0	52	28	0	20	0
Competitive							
Small							
Oklahoma	24	0	28	38	4	21	8
Idaho	22	0	23	23	14	18	23
Maryland	63	0	43	35	2	0	21
Utah	22	0	36	14	5	18	27
Medium							
Michigan	42	0	43	26	5	12	14
Montana	74	0	18	19	34	8	22
Colorado	78	0	44	31	10	6	9
Pennsylvania	53	0	32	45	4	0	19
Arizona	229	10	30	16	13	9	22
Large							
Oregon	397	15	46	12	10	12	5
Arkansas	559	4	44	32	12	3	4
California	913	15	45	12	10	7	11

[1] Sales = Sales Personnel + Advertising and Marketing

[2] Claims = Claims Attorneys + Claims Management Personnel + Physician + Nurses and Other Medical Specialists

[3] Underwriting = Underwriting Personnel + Actuarial Staff + Payroll Auditors

[4] Loss Control = Loss Control Engineers + Industrial Hygienists + Other Safety Personnel

[5] General = Other Public Attorneys + Data Processing Personnel + Researchers and Analysts

TABLE II-B

State Funds, 1974 - Earning Assets

	Earning Assets (Millions)				Ratio of Earning Assets to Earned Premium
	Bonds	Stocks	Other	Total	
1. N. Dakota	$14.7		$18.6	$33.3	3.92
2. Nevada	46.2	14.7	14.6	75.5	1.73
3. Washington	275.6	11.8	64.2	351.6	2.90
4. Ohio	1,176.6	107.8		1,297.9	4.06
5. Maryland	6.7	12.2	.3	19.2	3.49
6. Idaho	8.8		1.6	10.4	1.85
7. Oklahoma			10.2	10.2	1.50
8. Utah	19.8		2.6	22.4	2.38
9. Montana	25.4		1.1	26.5	1.80
10. Michigan	58.7		.6	59.3	3.40
11. Colorado	9.8		62.8	72.6	2.72
12. Arizona	128.5	27.8	9.1	165.4	4.38
13. Oregon	185.2	25.9	42.2	253.3	2.27
14. New York	460.0		26.0	486.0	3.91
15. California	370.2		10.0	380.2	1.64
16. Pennsylvania	44.2	1.3	1.4	46.9	3.08

SOURCE: American Association of State Compensation Insurance Funds (AASCIF) Statistics Report for 1974.

Table II-C

Allocation of Expenditures, Private Carriers, 1972-1974
(Mean of Ratio to Earned Premium)

Carrier Category	Incurred Losses	Loss Adjustment Expense	Net Commission	Other Acquisition Expense	Boards	Taxes	Total Expenses
Group							
1 (6)*	.43 (.37)**	.10 (.05)	.12 (.03)	.05 (.02)	.04 (.03)	.03 (.01)	.25 (.27)
2 (14)	.66 (.12)	.09 (.02)	.11 (.04)	.05 (.03)	.06 (.03)	.04 (.01)	.35 (.06)
3 (15)	.67 (.06)	.09 (.02)	.09 (.05)	.04 (.03)	.05 (.03)	.04 (.01)	.31 (.06)
4 (15)	.73 (.04)	.08 (.01)	.07 (.03)	.02 (.01)	.06 (.01)	.04 (.01)	.29 (.04)
Total	.66 (.17)	.09 (.02)	.09 (.04)	.04 (.03)	.06 (.02)	.04 (.01)	.31 (.10)
Individual							
1 (25)*	.60 (.25)	.09 (.05)	.11 (.15)	.07 (.05)	.09 (.06)	.03 (.02)	.35 (.14)
2 (30)*	.63 (.16)	.09 (.03)	.09 (.06)	.09 (.13)	.07 (.04)	.04 (.04)	.36 (.16)
3 (16)	.64 (.09)	.10 (.04)	.09 (.04)	.06 (.03)	.05 (.03)	.03 (.02)	.32 (.07)
4 (7)	.68 (.09)	.09 (.02)	.01 (.06)	.03 (.03)	.05 (.03)	.03 (.01)	.22 (.05)
Total	.63 (.18)	.09 (.04)	.09 (.10)	.07 (.08)	.07 (.05)	.04 (.03)	.34 (.14)

*Three factors account for differences between the ratios in the total expense column and the sum of the other five expense ratios. First, each ratio is the average of individual respondent ratios. The weighting values applied to these individual respondents will, therefore, differ in each computation. Second, miscellaneous expenses were included in the total expense calculation, but were not listed separately. Finally, in the three carrier categories marked with an asterisk, the number of respondents differ among the individual expenditure categories because of non-response to specific items.

** The numbers in parentheses are standard deviations.

Table II-E

Allocation of Expenditure for State Funds, 1972-1974
(Ratio to Earned Premium)

Respondent	Incurred Losses	Loss Adj. Expense	Net Commission	Other Acquisition Expense	Board	Taxes	General Expenses	Total Expenses
Exclusive								
(1) North Dakota	1.60	.21						.21
(2) Nevada	.82	.02						.08
(3) Washington	.89	.04		.03	.02		.02	.11
(4) Ohio								
Competition								
Small ($5-10 Million)								
(1) Maryland	.66	.08						.19
(2) Idaho	.77	.04			.01	.03		.13
(3) Oklahoma	.91	.10						.10
(4) Utah	1.26	.04				.03	.05	.12
Medium ($11-$49 Million)								
(1) Montana	.85	.05						.09
(2) Michigan	.83	.10	.07	.05				.24
(3) Pennsylvania	1.05	.16		.03	.01	.02	.04	.27
(4) Colorado	.74	.08				.01	.03	.12
(5) Arizona	.84	.07		.03		.05	.09	.25
Large (> $100 Million)								
(1) Oregon	.78	.06		.03		.04	.01	.13
(2) New York	.88	.10		.01	.01	.01	.08	.27
(3) California	.78	.07		.02		.02	.04	.16

Table II-F

Average Ratios of Losses Paid to Incurred Losses and
Loss Adjustment Expense to Incurred Loss
Private Carriers, 1972-1974

Carrier Category	Losses Paid to Incurred Losses	Loss Adjustment Expense to Incurred Losses
Group		
1 (3)*	.73 (.36)**	.19 (.09)
2 (10)	.74 (.09)	.14 (.03)
3 (12)	.78 (.12)	.13 (.04)
4 (13)	.80 (.08)	.12 (.02)
Total (38)	.77 (.13)	.14 (.04)
Individual		
1 (10)	.61 (.29)	.16 (.07)
2 (16)	.69 (.28)	.16 (.06)
3 (12)	.76 (.12)	.16 (.06)
4 (6)	.69 (.11)	.14 (.03)
Total (44)	.69 (.23)	.16 (.06)

*These numbers are the number of respondents used in the calculations of the ratio of losses paid to incurred losses. Almost all respondents provided information for the ratio of loss adjustment expense to incurred losses.
** The numbers in parentheses under the values are standard deviations.

As noted earlier, the ratio of losses incurred to earned premium is much higher for state funds. Six of the fifteen state funds providing information for the period 1972-1974 had loss ratios between .80 and .89 and four had ratios of .90 or more. The ratio of actual losses paid to incurred losses varied from .43 to .96 for the sample of state funds listed in table II-J, which would suggest an apparent difference in reserving practices among funds.

TABLE II-J

RATIO OF LOSSES PAID TO INCURRED LOSSES AND LOSS ADJUSTMENT EXPENSE TO INCURRED LOSSES, STATE FUNDS, 1972-1974

	Losses Paid to Incurred Losses	Loss Adjustment Expense to Incurred Losses
North Dakota	.66	.13
Nevada		.02
Washington	.96	.05
Oklahoma	.82	.11
Utah		.03
Montana	.43	.07
Michigan	.55	.12
Pennsylvania	.58	.15
Colorado	.85	.09
Arizona	.73	.09
Oregon	.64	.07
New York	.77	.12
California	.80	.09

These studies of the loss ratio illustrate the limitation of the value of the loss ratio as a measure for judging insurer effectiveness.

Table II-K

A Perspective on Acquisition Expenditures*, Private Carriers, 1974

Carrier Category	Ratios of Acquisition Expenditures to** Earned Premium	Total Expenses	Loss Adjustment Expense	Lost-Time Claim	Total Claim	Policies
Group						
1	.17	.58	1.38	--	--	--
2	.14	.42	1.53	$292	$124	$149
3	.12	.39	1.35	419	93	211
4	.10	.34	.48	298	69	267
Total	.10	.36	1.18	$288	$ 70	$236
Individual						
1	.18	.55	2.14	$677	$214	$ 54
2	.19	.55	2.08	635	176	197
3	.15	.46	1.46	215	86	153
4	.07	.35	.79	208	71	441
Total	.10	.41	1.12	$244	$ 80	$231

* Commissions and Brokerage Fees plus Other Acquisition Costs

** These are ratios of average within cells for the numerator and denominator. In some situations, there were a few observation differences within the cells for the numerator and denominator.

Table II-L*

Distribution of Personnel, Private Carriers*, Grouped by Dividend Rate (Percent of Total Non-Clerical Personnel)

Dividend Rate Category	Personnel Category Sales	Claims	Underwriting	Loss	General	Other
Group						
.04 (21)	.11 (.06)	.19 (.11)	.33 (.09)	.07 (.04)	.12 (.06)	.18 (.11)
.04-.08 (6)	.04 (.04)	.20 (.10)	.36 (.10)	.09 (.04)	.12 (.07)	.19 (.13)
.08 (15)	.21 (.14)	.21 (.14)	.21 (.10)	.06 (.04)	.10 (.04)	.23 (.10)
Individual						
.04 (6)	.36 (.33)	.14 (.11)	.21 (.16)	.05 (.06)	.13 (.11)	.16 (.11)
.04-.08 (3)	.12 (.06)	.26 (.20)	.18 (.01)	.15 (.05)	.05 (.01)	.39 (.20)
.08 (14)	.23 (.18)	.19 (.20)	.26 (.14)	.06 (.04)	.11 (.06)	.15 (.13)

* All cases used had earned premium greater than $5 million.

Table II-M

A Perspective on Total Expenses, Private Carriers, 1974

Carrier Category	Ratio of Total Expenses to Earned Premium	Ratio of Total Expenses to Incurred Loss	Ratio of Total Expenses to Lost Time Claims	Ratio of Total Expenses to Total Claims	Ratio of Total Expenses Less Loss Adjustment Expense to Earned Premium	Ratio of Total Expenses Less Loss Adjustment Expense to Incurred Loss	Ratio of Total Expenses Less Loss Adjustment Expense to Lost Time Claims	Ratio of Total Expenses Less Loss Adjustment Expense to Total Claims
Group								
1	.30	.55	---	---	.18	.32	---	---
2	.34	.50	$ 697	$296	.25	.36	$507	$215
3	.31	.44	1,078	239	.22	.31	768	171
4	.28	.38	877	202	.20	.27	615	142
Total	.29	.40	920	215	.20	.28	647	151
Individual								
1	.33	.60	---	$391	.27	.45	---	$292
2	.35	.53	---	321	.26	.39	---	236
3	.32	.49	$ 470	188	.22	.34	$323	129
4	.21	.31	810	204	.12	.18	457	115
Total	.25	.39	733	197	.16	.25	381	125

Table II-R

Summary Table of Financial Experience, Private Carriers, 1972-1974

Carrier Category	Underwriting Profit Rate	Investment Income Rate	Dividend Rate
Group			
1	.32 (.63)*	.04 (.01)	.08 (.05)
2	-.01 (.14)	.04 (.01)	.06 (.06)
3	.01 (.09)	.05 (.02)	.06 (.05)
4	-.02 (.05)	.06 (.02)	.06 (.04)
Total	.03 (.25)	.05 (.02)	.06 (.05)
Individual			
1	.06 (.24)	.11 (.28)	.15 (.17)
2	.01 (.27)	.06 (.05)	.10 (.08)
3	.05 (.12)	.05 (.02)	.08 (.05)
4	.11 (.11)	.06 (.02)	.15 (.08)
Total	.04 (.22)	.05 (.02)	.09 (.08)

* The numbers in parentheses are standard deviations.

Table II-S

Summary Table of Financial Experience, State Funds, 1972-1974

State Fund	Underwriting Profit Rate	Investment Income Rate	Dividend Rate
North Dakota	-.60	.20	
Nevada	.08	.04	.02
Washington	-.10	.17	
Ohio			
Maryland	.16	.18	
Idaho	.06	.20	.17
Oklahoma	-.01	.09	.09
Utah	-.38	.12	
Montana	.22	.16	.14
Michigan	-.07	.27	.09
Pennsylvania	-.30	.24	
Colorado	.06	.05	
Arizona	-.07	.30	.13
Oregon	.07	.13	.18
New York	-.16	.19	.05
California	.07	.10	.16

TABLE V-D

TIME BETWEEN NOTICE AND FIRST CHECK, BY MAXIMUM DISABILITY AND TYPE OF INSURER

(Mean Number of Days)

	(a) Temporary Total		(b) Permanent Partial			
State	Pvt. Carrier	State Fund	Self-Insured	Pvt. Carriers	State Fund	Self-Insured
Arizona	54	26				
California	12	13	18	80	122	
Michigan	20		120			
New Jersey		30			180	
New York	66	65	30	148	121	136
Colorado	17	40				
Maryland	35			89		
Georgia	29					
Illinois	20			73		190
Florida	20			54		
Oklahoma	10			55		

Source: Cooper & Co., Closed Claims Survey

From the Health Programs Study (HPS) interview survey, we have some indication of the length of time between injury and first workers' compensation contact. (see table V-E). In the five states under consideration, the proportion of cases with first contact under ten days ranged from 20% in Florida to 43% in Wisconsin, and the proportion with first contact over sixty days ranged from 12% in Wisconsin to 20% in Florida. The nature of that first contact varied considerably between states. For the sample of severely injured, 24% in Wisconsin perceived their first contact to be the first check received, while 3% initiated contact through a lawyer. However, in California, 18% initiated contact through a lawyer as opposed to 11% having initial contact by the receipt of a check. The insurance company was not perceived to have initiated contact

TABLE V-G

CONTROVERTED CASE BY INSURER FOR A SAMPLE OF STATES
(Percentage of Cases Within Cell)

Insurer	National	California	Colorado	Maryland	Michigan	New York
Stock	13	26	6	18	17	9
Non Stock	11	17	8	16	9	8
State Fund	6	12	6	6		5
Self-Ins.	19	18			40	9

Source: Cooper & Co., Closed Claims Survey

We would suggest that the extent of litigation in more serious and costly cases partially reflects the background of private carriers in the general liability insurance business. There, claims adjustment, as already noted, is part of an adversary legal process; and settlement, not reimbursement, is the prevailing objective. This is supported by data dealing with compromise and release settlements. Private carriers settled 63% of permanent partial cases by formal compromise nationwide, as compared to 20% for state funds and 51% for self-insured. The same relationship, at lower levels, held for temporary total cases.

The California Workers' Compensation Institute has suggested a three-pronged program to prevent litigation which would also appear to lead to improved outcomes.

- Furnish more information about Workers' Compensation to key audiences.
- Enhance the quantity and quality of timely communication during benefit delivery.
- Provide specialized training for claims technicians and others who are the human intermediaries between the injured employee and the system.

Summary Activity Table Showing Type of Activity, Costs or Mean Percent of Total Personnel, and Remarks
(Costs are Indicated as a Percent of Earned Premium)

Type of Activity	Range of Costs or Allocated Personnel: Private Insurers Group	Private Insurers Individual	State Funds (Competition)	Self-Insurers	Remarks
Marketing (percent of premium)					
Acquisition	2.5%	7%	2%	Not Applicable	Of 12 competitive state funds only 6 report acquisition costs. One exclusive fund shows acquisition costs.
Commissions	7%	2%	--		
Total	9.5%	9%	NA		
Underwriting (% of total personnel)	30%	25%	28%	Not Applicable	Separate costs not available. Underwriting expenses may be partially included in acquisition costs. Among private carriers underwriting personnel are indicated as a percent of total personnel for all property and casualty business.
Claims Adjustment Costs as % of premium	8%	9%	7%	about 6-10%	Self-insurers cannot be compared with carriers because their methods of cost allocation for loss adjustment expense vary greatly among themselves. Service provided by plant nurses may not be included in loss adjustment. There are also variations among carriers and state funds regarding allocation of legal and rehabilitation costs to loss adjustment.
Safety (% of total personnel)	8%	10%	10%	NA	Separate costs are not available. Private carriers are reporting figures based on all property and casualty personnel.
Medical Bills paid in 1974 as % of premium	18%	13%	19%	$47 per covered employee in our sample (no premium)	Payments during the year cover claims from all prior years as well as the present year; premium covers accidents in the 1974 policy year only. It represents revenue for the year.
Vocational Rehabilitation Services	NA	NA	NA	NA	Costs are distributed between internal staff and outside consultants. Costs may be allocated to claims adjustment or to medical costs. A portion of claims adjustment activity is involved with reemployment assistance to the injured.
Indemnity (Paid in 1974 as % of premium)	34%	25%	43%	$117 per covered employee in our sample (no premium)	Self-insurers pay out a bit less in medical cost per dollar of indemnity than do insurers.
During 1974 carriers incurred losses (paid plus estimates of future indemnity and medical costs)	71%	67%	86%	$126 per covered employee (no premium)	In our sample, self-insurers indicated that their liability for 1974 was about the same as the amount paid that year. Where permitted by jurisdiction many self-insurers operate on a pay-as-you-go basis.
Other costs including investment activities as a % of 1974 premium	9%	10%	5%	NA	There is no uniformity among self-insurers for reporting administrative costs. State funds are exempt from some of these expenses.

STUDY OF FEASIBILITY AND DESIRABILITY OF COMPETITIVE STATE WORKERS' COMPENSATION INSURANCE FUNDS

C. Arthur Williams, Jr. - Professor of Economics and Insurance,
College of Business Administration,
University of Minnesota

My name is C. Arthur Williams, Jr., Professor of Economics and Insurance in the College of Business Administration at the University of Minnesota. Senator Keefe asked me to talk to your Commission about (1) my work on state funds and (2) what further research I believe is necessary. In 1969 the Bureau of Labor Standards published a monograph I wrote entitled Insurance Arrangements under Workers' Compensation which included a chapter and some conclusions regarding state funds. During 1971-72, as a consultant to the National Commission on State Workers' Laws, I edited with Peter Barth the Compendium on Workers' Compensation published by that Commission. From 1972-1978, because of administrative duties at the University, I was less active in workers' compensation research but I tried to keep up with the literature. During 1977-1978, I was Vice Chairman of the Minnesota Workers' Compensation Study Commission. Currently, I am discussing with the U. S. Department of Labor a possible revision of Insurance Arrangements under Workers' Compensation. Since 1975, I have been a member of the Board of Directors of the St. Paul Companies, but in my research I have attempted to be as objective as possible and they have encouraged me to continue this stance.

As a member of the Minnesota Study Commission I voted against a state fund but for the new reinsurance association. My reasoning was that the burden of proof rested on those who favored a state fund and that, in my opinion, they still had

not proved their case. Another factor that influenced my decision was that unless the Minnesota state fund wrote a substantial share of the business in the state its exposure might be too limited to render adequate service and to stabilize its loss experience. Finally, no matter how poorly it might perform, a state fund once established, would be extremely difficult to phase out. Instead, I favored improving the present system. In my opinion, the reinsurance association would be an interesting experiment that might solve the problems created by reserving uncertainties. Furthermore, if the association does not work, it can be terminated with relative ease.

Private insurers and state funds can be compared with respect to (1) their financial strength, (2) the quantity and quality of the services they render, and (3) their premium charges. In 1969 I concluded on pp. 202-203 of Insurance Arrangements that except with respect to the cost factor, for which state funds must be given the edge because of their lower expenses, it is difficult to rate the different funding media using each single criterion. A composite evaluation is even more difficult because of their lower expenses, it is difficult to rate the different funding media using each single criterion. A composite evaluation is even more difficult because the individual ratings must be qualitative and the three criteria under investigation may not be of equal importance. However, the task is made somewhat easier by the fact that (1) solvency considerations do not favor strongly one approach over another.

On the average, private insurers probably rank ahead of state funds in servicing their insureds with competitive funds

probably performing slightly better than exclusive funds. With respect to cost, the ranking is reversed with a small part of the difference in expense ratios being explained by the taxes paid by private insurers, but not by most state funds. The tradeoff, therefore, appears to be somewhat better service for higher premiums. In part, however, the predominant position of the private insurer must be explained by a prevailing philosophical preference for private enterprise and competition and the limited selling efforts of state funds.

The "best" state funds provide about the same quality loss prevention and loss adjustment services as the "best" private insurers but at lower cost. Nevertheless, the cost differences have not been sufficiently high to encourage any state to establish a new competitive fund since 1933. Similarly, state funds have performed well enough to defeat any movement to abolish them. Because service and cost comparisons are not conclusive enough to outweigh subjective considerations, the burden of proof is heavier for those who advocate a change from the existing choice between a state fund and private insurers.

On page 206, I stated that objective comparisons suggest that employers receive somewhat better service at higher cost under a system that includes private insurers. In terms of service, the average private insurer ranks slightly higher than the average competitive fund which in turn ranks ahead of the average exclusive fund. Cost rankings are the reverse. The "best" state funds provide about the same quality loss prevention and loss adjustment services as the "best" private insurers, but at somewhat lower cost. Comparison of "best" or "average" systems

is dangerous, however, because this may not be the relevant comparison for a particular state.

Studies such as the Teknekron report and reports by various state funds have not changed my opinions significantly. I do believe, however, that the dramatic increase in workers' compensation premiums during the seventies has caused the cost advantage of state funds to become more important. For this reason alone, the issue deserves more serious study.

Before turning to several specific issues that I believe should be included in such a study, I want to emphasize two important problems in any comparison of private insurers and state funds. First, as already indicated, one must recognize the diversity among the insurers of each type. Private insurers clearly differ among one another as to financial strength, service, and cost. So do state funds. The importance of this observation is that within a state, employers can choose among many private insurers, but they have access to only one state fund. Second, measurement problems make it difficult to determine how the average private insurer performs relative to the average state fund. For example, relative financial strength is affected by relative reserve adequacy, which is difficult to determine. Also, there are no generally accepted yardsticks for measuring the relative quality of service such as loss control and loss adjustments.

Some problems requiring further research are the following:

1. What rate of return on net worth should private insurers be permitted to earn from all sources (underwriting and investment) as a result of writing workers' compensation

insurance? Theoretically insurers should be permitted to earn as much on this business as is earned by other industries facing similar risk. Generally, the higher the risk the higher the rate of return an industry should be expected to earn. If insurers earn more than a reasonable rate, their profits are excessive. If they earn less, investors will not be attracted to this business and employers will face an insurance shortage. Determining this reasonable rate of return, however, is not an easy task. For example, authorities disagree on the best measure of risk. They also disagree on the proper way to measure the rate of return on a single line of insurance in a single state. Indeed some believe such a measurement is impossible. In addition, one must recognize that over a short period of time, the profits of any industry may fluctuate significantly around its average rate of return in the long run. Any methodology developed to answer this question must be logically defensible, fair, and practical to administer.

2. How should private workers' compensation insurers recognize investment income in their pricing? Currently, this income is recognized by accepting a lower profit loading in the rates. For example, if insurers write $2 in premium per $1 of net worth, a 2 1/2 percent loading in the rates would produce a 5 percent rate of return, which is less than the risk free rate of return. Supposedly this 5 percent plus the investment profit is a reasonable return.

3. How reliable are the financial statements issued by state funds? What do they tell us about the financial strength of state funds? Some state funds provide excellent data; others leave

many questions unanswered. More often than should be the case, some state funds have been required to correct their reserve estimates. For example, according to a recent issue of Business Insurance a public accounting firm has just determined that the loss reserves established by the Ohio Fund are not adequate.

In addition to checking on the completeness and accuracy of state fund financial statements, analysts should use new financial tests such as the National Association of Insurance commissioners audit ratios to determine their financial strength.

4. What are the advantages and disadvantages of extending Minnesota's open competition law to workers' compensation insurance? As a member of the Minnesota Study Commission I voted in favor of such an extension. In my opinion, in the short run such an extension would raise workers' compensation premiums, but in the long run premiums would be less than under the present one-price (except for dividends) system. I would be more comfortable with this position, however, if we had more evidence on which to base a decision.

5. Are present requirements for self-insurance too high or too low? How does group self-insurance differ from individual self-insurance? What are the true costs of self-insurance? How do these costs compare with the costs of private insurance and state fund insurance? In my opinion employers who want to self-insure should be given that opportunity if the state believes that these employers will be able to pay workers' compensation benefits when the occasion arises and to service these claims in an acceptable manner.

6. In competitive state fund states what premiums would

a selected group of employers (categorized by industry, size experience) pay if they were insured (1) by the state fund (2) by the lowest cost private insurer, and (3) by the average cost private insurer? Past studies have compared loss ratios and expense ratios: premium comparisons would be more meaningful to employers and more revealing to legislators.

7. How is the Workers' Compensation Reinsurance Association performing? Has it reduced premiums in the short run? Will it reduce premiums in the long run? How can it be improved? How many years should pass before its continued existence should be evaluated?

8. How can the relative quality of services rendered by state funds and private insurers be measured? The Teknekron report contains some interesting suggestions on how these services might be measured but more remains to be done.

9. What have the "best" private insurers and the "best" state funds done that other insurers might be encouraged to copy? What loss control measures have they adopted? How do they adjust losses? Why do they have lower expense ratios? How do they service small employers?

In conclusion, because of the rapid rise in workers' compensation costs it is important to reassess the relative advantages and disadvantages of establishing a Minnesota competitive state fund. On the basis of the evidence available at this time, I believe that Minnesota should try first to improve the present system.

Workers' Compensation State Fund Study Commission - August 5, 1980

EXPERIENCE IN THE ESTABLISHMENT OF AN "OFF-SHORE CAPTIVE" INSURANCE COMPANY

Edward Driscoll - Private attorney, Larkin, Hoffman, Daly, and Lindgren, representing North Star Casualty Services

My name is Edward Driscoll. I'm an attorney in private practice with the firm of Larkin, Hoffman, Daly and Lindgren in Bloomington. I'm here today representing North Star Casualty Services, a Minnesota corporation that serves as consultant to a Bermuda insurance company bearing somewhat the same name--North Star Hospital Mutual Assurance and North Star Casualty. I might give you, Mr. Chairman, some background as to the history of this organization. Currently, North Star Hospital Mutual insures 23 Minnesota hospitals for malpractice. During the 1970s, the Congress of the United States and various federal agencies, together with this body, became concerned with cost containment in the health care industry and, through legislation and rule-making, started putting pressure on health care providers to contain cost. At the same time these health care providers, hospitals among them, started to feel pressure from private insurance carriers writing their malpractice and other forms of coverage. Rates were escalating. In the mid-70s there was even a suggestion that malpractice insurance might not be available from the traditional and conventional sources. And so as a cost containment measure and as a necessary means of obtaining insurance, these institutions started to explore alternatives to the traditional sources of insurance, the commercial carriers. During this period of time, the hospitals banded together and explored a number of alternatives. For example, they looked at forming a captive

insurance company in one of the United States jurisdictions that authorizes the formation of a so-called captive insurance company. Most specifically, they looked at Colorado and Tennessee. They did not find that that particular alternative would be a viable one. They continued to explore the possibility of establishing a mutual insurance company in this state. You may be aware that our statutes require, for the formation of a mutual insurance company, that you have 300 insureds. There are only, I believe, 187 hospitals in this state and so that became an alternative that was not available. They incidentally sought to amend the law to either provide a special circumstance for them or to reduce that number and were unsuccessful. They looked at the formation of a stock insurance company and that also proved for various reasons to be not a viable alternative. So, finally in 1978 they went to Bermuda and organized there a mutual insurance company to provide malpractice insurance for Minnesota hospitals. In 1979 workers' compensation insurance also became an issue for them, both because of the rates and because of some difficulty they were having in procuring insurance from commerical sources. And so again, they went through a very long process of studying the alternatives to commercial insurance. I was directly involved in that study and can tell you that we again looked at the possibility of forming a captive insurance in a United States jurisdiction. We looked at utilizing a then rather obscure provision that was placed in the law in 1978 that would allow a pooling for the purpose of providing workers' compensation in this state. In 1979, however, there were extensive revisions of the workers' compensation statutes, as this committee is well aware, and the jurisdiction over workers' compensation was transferred from the Department

of Labor and Industry to the Department of Commerce, the Insurance Division thereof. And the Department of Commerce undertook a rule-making procedure which, at the time we were looking at alternatives, promised to extend on for some time. As a consequence, we dropped the idea of doing a pooling in this state. We looked at the possibility of forming a reciprocal, which is an inter-insurance type of exchange authorized by Chapter 71A of the Minnesota statutes. The obstacle in forming a reciprocal as far as we were concerned, in addition to the capitalization and restriction on the amount of risk that could be underwritten by any one participant, was the fact that you needed 100 individuals to participate in the reciprocal. There simply weren't that number of hospitals available to make the concept feasible. Another alternative that we briefly looked at was the mutual insurance company, but again the law still required 300. We looked at a stock insurance company. And as a matter of fact we filed with the Insurance Division of the Department of Commerce for a certificate of authority to form a stock insurance company. Currently that application is still alive. We did notify the Commissioner's Office after a period of time that we had for the time being sought refuge again in Bermuda, but the application for a stock insurer is on file with the Department of Commerce. An alternative that I haven't discussed and the one that was ultimately selected in terms of the workers' compensation program is the formation of a Bermuda insurance company. The company was formed as a wholly owned subsidiary of the malpractice carrier. Going back just a couple years to refresh your memory, in 1978 the hospitals formed a mutual insurance company to write medical malpractice insurance. In 1980 that company put up the capital to form a wholly owned

subsidiary company, this time a stock company, to write workers' compensation insurance. Now, the workers' compensation laws of this state require that a company writing insurance in the workers' compensation field be an admitted carrier here. And as a consequence, a Bermuda insurance company, not admitted to write insurance in Minnesota, would not be eligible to qualify under our workers' compensation statutes; so, we, recognizing this problem, caused the Bermuda company to employ the services of what is known as a fronting company. A United States-based company has agreed to act as an intermediary to write insurance and then reinsure those contracts through to the company formed in Bermuda. As a consequence, currently a carrier based in the United States, named Ideal Mutual of New York, is writing workers' compensation for hospitals in the State of Minnesota and reinsuring 95% of the risk with the Bermuda Insurance Company which is a wholly owned subsidiary of North Star Hospital Mutual. So the insurance industry in this state has accomplished its objective. It has provided an alternative to the commerical insurers by forming two insurance carriers in Bermuda. One of these carriers writes medical malpractice insurance and the other workers' compensation insurance. The workers' compensation insurance is written in the United States by an admitted carrier and reinsured through to Bermuda. I have with me today Allin Karls who is President of North Star Casualty Services, a Minneapolis company that serves as consultant to the two Bermuda insurers, and Mr. Karls is prepared to discuss with you the experience of both the malpractice carrier and the experience of the workers' compensation carrier. You might keep in mind that, while the malpractice insurance has been in place for a period of two and one-half years, the

experience with workers' compensation is only four months old, and so the experience will not permit an in-depth view of where this company expects to go. At this time I'll introduce Allin Karls.

EXPERIENCE IN THE ESTABLISHMENT OF AN "OFF-SHORE CAPTIVE" INSURANCE COMPANY

Allin Karls - President, North Star Casualty Services

I'm Allin Karls and I'm President of North Star Casualty Services. I've met most of you before when I was with the Minnesota Hospital Association. Before that, I spent 15 years in the insurance business. I might just add a couple of things to what Ed said on both of those points. Bermuda is not all that soft a spot because they would not, for example, allow in a corporation that didn't have good solid financial backing. And while they will allow you to incorporate with minimal capital, the people they allow to come have to come with significant balance sheets. The kinds of companies that are there from this community are 3M, Honeywell. The hospitals that are involved in North Star had to submit their balance sheets and if those hospital balance sheets hadn't been of significant strength to carry it, they would have never allowed us in. Now the second corporation we set up is owned by the first and, therefore, is backed also by institutions that have significant financial strength. So, they are not pushovers. As a matter of fact, at the first go-around, the group has to meet with the committee of their Parliament that approved the application, and it included two actuaries, two insurance company presidents (who happened to be retired and living in Bermuda), and two financial officers. It was an eight-hour interview session, and it was the most intense that I have witnessed. So they are not lax in their approach but once they've made the judgment, then they are a little different in the way they go about the monitoring process.

Point number two, the problem with incorporating in Tennessee or Colorado is that if you operate as an admitted carrier in Minnesota, no matter where you're domiciled, you still have to meet the Minnesota requirements. So there's nothing to be gained, or very little to be gained, by going to another state.

North Star is one of 47 hospital-owned captives in the United States; so it is not a unique undertaking. A little over half the hospital beds in the country are now in totally owned insurance companies like North Star. Even that is very slow because industry set the pace, companies like Ford Motor, Carnation, 3M, General Mills, General Motors, etc., several years ago. There are now 900 companies in Bermuda alone, insurance companies in Bermuda, and there are other sites where there are a number of them also. The key is that in our case they are very much member-oriented. Even though the domicile is in Bermuda, most of the people that work with the company are internationally known names or are certainly leaders in their area. For example, in the case of North Star, there are legal firms like Mr. Driscoll's here in town that represent North Star, the money is at Northwestern National Bank; so it's a local banking firm. The auditors are Coopers and Lybrand, one of the largest auditing firms in the country; there are other insurance companies involved, Ideal Mutual being one, General Re-Insurance being another. The actuarial firm is Milliman and Robertson, the second largest actuarial firm in the country, etc., etc. And so basically, what North Star is is a structure of cooperative arrangements or contracting arrangements that provide for much of the same kind of strengths that you have when you have a conventional insurance company. The goals are not all that different. It's to have a

stable and secure company to provide the best insurance, to provide individualized insurance and to do it at the lowest possible cost. And the lowest possible cost is the key because of the way that this company goes about it. And that's basically to tell the hospitals and nursing homes who participate that they have to participate as an owner and believe me, the difference there is very significant. If they are not willing to assume the attitude that the losses are eventually theirs and that they are going to pay for their losses, North Star is not their answer. The only advantage to North Star is if they are willing to address the problems that lead to high losses and that's what they must do if they participate in a company like ours. The entire key is controlling losses. Let me just tell you a little of the experience our company has had, and I'm going to have to depart, Mr. Chairman, if you don't mind, for just a moment from the workers' compensation because that's very new, but I'll describe the professional liability experience which supposedly is a much more volatile line than even workers' compensation. If you'll harken back five or so years when all of the crisis was occurring, professional liability was quite clearly the worst-line that was underwritten by any company in the country, a very volatile line. And again keep in mind that North Star is a very small company, a very new company, but its first year it only had $900,000 in earned premium, $979,000. It set up loss reserves, for incurred but not reported as established by Milliman and Robertson, of $600,000. We paid losses that first year of $263, so a million dollars roughly in premium, $263 in losses. Now that's not unexpected because of the long tail in the professional liability business and so it was still under the projections but the numbers weren't large enough to

mean a lot. The loss ratio then was roughly .002% of the premiums. We started with assets then of $1,126,000 and surplus of $389,000, right at the minimum surplus. Again, however, backed up by the balance sheets of all of the owners of the company. The second year there was earned premium of $1,132,000; a review of the incurred but not reported loss ratio by the actuaries actually reduced that a little bit the second year to $500,000. The second year there were paid losses of $12,000 and so $976,000 was added to surplus. So now that surplus has grown from $389,000 to $1,486,000. And as I mentioned, the loss ratio at $12,000 was just under 1% for the paid loss ratio. The loss ratio for reported and paid was right at about 5% and that was at the end of year two. About three-quarters of the way through the third year in operation at roughly $2,000,000 in earned premium, the expected paid loss is going to be $56,000; the incurred but not reported surplus at about $700,000. There will be about another million added to surplus. The loss ratio will be about 3% and the surplus has now grown from $300,000 to $2-1/2 million. So, in other words, the surplus that started out at a ratio of 1 to 5 is now at a ratio of more than $1 in surplus for a $1 in written premium. So, the surplus is at a very secure level, much more secure than is required by law, and that has basically come about through the operations. It's also basically come about out of the recognition that you can do things to impact on losses. First thing that is required are some things that are unique in an arrangement like this where the people who are insured also own it on a small scale, a small enough scale that they can see very directly the benefits of anything they might do to cut losses because the company is small, because all the assets are theirs. The main thing that is required is commitment and involvement to a level

I would never have believed possible prior to my time being in the North Star consulting operation. For example, at the company level every hospital has to serve on at least one committee. Every hospital has to have a risk manager appointed and active. There is a committee of all those risk managers; they have to participate. There is an involvement that is unusual. They have to participate in educational programs. They have to attend regular briefing meetings. What occurs as a result of all that is a rather increased level of awareness. And that increased level of awareness changes behavior and the change in behavior has reduced losses. The second thing that is almost surprising to me is that the programs work. When the whole thing started out, there was a lot of talk about prevention and a lot of work that was done. Programs were designed and rather to my surprise, they worked, and they worked just about as we felt they would when we described them. And they're not all that unusual, they're not all that creative, but they basically come about from the partnership of hospital knowledge and insurance company knowledge and a working together to put things into place. The other things that surprised me, and I think it surprised the hospitals who make up North Star Hospital Mutual and North Star Casualty, is that they worked as fast as they did and that they impacted as quickly as they did on the loss patterns, because the theory that we utilized in working with the hospitals was to do things a bite at a time, to cut off very small bites. There is an assessment that is an early part of the loss control program where the loss control people go in, assess that hospital, evaluate where they are and come up with a thick book of recommended improvements. Now that's not all that unusual. The approach was going to be to take things one at a time leading with

the one that had the most exposure and have a very gradual improvement but have improvement. The fact has been that with all the increased awareness the losses have plummeted and the losses are much below the industry averages as our experience would indicate. And so we have been very surprised at how quickly that occurred. There is also a very early and effective loss settlement program and an early warning system. The early warning system is just aimed at identifying leading indicators that say this kind of thing is likely to be a problem. I'll give you a couple of illustrations. In the professional liability side, it means a person who is readmitted to the operating room when they are in the hospital already. We get notified of that regardless of whether there is any case or not and that's where we identify lots of things that we discover later are problems. But there are other indicators. Transfer to any other acute care facility, for example, which indicates somebody might be angry and upset and wanting to go somewhere else. In the workers' compensation, it's a question of raising the level of awareness of the person's supervisor, for example, that they really could come back to work and maybe do something even though the something they do is not full strength. We've done a few things that would seem to have very little impact on losses. For example: We discovered that in the accounting systems, at least of hospitals and nursing (this might or might not be true of other industries), if a person is off on an injury for workers' compensation, they are not charged against the budget of that individual unit and the workers' compensation claims paid are not usually charged against that unit. The first thing we did was go in and get agreement on the part of our members to charge the unit with the losses, the workers' compensation losses, and so a supervisor before that time basically kept

that person away. In other words, they didn't want somebody at work who was part-time or who could not do everything because they tended to look at them as somewhat of a handicap to have around. But when they're being charged anyway with the full cost, we're now able (I shouldn't say we're not able), we're working at it and we're making some progress at getting them to accept that person back. And we again don't ask the same questions they were familiar with being asked. We don't ask the doctor, "Can they come back to work?" What we ask is, "Can they carry two pounds, can they work two hours?" so we tend to ask what they can do rather than what they can't do. We get them back, even if it's an hour a day, into the psychology of being back at work. So, we really do some things that are just nothing more than some common sense things, and it's very difficult to do. We have not solved the problems. We've been in business since April and with about a million and a half dollars in premiums, have paid out $4,000 so far in paid losses. There is about another $4,000 reserved. So, the experience is very good, and we're very optimistic that we will be able to do something to improve the loss picture. And part of that something is just going to come down to human relations workings with the supervisors and the people that are off. Perhaps I ought to pause now and just find out if there are any questions.

Workers' Compensation State Fund Study Commission - August 19, 1980

ACTUARIAL ANALYSIS OF THE PRIVATE INSURANCE RATING SYSTEM

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Thank you very much for inviting me here to explain the elements of ratemaking. I hope that you will not be bored at the end of this long session. I also hope that by the end of the day you will be able to identify certain elements in the rate making procedure which will indicate differences in various workers' compensation approaches such as state funds versus private insurance carriers. I hope that my information, together with other testimony will assist you in your deliberations.

To begin; I would like to deliver to you a "chair" that I have constructed. (Exhibit "1") All actuaries are used to constructing tables and this is the first time I was able to construct a "chair." I believe it will help you understand the very fundamental ideas of the so-called "loss ratio" or claim cost ratio method of ratemaking. With the "Chair" we can examine the basis upon which one proposes rate changes or determines what percentage of increase is indicated by data.

The top of chair is labeled, P_c. It represents "premiums expected at current rates." If we are projecting premiums that is needed for a future period of time for all policyholders that will be buying workers' compensation policies from private carriers. "Premiums expected at current rates" is the amount of dollars the

companies expect to earn as premiums if rates are not changed. How much of these dollars will be available for one to pay for claim costs? Well, we need to look at the back rectangle of the "chair" and start taking away from this rectangle the dollars that are not available to pay for claim costs. We will take away, for example, a percentage of this premium which really has to be used to pay premium tax. Using current Minnesota's rate filing as an example, this means that 2.6% of the premium dollars cannot be used to pay for claim cost. And there is another percentage, for example, 2.5% which is loaded in the premium for profit. That percentage is expected to be retained by the company and, therefore cannot be used to pay for claim costs. Another percentage is going to be taken away to pay claim adjustment expense. And that, according to the current rate filing, is approximately 7.2% of the premiums. Similarly there are commissions and acquisition costs, so 17.5% went away to pay for that. Finally, there is the so-called general expenses--namely, the companies overhead expenses and operation expenses other than those that are categorized--which is presently 8% of the premium. What's left after we peel away all these necessary expenses are the dollars that are available to pay claim costs. It will be expressed as a certain percentage of the premiums. What is the percentage? It (denoted by "p" here) must be one minus the percentage for general expense, minus the percentage for claim adjustment expense, minus the percentage for premium tax, minus the percentage for profit allowance, minus the percentage for acquisitions and commissions. It, p, ended up to be a percentage which is 62.2% in th current filing. That is, out of all the premiums that are expected to be

earned only 62.2% of which will be allowed to pay claim costs.

Now, in the rate filing for example, consider only the 1976 policy year. This means that you are looking at all the policies that were sold during the year 1976. Well, first of all, data of premiums earned are premiums earned at rates that were then in effect in 1976, and it is an amount which is about $238 million. However, if premiums were all paid at current rates, the Minnesota Insurance Industry Rating Association estimated that premiums would be the amount of $329 million. Out of that amount, only 62.2% can be used to pay claim costs. Thus, 62.2% times $329 million, or $205 million, is what is available to pay claim costs. This is one one end of things. The question is how much is expected to pay out for those insureds? If this group of people were insured what would be the expected ultimate claim costs? By certain procedure, which I will illustrate later, the Rating Association projected that the cost is $287 million. The question thus becomes whether the expected premium amount is going to be sufficient to pay $287 million. Well, obviously it isn't quite sufficient. In fact, you can clearly see that 62.2% of $329 million is $205 million and it is less than $287 million needed. Well, how much will be enough? The amount of premium must be big enough such that 62.2% of which is $287 million. When you estimate future costs of expenses, they're peeled away at the same percentage as in current rates. In other words, whatever are the premiums needed in the future period of time, denoted by "P", 2.6% of it will be used to pay for premium tax, 2.5% will be for profit, 7.5% will be claim costs adjustment, 17.5% will be commissions and acquisitions, etc. Thus there is a corresponding subdivision of the future premiums. And after taking

away all those expense percentages there must then remain enough to pay for the expected claim costs, ultimate claim costs during that period. (Refer back to Exhibit 1). What I have just said is equivalent to this equation, because all this equation says is that if we peel the same percentage away for use as expenses, then what is left is the portion of the future premium that must be enough to pay for all the claim costs expected. That is the equation which one uses to determine the future premium amount needed once the expected ultimate claim cost is determined. However, instead of determining the actual future premium amount needed, you may just want to know what percentage increase is needed. So that the proposed premiums as a ratio to the current premiums will determine the percentage increase on rate level. Following the example discussed before, if you divide the P_C on both sides and divide the little p on the other side of the equation you get this equation which will determine a number something like 1.409. This indicates, that we would have to increase the current rates by 40.9% in order to get to a premium volume that will be big enough such that 62.2% of which will be sufficient to pay the ultimate claim costs that is expected during the future period of time. If we write this expression in a different way by putting the little "p" down at the very bottom and UCC divided by P_C (ultimate claim costs divided by premiums at current rate) at the top the fraction. You will find that it is a ratio of two things. A ratio of $(UCC/P_C)$to p. In this expression p is traditionally called the permissible loss ratio. That is exactly the percentage of premium which is left after all expenses allocations have been

taken out. The expression UCC/P_C is called the data indicated loss ratio. One then, from this ratio of the data indicated loss ratio to the possible loss ratio, determines the percentage increase needed from the current rate level. This interpretation of the equation gives rise to the so-called loss ratio method because all quantities referred to here are loss ratios.

The question might be why is it that in a rate filing that you never see this figure $462 million as the premiums projected. Well, the reason is that the ratemaking procedure needs to project a relative increase of what you have now to produce what you need for the same group of insureds for the future. Now the actual premium that they may earn during the future period of time may be slightly more or less than the $462 million depending on how the total set of the insureds and claims during the experience period differs from the insureds and claims in a future period.

This chair tells you more than a basic understanding of the loss ratio method. It gives you a graphic understanding of two more things which I want to talk about. Number one is this...let me also state the same procedure another way...you can say this... the 62.2% of P_C better be enough to pay ultimate claim costs. You can also say that the ratio of the total premium volume for the future to the premium volume that you expect at current rates should be the same ratio as the ultimate claim costs expected to the claim costs--dollars that are available at current rates to pay for claim costs. In other words, the big rectangle should have the same ratio as the ratio of the little rectangle here. Now, in fact, every one of these rectangles with respect to the one that it came from is expanding proportionately to an area from available

claim costs to the ultimate claim costs expected. This 8% general expense is now going to be of the future premium so therefore this area is going to be proportionately larger as this is to that. Similarly the acquisition and commissions are going to be proportionately larger also because this is 17.5% of the future premium, which therefore has the same ratio to this little rectangle that was 17.5% of the current premium rate.

So what does that say? That really says that as you need more money to pay for claim costs, all the expense elements are also proportionately increased. Every expense if you look at absolute expense dollars. Whatever is allowed under the current rate to pay for general expenses that amount would have increased 40.9% if we were using policy in 1976 data. 40.9% more expense dollars will be available to pay for general expenses. 40.9% more will be available to pay commissions and acquisition costs, etc. So that every little block is going up in the same proportion. That is what is intrinsic in the loss ratio method. There is no element here that does the trending. It is from the 1976 data that it indicates that in 1980, as indicated by the Rating Association 1980 proposal, they will be needing 40.9% more based on a claim costs analysis.

Actually, what you are trying to trace here is a trend from 1976 to 1980 as far as inflation is concerned. You are saying that 10% inflation rate from 1976 to 1980 seems to be reasonable.

You have to remember that this 40.9% is on top of this trend because if you have payroll that is increasing say at 7% a year, workers' compensation is determined on an exposure that is based on payroll.

So payroll is tracking inflation already. As payroll goes up 7% so will the premium dollar automatically increase by 7%. This 40.9% is not depicting that particular process at all. That is saying not moving time but just looking at...even assuming that we were still at 1976 but we changed our rates from 1976 to present and we changed our benefit level from 1976 to present but not having a trend or inflation effect in there. This is in addition to these things.

Expenses are also already going up with the inflation because as payroll increases premium dollars increase by the same percentage and the same percentage allocation in there for expenses is still there. That is why $462 million is not an accurate figure that they will earn then. What they really expect to earn is $329 million trended by inflation because of the payroll increase and on top of that 40.9% of that figure. The $329 million that would have been earned in 1976, if they were paying at current rates would have become a larger number by now because of inflation of payroll since 1976. So if an employer was paying a million dollar payroll in 1976, by now the employers will be paying $1,200,000 in 4 years, a 20% increase. The employer if no rates are changed will already have been paying on $1,200,000. This $40.9% says that 20% is not enough. I will still have to increase that amount by 40.9% and that's not related to inflation but related to actual claim costs not expected at the time the premiums were set for 1976. It is in addition to the inflation rate.

In Minnesota and several other states the rate proposal has recognized at least for the 8% general expense portion that it should not be moving as claim costs are projected to be moving here. There is no reason that the general expense should increase that much more than the payroll increase which is already contained in the premium structure, without any rate level change. The Rating Association proposal says that we really should recognize that and take this 8% and apply a trend on that, that says now expenses are generally company overhead expenses which really ought to move pretty much as the payroll increase is doing. Therefore, we should apply a smaller increase on the 8%. That will determine a certain strict dollar figure. Instead of multiplying this by 40.9%, if I take this rectangle and expand it by 1% or 2% or 3% which is just a little bit more than what they were getting before, then this rectangle will not be as fat as this which was the direct proportion of 40.9% more than that.

In the Rating Association's proposal for the company controlled expenses, which is actually a little more than the general expense, the acquisition costs and the general expense is controlled. It is not going to be allowed to move up 40.9% in addition to the inflation on payroll. By controlling that it will allow you to have a little more percentage to pay for claim costs in the future. Therefore, what they have done is to say now, if I needed that little bit less in expenses, then I actually need that much less in total premiums. So I can move the whole rectangle to the left a little bit and I will have a little bit extra. The ratio of this bigger rectangle to the

one that has accounted for the effective company controlled expenses is what they call the effect of limitation on company controlled expense.

With respect to a percentage, this effect will vary depending on this percentage. You have the larger percentage of 40.9% and then if you limit your expense to go only by 6% or so then the effect of the final projection will be higher. In other words, you will have a bigger difference between the projection which recognizes the limitation on company controlled expense versus the projection without that recognition. That effect in the Rating Association proposal was something like a 2.9% decrease in this projection. This rectangle that you can take away is approximately 2.9% less than what they otherwise projected.

That is the only expense element that they do that to. That element amounts to 11.6%, that is 8% general expense and 3.6% other acquisition.

If you have a policy for premium taxes so that you don't think that the tax ought to be much more than you had last year plus a reasonable inflation index, then you could apply the same thing to restrict the tax dollars that will be coming out of the total premium. But if you still maintain the tax policy of premium tax is a percentage of premium then companies will have to pay the 2.6% of whatever premium is. Not all the items can theoretically be moved down that way. Tax I recognize will be a little bit closer to general expenses than other ones.

Claim adjustment expenses are reasonably assumed to be directly proportionate to the claim costs. In other words, if you have to pay a million dollar claim costs, it appears that 11.5% of that will be paid for the lawyers and other adjustment expenses associated with paying the claims. It is reasonable to a certain extent that the claim adjustment expense will stay the same percentage of premium.

Profit allowance is an item which again has traditionally been a percentage of the dollars you are dealing with.

I am not opting for any of those, I am just illustrating the reasons that are behind every one of the allocations. I don't have a position on any of those.

The commission is again arguable,whether you should keep the commissions the same percentage as premium dollars. There everyone will have a different point of view. Traditionally, the commissions have been paid in proportion to the premium volume that the agents write. That is a policy decision and policy decisions will be changed. Those can be modified item by item. This illustrates that you can do it. There is no reason why you can't do it. All this calculation can be done once we know these allocations are allowed and what they are. The question is, how do we determine what those amounts are.

Now I am going to explain how data is going to be used to project for future period of time. If we are sitting here in August 1980, this point in time, if we were to do the rate proposal at this point, it will be proposing for policy year January 1, 1981 to December 31, 1981, which means all the

policies that are written during that period of time. Some may be written on January 1, 1981 and some may be even written on December 31, 1981. For all the policies that are written during this period of time, we would like to know what the premiums those policyholders would contribute if they paid at the present rate. We want to know what ultimate claim costs will be incurred for those policyholders. The only way we can estimate that is to go back in time and look at certain periods of time for which you will have a similar pool of insureds. You would say "I know something about them" and whatever they did or whatever claims they incurred during that period of time is a reasonable estimate of what those other insureds will do in the future for claims in the future.

So how far back must we go to find a piece of data that resembles that piece? We want to go back as little in time as possible because as you go further and further back in time the kinds of claims will be further and further different from what we are expecting for the future.

So we like to go as little back as possible. We look at what is available. We will find out that the most recent policy year data that is available would be the policy year 1978 if I am sitting here right now looking at what is available, because policy year 1978 deals with those policies that were written from January 1, 1978 to December 31, 1978. Some of the policies would be written on March 1, 1978 and will be expiring on March 1, 1979. Some, in fact, will not start until December 1, 1978 and would not expire until December 1, 1979. So the first

point in time where all the policies that are written in 1978 would all expire, would be December 31, 1979. All the policies that are written during this period will then have expired by that date. Therefore, we have at least one first look at all the possible data that is associated with this pool of insureds.

That data which is available on December 31, 1979 for this policy year 1978 is called the first report data for the policy year 1978, the first time you get a complete report for all the policies that are written during 1978. Since we are sitting in August 1980, that is the most recent policy year data, because if I am looking at 1979 policy year, it won't be available until December 31, 1980 and we are now only in August 1980. We don't have data for policy year 1979 yet.

So that's the most recent data, the first report 1978 data for policy year 1978 and that data will include data on claim costs, and data on premiums paid, and premiums earned.

The claim cost part is called incurred claim cost. Here is one peculiarity for insurance companies versus other kinds of operation, namely, they have to have an estimate of claim costs. I will explain incurred claim costs in a second. They have to have an estimate of claim cost not only based on paid claims because what is paid is not a good estimate of how much they would eventually expect to pay, because it takes a long time before a claim shows up and then goes through all process of claim adjustment. First of all, the injuries will have to take time to recover so you will not know exactly what the claim costs will

be until quite a bit into the future. You cannot base the data on paid claim costs because that will be a very small percentage of what you eventually will expect to pay out.

You will have the first report 1978 policy year data on claim costs and the incurred claim costs which includes three amounts. First, is the paid claims. That's something that is really clear-cut. Everybody knows how much they paid during that year for these policy holders, the claims that are submitted.

A portion of it will be so-called reserved on claims. Dollars reserved on claims. This means that claims have been reported to the insurance company by December 31, 1979 but haven't been completely paid out and you expect that for those claims you might have to pay another $20,000 or whatever. Those are put into the claim costs but they haven't been paid out yet. The company has put it into the loss column but it has not yet been paid out.

The third one, is the company's estimate with respect to those claims that have not yet been reported but have been incurred already. Something has happened. An injury has happened for those policy holders somewhere during this period but the company has not received a report on those claims. They have no actual known claim but from past experience they know that some of the injuries that occur during the latter part of the policy year may not be reported until a few months after December 31, 1979 and some may even have a long lag in time of reporting. So the companies put into the incurred claim costs an item which is called reserve on

incurred but not yet reported claims. That is the famous reserve on IBNR. That third portion of the incurred claim costs is really the company estimate of what will come in in the future and yet they don't know anything about it yet. Except just an anticipation that some will come in.

Not all the policies that are written during 1978 will be paying premiums at the same rate. That is why we really don't care about exactly what is the premium that is earned at those rates. What we really care about is if those insureds were paying at the present rate, what would be the premium expected. Therefore, an estimation process will take place because the data will be with respect to premiums that are written at various rates that are in effect during 1978. We have to take that and estimate what that premium would be if all those insureds at that point were not paying the rate that was then in effect but are paying the rate that is now in effect.

There will be a process that goes from the data to the future that we need. The reason actuaries like this kind of data is because you are projecting something which is dealing with a pool of insureds. This group of insureds are going to pool together for their liabilities in the future.

How do you define that pool? You define it by the starting date of their policy year. Why don't we project for all those policies that will be in effect during this period? That presents a problem because those that are in effect may not be starting in this period. Those people are really not pooled with this group. They have already paid for their premium so you are not

projecting for what premium you need to assess them. Therefore, it seems reasonable that for projection purposes you have to be dealing with the pool of insureds who are pooling together when they begin to pay premiums at the same time.

A recent trend in other rate filings has been that you use not the policy year data but so-called accident year data where you only deal with claim costs with respect to accidents that occurred during this period. That is an alternative to this. Then you have to relate to the premiums that match it.

For the policy year the data will be really the premiums that are paid by those policy holders during this period of time. For workers' compensation, premiums earned for this policy year and incurred claim costs for all the claims that are related to these policy holders are included.

There are two problems in going from the past to the future that are intrinsic in the data. One we have already explored which is the premiums earned for the year 1978, are premiums that are paid at the rate that was then in effect but that is not the quantity that was on the top of the chair that we needed. We needed to know the premiums if they were all paying at the present rate. That is one problem.

For workers' compensation premiums earned it has another problem, that is workers' compensation differs from most other lines of insurance in that it has a lot of experience rating plans in effect. Whatever was contained in the rate manual may not be the direct rate that is assessed to the employers on their policies. At the end of the year when an employer's experience comes into known data for the company, the premium assessed will be

slightly different from that originally projected based on the manual rate. Premiums that were reported at the first time when data was available, namely December 31, 1979, may change a little bit as you look at the same pool of insureds, when you look at the effect of experience rating plans. Throughout later years, there will be a slight change in premiums earned due to the effect of experience rating and payroll audits. It is on the audited payroll that you pay the premiums. This data is not only not the one we want because it is not at the rate we wanted, but also it is not yet so-called developed in the final state.

Similarly with claim costs. What was the problem with claim costs? The data as reported will be on claims that are somehow related to policies that are written in 1978. Therefore, those claims will be paid on the benefit level which was specified by the law during 1978. If there are many legislative changes that have occurred since 1978 what you expect for this pool of insureds, what their claim costs are to be are not just those claim costs that are reported for policy holders during this time because there is a difference in benefit levels that was due to law changes. You need to estimate this data and bring it through the law changes and effects on the claim costs until you project what is the claim cost that will be expected if they were paid at the proposed period of time. That is bringing it on benefit levels.

Claim costs have a similar problem with development just as I described about premiums. You see when claims are first reported at this point there are a lot of things that are estimated

about these claims. The only known fact about those claims are the paid claim costs and that is a very small percentage of the total incurred claim costs that is reported here. A large percentage of the incurred claim costs are so-called reserves on known claims and they may vary as the claim becomes more mature. As you look at it again a year later a portion would have been paid up and another portion might have turned out that the injury is not just a permanent partial but may be a permanent total by the time a year later you look at this person and find he has not recovered to the extent the claim adjuster expected. Or vice versa, it may look bad at the beginning and it turned out that the person recovered better so it became a lighter claim.

This being an estimate you expect that there are a whole bunch of claims that have been incurred but not yet reported. Maybe this year happens to be different from the basis on which you estimated this IBNR. Maybe lesser numbers of claims have been incurred but not reported. This is also an estimate. So a large portion of the incurred claim cost that is reported at the first report are really company estimates; claim adjuster's estimates and the company's actuary's estimates on IBNR. That whole thing would look much more mature a year later. A year later a larger portion of this will become paid. A larger portion of the incurred but not reported claims will become at least known and a smaller portion will be this total estimate here on the incurred but not reported claims.

A year later, the company people look at the same group of policy holders but they have a better understanding of how the

costs of the claims are related to these policy holders. It will change the amount that they estimate that they will be paying for the same policy holders now. You don't change the policy holders. You are still looking at the same pool but you have a second estimate at the end of next year, and the year after that and so on. Those estimates will have been much better estimates of exactly how much this pool of insureds will really have cost or the ultimate claim cost that is incurred by this pool of insureds. That is of course ideal. If we happen to be God we would know exactly what happened. At this point of time, I will have no knowledge of the second report because I haven't come to the point of time where the second report is available.

This estimation will be called estimation of the development of claims from its first report to the ultimate expected. That is what we need at the end. Companies have very sophisticated methods of trying to estimate these incurred but not reported reserves or number of claims that are incurred but not reported. However, there is always the possibility of something has changed from the past report that they are using to estimate. At the time that this policy year is being reported it is not factual data but an estimate. This being something that is not related to any facts, except the past experience, you can have a good estimate, but you have a lot of leeway with respect to this particular item.

There is no standard way that any regulators have established of how you must estimate this. Therefore, the companies have varied based on their own experience. Different companies have different reserving methods. If a company is experiencing a different kind

of financial data that year, it may affect how they will put this amount down. If the company executives think they are having a year that looks too good and that if they are reserving like they did in the past, they will pay a certain amount of tax on the earnings. But, if I were the company executives, if I can reasonably shift a certain amount of that to increase the adequacy of IBNR, then they have put some dollars that would be in the earning column to the loss column and they will not have to pay tax on that. I don't think that anybody would deny that that can happen. If you continue to be doing great, then you have no way to escape paying taxes.

That's fine in company operations but it really is not fair in rate-making procedures if we don't understand how that thing varies because we are basing our data on that particular policy year. If this year happened to be a good year with the company, they pad it a little more in here. The people for whom we are going to project the rates, based on this rate, are going to suffer because that portion is contained in the basis of loss. You will then project that you indeed do pay out a lot more claim costs for policy holders which may not be a fact, because a part of it is a shift, which will eventually smooth out the company. But the policy holders will then suffer and pay the consequences and there is no reason they should suffer for that. They are not the ones who have contributed the financial data and they have no way to retrieve it either.

It is important to have a good analysis of what IBNR is. I will show you where it actually will affect the projection and

how big an error that could contribute to and how severe that can be on the rates that are proposed. On the IBNR, I think the regulators insisted that the companies will put on some IBNR because they want them to make sure that they have a better estimate of their ultimate claim costs.

So now I have illustrated going from the past to the future and what is contained in a rate filing that portrays all the things I have just described in terms of numbers.

Contained as part of the data base for the Rating Association's filing is this 1976 policy year data. That is available on December 31, 1977. The data itself tells us that the standard earned premium for these policy holders are about $238 million and that the first reported incurred claim costs is $135 million, $392 thousand, etc. You will see that I have a word estimated here. That is to warn you of the fact that this number that is sitting here contains 1, 2, 3, of which 2 and 3 are more or less estimates by the company; the reserve on known claims and the reserve on IBNR. They have estimated the effect of bringing these claims paid at the 1976 benefit level to what they will be if they are paid at current benefit levels, the effect of which according to their calculation is a 29.6% increase due to legislative changes in benefit levels. Then they estimated the development of this first report data to ultimate which was something like 60.3%.

In our determination of a permissible loss ratio we have already taken care of the claim adjustment expense, so these are the two factors. One is the "on level" factor that brings the level

of benefits to the present level and one is the development factor. This number $287,663,000 is a number which you have seen before. It is projected ultimate claim costs of this pool of insureds if they were paid at current benefit levels and developed into an ultimate basis. That is the UCC that is in the chair, ultimate claim costs expected at current benefit levels.

The data tells us what the standard earned premium is for the policy holders in 1976 but we know that there are several rate changes from 1976 to present. The Rating Association estimated that effect. If all these people were paying present rates, the premium they expect to earn would be something like 33% more than this premium because the rate increase has accumulated in an average way of 33%. After development it will be 4.2% more. After payrolls are audited and experience rating plans become more settled etc., the premium will be 4.2% more.

As a projected Pc in the chair, the premium expected at current rates will be $329,803,428 based on the 1976 data. How did you project this? Well it is really a cumulative effect. It multiplies this by 1.33 to increase it by 33%, the result of which will be increased another 4.2% to get to this estimate. The claim costs as reported at first report don't look very bad, but if they were paid at current rates and the effect is estimated accurately as 29.6%, then 1.296 times that will be what you expect for the first report at current rates. Then you are going to expand it some 60.3% because you think based on past data the Rating Association estimated that what you know at first report will be so insufficient as to make a difference about 60.3%.

These effects are cumulative to give you a final answer. I want you to realize that if there were any adjustments in any one of the factors it has a direct impact on the rates. If you have correction on this and a correction on that, the effect is a cumulative effect. The problem with multiplicative structure is that it just keeps on accumulating. Some times if you make a small error on one item, it is then blown up by a second factor so that error will be expanded.

These figures don't show up in the Rating Association's filing because they were based on two policy years and I am just trying to simplify things and show you one policy year.

The next thing I want to do is go into these estimates and show you what was done to make those estimates. I will go right to the estimation of the development factor for claim costs, for ultimate claim costs. I just want to show you that what it really does is called a diagonal message. You use the data from the diagonal to look at it graphically. What it really says is this: if I am at a point where 1977 policy year data is available for both first and second reports, 1978 is only available at first report. For 1977 you have both a first and second report on premiums and losses. For policy year 1976 you would have data that is available for first, second and third reports. The data tracks backward. 1975 will have the fourth report data. If you display the latest two policy years which had first and second report that will be 1976 and 1977, and the latest policy years that had both second and third reports, you will find 1975 and 1976 are the two latest policy years that had both second report and third

report. The latest two policy years that had available both third and fourth report, are 1974 and 1975. The display goes diagonally backward.

The method right now is that if I am in this point of time, the latest first report data is 1978 policy year which doesn't show on this diagram here. That's the report that I want to project what the ultimate claim costs will be in order to determine what the 1981 policy year ultimate claim costs will be. In order to develop that one let's look back in time.

This is what back in time means. Let's look at all the back policy years and let us say that the first report to second report development will be estimated by the development from first to second for the latest two policy years where such development is available. Let's take the ratio to indicate the development. In this situation(this is very unusual and I will explain to you why) the losses actually developed downward, a number less than one. The ratio of 254 over 260. For 1976 policy year, the loss development for first to second report is 1.026. The average of these two is 1.003. The traditional method says that I would expect the 1978 first report data will develop by 0.3% to the next report. The next report when I took another look at 1978 data when I get to that point in time, I expect this will be an estimate of the first to second report for 1978 policy year. Then you do similarly using the latest two available n to n+1 report, and calculate an average development factor from n to n+1 report.

The product of those factors tells me that how I expect 1978 first report will develop to second report by this factor then the

second report data will be developed to third report by this factor and so on. It will be cumulative factor or effect. As the first and second and third multiply together it gives us a product which is a first to fifth report here, a development factor.

In this particular example it is only 3.2% versus the something like 60% for the one that is being used for the Minnesota rate. This is the data for Florida. It is not really depicting Minnesota. I'm using it here only to indicate so called diagonal method.

When you develop 1978 policy year data at first report, the factor was derived totally based on past data. It has nothing to do with how the first report of 1978 is derived.

Now this is all very fine if nothing really changes. If in fact the development of the past reflects the development of the future and the past is the best predictor of the future and there is no element that has changed in this drastically enough to mean that this is not a good estimate of that development for 1978.

But you can theoretically derive that if something like loss reserving policy has been changed, then this particular method will be doing the following. If in fact, there is a change in IBNR reserving policies where the reserve gets more adequate and the first report was already a good projection of the ultimate claim costs then what's happening here may already be in the ultimate claim costs and applying this factor to that will just give an over estimate of what the ultimate claim costs in 1978 will be.

You will say that this is not a good example because this happens to be one that is reflecting an over reserve already. But let me give you another example. If we base on past data we see

that we are going to say that the development factor as estimated in the Minnesota situation should be a factor of 1.603 which is derived in the way I just described based on Minnesota data. This is reflecting a particular type of past data where they were reserving at levels which obviously are fairly low because at the first report they are some 60.3% away from the ultimate costs. So the IBNR that is contained in the data that derived this particular factor will be in fact on the low side. But if in 1976 that piece of data on which you are going to apply this factor, the company discovered that they have not been reserving adequately and increased their IBNR reserving margin, then that would mean that their first report data is closer to the ultimate value already without any development. So they have already padded a little bit on the IBNR which included the development expected.

So if you apply this particular factor which was based on the lower IBNR reserving margin onto a piece of data which had a heavier reserving for IBNR, you tend to over estimate what you think your ultimate claim costs will be for this particular policy year. That factor when it is derived is reflecting something in the past which did not reflect whatever change in IBNR reserving policy actually happened for the piece of data that you are developing with. Now this is all theoretically arguable without any data. You can see that higher IBNR reserves will give you a better estimate of the ultimate, even at the very first report. Then the development ought to be smaller than is shown in the past, because you have already gotten to that point halfway already. On a theoretical basis it is easy to see.

Let me just try another way of explaining this. Let us look at the most recent data that was submitted by the Rating Association under the legislative bill, sometime in July. This particular requirement asks the company to show not just the first report data. The first report data is twenty four months away from the conception date of the policy year. This piece of data asks the insurers to separate IBNR from the total incurred. In other words, this is total incurred that includes IBNR and this is the amount of IBNR that is contained in that piece of data. So item 3 in the total incurred is spelled out right now in this piece of data and then a percentage is calculated. The percentage of IBNR as a percentage of total incurred would be 4.8% for policy year 1970 and 6.3% in 1971 at first report. All of these are at first report. The margin has been increasing from 4.8 up to 17.4 which is the latest policy year available at first report which is 1978.

In fact there was not much change from 1970 to 1974 as far as percentage IBNR is concerned. But starting with 1975 it starts increasing IBNR as a percentage of total incurred. That reflects two things. One is that the insurers obviously looking at their development of the past policy year may recognize that they have not been reserving for IBNR as adequately as they want. In other words, they really want to have a better and better estimate of the ultimate right at the first report. That is why they would increase IBNR to reflect the needed development.

Also, as we discussed before, it could be a reflection of the increasingly better financial situation since 1975. If you look at the rate change requests you will realize, I think, that 1975

was when things really went bad and the insurers looked at the back data and said our rates are totally inadequate. So as a general movement, all property casualty lines have increased their premiums dramatically. So that it could be reflecting a better and better financial situation for the companies or also a tendency to reserve more for IBNR.

But whatever it is, it is a demonstrated trend of having a higher and higher IBNR margin for the same reporting time which is reflecting that this particular figure of $203 million in fact is a better approach to the ultimate claim costs of 1978 than the $167 million for the 1977 policy year is to it's ultimate claim costs.

Now if you wanted to use that data just reflecting these past reserving margins which were necessarily showing a high development and apply it to an already in a sense more developed data then you would have over estimated the ultimate claim costs for 1978.

One of the advantages to having this piece of data available is that it provides an alternative method of looking at development. No matter how critical you are on data and whatever method has been used, one is always faced with the question of do you have an alternative way of suggesting that factor. Because you do need to project that factor. With the availability of such data, it really shows you one thing, if you are dealing with rate making where you are looking at past data and tracing out the development, there is really no reason why you should be looking at data that included a company's initial estimate of what the ultimate claim costs is.

There is no reason to have to look at the IBNR as part of the data because if you take just the paid and the reserved on the known claims (which is then more solid data) and you follow through the development, then to the extent it is not adequate it will show in the following development. It will bring you to a point in time when you have, say, the 8th report. You will find out that by the 8th report there really shouldn't be too much development any more so the ones with IBNR and the ones without IBNR should be very close together. If you are looking at rate making data which includes a development factor, you shouldn't have to depend on original estimates of IBNR.

So what you should do is to take away all the IBNR that is contained in these total incurred claim costs and look at a piece of data that doesn't have IBNR and trace the development that way. That will determine the development factor which will bring claim costs at first report that don't include IBNR to ultimate claim costs. You really don't care about what IBNR is. You want the best estimate of ultimate claim costs. So if you had a piece of data which is more factual and you develop a particular estimation even based on the same diagonal method but based on the data that didn't have that IBNR estimate in there, you will have a better estimate as to what the ultimate claim costs is because that development factor will not be affected by changing IBNR reserving practices. If you really want to talk about the development factor, then you should take the ultimate claim costs and divide it by the total first report incurred claim costs without IBNR and determine a factor that way. That is a better estimate of what the ultimate

claim cost is because you have the data and you should base an estimation on things that are more factual than things which are originally a rough estimate of things involved.

Suppose now I forget about having separation. I just notice that there is a change in reserving policy so I expect that my traditional method is not going to give me a very good estimate of the development factor on pieces of data that have more padding in reserve for IBNR. But look at the rate filing and say the following. At the time the rate filing was prepared, the latest policy year of which the first report only is available is 1976 policy year because it was prepared sometime last year. Therefore the rate filing is based on a piece of data like this. By now, when they submitted the date in July of 1980, two more reports are available of the same data. That would tell us that this is a more solid situation. Now we know the third report of 1976 policy year data, so that has to be a better estimate than when I only had the first report and had to get this development. It turns out that if you indeed use the third report and project the ultimate claim costs here, you will find out that the original estimate using only the first report of 1976 will give you a projection of ultimate claim costs which is something like 6% more than the projection of ultimate claim costs based on the third report data.

If you use my new method, where all IBNRs were eliminated, my method would have estimated that ultimate claim cost and showed that the original estimate was 7.3% over estimated. The alternative method which I am proposing here give you a better initial estimate because these two values are closer. It actually corrects for the

development that was in error in the original projection of the first ultimate development of 1976. So this is collaborating that this will be a better method, had we had no other data. My alternative method shows that if I had no advantage over these two recent reports I would still be able to get closer estimate of what you would have projected if you had these two more recent reports. This piece of data that is submitted on the first hand gives you more recent data which gives you a more solid prediction of the development factor. And those do not depend upon the separation of IBNR. The separation of IBNR, enables future rate filings to be able to use the piece of data even when you only had the first report available. But if you took away the IBNR and calculated a projection on development factor without IBNR, you will get a better estimate of the true development than the one with IBNR.

I really think that this kind of data is needed by an actuary to at least look at alternative methods and to compare and see. One of the tests of whether one estimation method is better than other is the kind of test that is available right in this data. If you have an alternative method you project something and if you find that projection even based on first report data gets closer to the third report projection, well, the third report projection is obviously better than the first report projection. That is the type of test that one really needs to perform to show that one method is better than the other. As we all know, estimates are estimates and they are not necessarily the truth but all we are trying to do is get closer to the truth. Having this kind of data really helps to do something like that. Otherwise, one can only theoretically

argue that if the reserving policy were increasing and if your data was reflecting a lower reserving policy than you tend to. It's a factor but you can't prove it.

In the rate structure we have this permissible loss ratio of .622. If you are studying state funds or whatever and judging many things, this might be one of the things you are looking at. Again, I have no position and I am only pointing out that the elements may vary when you have a state fund operation versus private insurers operation. In the very expense loading itself, if a state fund does not use or employ agents, does not pay commissions, there is 13.9% that is really loaded in the rate making for private carriers that is directly attributable to commissions. Out of the 17.5% relating to selling costs, 13.9% is for commissions and 3.6% is other acquisition such as writing up the policy and other things which doesn't relate to agents. If you are dealing with state funds and you don't expect to use the agency structure, this is the percentage you will not have expense.

Again, I am not saying this is good to do or not good to do but in many of the state fund operations, the premium tax is not assessed on the policies and there is a 2.6% that is related to the premium tax that the state fund doesn't have to pay. The profit loading, assuming that the state fund is not profit oriented, will be something which is not really necessary there in the premium. So these percentages are not expected to spend out if you are operating a state fund. This brings us to the last point. You do still expect obviously to spend acquisition costs, you still have to prepare the policies and what not. You certainly have general expense and to that extent you may have a bigger percentage for general expense. I don't

know. You still have to have claim adjustment expense which is something like 7.2%. Again, that depends on how it is, it may be up or down depending on how efficient the state fund is.

All these make it easier to see what one still needs to spend for a state fund. This last thing is something which I will explain a little bit more.

Because all the claims that are incurred do not get paid right away, the state fund will be able to receive something like a 13% return on the dollars you have held. This particular item obviously means the state fund will have the advantage over the private carrier. The private carriers actually do get something like a 13% return on the cash which is the claim cost they predict they will ultimately have to pay out but which they still hold generating that income. This estimate is based only on an assumption of a 5% rate of return or interest rate on every dollar they get to hold for a year.

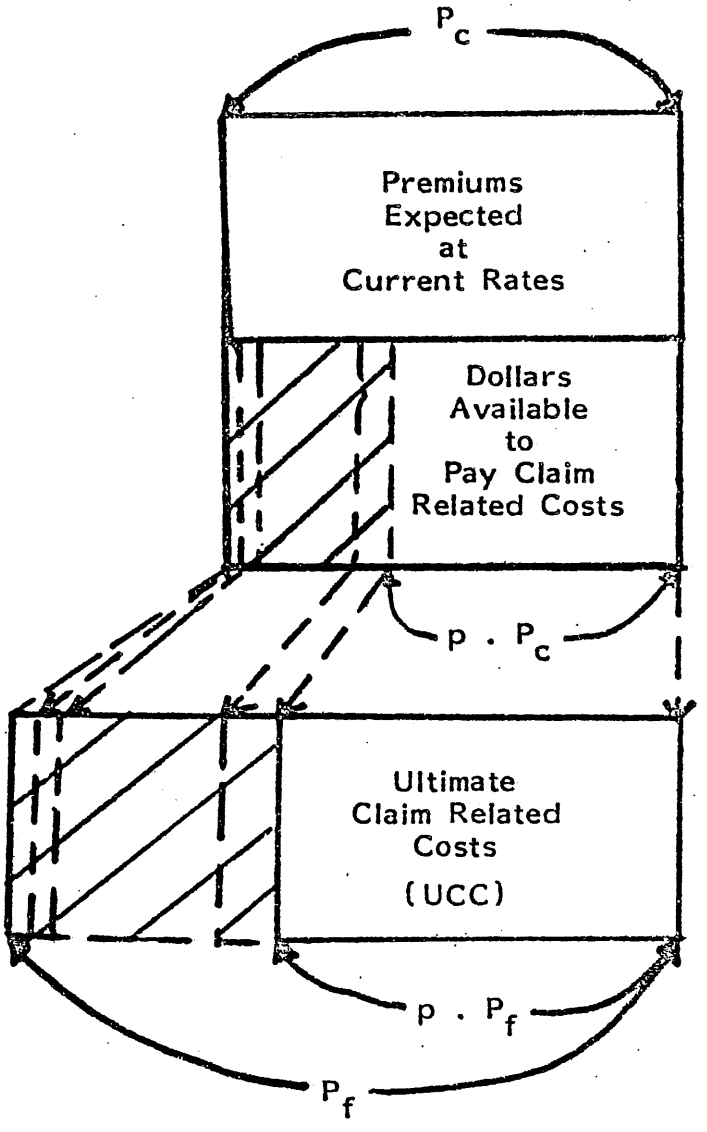
It is my position therefore, in traditional rate filings and even in predicting premiums the insurers must charge the policy holders that this should be taken into account in the rate determination. This is what I call discount procedure. The company's set aside $135 million at the end of the policy year for the claims that are expected for this policy year. Suppose this is the right factor to bring up to the current rate level that means that if these claims were paid at current benefit level it will be 29.6% higher than this. Whatever that amount is then it was developed to ultimate by data which traces out the past data which traces out what eventually got paid on an arithmetic sum. In other words, I expect that this cost one million, next year I expect a million point two etc. At the end, I find it costs a million six hundred thousand, So the rate now is based on this

amount which is the ultimate total arithmetic sum of claim dollars that you will eventually have to pay out in 10 or 20 years.

This particular amount does not reflect that a large percentage of these dollars are held by the insurance companies before they are paid out. This is being used here on the traditional method as a dollar that is compared to each dollar that is earned by the insurers at the time premiums are paid in. Well, premiums are generally paid in within a couple of years. So there is a difference in the time that premiums are paid in until claim costs are paid out. Obviously everybody knows that you have return that will be generated by this cash flow. Indeed, insurers do not need all of this money right at the time premiums are paid in to pay for that eventually 10 or 20 years.

Based on reasonable estimates of how this $287 million is going to be paid out in the next 20 years or 10 years, a certain percentage paid out in the first year, say 20% percent is paid out the first year, 38% is paid out the second year cumulatively, 52% at the end of the third year after the policy year etc. Based on reasonable estimates of this payment pattern and a percentage of rate of return for every dollar you hold, (let's make an assumption of 5%) you will find that they don't need all that money to pay in, they only need of somewhere in the neighborhood of 85% of that amount right at the time premiums are paid in, in order to provide for this amount when it comes time to pay out. This is obviously what your state fund will expect to receive on the cash flow but it should also be reflected in rate making for private insurance carriers. This sort of separates what portion of the expenses or return on cash flow that a state fund

would expect to retain. I don't know what effect income tax for earnings that differs from state funds versus private carriers which is a very complicated question. There is one element that will speak for conservative returns when you are projecting through a long term situation. It's reasonable to be a little conservative in that sense.



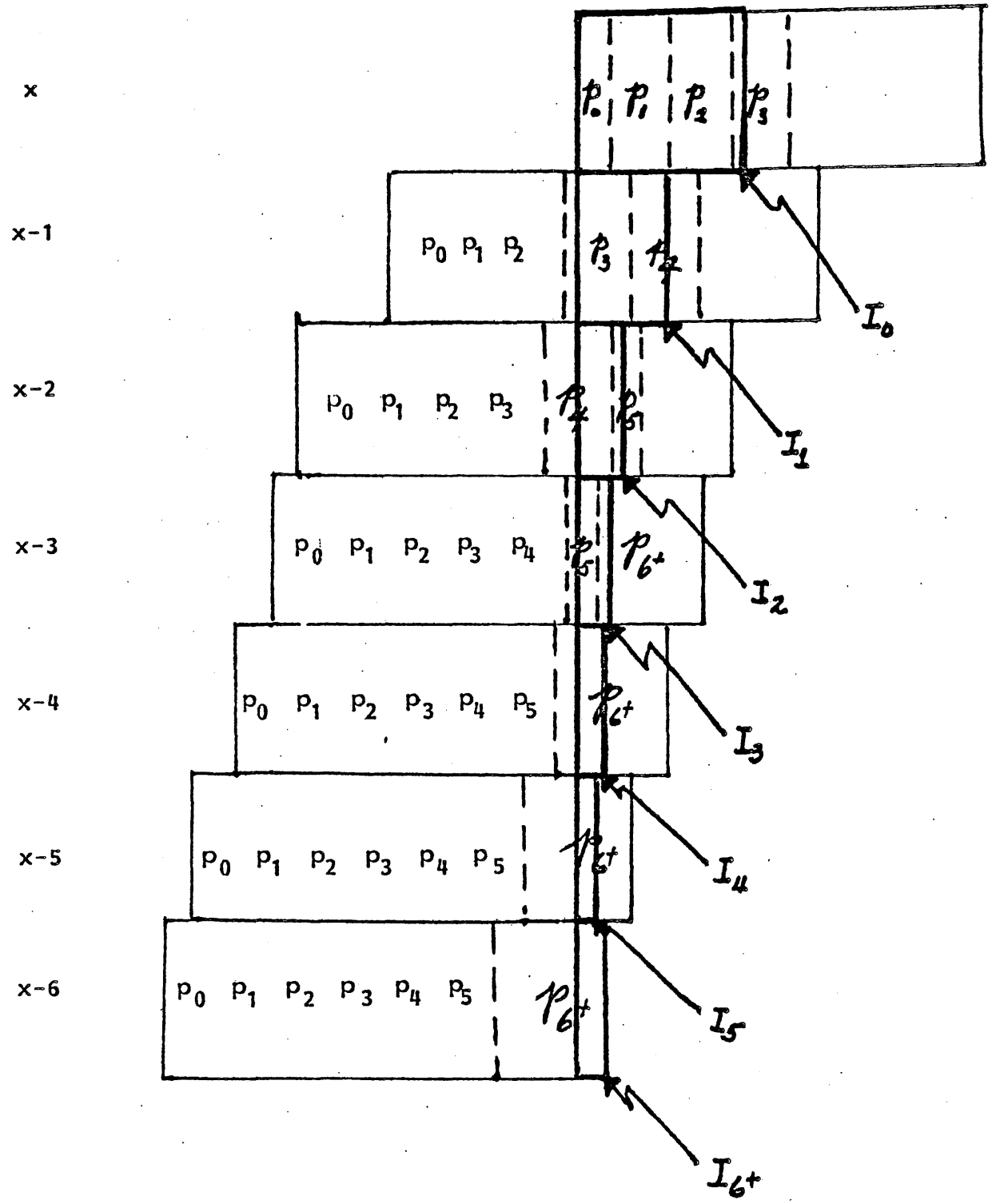
$$p \cdot P_f = UCC$$

$$\frac{P_f}{P_c} = \frac{UCC}{p \cdot P_c}$$

51

POLICY YEAR

CALENDAR YEAR
x



DERIVATION OF INDICATED LOSS RATIOS

1976 POLICY YEAR

Valued as of 12/31/77	To Current Level	Development to Ultimate	Claim Adjustment Expense	On Level Developed Data (1)x(2)x(3)x(4)
Standard Earned Premium				
399,643,277	1.305	1.034		539,118,781
Incurred Claim Amounts				
264,451,900	1.016	1.377	1.115	412,544,964
			Indicated Claim and Claim Adjustment Ratio	.765

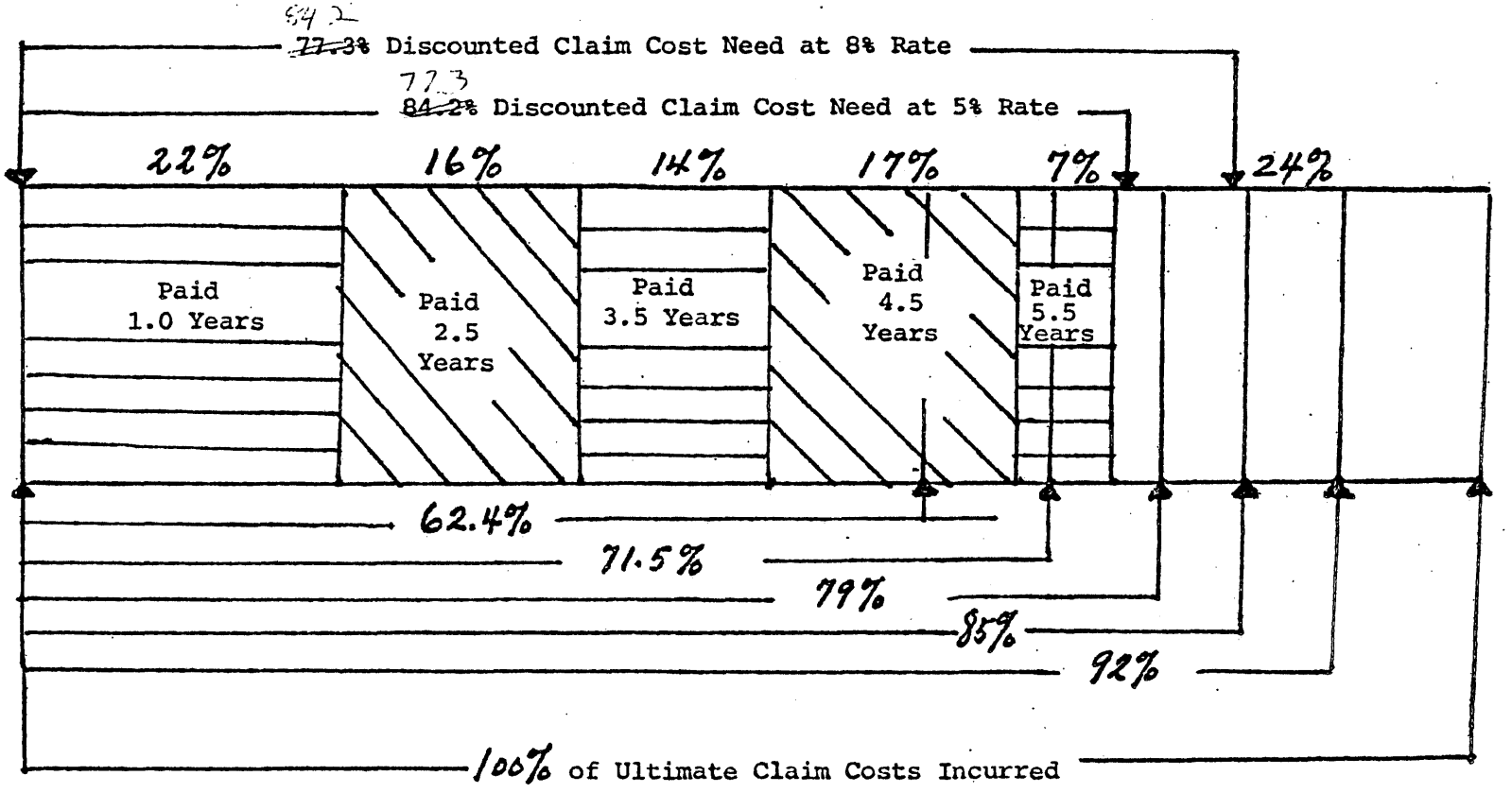
SPECIAL MINNESOTA CALL REPORTING IBNR LOSS RESERVES
BY POLICY YEARS-WORKERS' COMPENSATION

NAME OF CARRIER OR GROUP: TOTAL OF ALL 26 GROUPS

POLICY YEAR		TYPE	Reporting Month 12	24	36	48	60	72	84	96	108	120
	(1)	IBNR	2556640	1585185	461129	266002	238940	60213	108960	210509	160483	468287
1970	(2)	TOT.INCURRED	18871149	32984885	35437245	37274608	39459129	16685892	38291155	39412762	40579354	21259216
	(3)	% IBNR	13.5	4.8	1.3	0.7	0.6	0.4	0.3	0.5	0.4	2.2
	(1)	IBNR	4252039	2564191	637609	398442	259970	203704	274552	385996	165040	
1971	(2)	TOT.INCURRED	23087114	40825023	42507701	46757100	48224837	50075364	52126218	53459864	54424408	
	(3)	% IBNR	18.4	6.3	1.5	0.9	0.5	0.4	0.5	0.7	0.3	
	(1)	IBNR	5936979	2209956	1090080	399324	304412	449025	509492	12422		
1972	(2)	TOT.INCURRED	27294099	41689233	48020023	51196788	54731871	57830690	59363910	61308314		
	(3)	% IBNR	21.8	5.3	2.3	0.8	0.6	0.8	0.9	0.0		
	(1)	IBNR	5762814	2875116	887269	435130	833495	1206954	139598			
1973	(2)	TOT.INCURRED	31344513	53843335	58194442	63809297	69316855	72931353	72612328			
	(3)	% IBNR	18.4	5.3	1.5	0.7	1.2	1.7	0.2			
	(1)	IBNR	7382424	3315967	1334233	1408214	1813928	587059				
1974	(2)	TOT.INCURRED	38380624	62273995	71371678	79989853	81759997	84771972				
	(3)	% IBNR	19.2	5.3	1.9	1.8	2.2	0.7				
	(1)	IBNR	10037629	5477106	2546021	3453063	2463010					
1975	(2)	TOT.INCURRED	45383395	79754303	91573712	108410379	113168640					
	(3)	% IBNR	22.1	6.9	2.8	3.2	2.2					
	(1)	IBNR	17789780	11027353	8058764	6350810						
1976	(2)	TOT.INCURRED	62105209	111612264	130847187	146306210						
	(3)	% IBNR	28.6	9.9	6.2	4.3						
	(1)	IBNR	26953110	22155952	15352759							
1977	(2)	TOT.INCURRED	88477273	166929846	179969786							
	(3)	% IBNR	30.5	13.3	8.5							
	(1)	IBNR	44108990	35384489								
1978	(2)	TOT.INCURRED	141950756	203514101								
	(3)	% IBNR	31.1	17.4								
	(1)	IBNR	53540151									
1979	(2)	TOT.INCURRED	149020212									
	(3)	% IBNR	35.9									

DISPLAY OF
PAYMENT AND RESERVING PATTERNS
OF
ULTIMATE INCURRED CLAIM COST

MINNESOTA



Workers' Compensation State Fund Study Commission - September 3, 1980

FINANCIAL ANALYSIS OF THE CURRENT RATE OF RETURN FOR PRIVATE INSURANCE COMPANIES

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Thank you, Senator Keefe, and good afternoon. I hope you don't mind, I'd like to walk around a little bit as I talk because I have some transparencies here that I'd like to use. And, addressing myself in general form to Senator Keefe's letter, what I'd like to do if I could is start from ground zero which is really to describe in as graphic terms as I can how an insurance company works and the financial flows. To many of you who have already -- probably many of you worked for insurance companies ... I'm carrying coals to New Castle, ... and others, have done a fair amount of study work already. But I'd still like to do it so that we can define my set of terms and terminology and then we can all be working with the same frames of reference. And from there, what I'd like to do is present some statistics, some analysis, that we did as part of the work for the Minnesota Insurance Department, in connection with the rate hearing. And, finally, I would like to show you some empirical data that was collected from the history and background of the New York

State Fund to give you some additional frame of reference to see that these theories are in fact in practice, developing quite well. So in my first set of charts which I guess two-thirds of the room can't see -- I don't know what we can do to make it better, except, I don't know. Senator ...

[DISCUSSION]

Thank you, I think that helps tremendously. What I'd like to do first is describe what I call the "financial mechanics" of an insurance company. And I believe that this table accurately describes all of the financial flows that really occur. In fact, insurance premiums are collected, and, less their sales expense, the balance flows into a trust fund. I use the word "trust fund" so that you can dissociate yourself with some of the traditional insurance statutory terms like "unearned premiums" and "loss reserves". All I'm concerned with are the monies held. And the monies held (which are out of the balance of the insurance premiums after you have paid your sales expense,) together with the investment income earned thereon, constitute the total revenue of an insurance company. It's nothing more than premiums and investment income or your revenue. And the revenues are disbursed to pay claims, administrative expenses and if there's anything left over, that's called "change in surplus," which also some people

might define as "return on equity." I've used the term "change in surplus" also to dissociate you from the traditional concepts of what equity is -- whether it's shareholders' equity or what have you. Just change in surplus is the net change of all the transactions.

That in its simplest form describes the entire insurance financial flow. Now the only thing I'd like to do is show you that there are risk elements encountered along the way. By isolating one, the first risk element I've isolated in this particular case is the investment risk. So your insurance premiums less your sales expense flow into your trust fund, but the trust fund can have alternate outcomes. You could pursue what I show as "Strategy A" and "Strategy B." Strategy A would be a low-risk investment portfolio and let's assume that is all in 6 3/4% municipal bond yields of Triple A-rated or all in the shortest term treasury bonds, whatever it may be, with no risk of either maturity risk or principal risk or risk of interest or anything else. Or the alternative can be, you put all your money in common stock and you could have a fluctuation on your entire portfolio by as much as 25%. And by the way, I chose that number for illustrative purposes, but in fact, in any calendar year since recorded Dow Jones averages, the stock market has never really had more than a 25% up or down swing within a calendar year. There are periods

in between years where in fact you've had swings of 30% or more. But within any calendar year in recorded Dow Jones or S&P history, 25% has been the maximum swing. And no insurer really puts all of its money, all of its reserves, in common stock. But I wanted to give you the black-and-white scenario. So, as you follow through, notice that the change in surplus now has variations in outcome depending on the variations of investment. So your first risk isolated here was your investment risk. The second risk that one would isolate for the insurance industry is really the underwriting risk. That is, in the insurance industry uniquely your liabilities are uncertain. You might have on your balance sheet $50 million in loss reserves due and in fact there might be $50 million or that might be $60 million or it might be $40 million -- you really don't know what your liabilities are. So, unlike a bank, which might have $50 million due on the first and you know it's both $50 million and it's due on the first, in the insurance industry you don't know either the time of maturity or the actual payment. So claims have a variation. The one I've illustrated here is a fairly narrow claims pattern or loss ratio between 55%, let's say, and 75%. But clearly it's the outcome of your underwriting that also determines changes in surplus. So, assuming your investment income is certain but your claims are

uncertain, this industry uniquely with uncertain liabilities has the risk of payments of different maturity, different principal. So, again, the second risk element in the insurance transaction. Now, a going insurance company, therefore, is a reflection of the interaction between both of those risks. And by the way, I have eliminated several other risks and I can just talk about them for a second, not because I've ignored them totally, but because generally they're small. One risk is that you won't collect your premiums -- that's a possibility. One risk is your administrative expenses might be greater than you anticipated. Those are also risk elements, but I've ignored them because they are closer to controllable than the others and less subject to fluctuation. Nevertheless, they are also part of the riskiness of an entity. But an overall insurance entity, then, is the interaction between your investment risks and your underwriting risks. And the riskiness of the total entity is the interaction of those two. So if you run into a period where investments turn sour and underwriting turns sour, you can be hurt to the, let's say, maximum extreme or if you run into a period where investments are terrific and underwriting is terrific, you have a pretty wide variation, with the probability falling somewhere in between. Now, that's the insurance business -- that's it. Premiums less sales expense flow into

your trust fund. It's invested for return. The amount of return is dependent on the amount of risk you take. You also earn a spread on your underwriting -- it could be negative or positive. And that also is a function of the amount of risk you take. And the entity itself, the riskiness of the entity is the interaction of the two and determines how risky you will be in terms of your so-called change in surplus or return on equity. Now that's it. That's a reasonably good description of how the whole insurance industry works, in terms of all lines of business -- Worker's Comp, automobile, any line of business. Now, since that describes the industry, I just want to reflect one nuance of the transaction, which is to show you that there are both short and long-tail lines of business. Here your premiums (we've already netted our sales expense) flow into a trust fund. And the trust fund is invested at some level. The difference in a short-tail line of business is that the trust fund stays with you for a very short period of time. Let me give you an illustration: In Massachusetts, a dollar of automobile physical damage premiums collected by an insurer, invested and ultimately paid out in claims, generates over its entire life about 31¢ of investable funds. So that for each dollar premium, all you have is about 31¢ to invest over the entire life of the program, and it may take you 16 months

to pay out all claims and most of the claims are paid out within six months after the end of the year. So, pretty much by 18 months, most of your physical damage claims are already extinguished and disbursed -- all the funds are disbursed. So short-tail line of business gives you very little to invest. If you have very little to invest, even if you take a very risky position on investments, it's a relatively small fluctuation because you're not investing a lot of money. The second thing is that your underwriting tends to be skewed positively. You tend to make an underwriting profit on a short-tail line of business -- for two reasons. One is you're not making very much money on investments so you better be making it on the difference on underwriting or why are you in the business in the first place. And the second is that you're pricing your product in insurance before you really know your cost of goods sold. Well, in a short-tail line of business where the lead time is not more than 18 months to ultimate payment of all claims, well, then, you have a pretty good idea of what your claims payments will be. So you do pay, you do price a little better. So, short-tail lines of business tend to be skewed profitably in underwriting and have less investment income as a characteristic and the riskiness is a function of the interaction of these two, but it's clearly less risky because there are less investment funds to play

with and they tend to be positive because you can price better. And so your range of possible outcomes are far less broad than they are for general lines of business. Now I'd like to give you the contra to a short-tail line of business, basically this is long-tail line of business. In this instance a dollar of premiums generates $2.25 of investable funds. And so, the outcome of a plus or minus 25% is very, very, very important to the outcome of the total transaction. This could be Worker's Compensation, it could be auto liability. In fact, in automobile liability a dollar of premiums generates about $2.31 of investable funds over its life. Because it takes as long as 96 months to pay out all of the claims -- few claims beyond that. And so you're holding the money, the insurance company's holding the money for a long period of time on which it continually earns investment income. And therefore the investment outcome is a very substantial part of the transaction. As well, on a longer-tail line of business, then, your underwriting tends to be skewed negatively. You tend to have an underwriting combined ratio in excess of 100. You tend to lose money in underwriting -- (a) because you've got much bigger investment income subsidy, and (b) because you're pricing your product further away from the event, further away from the time -- when you price a Worker's Compensation risk now, you may be paying this

worker benefits escalated by inflation 40 years from now. And so it's tougher to price your product further away from knowing when your cost of goods is sold on. So that in fact, in Worker's Compensation insurance, there is somewhat a longer-tail line of business. And you hold the money for longer periods. And investment income becomes a more material part of the total transaction. Now, later, I'll show you how material that really is. But for the moment, let's just understand that this is an insurance company with a long-tail line of business. Worker's Comp is characteristically a long tail. Now, let me just take you through one story of the development of one insurance company and understand what can happen in terms of managing these risks. In this particular instance, back in the early '70s, '71 through '73, one major insurance company decided to increase the tail of its business -- that is, it decided that it could write medical malpractice, Worker's Compensation, and general liability better than its competitors. So it made a conscious decision, and from management decision, to start writing more of the long-tail business which had this somewhat greater underwriting risk inherent in the transaction. At the same time, its investment people recognized that the company was growing rapidly and that their mission in terms of supporting their parent was to build surplus as fast as possible, and they

felt that they could build surplus faster by investing more heavily in common stock equities with a variable or expected yield of 9% than they could investing in bonds at that time with an expected yield of 5%. Now, more important was, because you write a long-tail of business, you start to generate more funds -- more cash flow. So the cash flow was pouring in over the transom at the rate of $2 to $3 million a week. Well, if you're running an investment portfolio and you're in a net positive cash flow, you don't worry about liquidity. You don't worry about selling securities, you only worry about acquiring them; because if you need cash you just take it out of your cash flow. So the company did two things: one, it extended the maturity of its portfolio, buying municipal bonds further out into the future; and the second thing it did is it invested more heavily in common stock. And while it didn't invest a hundred percent of its money in stocks as this black-and-white illustration would show, in fact, it invested $2 of its surplus for every dollar -- $2 of common stock for every $1 of its surplus. So in fact it was on margin. It was using not only its own surplus to invest in the stock market, but it was using policyholder funds as well. Now, what happened was that the investment department in its view was supposedly supporting the growth of the company by trying to build the

portfolio yield and to build surplus as fast as possible. But what happened in 1974 was the stock market collapsed and the company experienced a huge decline in its portfolio, at the same time that its underwriting turned sour and it experienced very, very large losses in its underwriting account with reserve deficiencies and substantial current-year losses. And so the company suffered on both fronts -- it suffered both on underwriting and on investments. Now, if you had walked into the management of that company at the beginning of 1973 and said, "Gentlemen, your company has a one in ten probability of losing half of its surplus. Are you willing to take that risk? We've done an analysis. Here's your portfolio of securities. Here's the mix of business you're writing in insurance. You have a one in ten chance of losing half your surplus. Are you willing to take that risk?" Management, which was generally conservative, probably would have said no. But the fact is, because the investment department operates independently of the underwriting department and because the functions tended to be -- the industry parochially looked at these functions as separate and tended to look at investments as some other part of the business, the answer was, they took the risk, not knowing they took it. And somewhere during 1974 the company found that it lost half of its surplus. They were forced to liquidate their common stock

and cut back very substantially in some of their underwriting areas because at that point they were afraid that they'd actually become financially impaired. It was a very, very serious time and serious risk for a company that never would have taken the risk without knowing. The lesson to be learned from this is that in the insurance transaction, investments are not some peripheral independent part of the overall transaction -- they are an integral part of the total insurance transaction. And when you have a longer-tail line of business, investments become the more important consideration and are critical to the overall profit of the company. Now, that's how the insurance business works and that's what the long-tail line of business looks like, and it's an objective of management, an insurance company management, to get the maximum return on equity consistent with the risk. They will tend to write those lines of business which give them the maximum yield consistent with that risk. And since you can't write them totally alone, they tend to write portfolios of insurance across all lines. What I mean is you just can't write one line without necessarily doing business with brokers and getting some additional business. But that describes the insurance business in a nutshell. Now, that long-tail line also describes what we feel is Worker's Compensation insurance. Now, as part

of the hearing, what we did was we started to describe how important investment income is in a long-tail line of business, such as Worker's Compensation. So what we did was we created a hypothetical insurance company that wrote one year's premium. It had no capital and surplus. It started with zero. It started with no capital surplus and all it did was collect the premiums. That's the only source of revenues it had, initially. Then over the life of the policy, it paid out the premiums in claims and, in fact, in this illustration, I use a combined ratio of losses and expenses of 106%, and forget how I got there but I will just tell you that that was a hypothetical number and it was a 106% that we used in the hearing to show that you can have so-called underwriting losses but not necessarily have net income losses. Now the first thing I told you was that in the long-tail line of business, you hold on to the money for a long period of time. Let me show you roughly how long. This is the development of the ultimate pay-out patterns for Worker's Compensation insurance. Now, what you're looking at are percentages of ultimate, paid-out. Let me tell you what that means. Assuming I had $100 of incurred claims, I charged off income $100 of claims. I didn't actually pay it out in cash. In fact, during the first 12 months of the year, of the so-called policy year, all I actually paid out in

cash was 9.9% of my loss, my ultimate loss. So if I had $100 in claims, I paid out $9.90, and I had left $80.10 of the $100 to invest. In the second year I wound up paying about 26% and so on down the line through Year 13 in this case. And in Years 14 through 50, an additional 16% of the claims would ultimately be paid out. Now, these payment patterns are reasonably accurate. They were taken from ten years of data with all Minnesota insurers and 20 years of data with the New York State Insurance Fund. That's where the figures come from. That's the way Worker's Compensation pays out in terms of claims. So, you can see you're holding on to a lot of money in a Worker's Compensation risk, and it is a long-tail line of business and in fact a dollar of premiums for Worker's Compensation generates well over two and-a-half dollars of so-called investable funds. And if you don't think so, then test it empirically. Pick an insurer, take its balance sheet, and look at it. And say, look, the company has x dollars in capital -- let's say, $100 in capital. And now let's assume that it also has $300 of investments. Well, if $100 of capital is fully invested, that will equal $100 of investments -- where did the other $200 of investments come from? They had to come from being in the insurance business. And all you got to do is look at it empirically and compare that with the premium volume

they write. And you'll find that a company that writes predominantly Worker's Compensation, for every dollar of premium, if it's in a continuous business and been in the business a long time, it probably has two and-a-half dollars to invest for every dollar of premium it writes on an annual basis. And, as I said, investment income is an integral part of the total insurance transaction. Okay, so much for the tail. Now, I said we created a hypothetical insurer. I apologize for the tremendous amounts of information that are on these charts -- they come off one of our computer runs, and while they're not as difficult to see as I thought they'd be, fortunately -- I guess everybody can see them. Here is a very simple model. I'll describe it for you. The relevant year, by the way, is right here, next to my, on the right-hand side of my pen. You notice in the first year which is actually 1980, projected, the company writes a hundred million of insurance premium. And it incurs losses of 87.4% or $87 million. Now remember, of that $87, I said only 9% is paid out in the first year. The balance is transferred to loss reserves and paid out ultimately. As well, you have about 19%, or 19.4, total underwriting expenses. And those are your expenses which include your commission expense which is under acquisition, and your general expense which amounts to about 7.4%. The sum of your losses and

expenses produce an underwriting loss of $6.8 million. So for each $100 million dollars, the combination of your losses and your expenses exceed your premiums by 6.8%. Hence, the bottom combined ratio, 106.8. Also, if you will notice, there is an item called "change in investable funds". What that is telling you is, I started with no capital -- I started with no money. At the end of the first year, I've got $72.3 million to invest, on which I can earn investment income. Now since the premium came in over 12 months over the course of the year, I've only really had a portion of that money to invest. Notice in the second year I have no premium, no expenses to speak of, I have a small stub trail that I put in there. But basically I have no operating expense. What I do have is a decline in my investable funds of $23 million which, by the way, corresponds to what I showed you before, about 24% of my loss reserves are paid out in the second year. So, what I have is -- if you'll follow all of the ensuing years, year-by-year-by-year, you'll notice that I continue to pay out money. And what I did in this illustration is I -- rather than go out 40 years and bore you to tears if this isn't boring enough, is I truncated it and stopped at 14 years, so that at the end of the period in the 14th year you'll notice this big increase. What I did is I just paid out all the rest of the reserve. I could make the assumption

that I reinsured it, for example. What I did is I assumed the reserve was fully paid out and I closed the year. So that after the first year when I collected the premiums, I did nothing more than pay out claims and invest the money. Now, what you have to look at is the rest of the income transaction, which is over here. You notice that I have -- and in this illustration, let me tell you what else we did just to give you some of my assumptions. We used the insurance industry historical averages -- the historic portfolio that the industry has, the historic yields they've been earning. We used it as if this were an old-line insurance company that had been in business for 50 or 100 years and we used all the historic averages. So, the industry has income from taxable bonds (that is, governments, corporates, what have you), income from tax-exempt bonds, income from stocks (that's your dividend income), amortization -- we really didn't get into that -- and investments expenses, we stayed away from that for the moment. But what had happened in that year was an interest income of $2 million. Now, if it were a going insurance company then it had an underwriting loss of $6.8 million, an investment income of $2 million; so it had a net loss of $4.7 million. We assume that there would be a tax; in this case, it was a tax credit. And getting into this -- without getting into a whole discussion of

the relevant illustration, if we were a going insurance company, writing other lines of business, and were profitable, we would in fact have a tax credit equal to the excess of our underwriting loss. Conversely, if we just look at the tax that would be paid in future years, we could recoup our loss within a reasonable period of time anyway. So the tax was put in to add a sense of realism in the real world, but our after-tax loss, then, for the first year was $1.88 million. So, we started with zero surplus. We started with none. And at the end of the first year, we were —$1.88 million on an incurred basis. In the second year, all we did was pay out claims and earn investment income. Since we've already incurred the loss in the first year, the pay-out of claims was merely a reduction in cash -- it wasn't a charge to income. In the second year we earned investment income of approximately $2.5 million and that constituted our only income. In the third year, $2.3, $1.8, $1.6, $1.4, $1.4, $1.3 -- we're earning those investment incomes over that period of time. And so we go until the end of the 14th year when we terminate the transaction. And without going through all of it, you can see that each year the change in surplus is positive. Now, at the end of -- these are the balance sheets. This is just the liability side of the balance sheet. I don't have to bore you with the asset side. But you can see what

happened is, we started with total capital surplus of zero. At the end of the first year we were minus a million eight [$1.8 million]. By the end of the second year we actually had a positive surplus. And so on until the 14th year when you'll notice that we had less in the till after paying out all claims. Notice that our liabilities are entirely discharged. We don't owe a single penny. At that moment in time, we have $19 million -- approximately $18.9 million left. So, let's see what we said. We've written $100 million of premiums in one year one time. We had a 106.8% combined ratio, which means we lost money on underwriting -- no question about it, and it was a substantial loss by insurance terminology because, for the industry overall, the worst loss in the history of the industry was a 107.7%. That doesn't mean individual lines don't have larger losses. But here we've lost money overall. And meanwhile, at the end of the 14th year, on just that one year, having lost money in underwriting, having paid out all our claims, we're left with $19 million. Okay. That's another way to describe the transaction I describe in the flow chart. Now I want one other piece. I told you that I did this on historic yields. The industry's historic yields are 5%. It was a battle in the rate hearing to try to, to come to terms with some people in the industry who wanted to use historic yields as their method for

calculating the investment income that should be in rates. But the industry is not receiving historic premiums. It would be getting $100 in cash today, and they're going to be investing that $100 in cash today for the future. So that, they're not going to accept premiums, they're not going to allow us to give them a 4% U.S. Government Savings Bond and tell them it's worth par. So that, why should we accept historic yields. We've got to use projected yields. Let me show you the difference, and it will give you an illustration of the sensitivity of a Worker's Compensation insurance line to investments. In this illustration, which bears a remarkable resemblance to the last one, all I did -- (and the top says "Present Yields With Even Portfolio Distributions"), all I did was take the portfolio which was invested at historic yields and put it in at current yields. I went to the newspaper and I said, okay, what can you really get on municipal bonds. Eight percent, that's it. What can I get on a U.S. Treasury -- 9.6, that's it. What can I get on corporates and stocks, etc. And I put those in, for my illustration. Everything else is identical. I have a 106.8 combined ratio. I have $72 million in cash flow. I pay out $22 million in my second year and everything runs off, and I run it out for 14 years. Okay. So on down the line -- I will just go, if I can .... My investment income: Notice first, if you remember in the

first year I lost $1.8 million? Yet if my yields were current, I only lost $900,000. If you recall the illustration of the second year, I earned $2 million; now I'm earning $4.7 million. I'm just -- all I did was write it at current yields. Let's get to the balance sheet and in fact, let's skip as much as I can here, get to the terminal balance sheet, which is right here. At the end of the transaction I have identical combined loss and expense ratio. I have $43 million, as opposed to $18.9 million. The only thing I changed were investment yields. Okay? So, you can see that Worker's Compensation insurance is excessively, or extraordinarily sensitive to changes in interest rates. The other thing you can see is that I can make an enormous amount of money and still have an underwriting loss. Profit is the difference between premiums and investment income, less all expenses. And I don't care how it's earned -- whether it's earned by capital gains or by investment yields or by whatever: it's simply the difference between what you collect, less what you pay, and when it's all over, what's left on the table. And as long as you look at it that way, it is, in its simplest fashion. All we've done is the mathematical calculations to take it out to its ultimate. That is the business of insurance for any lines, and that is Worker's Compensation. Specifically, those statistics bear a fairly close resemblance

to reality because what we did is we recreated the insurance transaction. Now, one other thing ... I just want to take you one more building block along the way. And that is that an insurance company doesn't just write one year's one time, but it writes one year every year, and keeps writing over and over and over again. So we said, how much is the insurance industry really earning in terms of return on equity in this business. And remember that the insurance rate formula in the hearing called for a fixed 2-1/2% profit. Well, our contention was that if the underwriting profit is fixed and the investment yields are variable, then the profit the industry's going to make will vary depending on interest rates. And if interest rates go up, the industry's profit will go up. And we've already demonstrated that just changing the yield while keeping the combined ratio constant would increase the profit in this illustration in a money-losing situation from something like an $18 million to a $42 million change. So if the industry had a fixed 2-1/2% profit, then the same thing would happen: the profits would go up by that amount if you just kept staying with a constant underwriting profit of 2-1/2%. Okay. In this illustration, we created a model of an insurance company just like the other models except for one thing: and that is that it wrote premiums every single year. Now, since what we wanted to do was

create a company almost from the ground up, what we did is . . . let me go back just a drop. We created a company that wrote $100 million of premium every year, year-in and year-out. And it looks something like this. And every year -- in this case, we used ... by the way, forget the first year because that's merely -- this year is just a stub year to get things going. It's not part of the calculation. But, what we did is we started with a 97.5 in every single year. That was the 2-1/2% profit that the, margin that the industry asked to be included. So instead of the 106.8 the two previously illustrations shows, now we're dealing with a so-called 97.5. But every year we're writing $100 million of premiums. And we're building this company from the ground up. So it's not until the 15th year, since I told you I truncated the illustration at 14 years, that we add a year and lose a year. By the 15th year, we're really in what you'd call equilibrium. Because we're now a mature company. We're adding a year; we're losing a year. And we just go on and on and on into infinity. During the early stages all we're doing is building from the ground up. So it's really in the 15th year that we get an idea of what this company looks like, and it's something like this, and that is 1994, we're writing $100 million in premiums; we have policyholder -- a total underwriting expense, 97 combined

ratio; virtually no change in investable funds. In other words, it starts to get constant because now we're adding and losing about the exact amount, and so our net cash flow is almost identical, just looking for the investment income illustration -- it should be about here. And again, in 1994 what's happening is, I have a small gain from underwriting that's $2.5 million every single year. That's my gain from -- that's my 2-1/2%, my underwriting margin, it's every year. Second, I have investment income of $34 million -- $34.1 million. So my pre-tax income is $36 million. My tax -- again, this is on the same portfolio that the insurance industry has, with historic yields -- is $15.8 million. So my net income is $20.8 million -- $21 million. Okay, that's my net income, year after year after year. And that's what it will be on $100 million of premiums. For every $100 million of premium I'm going to write, I'm going to have a net income of $21 million. To perpetuity -- as long as I write the same volume. Now, in insurance terminology, how much capital do I really need to write a $100 million of premium? Well, the insurance industry historically has been writing something in the neighborhood of 2 to 1 -- $2 of premium for each dollar of surplus. So, if, in this illustration I'm earning $21 million I should show you that on my balance sheet I did put in a surplus of $50 million which gives me the so-

called 2 to 1 ratio. You'll notice it's under the item -- [CONVERSATION/CONFUSION RE WRONG CHART] This is not the matching chart. Let me tell you what the numbers are and you'll trust me that these are the correct numbers. What we have is $50 million of surplus. And the net income I showed you was about $20 million -- $21 million. So what I'm saying to you is that in a continuum with a 97-and-a-half combined ratio and current yields on my portfolio, going on and on and on, I would be earning about a 40% return on equity. That is a fairly substantial amount of return on equity, and in a free economic market I suspect new entrants would come into the business and price the product lower to make up some of the difference. But that is exactly what happens. And when we created a model of a company in, repeating every year that transaction -- it just writes a $100 million of premium, 97-and-a-half combined ratio, pays out the pattern identical to what the pay-outs are and I'm telling you that the terminal period, when you really look it over and over, they're going to be earning a 40% return on equity. I'm sorry I don't have -- I thought, I must have, when I put my figures together, I must have taken the wrong things. The model is called "Minn. III With Capital," which is Minnesota, it was our third model run, and this time we used capital. In the previous models, we told you, we used

none. So, now you can see, (a) what happens in a single year carried out to a conclusion. Sometimes you just have to see it year-by-year-by-year to understand. We started with flow charts and showed you how the insurance industry works. We then went to, from we understand the industry and its dynamics, we then went to a real illustration of the single year. We've now built multiple years so that we've gone up to a going concern value. Now it'll just be the last thing: some empirical point to see that this is for real. What we dealt with is the New York State Fund. And for today's presentation, what I did was I collected data on the New York State Worker's Compensation Fund. This goes back to 1969 when the fund wrote $90 million of premium. The Fund had a 19% expense ratio, 110 combined ratio, and had $14.6 million of net investment income. 1969. It also paid out a substantial amount of dividends so that if the combined ratio in 1969 was 115%. And the Fund had capital and surplus at that period of time of $23.5 million. So it was writing a little under 4 to 1; it had a 115 combined ratio; it had $15 million of net investment income. That's the New York State Fund. Now if you'll just follow this line, you'll notice that their year-by-year 69: 115; 70: 116, 110, 113, 123. And even with a 123 combined ratio this surplus held constant in the $20 million range while they had modest growth in premiums

from $90 million to $116 million. Let me carry it out one step further because during this period of time you know what was happening -- investment yields were going up; and as new money came in, it was being invested at increasingly higher yields. For example, that investment income went from $14 to $16 to $19 to $20 to $24 million by 1973. The figures I'm going to show you and the projections that I'm going to give you [COUPLE OF WORDS INAUDIBLE]. The New York State Worker's Compensation Fund in 1974 had a 125 combined ratio. 126, 119, 108 -- finally, it had a 99 and 82. The first two years it ever made so-called "underwriting profit." But look what happened. First, it went through some periods where, by the way, it suffered some investment losses; it also went through periods where it suffered, as I say, 123 for three straight years -- '73, '74 and '75. And its surplus dropped to $7 million. With a 119, a 108, its surplus rose back to $22 million. With a 99, surplus went to $47 million. With an 82, surplus went to $140 million. Let me tell you that by 1982 -- that's right, by the end of '81, I'm sorry, by the end of '81, with projections, the New York State Worker's Compensation Fund will have a surplus of $400 million. So that between 1969 and 1981, this Fund will have accumulated approximately $380 million, out of retained earnings. And during that period only two years did it have an

underwriting profit: 1979 and 1978. And the result of that underwriting profit, by the way, was to foster a substantial reduction in rates in New York State. The State Workers' Compensation Board reduced its rates across the board by 10%. As well, the Fund itself instituted an additional 25% deviation downward from the State rates. And again, I showed you the combined ratios were well over 100. Look at the accumulation of investment income: 27, 32, 45, 52, 63, $86 million. 1980 investment income for the New York State Fund will be $120 million. 1981 investment income for the New York State Worker's Compensation Fund will be in the neighborhood of $142 million. So that its surplus of $140 will have an increment in 1980 at break-even at 100 combined ratio of $120 million. That will go from 140 to 260. In 1981, an additional $140 million increment at break-even will take that 260 to 400. Premiums, by the way, written grew from $90 million that I showed you to about $400 million currently. And in fact they have $400 million now. In fact, coming from $7 million of surplus less than ten years earlier, '73, to $400 million in '81 is almost an embarrassment of riches to the State Fund. And it was all a combination of substantial increases in investment income and a modest -- in this case -- a dramatic reduction in its underwriting trade ratio. But it's clear that even through 1977, the Fund was starting to build

dramatic investment income and could sustain it in all of the period. Only two years did it have underwriting gains. And once it had underwriting gains, the profits were staggering. That gets back to what I tried to say about the 2-1/2% profit formula. Here, with a .15% underwriting profit, the State Fund earned something in the neighborhood of $20 some odd million dollars. And this, by the way, is statutory basis. And there is no incentive for the Fund to run -- it's not a stockholder-owned institution -- and there is no incentive for it to run to maximize reported profits. They take all the securities losses they can take. They do everything they can to take conservative stance on their capital and to take a conservative investment position. So you can see they're not in the game of selling stock and trying to get earnings per share going up every year. And yet their surplus is going up and it is an embarrassment of riches. That's the Worker's Compensation business -- that's the State Fund. Now, what's its purpose? I personally believe in open competition; I think rates should be by competition, and let the returns on equity that anybody can earn justify the risk that individuals will take; and in a free market you'll find that institutions will price down to an economic level. If the industry can earn a 40% return on equity, they're not going to earn it very long because new competition will enter the market. A

State Fund can provide that kind of competition, I think -- if it's well-run, if it's well-administered, if it does a decent job. The second thing it can do is provide stability of market. If things do get bad, the State Fund becomes your market of last resort when the carriers pull out. And finally, it can provide certain other disciplines that help a free market go. So I can show you, (a) that the Worker's Compensation business is not a bad business to be in if you want to go into business. Should the State go into business? I can't really say -- it's not my expertise. I can only tell you that my expertise is the insurance business and that's a good business. And then I can only say, this is how it works. Investment income is an integral part of the transaction. It cannot be ignored. And finally I say to you that we've had huge increases in yields, and with those increases in yields it's clear that that changes the shape of the business because you earn more from investments than you earned previously. And finally, I just say, "Here's the State Fund -- New York State." And it's wallowing in cash. It has $2.2 billion -- actually a billion-eight ($1.8 billion) last year but it's going to have two billion-two ($2.2 billion) in assets projected. And by the way, some of those assets were used to bail out New York City, so that in fact they also used it as a financing tool for some of the municipal

financings of New York State and New York City. Nevertheless, that is not a key issue. All I can say is that the economics are as I've described them, and that's the way they work. I'm open to any questions, and I thank you for your attention.

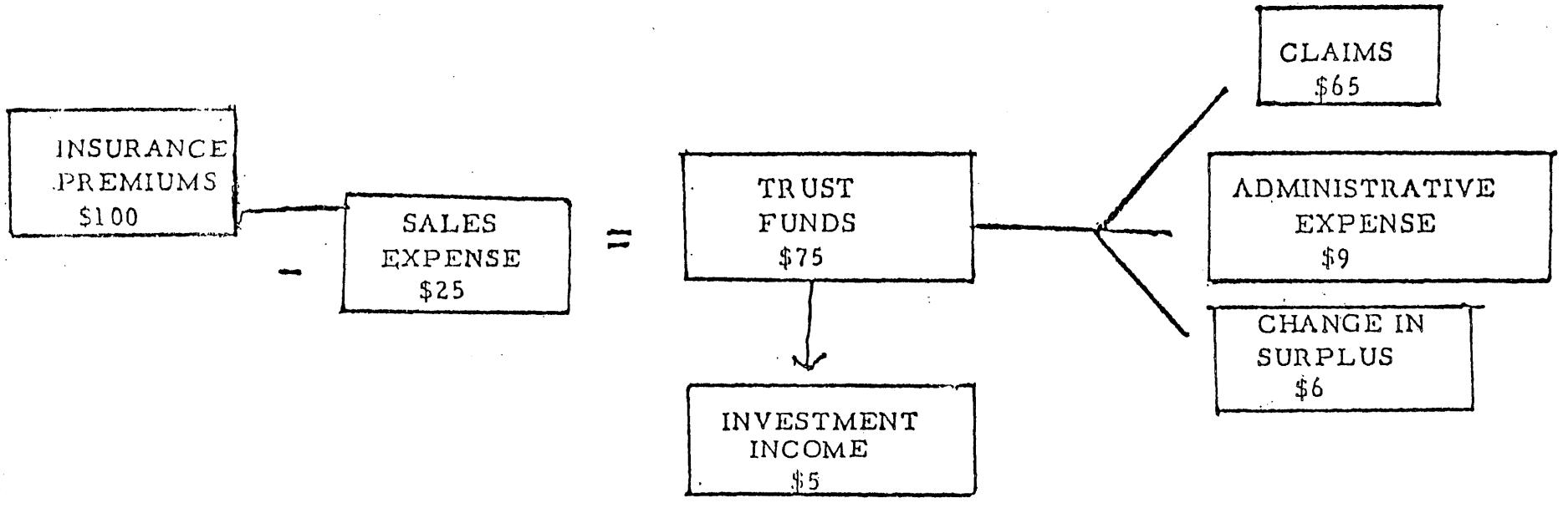
[END PRESENTATION]

(Question-Answer Period Follows)

EXHIBIT A

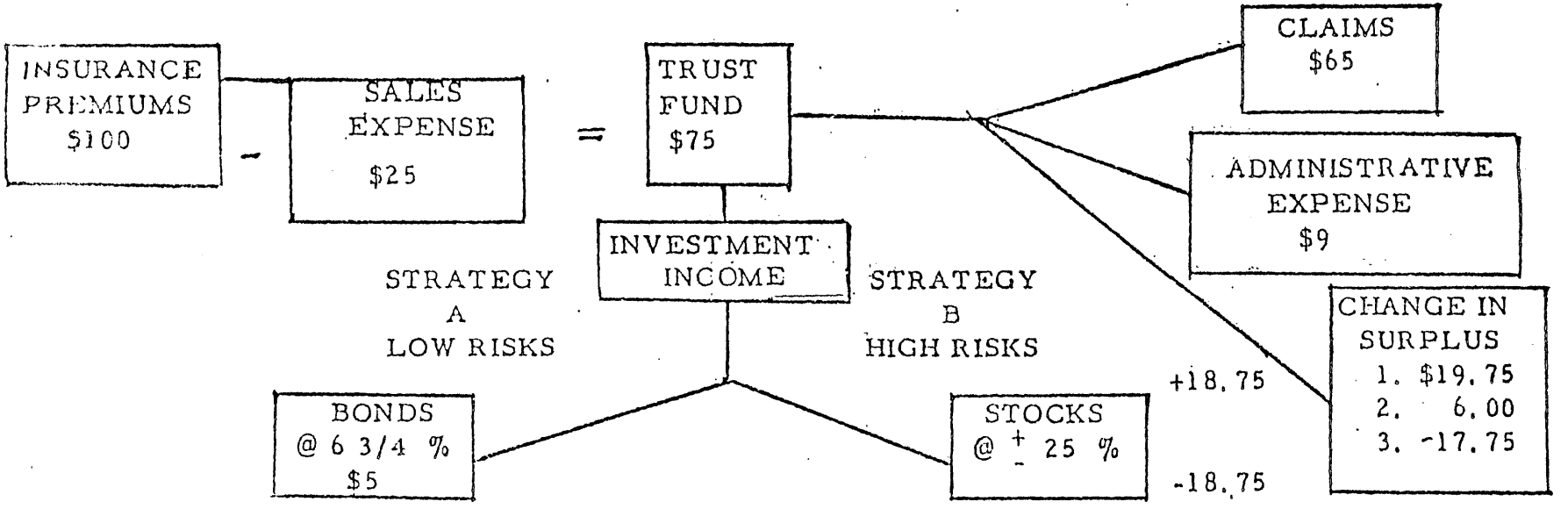
PROPERTY & LIABILITY INSURANCE
FINANCIAL MECHANICS
TOTAL COMPANY

CHART I



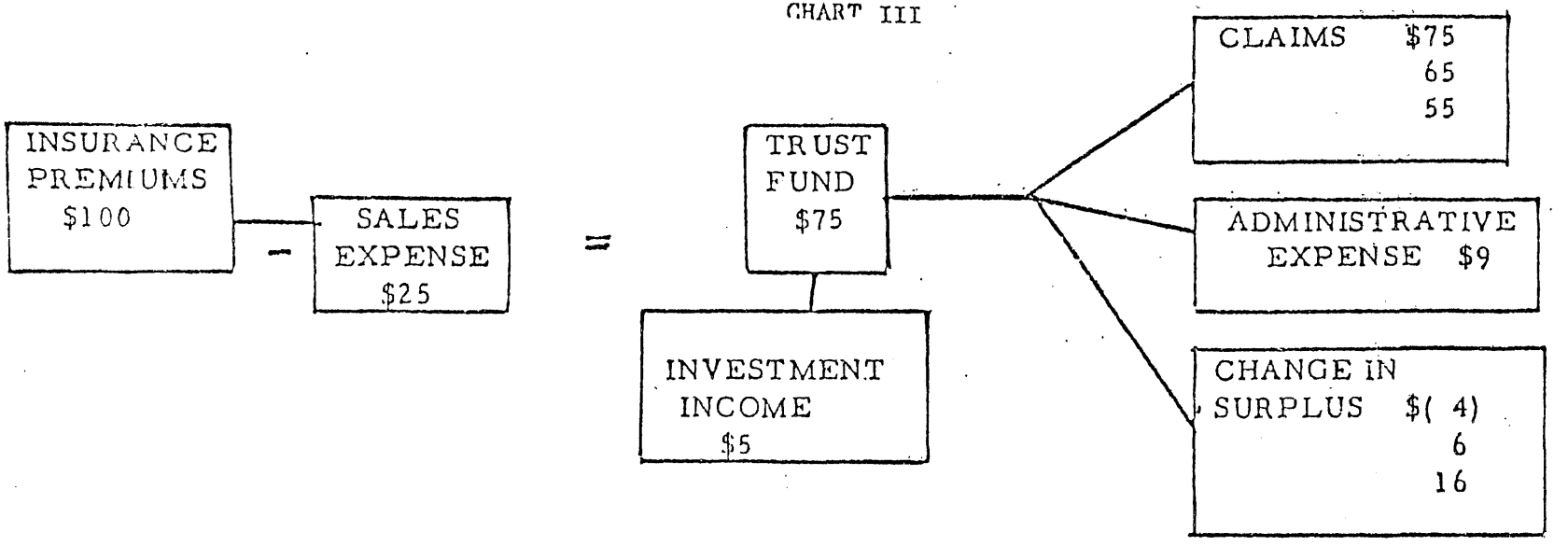
PROPERTY & LIABILITY INSURANCE
INVESTMENT RISK ELEMENTS
TOTAL COMPANY

CHART II



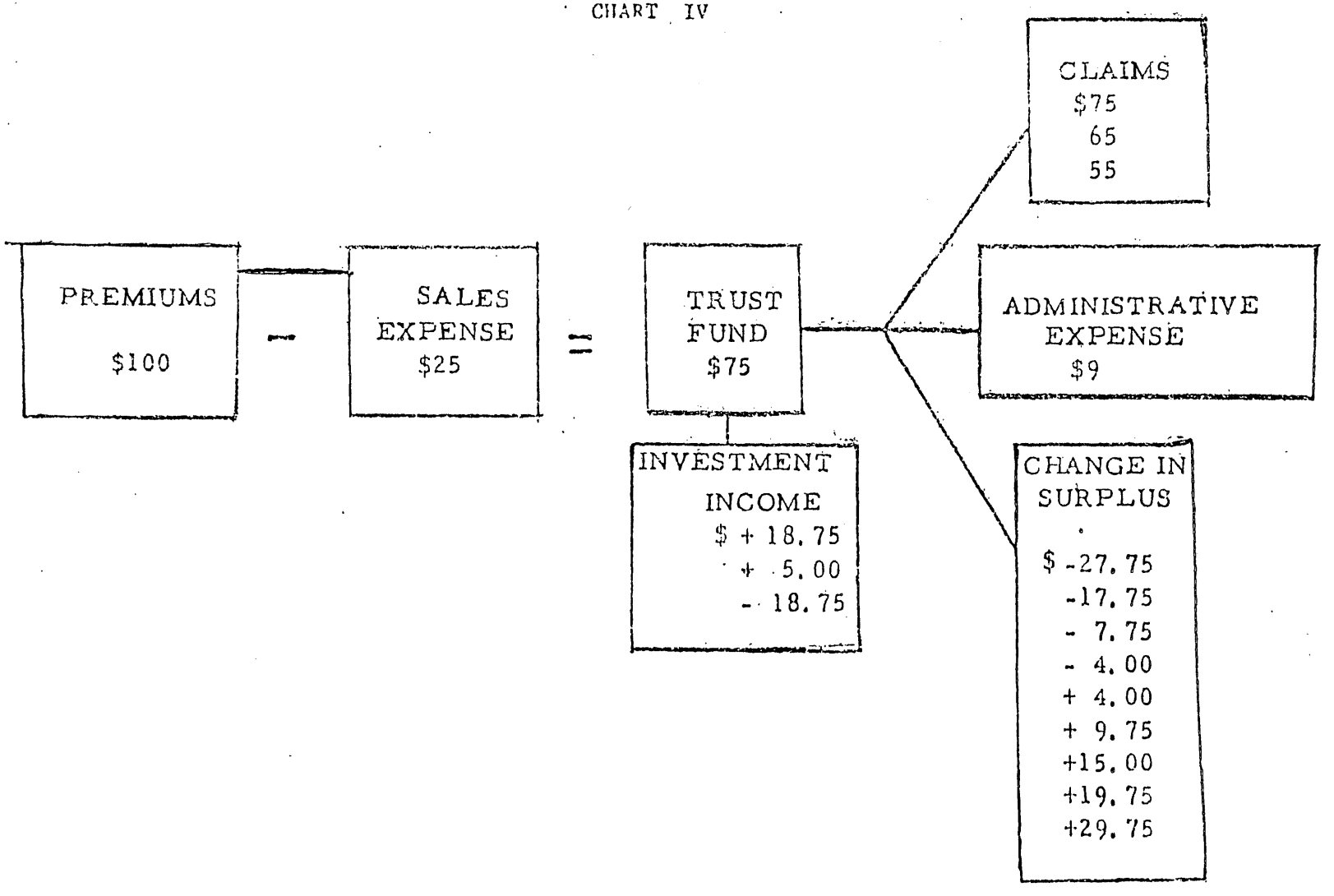
PROPERTY & LIABILITY INSURANCE
UNDERWRITING RISK ELEMENTS
TOTAL COMPANY

CHART III



PROPERTY & LIABILITY INSURANCE
COORDINATION OF RISK
TOTAL COMPANY

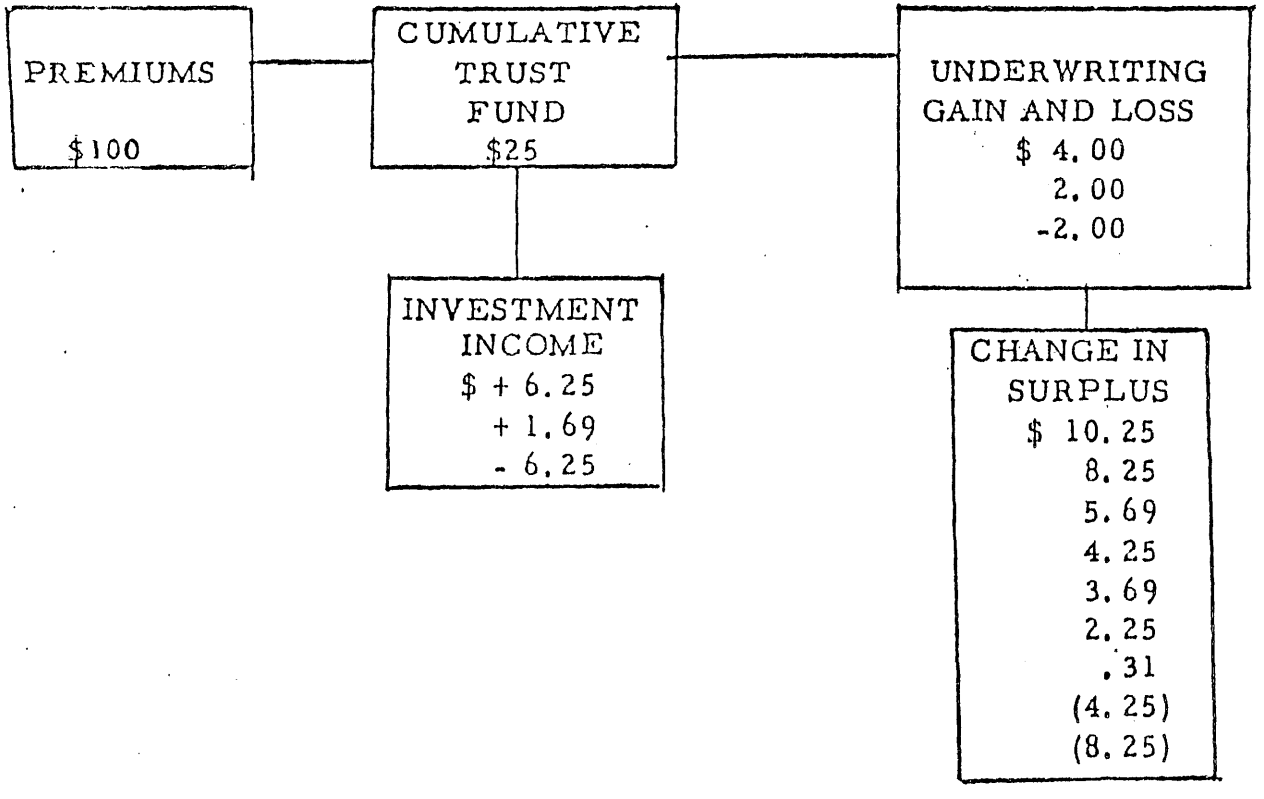
CHART IV



PROPERTY & LIABILITY INSURANCE
RISK CHARACTERISTICS BY LINE
TOTAL COMPANY

CHART V-A

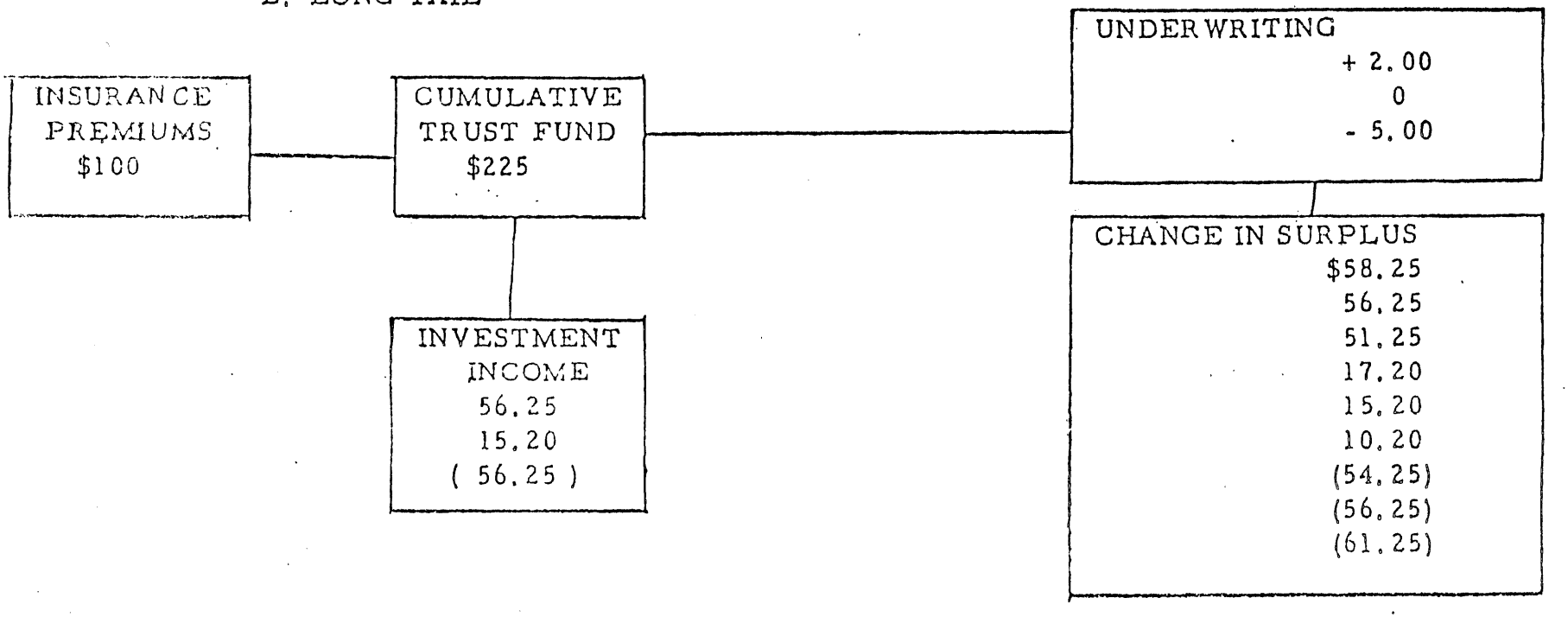
A. SHORT TAIL



PROPERTY & LIABILITY INSURANCE
RISK CHARACTERISTICS BY LINE
TOTAL COMPANY

CHART V-B

B. LONG TAIL



Present Yields with Even Portfolio Distr

PRESENT YIELDS WITH EVEN PORTFOLIO DISTR

UNDERWRITING
INCOME STATEMENT
STATUTORY BASIS
$ THOUSANDS

TOTAL ACROSS ALL LINES

PERIOD OF:	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS
ENDING AT:	12/1979	12/1980	12/1981	12/1982	12/1983	12/1984	12/1985	12/1986	12/1987
NET PREMIUMS WRITTEN	10.0	100010.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN PREM. RESERVE	*********	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NET PREMIUMS EARNED	10.0	100010.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
LOSS & LOSS EXP. INCURRED	8.7	87408.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0
ACQUISITION EXP. INCURRED	0.3	12001.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
GENERAL EXPENSE INCURRED	1.0	7400.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL UNDERWRITING EXP.	1.3	19401.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0
POLICYHOLDER DIV INCURRED	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PRETAX UNDERWRITING GAIN	0.0	-6800.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN INVEST. FUNDS	0.0	72309.4	-22680.8	-14023.0	-7925.3	-5040.9	-3272.6	-2730.6	-2026.1
LOSS & LOSS EXP. RATIO	87.4	87.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EXP. RATIO (TO PREM. EARN	12.6	19.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
POLICYHOLDER DIV. RATIO	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COMB. RATIO (TO PREM.EARN	100.0	106.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EXP. RATIO (TO PREM.WRIT.	12.6	19.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COMB. RATIO (TRADITIONAL)	100.0	106.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0

PRESENT YIELDS WITH EVEN PORTFOLIO RISK

UNDERWRITING
INCOME STATEMENT
STATUTORY BASIS
$ THOUSANDS

TOTAL ACROSS ALL LINES

PERIOD CF:	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS
ENDING AT:	12/1988	12/1989	12/1990	12/1991	12/1992	12/1993
NET PREMIUMS WRITTEN	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN PREM. RESERVE	0.0	0.0	0.0	0.0	0.0	0.0
NET PREMIUMS EARNED	0.0	0.0	0.0	0.0	0.0	0.0
LOSS & LOSS EXP. INCURRED	0.0	0.0	0.0	0.0	0.0	0.0
ACQUISITION EXP. INCURRED	0.0	0.0	0.0	0.0	0.0	0.0
GENERAL EXPENSE INCURRED	0.0	0.0	0.0	0.0	0.0	0.0
TRTAL UNDERWRITING EXP.	0.0	0.0	0.0	0.0	0.0	0.0
POLICYHOLDER DIV INCURRED	0.0	0.0	0.0	0.0	0.0	0.0
PRETAX UNDERWRITING GAIN	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN INVEST. FUNDS	-1507.6	-1468.5	-1318.1	-1229.8	-1143.3	-14443.4
LOSS & LOSS EXP. RATIO	0.0	0.0	0.0	0.0	0.0	0.0
EXP. RATIO (TO PREM. EARN	0.0	0.0	0.0	0.0	0.0	0.0
POLICYHOLDER DIV. RATIO	0.0	0.0	0.0	0.0	0.0	0.0
COMB. RATIO (TO PREM.EARN	0.0	0.0	0.0	0.0	0.0	0.0
EXP. RATIO (TO PREM.WRIT.	0.0	0.0	0.0	0.0	0.0	0.0
COMB. RATIO (TRADITIONAL)	0.0	0.0	0.0	0.0	0.0	0.0

PRESENT YIELDS WITH EVEN PORTFOLIO DISTR
SUMMARY
INCOME STATEMENT
STATUTORY BASIS
$ THOUSANDS

PERIOD OF:	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS
ENDING AT:	12/1979	12/1980	12/1981	12/1982	12/1983	12/1984	12/1985	12/1986	12/1987
TAXABLE INTEREST INCOME	*********	1459.1	2760.1	2119.0	1849.2	1739.4	1699.7	1705.0	1737.0
TAX EXEMPT INT. INCOME	*********	1287.1	2311.0	1876.3	1618.9	1501.1	1466.3	1471.1	1499.4
DIVIDEND INCOME	*********	564.5	1023.0	840.4	729.2	680.5	665.0	663.6	669.2
AMORTIZATION INCOME	*********	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
INVEST.EXP. (INCL.AMORT.)	*********	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PRETAX INT. & DIV. INCOME	*********	3310.7	6094.1	4835.7	4197.3	3921.0	3831.0	3839.7	3905.5
REALIZED CAPITAL GAINS	*********	0.0	-0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL PRETAX INV. INCOME	*********	3310.7	6094.1	4835.7	4197.3	3921.0	3831.0	3839.7	3905.5
PRETAX UNDER. GAIN (STAT)	0.0	-6800.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL PRETAX INCOME	*********	-3489.9	6094.1	4835.7	4197.3	3921.0	3831.0	3839.7	3905.5
TAXES INCURRED	*********	-2523.3	1365.5	1064.6	927.1	870.9	850.7	853.2	868.9
NET AFTER TAX INCOME	*********	-966.6	4728.6	3771.1	3270.2	3050.1	2980.3	2986.5	3036.6
DIVIDENDS DECLARED	*********	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CHNG. IN UNEARN. APPREC.	*********	-0.0	0.0	0.0	-0.0	0.0	0.0	-0.0	-0.0
OTHER ADJUSTMENTS	*********	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN SURPLUS	*********	-966.6	4728.6	3771.1	3270.2	3050.1	2980.3	2986.5	3036.6

PRESENT YIELDS WITH EVEN PORTFOLIO DISTR
SUMMARY
INCOME STATEMENT
STATUTORY BASIS
$ THOUSANDS

PERIOD OF:	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS	12 MONTHS
ENDING AT:	12/1988	12/1989	12/1990	12/1991	12/1992	12/1993
TAXABLE INTEREST INCOME	1791.5	1858.1	1922.1	1997.5	2095.7	1978.2
TAX EXEMPT INT. INCOME	1544.5	1601.5	1679.3	1766.4	1854.5	1686.4
DIVIDEND INCOME	665.5	710.4	741.0	775.7	814.3	759.3
AMORTIZATION INCOME	0.0	0.0	0.0	0.0	0.0	0.0
INVEST.EXP. (INCL.AMORT.)	0.0	0.0	0.0	0.0	0.0	0.0
PRETAX INT. & DIV. INCOME	4021.5	4170.0	4342.4	4539.6	4764.5	4423.9
REALIZED CAPITAL GAINS	0.0	0.0	0.0	0.0	0.0	-0.0
TOTAL PRETAX INV. INCOME	4021.5	4170.0	4342.4	4539.6	4764.5	4423.8
PRETAX UNDER. GAIN (STAT)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL PRETAX INCOME	4021.5	4170.0	4342.4	4539.6	4764.5	4423.8
TAXES INCURRED	396.3	530.0	962.9	1001.6	1051.6	991.2
NET AFTER TAX INCOME	3125.2	3239.9	3379.4	3538.0	3712.9	3432.7
DIVIDENDS DECLARED	0.0	0.0	0.0	0.0	0.0	0.0
CHNG. IN UNEARN. APPREC.	-0.0	-0.0	-0.0	-0.0	-0.0	0.0
OTHER ADJUSTMENTS	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN SURPLUS	3125.2	3239.9	3379.4	3538.0	3712.9	3432.7

	N.P.E. 000's OMITTED	LOSS INC. TO PREM. EARNED	EXP. INC. TO PREM. WRITTEN	COMB. LOSS & EXP.	NET INVEST. INCOME 000's OMITTED	DIVIDENDS AS A % OF EARNED	COMBINED RATIO AFTER DIV. DECLARED	POLICYHOLDER'S SURPLUS AS OF
79:	421,096	72.3	6.8	79.1	86,255	3.17	82.27	140,963,786
						Addition to surplus from income after dividends:		93,521,772
78:	299,590	88.4	8.5	96.9	63,251	2.95	99.85	47,442,014
						Addition to surplus from income after dividends:		24,494,753
77:	216,951	96.4	8.7	105.5	52,089	2.73	108.23	22,947,261
						Addition to surplus from income after dividends:		9,470,042
76:	164,806	103.7	12.4	116.1	45,439	3.59	119.69	-13,477,219
						Addition to surplus from income after dividends:		6,237,065
75:	139,240	108.3	14.0	122.3	32,216	4.51	126.81	7,240,154
						Addition to surplus from income after dividends:		(6,559,623)
74:	124,223	104.9	15.8	120.7	27,269	4.73	125.43	13,799,777
						Addition to surplus from income after dividends:		(7,459,256)
73:	116,529	98.3	20.7	119.0	24,669	4.97	123.97	21,259,033
						Addition to surplus from income after dividends:		(4,372,645)
72:	114,769	90.3	17.5	107.8	21,645	5.53	113.33	25,631,678
						Addition to surplus from income after dividends:		170,238
71:	114,594	89.0	16.1	105.1	19,177	5.32	110.42	25,461,440
						Addition to surplus from income after dividends:		1,670,687
70:	100,377	97.2	13.4	110.6	16,649	5.45	116.05	23,790,753
						Addition to surplus from income after dividends:		204,237
69:	90,090	91.2	19.1	110.3	14,581	5.01	115.31	23,586,516

Workers' Compensation State Fund Study Commission - September 17, 1980

EXPERIENCE WITH THE RECENT RATE HEARING: OPEN RATING AS AN ALTERNATIVE TO REGULATED RATES

Michael D. Markman - Commissioner, Division of Insurance,
Minnesota Department of Commerce

As you are aware I haven't yet received a recommended order from the hearing examiner in the current workers' compensation rate case, so it's premature to speculate on that decision; however, I've studied our system over the last year, both in preparation for the hearing and as an ongoing part of the hearing itself.

I have concluded that the process that we are now involved in, the rate hearing itself, and all the matters related to the rate hearing really don't make any sense. It's a system that actually makes sure that we have rates in Minnesota that increase the cost of workers' compensation.

If one goes back in the history of workers' compensation, one finds that the current rating law was first enacted in 1921 and that the concern that the legislature had at that time was that the insurers would be charging rates for workers' compensation that were way too low. There was no rating law until 1979 that established a standard which protects us at all against rates being too high. The rating standard has been changed but it shows what the law was originally enacted to accomplish. There are still some sections that are on the books today that indicate just what the concern was; for example, an insurance company can't discriminate unfairly by charging a rate for other lines of insurance which is less than it would normally charge in order to get the workers'

compensation business. There was concern at one point that an insurer would charge $1 for all the other business just to do workers' compensation business because the rates were so high. That was the entire reason for the rate hearing through 34 years of existence - to make sure that rates were high enough that insurance companies would not get out of hand and start driving the rates down to the point that they would be inadequate.

There are several things that have happened over the past few years that really make the concern over adequacy of rates outdated at this point. The first is that insurance companies are substantially larger and more sophisticated than they used to be and are now diversified. Therefore, they are less likely to have any threat to solvency because of any activity in workers' compensation in Minnesota. They could practically give it away in Minnesota and really not endanger their company's solvency. They could make it somewhere else. It is almost totally impossible for us to have insolvency directly as a result of the rates that any company would charge for Minnesota workers' compensation.

It's also no longer a concern for the payment of the injured worker because if the company were to become insolvent in Minnesota, the rating association would step in and pay benefits to the injured worker instead of the insurance company and then go back and assess the rest of the insurance companies to recover the money. So even if the company were to go broke, the worker would still be paid. That mechanism was not in existence when the original rating law was drafted.

We also have, I think, better regulatory techniques for preventing insolvency of insurance companies. I think we have a ways

to go yet, and we'll be back to talk about that in a few months, but essentially solvency is much better regulated right now in Minnesota and other states as well, so the old concept of a rating bureau approach to workers' compensation rating in order to protect the solvency just doesn't make any sense anymore.

What we've really done the last few years is to take the old system that was established solely to make sure that the rates didn't get too low and say now this is the system we're going to use to make sure that the rates don't get too high. I think that when you go to limiting increases you lose something in the process. In fact, I think that the current system that we have really may not be an appropriate mechanism for regulating rates.

Rates for workers' compensation for use by the entire marketplace doesn't make sense. In fact I think the culprit is the cartel approach that we currently have. Our current concept of cartel pricing is inappropriate for a number of reasons.

First, it doesn't recognize the fact that insurance is being written by 200 or more individual companies and each of those companies is making a series of decisions itself in order to go about writing workers' compensation. The one decision that it doesn't make is how much it's going to charge.

But we set a rate at the Insurance Division for the entire market and we treat it as one large company that writes an average book of business. But there is not a company in the State of Minnesota that writes an average book of business.

In fact, the part that we can't control in this equation is the underwriting that the insurance companies do and the underwriting decision that the insurance companies make as to what kind

of employer to whom they are going to provide insurance. Are they going to write for small employers or are they not going to write for small employers? What classes of business are they going to take? What classes of business are they not going to take? What minimum premium will they accept? There is no regulation of any of the underwriting decisions that the insurance companies undertake and I think it would be impossible to do that in any kind of consistent manner.

When you're stuck with one set of rules and you've got to apply them to 200 insurance companies, there is a question as to whether or not that can be appropriately done.

As it turns out, this underwriting decision that companies make is at least as important in the kind of performance that the company has over the longer term as the rate that they ultimately get to charge. If they perceive the rates to be too low, then they simply send more business to the assigned risk plan and keep what they think to be the better business. If they perceive the rates to be substantially higher, then they will go back to the assigned risk plan and get the business back out. So no matter what the Commissioner does with the rate, he can't control what kind of performance an insurance company has; insurers just change their underwriting practices.

I have prepared a chart (see exhibit) which gives some indication of how the experience varies from company to company. What this chart reflects is not profit by any means. We left the investment income and expenses out just to show what the loss ratios are that companies are experiencing. We took the period from 1970 to 1979 and we just took seven companies or groups of

companies, some picked because they are biggest, others picked because they happen to be a good example of what a company can do. None of these are tiny companies, obviously.

What you do see is that over the period 1971-1979, companies have an average loss ratio of 66.6 although we have an 83.5 for St. Paul Mercury, a smaller affiliate of St. Paul Companies. Employers of Wausau had 80.4. All those companies wrote at the exact same rate.

We tell insurers, you take the rate we set and make out of it what you can and we see a tremendous variation of profitability of companies measured by their loss ratio. We also see their minimum and maximum over that period with some very wide differences. In fact, one of the companies one year wrote at a 31.4% loss ratio and another company's loss ratio carried all the way up to 141.2%.

You see generally everyone is able to do reasonably well in at least one year and some did very well in all years. The bottom line is just comparing the minimum and maximum of those seven companies that we have listed in terms of what their loss ratio was. Even in the years of 1977, 1978 and 1979, when there has been concern in the insurance industry that the rates were really inadequate (and there were rate proposals before the Insurance Commissioner at that time) there were some very profitable companies out there. You can also see that on the other side, there are some very large losses, especially in the 1976, 1977, 1978 period. In 1979 they did come back down.

I would not rely on these last values here. In 1979 particularly, that 76.5 - I don't know which of the companies had that but that's a number that will almost surely grow because of development.

The point is that we set the rates for the industry but the only part of the industry's activities that you are controlling are the rates they charge. We force the companies to compete on the basis of risk selection.

From a public policy standpoint, this kind of competition is really not at all what we want to foster. Companies that are the most stringent in their underwriting are the companies that are rewarded by the system. The company that sends a lot of employers to the assigned risk plan makes a lot more money. On the other hand, the company that tries to maintain the large voluntary market for whatever reason turns out to have problems trying to make a profit with the rates you are given because you are, by definition, only given average rates. In fact, by sending employers to the assigned risk plan, an insurer does much better. By trying to be responsible and write a larger book of business either to maintain an agent force or to sell other lines of insurance or whatever reason, an insurer can make a larger private market but makes less money. The tighter we draw the limits around the rates the larger becomes the assigned risk plan.

Employers just do not like the assigned risk plan. I must say that I don't totally understand that because it doesn't cost any more except for dividends. However, based upon the public hearings that we had as a part of the rate hearings, one of the conclusions I have drawn is that this concern about the assigned risk plan is a real one. More than just the economic consideration, I think employers feel as if insurers don't want their business. That irritates the employer. But we force many employers into the assigned risk plan and reward the company for doing

that at the same time. I'm not sure that that's really what we want to be doing.

One other aspect of the current cartel approach to rate setting that we use is that companies that write other kinds of commercial business take some of the rate deficiency if they perceive there will be any from the workers' compensation system and load it into the other lines of business. That is a suspicion that I have. We set out to see if there was any way that we could measure this phenomenon.

We went to the profitability tables that the National Association of Insurance Commissioners prepares which has each line of business identified by state. One can look at the profitability of each line of business. The states that have higher profitability for workers' compensation have lower profitability for the other commercial lines of business and the states that have low profitability for workers' compensation tend to have higher profitability for commercial auto, commercial peril and so on. So there's another part of the system that we don't have any control over due to our current rate setting process. The other lines of business, in fact, are an extension of the advantage to the large employers because the large employers have some market power that they can use to go shopping to get a better rate. The small employer just has to take what it can find in the other lines as well.

I think that if we were to change the current system, to get out from the cartel rating and if companies weren't allowed to hide behind the cartel, there would be some significant changes that would help. First of all, insurance companies currently

hide behind the rating bureau and they have such a reliance on the rating bureau that some of the other things that we have tried to do, to try to inject some competition into the system, probably aren't going to work.

In particular the change that was made in the last 1979 session to allow companies to deviate downward for particular risks that they want to, cannot work because the rating bureau has such tight control over all the companies' activities that companies don't spend time analyzing risks in workers' compensation. It's not profitable to do that. You don't get any positive return from putting your best people on workers' compensation because it all comes out of the bureau anyway. So the more time and effort you spend on workers' compensation the less return you get if you have to use the bureau rates anyway.

So I think the system is effectively insulated from any significant impact on the opportunity to write lower rates and to figure out when it's profitable to do that and when it's not. Although that might happen over a 30 year period, it's just not going to make very much difference in the short run.

Senator Keefe: Excuse me, when you can only deviate down, there's no point in figuring out whether you need to deviate or not because the only thing you can get is bad news? Right?

Mr. Markman: Well, the rating bureau has told you whether or not the rate overall is adequate. It's probably said, "No, it's not because the Commissioner didn't give us as much money as we want." So when you think that rates are too low in the first place, you don't go out and figure out if particular classifications may be too high. The only time an insurer is

going to cut a rate is in response to somebody else making a better offer. Nobody is out trying to make the offer. There is no pressure, and while I think there is nothing wrong in having the so-called "Brad Robinson amendment", it is not going to do anything significant for a long, long time.

I think there are some significant, positive results that will also occur if we get out from under the cartel rating system. First of all, companies are going to be forced to make their own decisions. I think that's a positive change that could be forced upon the system. That is, making insurance companies figure out for themselves and make decisions regarding workers' compensation insurance independently is positive. As a result, we could have an insurance industry itself getting much more thorough in their understanding of workers' compensation business. I think that when one spends very much time with the insurance industry one discovers that they probably understand less about their own workers' compensation than they do about any of the other lines of business that they write, from top management on down because they don't have to understand it. The bureau does it all. If you have people that specialize in workers' compensation you don't get any return for those expenditures. You don't put your best thinkers on workers' compensation because it doesn't make any difference.

There are a number of other aspects of business where insurance companies now rely upon the rating bureau. The bureau develops not only the rates themselves but also discount plans, and the classification system. Regardless of what company you go to, the classification is made by the rating bureau. If you think you are in the wrong classification, you go to your agent

and say, I think I'm misclassified and the agent will go to the rating bureau, the rating bureau will go out and say, "No, we were right in the first place." That's the end of the story unless you want to pursue it and take it to the Insurance Commissioner.

So, I think there are a number of negative things that the rating bureau offers for companies themselves. I think that if the average employer could go out and shop for a better price that it would be of significant benefit for everyone.

One of the most irritating things to the employer, is the whole notion that no matter what he does for workers' compensation insurance he can't get a different rate. He can spend all the money he wants on safety equipment and improving his work place and the first year he gets no impact and the second and third and fourth year, he gets whatever the mysterious experience rating plan gives him. But whatever else he does, he can't get any different kind of quote from any different insurance companies. No matter what he does, he can't get a different rate. No matter what insurance company he goes to, he gets the same answer as to what his rate is, and we tell him he has to buy it. That is really the irritating part, we say to employers, you have to buy it. Up until recently, we didn't even let the insurance companies charge any less, even if they wanted to.

For that reason I think that the whole workers' compensation system has a black eye. This whole idea that you get the same rates adds to the problem.

In addition, I would say that workers' compensation is the least innovative of any line of the insurance business. The only

innovations we ever see come into the workers' compensation system are the result of some individual company going self insured. An insurer having trouble holding onto a jumbo account will go to the rating bureau and say, "We need some kind of a program to handle this employer, otherwise they are going to self insure." And the bureau says, yes, that's probably true.

As a result of competition from self insurance we find some innovations occurring in the insurance market but that's the only place where we get innovation, and in fact, when the innovation finally comes, it comes about for everybody all at the same time and in the same way. And finally, it is only important to big business because they are big. Small business does not have the kind of market power they need in order to get somebody to propose innovations at the rating bureau. Consequently, the basis on which workers' compensation business is written never changes, with the exception of the changes that are the result of competition from self insurance.

One other aspect of the current process that I think needs to be explained a little bit (and this is going to be somewhat sketchy) is involved right here in itself and I think there is one thing that everyone ought to be aware of related to the whole notion of investment income. Whatever investment income is worth to the rating process, it is only worth it once and once it is recognized, it can never be used again in terms of setting rates because you take it out of base only once.

I'll explain it in terms of an example. I think it's simpler to understand than the formulas that are used in setting workers' compensation rates but essentially the same thing is going on.

You assume that the worker is earning $10,000 and the cost of living is going up by 20% a year. The first year he makes $10,000 and spends $10,000; the second year he makes $12,000 and spends $12,000; the third year he makes $14,400 and spends $14,400 and so on. That's fine, you can continue that on forever, but now suppose that in the second year he discovered that he really did have this other source of income that was worth $2,000 to him. So the second year he needs $12,000 but you only pay him $10,000. The other $2,000 is investment income and now he is up to $12,000 and then the year after that he needs $14,400. You have already required him to use his $2,000 of investment income so now you have to give him another 20% increase and you're back on the 20% rate increases every year.

That's exactly what we are facing with the investment income. So unless interest rates change significantly or unless we extend out the tail of workers' compensation (and it's difficult to extend out the tail of workers' compensation very much more), the opportunity to take investment income into account and make the meaningful change in the rate procedures only happens once. In fact, if the Insurance Commissioner would have done that for whatever reason 10 years ago, there's no way that the current Insurance Commissioner could come in and (assuming they did it right) make an adjustment. If there is anything to the investment income, it's only going to be done once. It may happen this year or in some future year but it's never going to happen more than once. I think that anybody that thinks about investment income and thinks that this is going to solve our problems is wrong. It might help once but beyond that it isn't going to make a

difference in terms of percentage increases in the rates.

After having looked at all these issues for some period of time, it is my conclusion that we really do need to seriously look at an alternative to the current cartel process that we have acquired and used in Minnesota through our law for the last of 50 years to 60 years. It's now time to figure out how it is that we can get the insurance industry off the cartel, to think about the business themselves, set their own rates, and to the extent that competition can be an effective factor in workers' compensation marketplace - you make it one and make the insurance companies do it themselves. Mr. Chairman that concludes what I have to say.

Pure Loss Ratio Experience for Workers' Compensation Insurance

for the years 1971-79 valued as of 12/31/79*

Company	mean**	standard deviation	range	minimum	maximum
American Mutual Cos.	46.6	10.6	34.0	33.3(1972)	67.3(1971
Western National Group	51.9	12.0	38.2	31.4(1975)	69.6(1972
Liberty Mutual Group	60.9	9.3	26.9	49.6(1971)	76.5(1979
Home Insurance Group	64.2	13.0	37.2	38.4(1979)	75.6(1973
St. Paul Fire & Marine	71.3	26.6	84.0	49.5(1974)	133.5(1978
Employers of Wisconsin	80.4	10.6	28.0	65.0(1972)	93.0(1977
St. Paul Mercury	83.5	35.1	98.3	42.9(1972)	141.2(1976

Seven Company 1971-79 Range of Experience Percentages (low, high)

	mean	deviation	range	minimum	maximum
1971-79 total	46.6, 83.5	9.3, 35.1	26.9, 98.3	31.4, 65.0	67.3, 141.2

Individual Policy Year Data

	pure loss ratio	range	mean**	standard deviation
1971	51.0, 82.0	31.0	65.2	14.1
1972	33.3, 74.0	40.7	56.2	14.6
1973	40.1, 89.1	49.0	63.5	15.7
1974	43.3, 86.5	43.2	60.3	14.4
1975	31.4, 89.1	57.7	66.8	19.8
1976	46.2, 141.2	95.0	79.8	31.9
1977	41.0, 131.6	90.6	70.3	32.0
1978	41.0, 133.5	92.5	66.2	33.3
1979	38.4, 76.5	38.1	62.5	18.9

* Data taken from I-57 Form

** Averages are not weighted

Workers' Compensation State Fund Study Commission - October 7, 1980

THE CASE AGAINST STATE FUNDS

Robert D. Johnson - Vice President, Insurance Federation of Minnesota

I am going to make a few remarks regarding the statutory charge given this Commission, that being the feasibility of the state fund, then Mr. Craig Anderson of the Workers' Compensation Insurers Rating Association of Minnesota, Assistant Manager of Statistical Services, is going to give us a critique of the testimony given by Mr. Kramer, which was the specific request of the Chairman. Mr. Anderson is going to be highlighting the deficiencies of the Kramer analysis, which was presented at the most recent rate hearing. In addition to the Insurance Federation of Minnesota, I am also testifying on behalf of three trade associations, national, property/casualty insurance company associations; the American Insurance Association; the Alliance of American Insurers and the National Association of Independent Insurers. Those three associations represent carriers who write virtually 100% of the private workers' compensation insurance written in Minnesota. I am also testifying on behalf of the two major insurance agent producer associations, the Minnesota Association of Professional Insurance Agents and the Independent Insurance Agents of Minnesota.

The purpose, again, of the Commission is to study the feasibility of the competitive state fund, and I am sure it is no surprise to anyone here that our position is one of opposition to the establishment of any state fund for workers' compensation in Minnesota. Our position is premised on the thought that a state

fund adopted in this state is not going to be in accord with all interests of the workers and employers in our state. Experience to date in the states that have adopted within their systems state funds has shown insurance company protection and services superior to that of the state operated mechanisms. Still, the experience to date in all state fund systems show deficiencies and show weaknesses that I believe lead to the conclusion that a state fund is not a viable public policy option, and that Minnesota should deal with the problems that we are struggling with in our workers' compensation system. I have identified six weaknesses, which I will discuss separately.

First of all, let's take general state fund weaknesses:

(1) Failure to operate in a financially responsible manner;

(2) The potential for increases in the real cost of the State-operated system;

(3) Inequities in the distributions of the costs within those mechanisms;

(4) Failure of state funds to match services available under private insurance systems;

(5) The necessity for subsidies or economic advantages for state fund mechanisms;

(6) The difficulties experienced by employers in all state fund states to obtain certain coverages that they need under the workers' compensation alws.

It is not my intention to give a thorough listing of specific problems in specific states in order to substantiate these weaknesses that I have outlined. I am going to highlight specific state funds under each of these examples of weaknesses that will speak for themselves. It is not necessary for me to provide that

much detail under each one other than outlining the basic comment and citing the source of the information that I am using. What I have attempted to do is pull together previous testimony, and everyone here has probably heard one or all of the materials that I am going to be referencing. I am going to refer to the testimony that was made before this Commission and before the original Study Commission, highlighting the remarks that were made by the proponents, if you will, of the state fund mechanism.

The first area that I mentioned as a weakness of the state fund mechanism is the failure to operate in a financially responsible manner. The first example that I would reference is the Washington State Fund. I am pulling some examples from monopolistic state funds even though the specific issue that this Commission is addressing is the competitive state fund. I think that the monopolistic state fund mechanism is legitimate to look at because they are state-operated mechanisms. Mr. Joe Davis, the President of the Washington State Labor Council, AFL-CIO, testified before the original Study Commission on October 23, 1978, and his comments should be considered. Mr. Davis testified as to organized labors' perception of the Washington State Fund. One of the questions that was raised to him following the presentation was a question regarding why rates had increased so dramatically in that state over the period 1975 through 1978. The magnitude of the kinds of rate increases during that period of time was in many instances changes of over 100% in individual classifications. Mr. Davis very plainly explained what had happened in the state, "We had a political manipulation, which is possibly one of the unfortunate attributes of a state fund operation. Those rates were deliberately held down for two years when they should have been going up." I think

that comment stands on its own, and I need not make any remarks on it.

The second example that I'll speak to under the issues of the financial management of state funds is the Ohio State Fund. Everybody has heard so many things about Ohio that it's sometimes hard to believe that we are all talking about the same numbers and trying to make an analysis on the same data base. The one witness that we need to quote from is Mr. John Cantlon, an Ohio employer consultant. He is the main person from Ohio who travels around the country advocating the Ohio State Fund. He is a provider of administrative services to Ohio employers on a fee basis, services they cannot get from the Ohio State Fund. He testified on October 2, 1978, before the original Study Commission, and at that time the question of the deficit in the Ohio State Fund was raised, alleged to be $1.3 billion. Mr. Cantlon responded that the deficit had been reduced to $500 million. He said that the fund was underreserved. He went on, however, to say that there is nothing wrong with a fund that is underreserved. He likened a fund that is not actuarially sound to the operation of the Social Security system.

More recently, regarding the data base for the Ohio Fund, is the Arthur Andersen Company review of the Ohio Fund. It sheds a little more light on trying to solve the mystery of what is going on in the Ohio State Fund, what is the data base we are talking about and what numbers can we use to make an assessment. This analysis was reported on in the July 21st, 1980, issue of Business Insurance, which is a professional trade magazine for risk and insurance managers. The first summary reported in that article was that reserves needed to pay for workers' compensation claims

were understated by about $500 million. Second, that the Ohio Fund's marketable securities were overvalued by about $40 million. Third, that although the State reported more than $29.2 million in the accounts receivable of the Fund, the Andersen report raised serious questions about the collectibility of a significant number of these accounts. Finally, a key item in the report stated that the workers' compensation records for the years 1977 and 1978 were so disorganized that an audit in accordance with generally accepted auditing standards could not be completed on the Ohio Fund. That general criticism, I think, helps to explain the problems with making the assessment on solvency of the Ohio Fund. That comment was reinforced by a particular statement that Professor Williams made on July 22, 1980, before this Commission, when he stated, in response to a question on what are further areas that he would study if he were to redo his 1969 study comparing competitive insurers with state funds; one of the issues that he saw and he was not comfortable with at the time that he made his 1969 study was a serious question he had regarding the financial data for state funds. He felt there were serious questions regarding the validity of what was available and a need to have outside checks on the data to provide more credibility to it.

The third state fund that I will briefly comment on is the Pennsylvania State Fund. Governor Dick Thornburgh very recently established a study commission, as everybody is doing around the country to look at their workers' compensation system, to review specifically the Pennsylvania State Workers' Compensation Competitive Fund, and to make an evaluation of its future within the system. In announcing the appointment to this study commission,

the governor stated, and I quote, "A sound workers' compensation system is an essential component of a successful state economy; yet the Commonwealth Workers' Compensation Insurance Fund is not actuarially sound."

In addition to that, consideration should be given to remarks of the Insurance Commissioner from Pennsylvania, which he made on February 21, 1980, before a Senate Labor & Industry Committee at the Pennsylvania Legislature. Commissioner Harvey Bartle said the following: "In addition to self-insurance and the purchase of coverage through the private insurance market, employers may obtain coverage through the State Workmens' Insurance Fund, known as the SWIF. Shortly after I was appointed Insurance Commissioner, I received information that SWIF was financially troubled. In essence, the fund is now on a cash-flow basis without adequate resources set aside to guard against high claims in the future or future claims which have already been filed. I have publicly stated that the Fund is not actuarially sound. The Governor has signed an executive order establishing a study panel to review SWIF and report back to me by the end of the year."

I will now shift to the second and third weaknesses that I outlined initially. These are the potential for increases in the real cost of the system, in combination with the failure of state funds to match services available under a private system. Again, I believe that the experience of state funds we have seen around the country, which has been presented here, shows that in terms of services and benefits provided employers and employees, private carriers outperform state funds. The kind of services that we are talking about, I believe, are essential in a workers' compensation

system to prevent accidents and in keeping people out of the system, which are goals everybody shares and want to promote as much as possible. Also included here is effective rehabilitation, which is essential to get injured workers back on the job and back to gainful employment, another area that everybody should be heading for. The testimony of state fund witnesses before this body and the earlier Study Commission show that there are many omissions in services provided in this area. If we are going to make an assessment as to the advisability, from a public policy standpoint, of adopting the state fund mechanism, we have to accurately understand where these deficiencies are and whether a state fund mechanism is going to help our system and effectively deal with problems that we agree need attention.

I will briefly return again to Mr. Cantlon. I already outlined his position with the Ohio Fund. It is an interesting comment to consider that whenever you see data on the Ohio Fund, you do not have included in the data the administrative services charges which Mr. Cantlon bills Ohio employers, in providing administrative services that are not available to Ohio employers through the state fund. I think in this instance that, again, this is just an example of service deficiencies in the Ohio Fund, forcing the employer to go on the market and buy those services.

Mr. Don Kramer, in testimony before this Commission back on September 3, 1980, responded to questions raised regarding a comparison between the New York State Fund and private carriers in that state. Mr. Kramer conceded that the private carriers in that state are superior to the New York State Fund, both in the provision of safety consultation and in the provision of effective

rehabilitation services. Again, it is critical that we recognize the need for a workers' compensation system to provide adequate resources to job-site safety and to effective rehabilitation once injuries happen.

The final state fund that I will make a few comments on is Colorado, which fund was summarized by Mr. Glen Adams, General Manager, and the leading advocate around the country of competitive state funds, certainly in terms of the number of appearances before legislatures. When he testified back on September 25, 1978, at the original Study Commission, Mr. Adams made a whole series of comments that reflect on how the fund actually operates and functions within their system, which comments raise the question in my mind of whether this is a system that will benefit injured workers and employers in our state. I will read you some of the comments that were given in describing the manner of how that fund operates. Mr. Adams compares their payment of claims to an assembly line process. He went through the numbers of the people, the numbers of policyholders that the fund services, the number of initial reports that they receive a year, all of which establishes serious questions regarding the effectiveness of their claims handling, especially as this relates to fiscal accountability. Mr. Adams stated that they use telephone adjusters only and don't have any people on the street. In the area of safety consultation, Mr. Adams in responding to a question regarding how much they provide employers stated that they don't provide it unless the employer requests the Fund to give them safety consultation.

More recent information on the Colorado Fund is also instructive. I came across a series of articles which recently

appeared in The Denver Post, by Mr. Frank Moya, who made an analysis of the Colorado Workers' Compensation system. Much attention is given to the state fund, due to the share of the market that the state fund has. I will quote a couple of paragraphs out of an article in the July 1, 1980 edition, which article is entitled, "Employer's Get a Big Cost Break, While Claimants Wait and Wait." Here's the quote from Mr. Moya: "But although employers get a tremendous cost break, injured employees for whom the Workman's Compensation system ostensibly was designed to benefit get no breaks at all. The larger the State Fund's share of the insurance business gets, the more haggard its staff becomes, said Glen Adams, the Manager of the State Fund. Adams has admitted that because of understaffing, many legitimate claims made by a portion of the estimated 1.5 million workers in Colorado covered by Workman's Compensation to the State Fund are turned down because of lack of investigation by state employees. An injured worker whose legitimate claim is turned down often must wait months to get a hearing that could result in reversal of that refusal. And many injured workers, unsophisticated about the workings of the system and unrepresented by lawyers, never appeal an initial denial of a claim, state officials concede. Moreover, even when the claims aren't turned down, understaffing in the State Fund and in the Colorado Division of Labor, which runs the workers' compensation system, results in slow processing of claims. Attorneys who represent injured workers advise their clients that even if everything goes right and their claim is declared promptly by state officials to be a legitimate one, it is a minimum of six weeks before they will

receive their first check." This article amply substantiates the kind of situation that the Colorado State Fund finds itself in with the statutorily mandated reduction of 30% off of the manual rate developed by the National Council, simply one of unmanageability. It is essential that we understand how the Fund functions and how it operates before making an assessment as to whether or not it is an advisable alternative.

Another area to consider is the Colorado benefit levels. Everyone is apprised that the substantive Workers' Compensation law in Minnesota is vastly different from Colorado and Colorado, almost without exception, pays out significantly lower benefits to workers. There were a couple of instances that were highlighted in the recent series mentioned above. Colorado has a provision reducing benefits 50% if a workers is negligent and violates a safety regulation, while there is no penalty to employer for the same violation. Also, Colorado appears to subtract 100% of social security benefits payable from workers' compensation benefits due in death cases.

The next area I will comment on involves the questions of subsidies for state funds, and the statutory, economic advantages provided many funds. Obviously, it is essential to accurately measure those kinds of costs that state funds don't have to pay and private carriers do, if a fair comparison is to be made between the two types of systems. To the extent that the state fund is exempted from certain expenses, there will probably exist subsidies for taxpayers to finance. These exempted costs must be recognized to explain fully cost differentials between private carriers and state funds. We need to have an understanding of

cost differentials if we are going to make a comparison between systems and show that there are different administrative costs incurred by the two kinds of mechanisms. The earlier memo of July 8, 1980, by Mr. Seaton explained part of the cost differentials that we see in showing that many state funds don't pay premium taxes. Mr. Kramer, in his testimony on September 3, 1980, testified that the bulk of the difference between the administrative costs of the New York State Fund and private carriers is attributable to statutory, economic advantages provided to the New York State Fund. He mentioned specifically the issue of the corporate income tax, both state and federal, that the fund is exempted from paying.

Another area which is essential to understand the differences between the two mechanisms was testified to by Mr. Jerry Weber on July 8, 1980, before this Commission, when he stated that the vast majority of the State Funds do not incur any expenses in the area of acquisition costs. He mentioned only a few exceptions out of all the funds in existence. These costs are an essential part of the private insurance market mechanism and provide an important point of contact for the employer with the workers' compensation system.

Finally, we should consider here the whole issue of start-up costs for a state fund. Funds will need to be generated from some source for a fund to be operational in a state and this will likely be taxpayers dollars. The original Study Commission obtained a report by Woodward and Fondiller, a consulting actuarial firm, which made an assessment for the State of Alaska regarding state fund start-up costs, that being the initial capitalization and also operating expenses. The bottom line is that the larger the

share of the market you assume the state fund will capture, the more money you need.

The final area deals with employer difficulties in obtaining the coverages they need from state funds. Mr. Glen Adams, on September 25, 1978, testified that when you are dealing with that state fund that you cannot get the all-states endorsement. If you're operating on a multi-state basis, with your headquarters in Colorado, and you're insured with the state fund, you're going to have to go out to those other states and buy a separate policy there. This is a similar fact for all state funds.

My two concluding comments deal with the Wisconsin workers' compensation system and some remarks by Professor C. Arthur Williams. Wisconsin is characterized as having the same benefits as Minnesota, but with rates 50% lower than ours. I do not believe this is true. In fact, if you look at the statutes, you can definitely prove that the benefits are not the same between these two states. Wisconsin has no state fund in their system, yet their rates are in many cases significantly lower than Minnesota's. Mr. Hugh Russell, Assistant Commissioner of Labor and Industry in Wisconsin, testified on this issue before the original Commission on October 30, 1978, and questions were asked of him on why are the rates so much lower in Wisconsin. I'll read a quote from Mr. Russell which answered this question and which summarizes our opinion on where costs in a workers' compensation system can be affected: "Many things can technically be said about setting insurance rates. Basically, insurance rates are a reflection of what is actually going on within the system -- what it costs, what the injuries cost, how much it costs to administer them.

There are basically about five different ways in which you can directly affect the cost of the operation of the system and have that reflected in the insurance rates. That's in the area of safety, the injury that does not happen does not cost anything. You can affect it by reduction of benefits, overall or selectively. You can affect it by the evaluation of disabilities under the system. You can affect it by the prompt re-employment or rehabilitation of the people who are injured. You can affect it by dealing with the cost of litigation and litigation is the expensive part of the process." That comment certainly was substantiated by the work product of the original Study Commission and it mentions many of these areas as being significant areas that impact on the cost of the system.

I would conclude by concurring with the remarks which Professor C. Arthur Williams made when he summarized his position back on July 22, 1980, before this Commission, that the only reason to adopt a state fund mechanism would be because of the value judgment that the government should be in the business of selling workers' compensation insurance, and that he found, and I concur, that there isn't any objective basis or reasons for adopting a state fund. The burden of proof should be on the advocate of changing the current system. That concludes my comments on the state fund.

Workers' Compensation State Fund Study Commission - October 7, 1980

ALTERNATIVE FINANCIAL ANALYSIS OF RATE OF RETURN FOR PRIVATE INSURERS

Craig Anderson - Assistant Statistical Manager, Minnesota Workers' Compensation Insurers Rating Association

My name is Craig Anderson and I am the assistant to the Statistical Manager of the Rating Association. I have been asked to respond to some of the comments that Donald Kramer made before this commission last month. I want you all to know that I am not an investment analyst and not being in that capacity I don't intend to go into the guts of Mr. Kramer's model, but what I am is basically an actuarial analyst, so as you will see as I go through this short presentation what I intend to do is criticize some of the input that Mr. Kramer used in his model.

The first thing I want to do is give you a quick little graphic model. The question we had asked here is what is Donald Kramer trying to do? I put together as simple a picture as I can. We have, what I would consider, a model representative of a lens. We have facts, assumptions and subjective judgments that he showed through his model that we statisticians would call an algorithm, it projects out certain results.

What does Mr. Kramer need to know? This determines what facts and assumptions and judgments he should use and what kind of a model he should put together. Well first off, when we are talking about Minnesota workers' compensation investment return, it would be best to know what the general insurance transaction is all about. These sorts of items include what sort of cash flows go on in an insurance company, how dollars are invested, what happens to them

when they are put into the trust fund, what securities are invested, what are you investing in, for what lengths of time are you investing your securities, and things like this. These are the points I don't intend to contest today. Basically the points that he inputs directly into the model, into the lens that we have right here. The points that I would like to address, basically what we are talking about, if you recall, he (Kramer) said that the carriers in the State of Minnesota or a state fund can earn 40% on equity.

The points that we would like to critique are basically some things in the subjective judgment. They basically fall in two areas. The first area is the pay out pattern that Mr. Kramer uses. And more explicitly the losses available for investment that he comes up with over time. The second point that we would like to talk about is the underwriting results that he assumes are going to occur in Minnesota either under the standard we're under or a prospective state fund. Any model builder can solve any kind of problems he's got with his subjective judgment if he makes himself familiar with the system he is trying to simulate or if he relies on some sort of expert advice. The problem with the Kramer methodology is he has really done neither.

Specifically let's go to the pay out pattern first. To make this perfectly clear so that everyone understands it. Mr. Kramer, in his pay out pattern, where he determines how much losses or what volume of losses are available to be invested at certain periods of time, has used the New York State Fund experience exclusively. He has used no Minnesota data whatsoever. Secondly, he has not compared the laws in New York and Minnesota at all to determine whether the New York pay out pattern is even representative of

the Minnesota situation. Finally, he bases the entire tail of his model on losses that started to be incurred in New York in 1965 and he has not been able to tell us to this day how those sorts of losses are representative of 1981 losses in Minnesota. The final thing I would like to say about this is the insurance staff that hired Mr. Kramer to do this analysis also hired a very reputable nationally known property and casualty actuary by the name of Wolfe, who is a very progressive actuary by the way, and he has been a great adversary of us for the last two rate hearings. Mr. Kramer did not consult with this man at any time to determine whether his pay out patterns were correct or any of these other points.

Now these can all be considered minor points but the biggest problem was the entire pay out pattern, is that it completely and totally ignores the effects of the Minnesota Workers' Compensation Reinsurance Association on dollars left available to reinvest. What I put together hopefully can explain this so everybody can understand what I am talking about. What we have here is an average permanent total in Minnesota of $650,000. That's the average, ultimate amount to be paid to an injured worker, in both indemnity and medical benefits over time. This amount was calculated by the Workers' Compensation Reinsurance Association. That's basically what they are predicting, an average permanent total case of about $650,000. Now we know that today the maximum the carrier can insure, can retain on his books for this case is $320,000. So we take $320,000 from the $650,000 and that gives us $330,000 left, to be paid by someone else, partially by the reinsurance association right away or in years to come. We also know that the permanent total annual benefit payments carriers would pay runs about $12,000

per year. We know that because we keep individual case reports from all our carriers. We have done some initial work on that to determine every year what the annual benefits look like when you start out. This has been estimated at 6% escalation per year.

Now what this chart (VI) actually shows is what it says, what kinds of funds are available for investment over time. Over here, of course you have dollar amounts, on the bottom we have number of years. We can see that an average permanent total claim of $650,000 is going to be paid out totally over a period of 25 years. But let me remind you of two items Mr. Kramer stated in his little presentation. He said that after ten years, carriers or a state fund will have greater than 20% of their dollars that they collected at the start of the period left to invest. And he also stated that carriers or a state fund will have greater than 16% of their dollar left to invest after 13 years.

Well now, we can see that if the Workers' Compensation Reinsurance Association reserve limit of $320,000, that under just a permanent total case, this is indexed total cost, at ten years, that case is going to generate only 5.9% left for that carrier or the state fund left to invest after 10 years. And after 13 years only 3.4%. There are only two kinds of cases that are going to go beyond 10 years, the permanent total case and there are going to be some death cases. If we add the death cases to the 5.9%, that number will increase to 7.8% total cost left to invest after 10 years. If we add the death cases to the 3.4%, you get 3.7% left to invest after 13 years.

Now what does this tell us. Remember Mr. Kramer said we are going to have 16% left to invest after 13 years for our ultimate

pay out. What this simply tells us is that the reinsurance association has in effect limited the amount of money either a state fund or a carrier in the state of Minnesota will have to invest by 13.3%.

Now what does this do to the bottom line? We didn't put the numbers in here but as far as rate of return is concerned we have calculated that the reinsurance association limits the rate of return that carriers or a state fund could expect by upwards of 60%. Now we did this calculation in exhibits that we prepared for the rate hearings. We took the facts into consideration that the reinsurance association would have some sort of an effect on dollars left to invest. What this finally comes out to is, if you took Kramer's projected return of 40% and you reduced it by 60%, of course you are going to end up with 16%. This is just the first point.

The second point I would like to bring up is something that I am sure you have all seen before. This is the actual calendar year net combined ratio for the last 4 years that we have statistics on right now. We are still looking at the 1979 figures. What Mr. Kramer assumes, and the only way he gets his 40% rate of return, is that there is going to be perfect underwriting in the State of Minnesota forever. Not just for one year or two years or five years, but forever. For every year that he has in his model, he assumes that the carriers or a state fund is going to receive 2½% on their underwriting. That leaves out investment income entirely. We are not going to argue whether underwriting results have gone to the point where there is no turning back, but I don't think any rational person would agree that underwriting results are going to be perfect for the rest of the history of this state in workers' compensation.

Now let's just put a piece of paper across here to show you what he says is going to happen. In 1978, we had a combined ratio on a calendar year basis as a percent of that premium of close to 125%. Again, this is calendar year data, this includes loss reserves. We have done the same exercise on policy year data including loss reserves. We have done it on paid data at 4th report or 5th report where we have excluded loss reserves and IBNR, and we still see the underwriting experience deteriorating in this state in the last five years. This is a subject that was brought up at the rate hearings. There were a lot of actuarial people there, Lena Chang for one, Bob Lowe for another. Each was questioned, what is going to happen? What is going to happen to underwriting results in the state of Minnesota? There wasn't one witness, one actuarial witness, that testified that underwriting results are improving in this state.

To top this off, let me get something else here. Something that I am not too sure anybody here is aware of. Since 1975 carriers in the state of Minnesota have received a 4% rate increase cumulative due to experience. You say how can that be with a 50% rate increase in this state since 1975. Over 90% of the rate increases that have been granted by the Insurance Commissioner in this state have been due to changes in laws. Over 90%! Over 80% of every thing the industry has filed for since 1975 has been disapproved due to experience changes. In fact, in 1975, there was a reduction in experience that the Insurance Commissioner ordered and not until 1978 did that reduction show up.

Now Mr. Kramer (again, I can't emphasize this enough) assumes that underwriting results are going to yield a 2½% profit forever.

I have just shown (I hope that I have made it clear) that witnesses at the hearing continued to contend that the underwriting results are not any better. They are deteriorating. Carriers have received a 4% rate increase in the last five years, that is 8/10 of a percent per year over payroll increases. I want to make that clear so everybody knows I am not excluding the increases that have been incurred due to payroll. No prudent person believes that underwriting results are going to develop in that sort of a way so they are going to be pertinent forever.

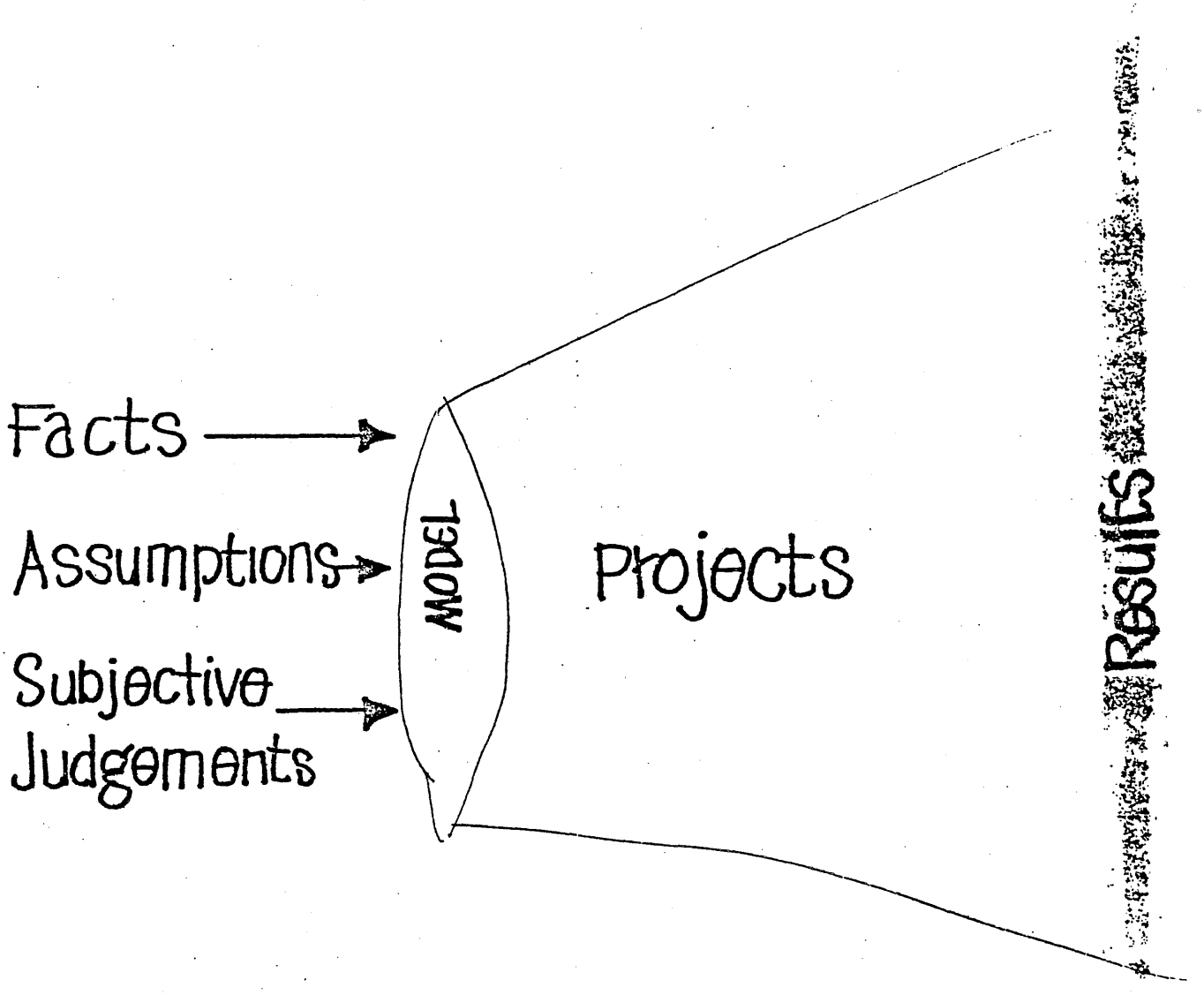
What we have done in our model is not take the 25% underwriting cost. We put something close to 10% underwriting costs for 1981 in our model. This is basically the result we come up with: about 5% or 6% rate of return on equity overall. That includes underwriting results. That includes approximately a 3% rate of return on premiums.

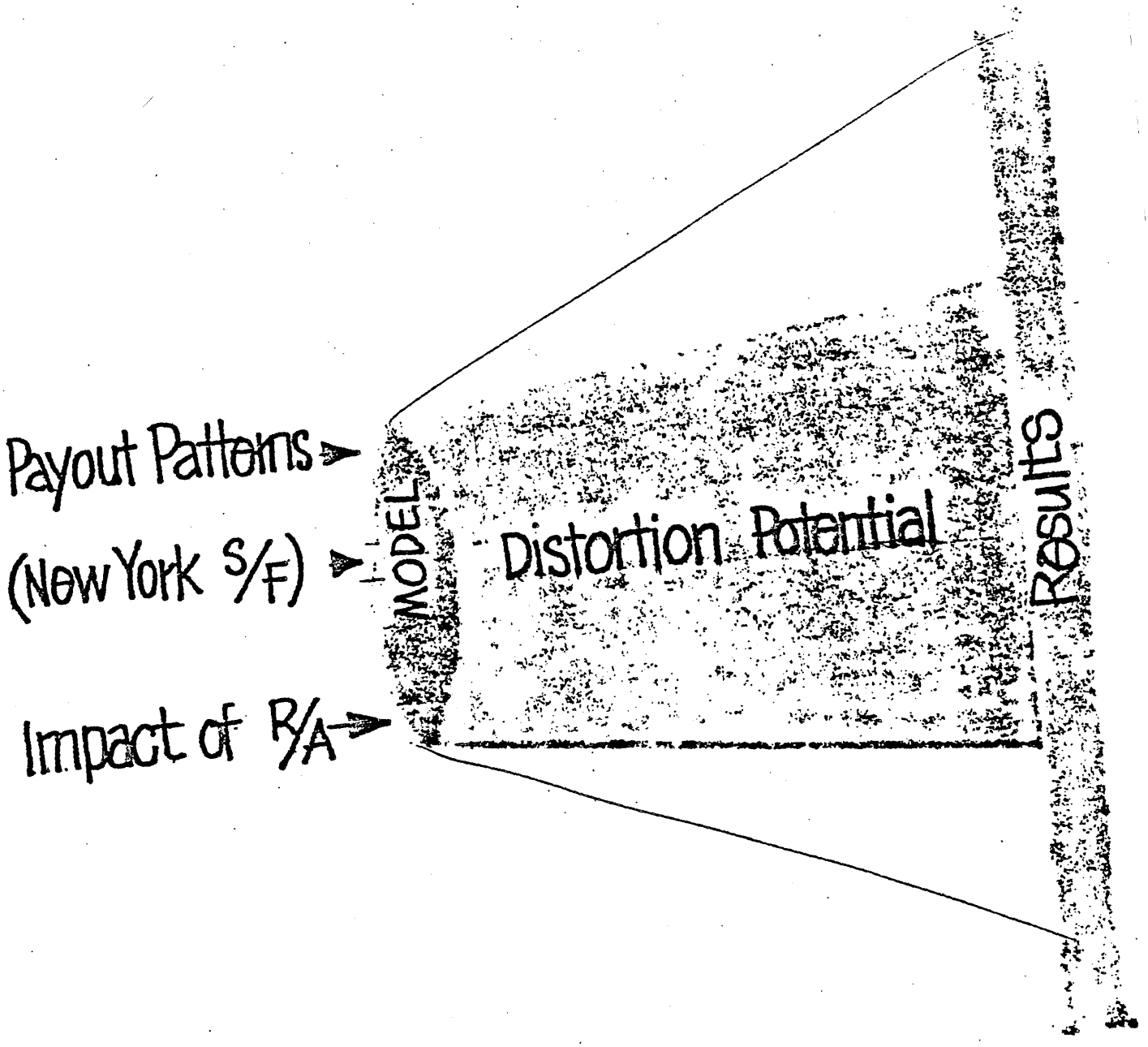
I guess to wrap this up let me make the following observation. We asked Donald Kramer at great length at the rate hearings about his model. We wanted to know why he continued to assume that underwriting results were perfect, why he used the New York pay out pattern, why he didn't take into consideration the reinsurance association. When it finally came down to the bottom line, what his final comment was, "well this sort of return can occur or might occur in a few cases with a few carriers and my model can be used in any state, all you have to do is change the input".

Well we contend we have changed the input and we have changed what we feel Mr. Kramer is saying might occur to what we feel will occur. Our caution is simply this: Mr. Kramer said that a 40% rate of return is possible. This could lead people to believe

that under a state fund you could discount your losses by 20%. If that sort of thing occurs, we feel that this is the real rate of return that could be realized.

I


Facts
Assumptions
Subjective Judgements
MODEL
Projects
Results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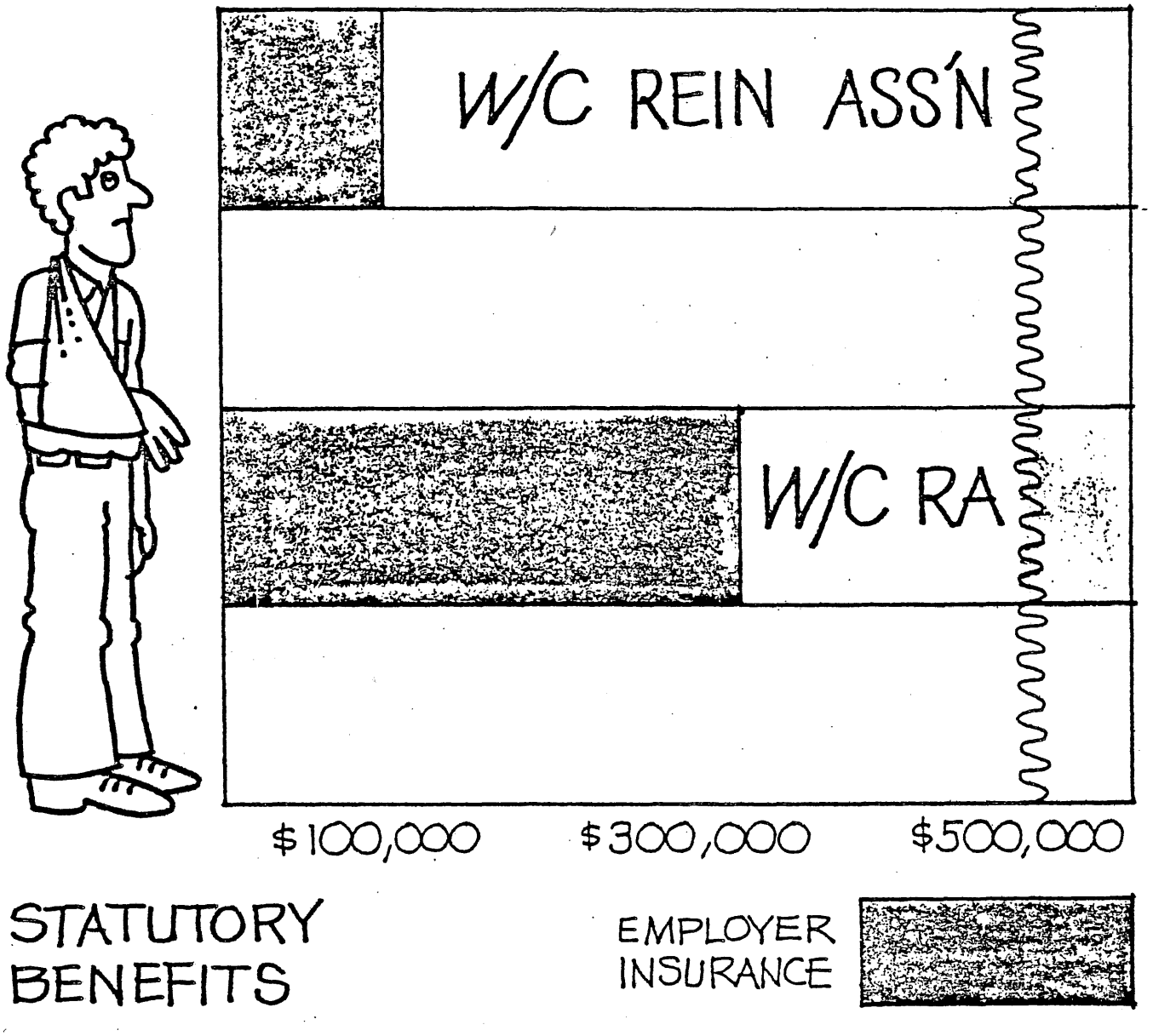
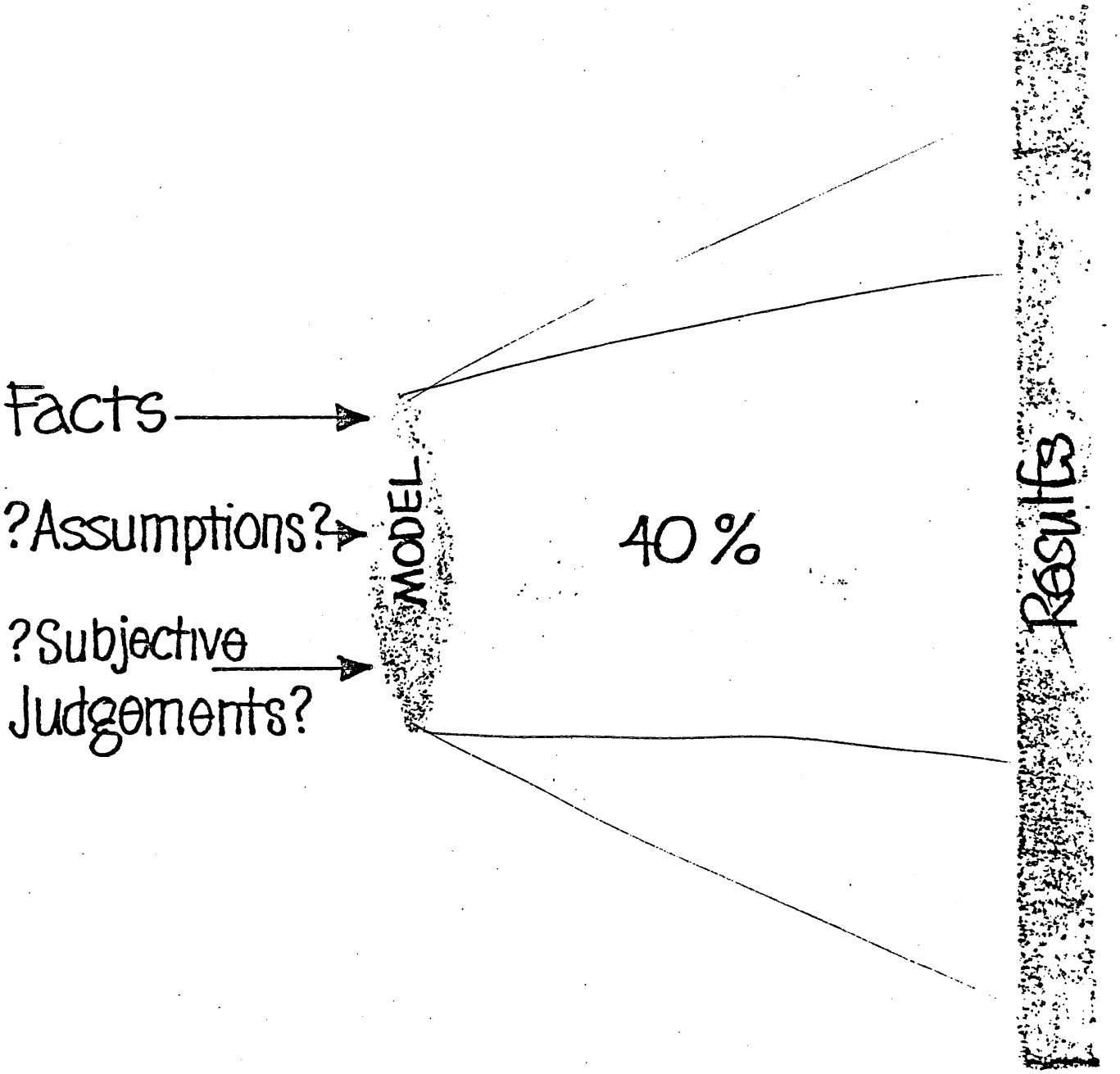
(New York S/F)
Impact of R/A
MODEL
Distortion Potential
Results

Reinsurance



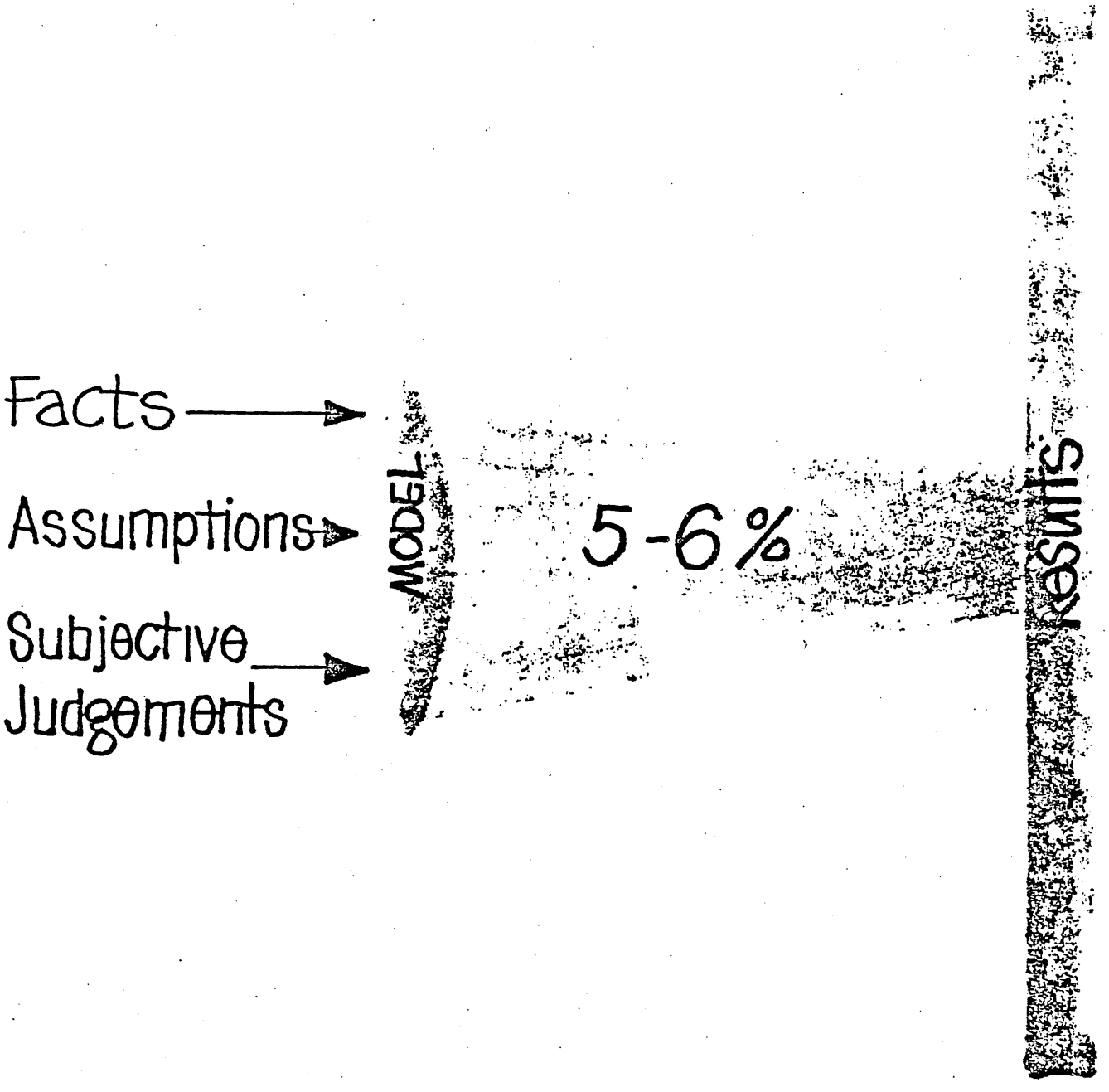
IV

Rate of Return Kramer Data



V

Rate of Return Minnesota Data



VI

AVERAGE PERMANENT TOTAL IN MINNESOTA Funds Available for Investment

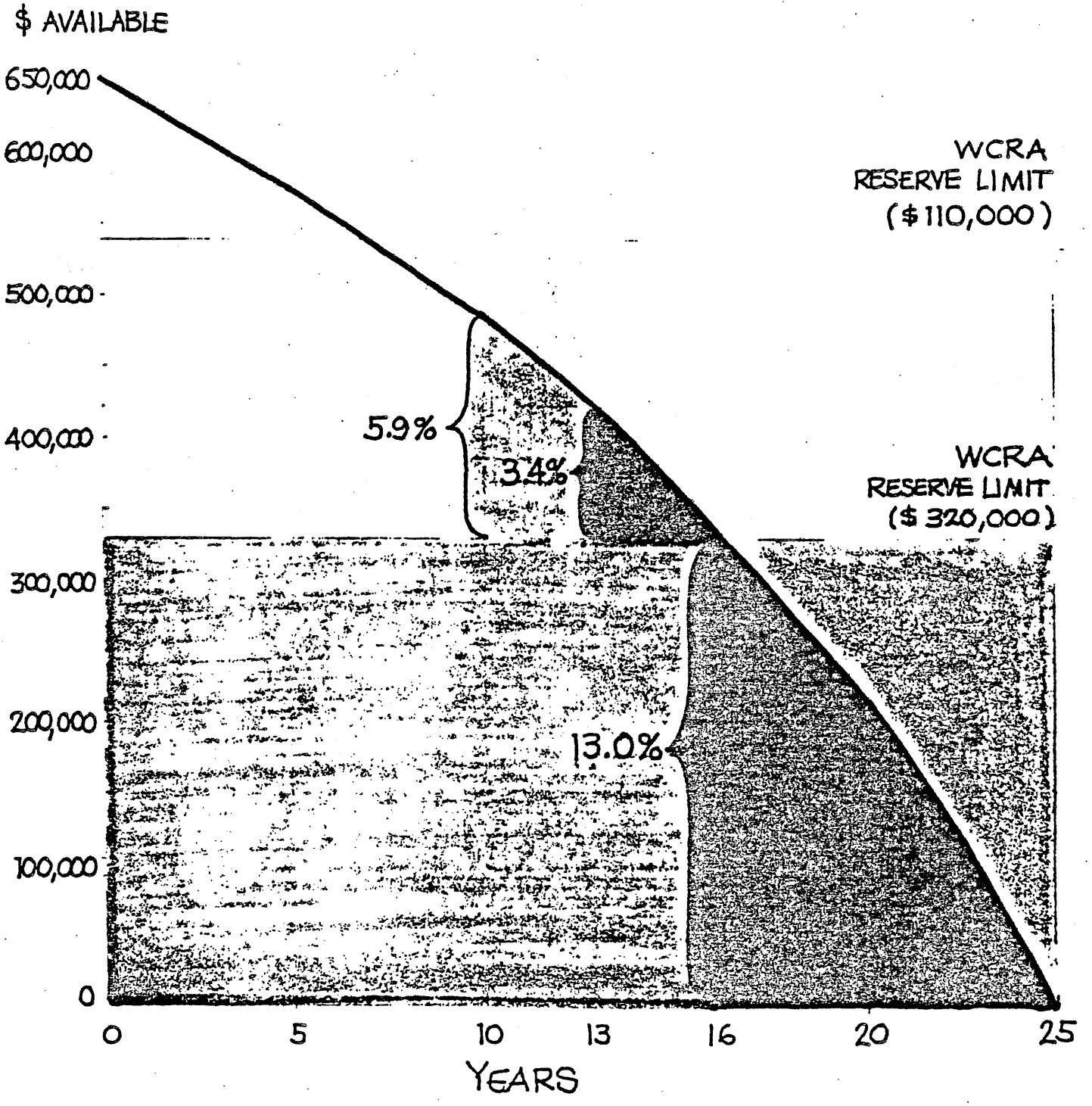


Exhibit A

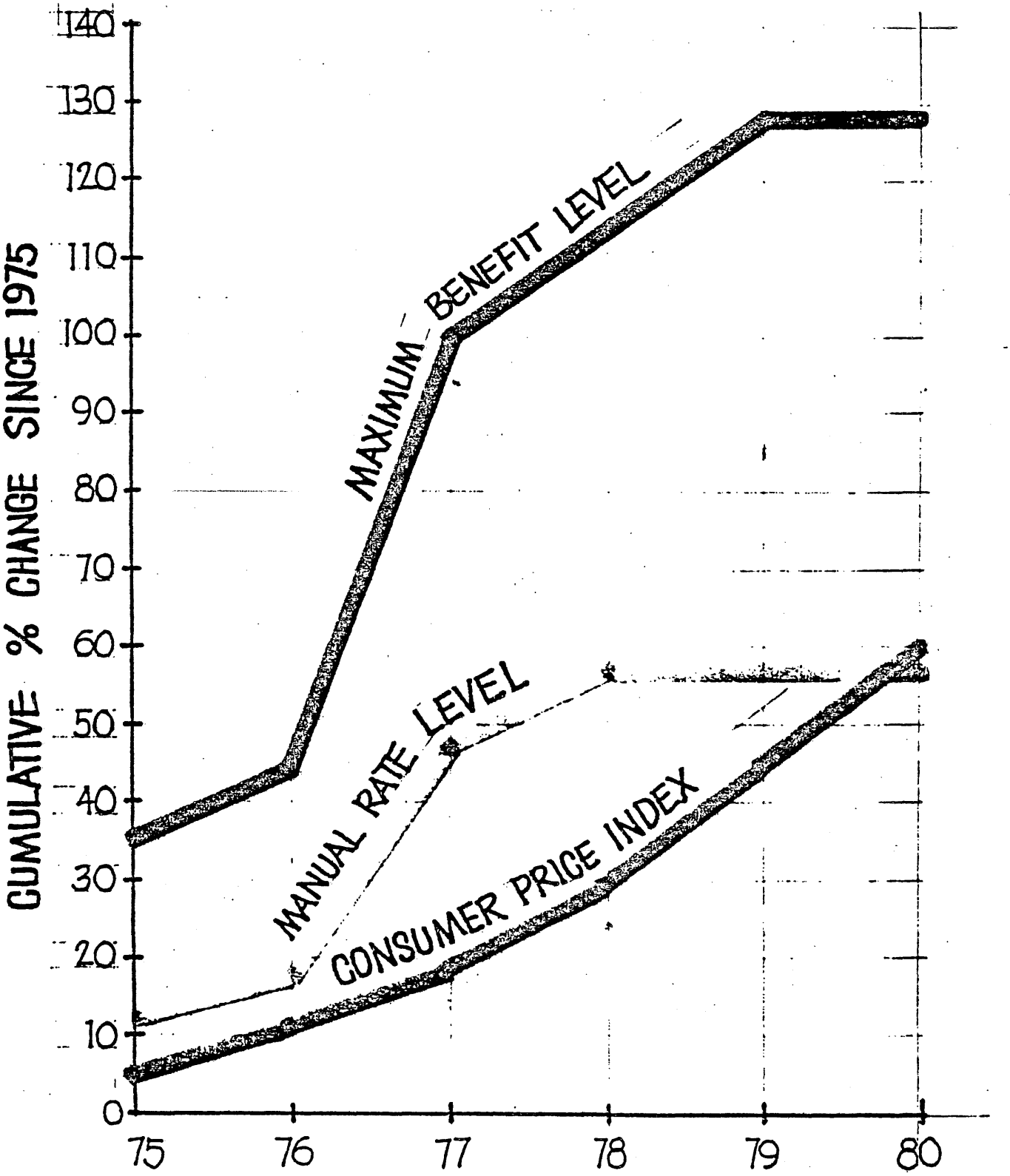

CUMULATIVE % CHANGE SINCE 1975
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
75
76
77
78
79
80
MAXIMUM BENEFIT LEVEL
MANUAL RATE LEVEL
CONSUMER PRICE INDEX

Exhibit B

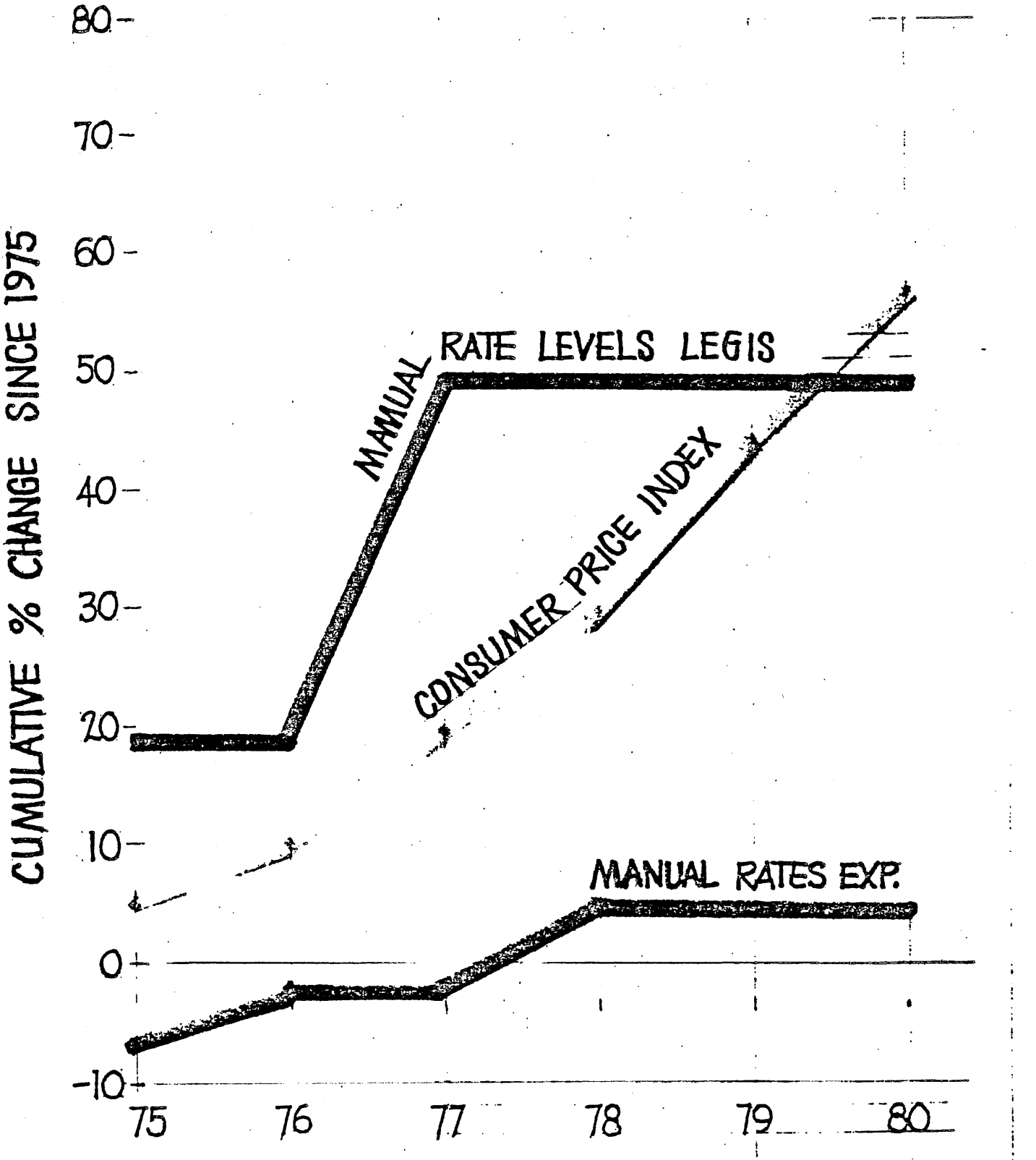
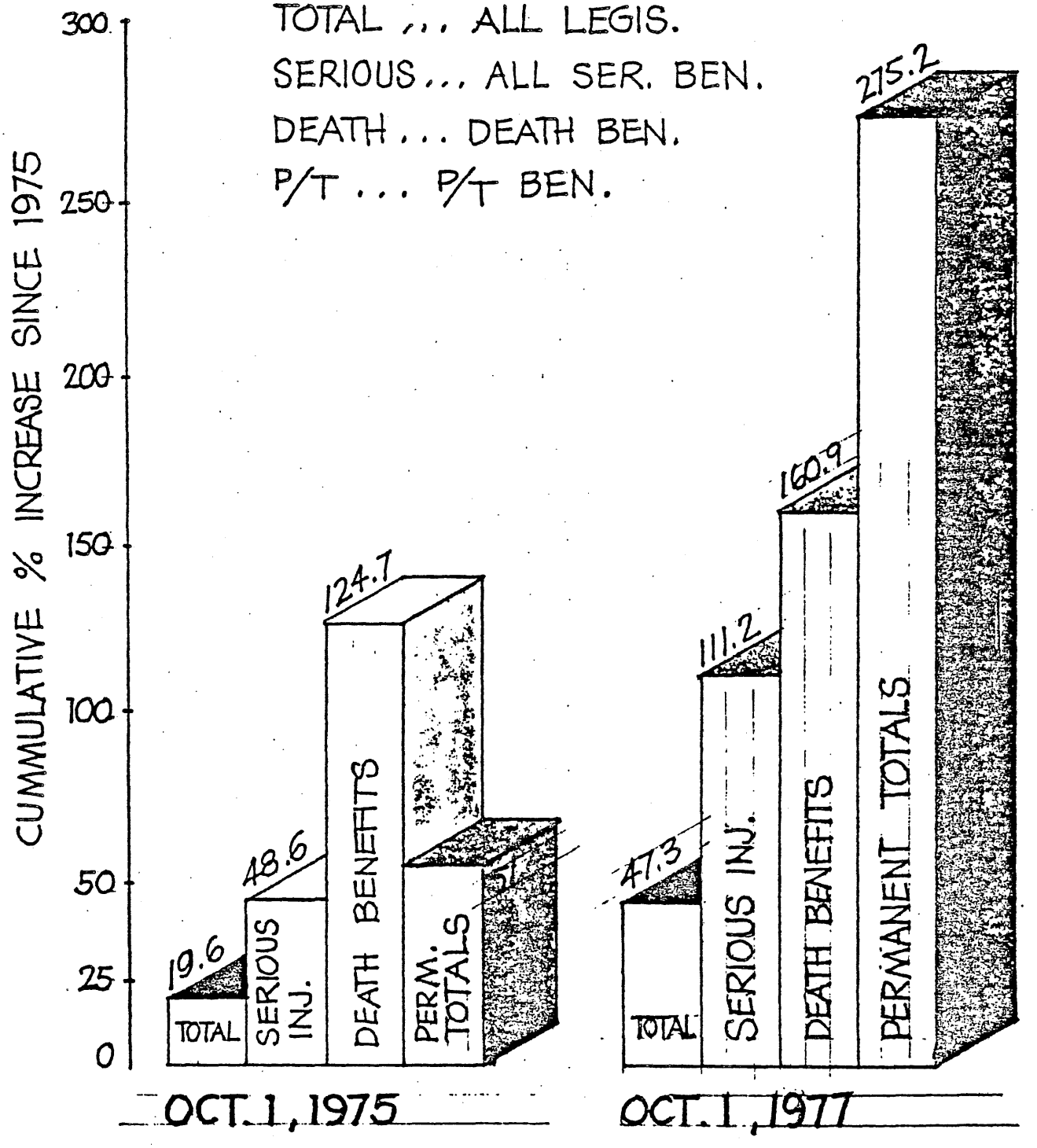

CUMULATIVE % CHANGE SINCE 1975
80
70
60
50
40
30
20
10
0
-10
75
76
77
78
79
80
MANUAL RATE LEVELS LEGIS
CONSUMER PRICE INDEX
MANUAL RATES EXP.

Exhibit C

CHANGE IN MAN RATE LEVELS DUE TO:

TOTAL ... ALL LEGIS.
SERIOUS ... ALL SER. BEN.
DEATH ... DEATH BEN.
P/T ... P/T BEN.



TTT

THERE WILL BE SOLID BARS ON THIS !

Exhibit D

Losses, Exp. & Div. as % of Net Prem

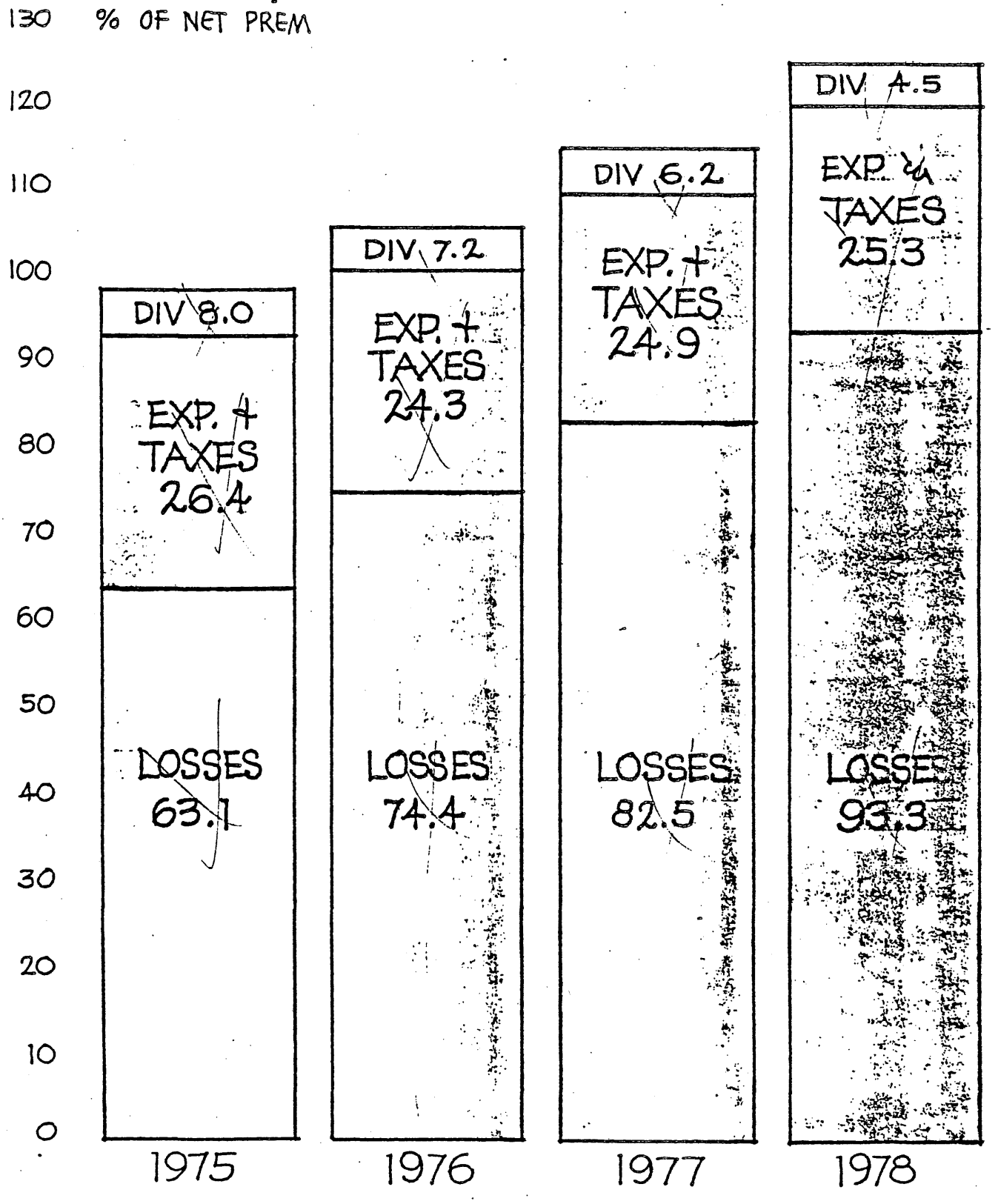
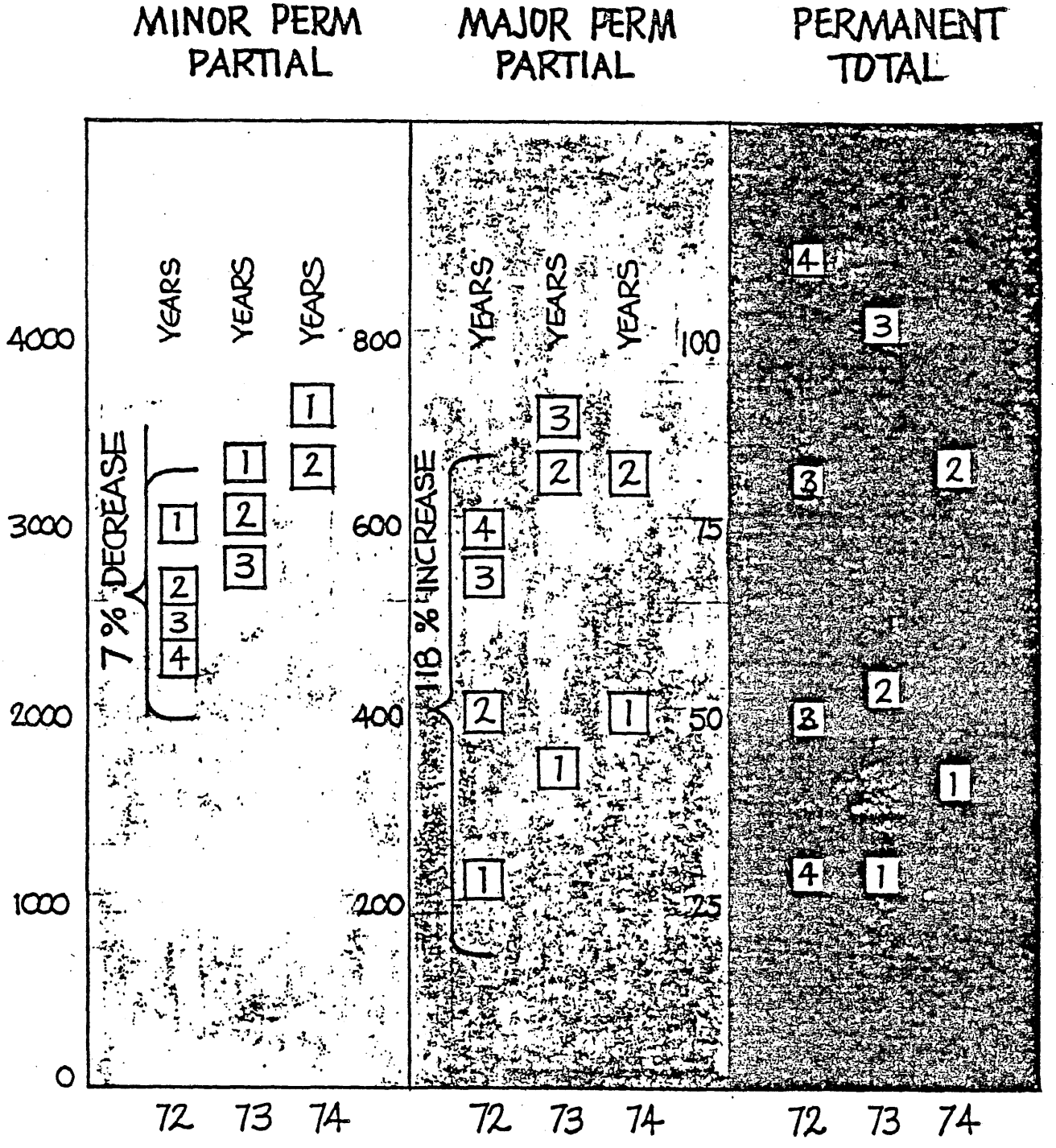


Exhibit E
Case Count Development by Injury Type



EXPERIENCE OF A MULTI-STATE EMPLOYER IN STATE FUND STATES

Al Brosius - Director of Corporate Insurance and Risk Management, Honeywell Corporation

Mr. Chairman and members of the Commission, my name is Al Brosius and I am Director of Corporate Insurance and Risk Management for Honeywell. My responsibilities include property, casualty and employee benefit coverages for all U.S. operations, as well as coordinator and consultant to our foreign subsidiaries on insurance matters. I have been asked by Senator Keefe to come here today and give you our experience with state funds and self-insurance and this is the only aspect I am prepared to address.

In worker's compensation, we provide coverage for employees in all states which comprise about 75,000 employees with a payroll of $1.5 billion. We self-insure in eleven states (Arizona, California, Florida, Illinois, Massachusetts, Minnesota, New York, New Jersey, Ohio, Pennsylvania and Washington); state funds are used in four (West Virginia, Wyoming, North Dakota and Nevada); and we insure in the remaining 35.

We periodically make financial studies by state to determine the most appropriate way to fund our workers' compensation. In Ohio and Washington, our experience with state funds may be of interest. We had been in their state funds for many years prior to 1972 when we studied the feasibility of self-insuring which was a permitted alternative to the state funds. Our analysis showed both states to be quite similar in many respects. We compared our claims to the premium paid for several prior years and found average loss ratios

about 10% in each state. Projecting our future claims and other costs of self-insuring compared to the state fund premium showed a likely savings of 73% in Ohio and 64% in Washington. As a result we went self-insured in these states in 1973.

Our experience indicates that we were not getting a fair reflection of our good experience in our premiums paid. Conversely, if our experience had been poor, we probably would have stayed in these state funds. These funds are probably not going to be attractive to the better risks. Also they didn't provide much incentive to improve experience as do self-insured or experience-rated insured plans. In both of these states, Honeywell did not have a large premium, so our experience was not given much credibility. Credibility factors vary with the size of the risk in that state and determine to what extent a risk's experience will be used to modify the manual rate.

Due to the probability of the good risks leaving and the poor risks staying, the state fund could suffer from adverse selection. The state fund would then have to raise its rates to offset its bad experience, further driving out the better risks.

If we had the option of commercial insurance in these states, we would probably have done this since our premium in each was not large enough for us to normally consider self-insurance. However, we didn't have this option under the state laws. We have found insurance to be a good alternative to self-insurance in our other 35 states. We can get the experience rating which we want through retrospective rating and premium modification factors. Self-insurance requires considerable effort to get the state's approval, set up claims administration, banking arrangements, excess coverage,

bonds and state reports. It is not worth the trouble except in states with substantial payroll. We are still in state funds in North Dakota, Wyoming and Nevada because they are monopolies and although West Virginia permits self-insurance, we don't have enough payroll there to bother.

Our experience in dealing with state bureaus has been difficult at times and they can be quite demanding. We much prefer to deal with private businesses who usually are more customer and service oriented than our civil servants.

In summary, our experience with state funds leads us to conclude that we would prefer either commercial insurance or self-insurance if these alternatives were available to us for reasons of lower cost and better service. If you have any questions, I would be glad to try to answer them.

OHIO STATE SELF-INSURANCE STUDY

EXPERIENCE

Year	Premium	Claims	Loss Ratio
1972	$35,010	$3,434	9.9%
1971	32,779	3,198	9.8%
1970	26,409	3,718	14.1%
1969	25,629	1,826	7.1%

Combined Premium	$119,827
Combined Claims	$ 12,176
Combined Loss Ratio	10.2%

PROJECTION 1973

Projected Annual Premium 19,198 (last half 1972) x 2 = $38,396	$ 38,396
Projected Annual Claims 38,396 x 10.2% = $3,916	$ 3,916

OHIO STATE SELF-INSURANCE STUDY

COST DATA

(1)	Projected Loss	$ 3,916.00
(2)	Payment to State (Safety & Hygiene) 1.75% x 38,396	672.00
(3)	Payment to State (Administrative Expense) .009 x $100 of gross payroll .009 x 90,368 = 813	813.00
(4)	Payment to State (Contribution to Disabled Workers Relief Fund) $.03 x $100 of gross payroll $.03 x 90,368 = 2,711	2,711.00
(5)	Surety Bond $100,000	525.00
(6)	Stop Loss Reinsurance - $100,000 Retention	413.00
(7)	M&M Claim Service ESIS - $2,580 M&M Override - $200	2,780.00
Total		$11,830.00

COST COMPARISON
PROJECTION - 1973

Projected Premium to State	$38,396.00
Projected Cost Self-Insured	11,830.00
Interest on Reduction in Advance Premium 25,124 x 6% = 1,507	1,507.00
Projected Potential Savings - Self-Insured	$38,396.00 - 11,830.00 $26,566.00 + 1,507.00 $28,073

Projected Percent Savings - Self-Insured - 73%

WASHINGTON STATE SELF-INSURANCE STUDY

EXPERIENCE

1970

	Total Premium	Pension Assessment	Loss
3rd Quarter	$ 6,883.02	-	$526.03
4th Quarter	7,145.48	-	693.61

1971

1st Quarter	$ 5,761.68	-	$320.08
2nd Quarter	5,887.45	-	284.97
3rd Quarter	7,247.53	$1,737.00	895.77
4th Quarter	7,604.92	1,812.00	500.92

1972

1st Quarter	$ 8,654.80	$1,862.00	$1,422.13
2nd Quarter	9,102.15	2,054.00	648.81
Total	$58,287.03	$7,465.00	$5,292.32

Total Premium	$58,287.03
Total Pension Assessment*	7,465.00
Net Total Premium (Excluding Pension Assessment)	$50,822.03
Total Loss	$ 5,292.32
Loss Ratio	.104

*Pension Assessment is charged the same whether self-insured or w/state

PROJECTION - 1973

Average Quarterly Net Premium (70-72) (Excluding Pension Assessment)	$ 6,352.75
Projected Annual Premium 1973 = $9,329.24 x 4 =	$37,316.96
Projected Annual Loss 1973 = $37,316.96 x .104 =	$ 3,880.96

WASHINGTON STATE SELF-INSURANCE STUDY

COST DATA

(1)	Projected Loss	$ 3,880.96
(2)	Administrative Assessment $3,880.96 x 11%	426.90
(3)	M&M Claim Service (ESIS) A. ESIS = $2,400 B. M&M Charge = 300	2,700.00
(4)	Stop Loss Reinsurance A. $200,000 Retention B. Rate = .0275/$100 Payroll = $2,483	2,483.00
(5)	Surety Bond $100,000 Rate = $5.25/$1,000/year	525.00
Total Cost		$10,015.86

COST COMPARISON
PROJECTION - 1973

Projected Premium to State	$37,316.96
Pension Assessment	5,400.00
Total Cost	42,716.96
Projected Cost Self Insured	$10,015.86
Pension Assessment	5,400.00
Total Cost	15,415.86
Potential Savings as Self Insured	$27,301.10
Percent Savings	64%

Workers' Compensation State Fund Study Commission - October 21, 1980

AASCIF MODEL STATE FUND LEGISLATION: MONTANA EXPERIENCE WITH OPEN RATING AND THE COMPETITIVE STATE FUND

Norman Grosfield - private attorney, former Deputy Administrator and Chief Legal Counsel of the Montana Division of Worker's Compensation and former Vice President and executive board member of the American Association of State Compensation Insurance Funds

Mr. Chairman and members of the committee, I am now in the private practice of law in Helena, Montana. In a large two man law firm. At the present time, our law firm probably does 60 to 70% of our work in the workers' compensation area. We represent claimants. We also represent self-insured employers and private carriers, although maybe after today we won't after they find out I am testifying.

The AASCIF bill is before you. It was drafted by a committee of six made up of either the chairman or director of the state fund or the head of the law division within the state fund. The committee included the head of the legal division of the Colorado State Fund, the New York State Fund which is over a billion dollars operation, the Oregon State Fund, and the Nevada State Fund, the chairman of the West Virginia State Fund, and myself. The idea behind drafting the proposed model bill was because AASCIF, which is in effect the state fund trade association, had been contacted on many occasions for information concerning a proposed bill or how a state should go about drafting a bill and because of that it was decided to draft a model bill and try and take the best from all states and leave the worst out. In most states, the greater portion

of the proposed implementing legislation is such that it could be worked within the legal structure of any state. We spent several months on it. We went through several drafts and we came up with what is before you.

Frankly, the bill is fairly short and we decided ultimately after going through several drafts with lots of specifics that all you needed to start a state fund, a competitive state fund, was some fairly basic legislation. In effect, all a state fund is is an insurance operation. Competitive state funds operate almost identical with the insurance industry. A state fund is a mutual insurance carrier. It's not in the business for profit and technically neither is a mutual insurance carrier. So it is almost set up like the articles of incorporation of a mutual insurance carrier. I would like to quickly go through and direct you to some of the details in some areas, and I would like to set forth some of the basic concepts and some of the thought processes that we went through in drafting the proposal. Then, I would like to comment on the operation of the state fund in Montana and maybe some philosophical comments about state funds in general.

Basically, the first page sets forth the creation and purpose. The purpose is to create a state fund to insure workers' compensation if that is an appropriate requirement in a state. Most state funds on the coast do write a substantial amount of longshore and harbor workers. The state fund of Oregon is the largest writer of longshore and harbor workers in the State of Oregon. California now writes a substantial portion.

What we would suggest is that a board be appointed to remove the state fund from politics as much as it possibly can be. The State Funds of California, Oregon and Arizona have a board that is in effect a board of directors, just like an insurance carrier would have. There are several different approaches. We have proposed a five member board appointed by the Governor to serve for certain terms. Again, there is a great deal of flexibility on that. The second page sets forth the detail on how the board should be appointed. It provides for terms et cetera. But under subsection f, page two, you will find the important language regarding the creation of the board where it provides that the board shall be responsible for setting forth general policies for the operation of the fund. Again, like a board of directors. On Page three, the board is given full power, authority and jurisdiction over the fund. Once the board is created, neither the Governor nor the Legislature has any direct control over it. Of course, the Legislature can change the implementing legislation. But the board concept has worked very well in states that have it. In Montana, I was appointed directly by the Governor. I served at the pleasure of the Governor and I frankly do not think that is the way to go about it. A state fund, probably of all state agencies, should be the most apolitical or non-political of any governmental entity I can think of. It is the closest government agency operation to private industry that I can think of.

We would suggest that the board be allowed under section 4, page three, to appoint a manager of the fund. This manager in effect would be like the president of a corporation. His duties would be to carry on the day to day operations of the fund. The manager would have to have certain credentials. He would have to have experience

in management. By the way, we suggest that the board members either be policyholders or employees of policyholders of the state fund. We would suggest that the manager be given a contract for certain term, four years or whatever, to remove politics as much as possible from the operation of the fund. From my experience in dealing with a state fund and also my discussion with competitive state funds, politics really plays a very small part in the operation, if there is ever any. I think there is very little in the way of politics in the operation of state funds. But in order to insulate further that possibility, we would suggest a board for a term and a manager for a term. We do provide alternatives at the bottom of page three that the manager could be appointed by the Governor or whatever and that of course, is a political decision that would have to be left up to each state. On page four, we provide that the manager shall perform all acts necessary or convenient in the exercise of the powers that are given him. He has to have the power to operate a business. In many cases, it is a very large business dealing with hundreds of millions of dollars and sometime in excess of a billion dollars. We provide under section 6, page 4, that the manager, subject to board approval, may adopt rules and regulations for running the business. Any business has to adopt procedures to follow. We would merely put that in the statutes. We would provide an annual audit, section 7, page four. Section 8, we set forth certain administrative powers governing the fund, contracting with physicians, making safety inspections, acting as the fund's collection agency. Again, these are functions that are required of any insurance system. In section 9, we require a report to the Governor and I assume that Minnesota is much like all other states in that every agency must issue an annual report to the Governor regarding

its operation.

Section 10 is probably the meat of the operation in any state fund or in any insurance system to do what it is created for and that is to provide insurance to employers who wish to enroll with the state fund. We have set forth authority to provide such insurance, to provide services that an insurance carrier writing workers' compensation should do. We also provide in there that the fund shall be allowed to reinsure and I expect any fund would have the inherent power to do it anyway but we wrote it in.

Section 11 provides that the monies and assets of the fund include the premiums that would be collected, all property and securities acquired by the fund, and all interest and dividends. The fund is only in the operation of paying benefits to injured workers. The employers pay to the fund and the workers are entitled certain benefits as mandated by law. We want to make it very clear in the law that these funds cannot be used for any other purpose. There was an attempt in Oklahoma to utilize some state fund assets to subsidize and underwrite the teachers' retirement system. The Supreme Court in the State of Oklahoma found that it was unconstitutional to do so because those monies were vested. I am certain that that was the right decision and I am surprised that the Legislature, I should say that I am not surprised at anything a Legislature would do in my experience, but I am surprised that a Legislature would attempt to do that. It certainly was in error. Under Section 12, the custodian of the fund would be the state treasurer or however the financial system is set up in a particular state and again, that language would have to be changed to coordinate with the financial system in each state. Section 13 establishes powers of the fund. We go into some detail

there. In Section 15 we provide that an employer who intentionally misrepresents payroll for premiums collection purposes is subject to three times the amount of the difference in premium had there not been a misrepresentation. The reason we put it in is that several state funds have such a provision and it was thought it should be included. We had a provision in Montana law that we could charge 10 times the amount of premium that should have been charged because of misrepresentation of payroll. We never exercised that option. I don't know that it was ever exercised. I would feel kind of foolish doing that. Finally, we provided that each state will have to decide if the state fund should be operated like another agency. We call the state fund an independent public corporation in our implementing legislation. It could be called many things but it is in essence much different than most state agencies, it operates differently and therefore, we tried to separate it from the general executive branch structure.

Now in attempting to come up with money to start a state fund, one alternative would be selling bonds. However, I understand there is a restriction in the Minnesota Constitution on that. I suppose the only viable alternative is to provide an appropriation from the general fund of the state and provide that that appropriation shall be paid back when the state fund gets on its feet. My belief is that it would not take a great deal of money to start a state fund even in a state such as Minnesota. Here is the reason. A state fund is going to start insuring employers immediately. It is going to start bringing in premium dollars immediately. However, its contingent liability does not come for some time. Every employer insured with the state fund is not going to have a catastrophe on the first day that

he is insured. It is going to take quite a while for the liability to develop. That is why a lot of people think self insurance is a great thing. I would say this about self insurance. I think every employer that is self insured is going to save money. I suspect that you could substantiate that in any kind of study conducted. In 1979, Montana allowed public corporations to self insure if they met the qualifications of self insurance for others. We have one city that is attempting to do that now. Self insurance is a great thing for the first five years because there is very little contingent liability. But after ten or fifteen years, when you have a backlog of cases, it can become extremely expensive. However, for the large employer it still probably saves money to self insure as opposed to going to a private carrier or a state fund. Are there questions about the bill itself?

I must point out that we tried to make it in effect a skeleton bill because we think a state fund should have broad authority to operate as much like an insurance company as it possibly can and you have to give the board and the manager that authority to carry on a sound and actuarily effective insurance system. We did not put a lot of detail as to how checks should be paid out, et cetera. Some state funds implementing legislation is just terrible, it requires a 1915 operation because that is when most of them were created. A lot of state funds are going to the Legislature and getting what I call garbage out of the statute books so that they can operate more effectively. It is my belief that this implementing legislation, when appropriate changes are made to fit it in with the governmental structure of a state, would be very adequate. It probably is truly a model for any state fund operation. I think most of us on the committee felt that

we could operate very nicely under it.

A few things about the state fund in Montana. It was created in 1915 and it has grown tremendously in the last few years. It contracts with an independent actuarial firm out of San Francisco. We have had some interesting experiences in the last few years. It is my understanding that benefits are high in Minnesota and they are high in Montana. The only difference I suspect is the escalator clause that Minnesota has in its operation and that can be terribly expensive. There is no question about that. That's why we stayed away from it in Montana because it is expensive, even a 6% escalator. But apart from that the benefits are fairly similar. In 1973, the Legislature of the State of Montana adopted most of the essential recommendations of the National Commission of State Workmen's Compensation Laws. This was the commission that I am sure all of you have heard about a great deal. The study was mandated in the Occupational Safety and Health Act. Montana was one of the first states to comply with a substantial number of the recommendations. We do not comply with three of the essential recommendations that are minor and there are some technical problems with them. The private carriers and the state fund became very concerned about the costs. The first year in which the new benefit provisions were in effect, fiscal year 1974, there was a 36% increase in rates by private carriers. There was 39% increase by the state fund. In 1975, there was a 13.5% increase by private carriers and a 10% increase by the state fund. In 1976, 2.6% increase. In 1977, there was a 10% increase by private carriers. In 1978, there was a 26% decrease in rates by private carriers. In Montana, the state fund became too competitive. The rates were generally 30% to 40% below what the private carriers were charging and even then, we had an embarrassment of

riches. There is an audit every year to determine whether the fund is actuarily sound. The state fund grew very substantially. In fiscal year 1977, 10,549 employers enrolled with private carriers and there were 16,935 employers enrolled with the state fund. In 1979, fiscal year, there were 9,604 employers enrolled with private carriers and there were 20,189 employers enrolled with the state fund. It has become quite a problem. The state fund has too much business. Under Montana law, private carriers are required to belong to a rating organization and the National Council on Compensation Insurance (N.C.C.I.) is the only viable rating organization in the state. I would contact N.C.C.I. and explain that we did not want all this business. Why are your rates so high? Private carriers in Montana had the best loss ratios of any state in the Union. For a couple of years it was below 50% and yet rates keep increasing. And they would say, well our figures dictate that this must be done. Yet, finally in 1978 they got the message because the insurance agents in the state raised so many problems and so many questions and finally decided that the state fund was actuarily sound and the problem was with the private insurance industry. N.C.C.I. did reduce rates by 26%. However, under the present system the state fund in Montana still has rates that are substantially below private carriers.

My experience with actuaries and accountants is interesting. There is the old story about the accountant and the lawyer or the actuary and the lawyer. You ask the accountant what two and two is and he says four. You ask the lawyer and the lawyer says what do you want it to be. I have found that the science of actuarial work is actually an art. This is also true with accountants. Private indus-

try is there to make a buck. That's okay. I'm all for that. I think an exclusive fund is a bad system. But for some reason private carriers, and they really control the National Council on Compensation Insurance, thought that they needed substantially higher rates in order to underwrite the costs. I can give you a comparison in 1978 between the rates charged in Montana by private carriers, and those charged by the fund. I can also give you the Minnesota rates for that year. I understand that Minnesota also has its own rating organization which I think is good. It appears the class codes are similar, although it's hard to make a comparison between states because we are dealing with different benefit schedules. In fiscal year 1978, the state fund farm rate was $7 for each $100 of payroll, and $10.23 for private carriers. That farm rate has now gone down $5.95. The Minnesota rate was $13.20. Logging was $27.50 in Montana for the state fund and $26.18 for private carriers, and $39.56 for Minnesota. The logging code was one class code where private carriers were lower than the state fund, but this is no longer the case. Logging is a very big business in the state of Montana and there are a lot of employers insured with private carriers. That's one code that we are always concerned about. The rate now in logging is down to about $19 or so and the private carrier rate is not too far away, I think it is about $26. In carpentry construction - private residences, the state fund was at $4.45 and private carriers at $6.13. In Minnesota $6.85. In another carpentry code called not otherwise classified, the private carrier rate was $5.40, excuse me the state fund rate was $5.40 and the private carrier rate was $8.17 and the Minnesota rate was $14.31. In clerical which is a large class code, our state fund rate was $.25, private carrier rate was $.31 and Minnesota's was $.23. Generally speaking the state fund rate in Montana

was anywhere between 20% and 40% below what private carriers were charging and during those years, we paid dividends of . . . for one year we paid a dividend of 33%. In other words for eligible employers, we sent back 33¢ for each dollar they sent in to us. The dividends have changed year to year. They have averaged in the last five years about 20%. Private carriers that are mutual carriers also pay a dividend, although I don't know what the figures they paid out were.

I guess the message I am trying to tell you is this. The state fund in Montana acted as a control on workers' compensation insurance costs. It is my belief that if we had not had a competitive state fund in Montana with the high benefits that are nearly equivalent to Minnesota's, our rates would have skyrocketed and been much higher than they are now. The rates charged today for some reason are about the same percentages that were charged back in 1973. I am not saying that we have a perfect system. We have lots of problems. We have litigation although it is not quite what it is in Minnesota or some other states. We have a very liberal court. We represent insurance carriers, employers and we are continuously told by the court, you are wrong and advised as to what the current law in Montana is. I see that we are going to have continuing problems. I think the costs of workers' compensation insurance are going to increase. But the state fund acts as a control device in keeping the private carriers alert to the fact that somebody is watching and if they get too high, they are just not going to sell any insurance. That is what has been happening. Frankly, the state fund is getting too large because it just doesn't have the capacity to handle it. I became very concerned about that. I joined with the insurance agents in Montana in an

attempt to see what was going wrong. We finally got somebody's ear back in New York and the rates of private carriers were reduced. They are becoming more competitive and I hope that they become more competitive all the time. We do allow self insurance in the state. I think that is good. We have about 67 self insured employers. The large employers, I assume, much like the employers that are self insured in the State of Minnesota.

The state fund of Montana operates nearly like any other insurance carrier. It has an experience rating system, and it uses the same system that private carriers follow as adopted by NCCI. The state fund contracts with NCCI for experience rating. The state fund pays dividends. The one subsidy that I think exists is that the state fund does not pay a premium tax. I think it should. I think any competitive state fund should pay the same taxes that any private carrier pays. The state fund went to the Legislature and stated it should pay a premium tax. The premium tax is 2.75%. I think that is the only true subsidy that somebody can come up with and argue, at least in the state of Montana. 2.75% is not going to make any difference when there is a 20% to 40% difference in rates between private carriers and the state fund operation.

At the present time we do have a review committee that includes representatives of the state fund and private carriers to try and work out mutual problems. To try to equalize any difference. We are pushing for an equalization of the premium tax for all insurance carriers. We are reviewing what is called the classification and rating committee system. We think there should be a strong classification rating committee that works as a buffer between the national rating organization and the insurance industry in the state where employers can go and try to get redress, to determine whether they are improperly classified and to make sure that all insurance carriers

follow the same classification system. Those things are taking place and I think we will be successful. In Montana, we have a free floating rate system. I think we are the first state to adopt it. Every carrier can adopt any rate schedule it wishes to. However, we have had a hard time convincing private carriers that they should vary from the advisory rates set by NCCI. One problem we have in Montana is that the population is so small it is hard sometimes to get the attention of a large carrier in Hartford, Connecticut and convince the insurance industry it really should pay attention to Montana. The carriers are now starting to deviate their rates. They can change any rate they wish to. One domestic carrier in the state adopted verbatim the state fund's rates. It is writing lots of business and I know it is going to make money. It felt assured that the state fund rates were correct and the rates were adopted across the board. I told the state fund actuary that he should send them a bill. I think the arguments against the floating rate system are not valid.

Anti-trust laws are not applied to the insurance industry in this area at least. I think a strong insurance commissioner can make sure that the insurance companies are going to be solvent and can get the information to make sure that no insurance company is going to go under and that's the solution to the arguments regarding the fixed rates for all workers'compensation insurance carriers. In Montana, the state fund discounts it's reserves. I find that private carriers in the state sometimes do not even make a discount in a permanent total case or a death case. So we have permanent total or death cases worth $400,000 or $500,000 and the carrier will set aside $400,000 or $500,000. Now that obviously

inflates the liability that is incurred in the state. When I was the administrator I encouraged insurers to use discounting. We do in the state fund but we don't do it enough. I think that there should be more discounting. I think the reserving issue is something that could be looked into and could be very interesting reading. If somebody could ever quite figure it out. With state funds, the information is there in black and white. They all have to send out annual reports and they do. The interest income is utilized to a certain degree in the rating structure for a state fund and it is going to be utilized more all the time. But that is a subject that would take years I suspect to have a good understanding as to how it works.

I would say this that there have been attempts mainly by the insurance agents in Montana to abolish the state fund and in turn, organized labor would come in and try to abolish the private carriers as far as workers' compensation is concerned. This fight went on for years. I finally got the sides together and said let's not go through this because no one is going to win. We both know that the Legislature will not adopt either proposal and it will just be a bloodletting.

The business community in the State of Montana would be the first to object to doing away with our state fund, because they see it as a control system. If you haven't gleaned this before, I guess I support a competitive state fund. I think that there are good reasons to support a competitive state fund. However, I have to say it is not a panacea. I cannot assure Minnesota that a state fund would reduce or control or stabilize rates. However, I suspect

it would have at least a stabilizing effect. If a Minnesota state fund got to a point where it was as competitive as it is in Montana (it is too competitive now because we have too much business) or Colorado, or Oregon or California or Arizona, I truly suspect the rates would be reduced.

There are certainly arguments against state funds. There are philosophical and political arguments that can be made. I can only testify as to my experience with one state fund operation. By the way I am not speaking for AASCIF today because I no longer belong to AASCIF, since I left state employment in July of 1979. I made it clear to the president of AASCIF I would not speak for the organization but I would speak as to what I recall the thought process was when the proposed model legislation was drafted. But AASCIF does have a lot of valuable statistics and information to provide. There are many state fund representatives that can provide valuable information to you. I believe you have already heared from certain AASCIF representatives. Basically that is what I had to say.

I did read your report that was submitted. I must compliment the drafters of the report. It is excellent and a lot of work obviously went into it. I did read that one suggestion in creating a state fund in Minnesota would provide that all public employees be covered by the state fund under a start up system. In Montana, we just reversed that and we removed the requirement that all public corporations must belong. Certain public corporations can now go with private carriers although few have done so because of the competitive rate structure. I realize it is one way to get a state fund going in a state that does not have one at the present time. I would suggest

that if that is done that it be limited to a five year period. Then public corporations could go with private carriers after that period of time.

There are a lot of states reviewing this legislation. I have testified in the State of Kentucky. The president of AASCIF has received requests for information from the State of Georgia and, I believe, Indiana and Illinois recently. So there is some interest in this. Thank you.

EXHIBIT "A"

Bill No. _____

IN THE LEGISLATURE OF THE STATE OF _____

FOR AN ACT ENTITLED: "AN ACT CREATING A NON-PROFIT COMPETATIVE STATE COMPENSATION INSURANCE FUND TO WRITE WORKERS' COMPENSATION INSURANCE, OCCUPATIONAL DISEASE INSURANCE AND EMPLOYERS LIABILITY INSURANCE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF _____

STATE COMPENSATION INSURANCE FUND

Section 1. DEFINITIONS. In this chapter;,

(a) "Manager" means the manager of the state compensation insurance fund;

(b) "Fund" means the state compensation insurance fund;

(c) "Board" means the board of directors of the state compensation insurance fund.

(NOTE: Sub-section "c" should be deleted if it is determined that the manager is to be appointed by the governor and no board of directors is created).

Section 2. CREATION AND PURPOSE OF THE FUND. The State Compensation Insurance Fund is created as an independent public corporation and the purpose of the state compensation insurance fund is to insure employers against liability for injuries and occupational diseases for which their employees may be entitled to benefits under the workers' compensation law, occupational disease law, employers' liability law, and the federal Longshoremens and Harbor Workers' Compensation Act.

Section 3. APPOINTMENT OF THE BOARD:

(a) The state compensation insurance fund shall be under the direct supervision of a board of directors which shall consist of five members to be appointed by the governor. Each

member shall be a policyholder or an employee of a policyholder of the fund.

(b) Of the members of the board one shall be appointed for a term ending _____, and each other director for a term expiring one, two, three and four years thereafter. Upon expiration of any of the terms, the appointee or his successor shall be appointed for a term of four years. Appointment to fill a vacancy caused by other than expiration of the term shall be for the unexpired portion of the term.

(c) Each appointed member of the board shall receive as compensation _____dollars per day while in actual attendance at meetings of the board and shall be reimbursed for mileage and subsistance [as allowed by law] [or administrative rule for state employees.].

(d) The chairman shall be appointed annually by the governor [shall be elected by the members of the board]. The board may adopt rules and regulations, as it deems proper for the conduct of its business. The board may from time to time amend or change the rules and regulations and may cause them to be published and distributed.

(e) The board shall meet at least once every three months. Board meetings may be called at any time by the chairman of the board or the manager of the fund.

(f) The board shall be responsible for setting forth the general policy for the operation of the fund.

(g) There shall not be any liability in a private capacity on the part of the board of directors or any member thereon, or any officer or employee of the fund for or on account of any act performed or obligation entered into in an official capacity in connection with the administration, management or

conduct of the fund or affairs relating thereto.

(h) The board of directors is hereby vested with full power, authority and jurisdiction over the fund. The board of directors may perform all acts necessary or convenient in the exercise of any power, authority or jurisdiction over the fund, either in the administration thereof or in connection with the insurance business to be carried on by it under the provisions of this chapter, as fully and completely as the governing body of a private insurance carrier to fulfill the objectives and intent of this chapter.

Section 4. APPOINTMENT OF MANAGER:

(a) The board of directors of the fund shall appoint a manager of the fund who shall be in charge of the day-to-day operation of the fund. The manager shall have proven successful experience as an executive at the general management level. The manager shall be appointed for a term of [four years, five years, or six years]. The manager shall receive compensation as set by the board [or pursuant to Section _____], and may be removed only for cause by the board.

(b) Before entering on the duties of the office, the manager shall qualify by giving an official bond in an amount and with sureties approved by the board. The manager shall file the bond with [appropriate state official]. The premium for the bond shall be paid by the fund.

NOTE: Alternative section for direct appointment of the manager without the creation of a board of directors.

Section Alternate 4.

(a) The manager of the state compensation insurance fund shall be appointed by the governor [for a term of six years or until his successor is appointed], [or the manager shall serve at the pleasure of the governor], [subject to con-

firmation by _____]. The governor may remove the manager in the same manner as provided in [Section _____]. The salary of the manager shall be _____ [or subject to the law of the state].

(b) Before entering on the duties of the office the manager shall qualify by giving an official bond in an amount and with sureties approved by the governor. The manager shall file the bond with [appropriate state official]. The premium for the bond shall be paid by the fund.

NOTE: If the alternative method of appointment of the manager by the governor is chosen, this will necessitate adapting some of the preceeding and following sections to conform to this method because the sections are written with the assumption that there will be an appointed board of directors. It will be necessary to delete or modify all section relating to the board.

Section 5. GENERAL POWERS. The manager [subject to the authority of the board of directors] has full power, authority, and jurisdiction over the fund. The manager may perform all acts necessary or convenient in the exercise of any power, authority or jurisdiction over the fund, either in the administration of the fund or in connection with the insurance business to be carried on by the fund under the provisions of this [chapter], including the establishment of premium rates.

Section 6. RULES AND REGULATIONS. The manager, subject to board approval, may adopt rules and regulations relating to the conduct of the business of the fund.

Section 7. AUDIT. The manager shall have an annual audit of the books and records of the fund made by a duly qualified independent certified accountant, and have an abstract summary of this audit prepared for public use.

Section 8. ADMINISTRATIVE POWERS. In conducting the business of the fund the manager may:

(a) contract with physicians, surgeons, hospitals, and rehabilitation facilities for medical, surgical, and rehabilitation evaluation and treatment and the care and nursing of injured persons entitled to benefits from the fund;

(b) make safety inspections of risks and furnish advisory services to employers on safety and health measures;

(c) act for the fund in collecting and dispursing money necessary to administer the fund and conduct of the business of the fund.

Section 9. REPORT TO THE GOVERNOR. Annually the manager shall report to the governor the business done by the fund during the previous year and shall submit to the governor a statement of the resources and liabilities of the fund.

Section 10. POWER TO INSURE. The fund may:

(a) insure an employer against any workers' compensation and employer liability such employer may have on account of bodily injury or occupational disease to his worker arising out of and in the course of employment, as fully as any other insurer;

(b) insure employers against their liability for compensation or damages under the United States Longshoreman's and Harbor Worker's Act or any extension of that Act, as fully as any other insurer;

(c) furnish advice, services and excess workers' compensation and employer liability insurance to any employer qualified as a self-insured employer; [if the state permits self insurance].

(d) reinsure any risk or any part thereof.

Section 11. MONIES. The monies and assets belonging

to the fund are:

(a) all premiums and other monies paid to the fund;

(b) all property and securities acquired through the use of money belonging to the fund;

(c) all interest and dividends earned upon money belonging to the fund and deposited or invested as provided in this chapter.

Section 12. CUSTODIAN OF THE FUND.

(a) The [state treasurer or equivalent] is the custodian of all monies and securities belonging to the fund. The [state treasurer or equivalent] is liable on the bond of [state treasurer equivalent] for their safekeeping.

(b) The manager shall deliver all money collected or received under this chapter to the [state treasurer or equivalent] or deposit it in banks in the state designated by [the state treasurer or equivalent]. The interest accruing on the money shall be credited to the fund.

(c) All securities belonging to the fund shall be held by the state treasurer (or equivalent) who shall hold them until they are disposed of under the provisions of this chapter.

(d) The money of the fund is not state money. The property of the fund is not state property. The fund's money and property shall be used exclusively for the operation and obligations of the fund.

(e) No money may be expended from the fund except on properly authorized vouchers presented by the manager to the [state treasurer or equivalent]. However, the fund may maintain a checking account from which it may pay, by checks signed by the manager, obligations before submitting vouchers to the [state treasurer or equivalent].

(f) The state shall not be liable beyond the assets of the State Compensation Insurance Fund for any obligations in connection therewith.

Section 13. POWERS OF THE FUND. The fund may:

(a) use its assets to pay medical expenses, rehabilitation expenses, compensation due claimants of insured employers, and to pay salaries, administrative and other expenses;

(b) declare a dividend when there is an excess of assets over liabilities, necessary reserves, and a reasonable surplus for the catastrophe hazard;

(c) rent, lease, buy, sell, property in its own name, construct and repair buildings as necessary to provide office space for its operations;

(d) sue and be sued in its own name;

(e) enter into contracts relating to the administration of the fund;

(f) perform all the functions which are necessary or appropriate to carry out the administration of the fund;

(g) hire personnel and set salaries and compensation to accomplish the purposes of its existence and operations.

Section 15. LIABILITY OF EMPLOYER. An employer who intentionally mis-represents any material fact upon which his premium under this chapter is based is liable to the fund for three times the amount of the difference in the premium paid and the amount the employer should have paid if his payroll had been correctly computed. The penalty shall be collected in a civil action.

(NOTE: Each state should determine if other state laws are applicable or should be made applicable to the fund.

Such laws as administrative procedures acts, public employees retirement acts, state personnel acts and civil service acts should be considered. In addition, it should be determined whether the fund should be subject to the state budgetary process and supervision by the state insurance commission.)

(Further consideration should be given to providing that all state agencies and all political subdivisions of the state must insure their liability under the workers' compensation act with the state compensation insurance fund.)

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