Chapter 3

Understanding how Premiums Are Calculated

In Chapter 2, we touched upon why the phrase "Guaranteed Cost" can be misleading. When insurance people talk about a "Guaranteed Cost" Workers Compensation insurance policy, they mean that the policy's premium is not adjusted to reflect the cost of claims paid under the policy. However, a "Guaranteed Cost" premium is not guaranteed to stay the same as the original premium on the policy. The actual premium charges for the policy can and will be adjusted to reflect the actual payroll of the insured business, so the premium shown on the policy is not the final premium that will be ultimately due for the coverage. The original policy's premium is an estimate, subject to later revision. In my experience as an agent and consultant, I've learned that, while many of those adjustments made by insurance companies are proper and according to the rules, ***many others are not.***

I don't think I can stress this enough. Insurance companies make lots of mistakes in computing Workers Compensation insurance premiums. Human nature being what it is, insurers tend to catch the mistakes that would cost them money—mistakes that lower premiums. They are nowhere as vigilant about catching mistakes that increase premiums.

To avoid paying premiums charges that are not correct and are not according to the rules, businesses need to learn the basics about how Workers Compensation insurance premiums are calculated—***and sometimes miscalculated.***

Calculating Premiums

Not all Workers Compensation policies are "Guaranteed Cost." But all policies use the guaranteed cost premium computation formula as the starting point. *Loss-sensitive* policies make additional adjustments to premium; they start with the same formulas and rules that are used for guaranteed cost policies. So understanding how guaranteed cost premiums are calculated is fundamental to understanding how all Workers Compensation insurance premiums are calculated.

Rate Times Hundred Dollars of Payroll

This is the most fundamental calculation at the heart of Workers Compensation insurance premiums. Virtually all Workers Compensation insurance premiums are calculated by multiplying a rate times hundred dollars of payroll. (For a few kinds of work such as domestic workers, premium is often calculated on a per capita charge.) There have been efforts in recent years to allow construction-related employers to calculate premiums on an hours-worked basis, but this has only been approved in the state of Washington so far. The idea is that payroll fluctuations roughly match up with fluctuations in workplace exposure to injury. It's also a verifiable number that insurance companies can audit without undue difficulty.

In this book (and the insurance industry generally) payroll is often described as the basis for Workers Compensation premiums, but that's not technically accurate... It's really **remuneration** that is the basis, and remuneration can include more than just payroll. The insurance industry, in its wisdom, figured out that if it based premium charges solely on payroll, some employers

would inevitably try to hold down payroll costs (and thus their Workers Compensation costs) and compensate employees in other ways as much as possible. Insurers feared this would distort matters and shortchange them on premium, so "remuneration" is defined pretty broadly to discourage such maneuvers. Of course, for most employers, remuneration is almost exclusively payroll, but sometimes an employer can get tripped up by not understanding what really constitutes remuneration under the terms of Workers Compensation policies. In this book, we will usually use the term "payroll" but understand that this is really shorthand for "remuneration", as defined below.

Under NCCI rules (National Council on Compensation Insurance) remuneration *includes*:

Wages or salaries (including retroactive wages or salaries;
Total cash received by an employee for commissions and draws against commissions;
Bonuses including stock bonus plans;
Extra pay for overtime work (but this can be adjusted to remove the premium portion);
Pay for holidays, vacations or periods of sickness;
Payment by an employer of amounts that would have been withheld from employees to meet statutory obligations for insurance or pensions plans such as the Federal Social Security Act or Medicare;
Payment to employees on any basis other than time worked, such as piecework, profit sharing or incentive plans;
Payment or allowances for hand tools or hand-held power tools used by employees in their work;
The rental value of an apartment or house provided to an employee based on comparable accommodations;
The value of lodging, other than an apartment or house received by an employee as part of their pay to the extent shown in the insured's records;
The value of meals received by employees as part of their pay to the extent shown in the insured's records;
The value of store certificates, merchandise, credits or any other substitute for money received by employees as part of their pay;
Payments for salary reduction, employee savings plans, retirement or cafeteria plans (IRC 125) that are made through employee-authorized salary reduction from the employee's gross pay;
Davis-Bacon wages or wages from a similar prevailing wage law;
Annuity plans;
Expense reimbursements to employees to the extent that an employer's records do not confirm that the expense was incurred as a valid business expense.

But NCCI manual rules also specify that certain things are *excluded* from the definition of remuneration:

Tips or other gratuities received by employees;
Payments by an employer to group insurance or group pension plans for employees;
Payments by an employer into third-party trusts for the Davis-Bacon Act or a similar prevailing wage law provided the pension trust is qualified under IRC Sections 401(a) and 501(a);
The value of special rewards for individual invention or discovery;
Dismissal or severance payments except for time worked or vacation accrued;
Payments for active military duty;
Employee discounts on goods purchased from the employee's employer;
Expense reimbursements to employees to the extent that an employer's records confirm that the expense was incurred as a valid business expense;
Supper money for late work;
Work uniform allowances
Sick pay paid to an employee by a third party such as an insured's group insurance carrier that is paying disability income benefits to a disabled employee
Employer-provided perks such as:

- Use of company-provided automobiles
- Airplane flights
- Incentive vacations (e.g., contest winners)
- Discounts on property or services
- Club memberships
- Tickets to entertainment events

Employer contributions to employee benefit plans such as:

- Employee savings plans
- Retirement plans
- Cafeteria plans (IRC 125)

National Council on Compensation Insurance is an insurance-industry organization that, among other things, writes the rules that are used in most (but not all) states that govern how Workers Compensation insurance premiums are computed. It is a private corporation, technically owned by member insurance companies. It essentially acts as a centralized organization for Workers Compensation insurance ratemaking, giving a large degree of standardization to the industry. It has historically been known as a **rating bureau,** although in more recent years regulators have adopted the term "advisory organization." We'll get into more detail about NCCI and other rating bureaus later on in this book.

NCCI writes various manuals that are filed with state insurance regulators on behalf of member insurance companies. In theory, insurance companies could develop their own manuals and file them with regulators, but they have historically rarely chosen to do so. Instead, they find it more economical to be members of NCCI (and other rating bureaus) and let those rating bureaus handle the work of developing manuals of rules, and gathering data used for ratemaking and experience modification factors.

Keep in mind, the above lists of inclusions and exclusions for remuneration are from NCCI manual rules, and NCCI rules are used in most, but not all, jurisdictions. In Pennsylvania and Delaware, for example, the rules of the separate rating bureau used there do not allow the premium portion of overtime pay to be excluded from remuneration. Ohio also does not allow the premium portion of overtime pay to be excluded when computing Workers Compensation charges in its state monopoly fund system. Some other states also do not use the NCCI manual rules, so always check carefully if the rules in your particular state vary.

Remuneration is one important element of Workers Compensation premiums—and another is the rate that gets multiplied times each hundred dollars of remuneration. So next we need to understand how those rates are developed and applied in the computation of Workers Compensation insurance premiums.

Manual Rate

The rates you may see on your company's Workers Compensation policy or audit billing statement are manual rates. Workers Compensation insurance rating systems assign different kinds of work to different classifications; each classification within a particular state carries its own rate per hundred dollars of payroll (or remuneration.)

The idea is that different kinds of work have different inherent exposures to workplace injury and illness, and so should have manual rates that are commensurate with that exposure. Thus, the manual rate for clerical work is typically the least expensive classification (with a rate in the range of 30 to 50 cents per hundred dollars of payroll) while the manual rate for a riskier kind of work such as roofing might have a manual rate of 25 or 30 dollars per hundred dollars of payroll.

A typical Workers Compensation insurance policy for a manufacturer might have three different classifications, each with its own manual rate, while a policy for a construction-related employer might have five or six different classifications. Some kinds of employers, such as temporary employment agencies or employee leasing companies can have dozens or even hundreds of different classifications on their policies. Each classification will be listed, with a brief written description and a code number (NCCI and most other rating bureaus use a four digit code system) and the manual rate for each.

The manual rate for a classification is the rate per hundred dollars of payroll that a particular insurance company has filed to use in a particular state. Some states require that all insurance companies use the same schedule of manual rates within their jurisdiction, but nowadays many states allow competing insurance companies to develop their own schedules of manual rates.

However, the manual rates used by a particular insurance company will be the same for all policyholders insured by that particular insurer. So if hypothetical insurer Amalgamated Insurance Giant has filed to use a rate of $0.35 for clerical work (Code 8810) in the state of Illinois, every insured of Amalgamated Insurance Giant will get that $0.35 rate for clerical work in Illinois.

In other words, the manual rate doesn't vary based on your company's past loss experience or any other underwriting evaluation done by the insurance company (that's accomplished by subsequent rating factors.) The manual rate is really a starting point for calculating premiums; the rate is then adjusted to reflect your company's particular loss history and other credits or charges made by the insurance company.

Years ago, it was standard in all states to have just one set of manual rates that had to be used by all insurers in a state. So every insurance company would use the same manual rate for clerical work, for instance. But that has changed dramatically over the course of the past two decades, as most states have introduced some form of competitive rating to Workers Compensation insurance. That means that in most states, insurance companies are encouraged to develop their own schedules of manual rates, with the idea being to foster price competition among insurance companies. So the manual rate for Code 8810 could be $0.35 from Amalgamated Insurance Giant, but $0.43 from National Mutual Insurance.

The Classification Problem

Of course, most businesses aren't exclusively clerical in their work exposures. And one key to making sure your Workers Compensation insurance premiums are correct is making sure your insurance company is using the correct classification code for your particular workplace exposures. Classification systems for Workers Compensation insurance aren't always as clear-cut and easy to administer as might be wished, so mistakes in assigning the correct classifications (and thus the correct manual rates) are far from uncommon. Sometimes the difference between qualifying for a low rated classification and a higher rated one is subtle.

One important principle of Workers Compensation classification is that, generally speaking, it is the overall business enterprise that is classified, not the particular job functions. So, for example, a janitor in a manufacturing plant is not assigned to a janitorial classification but instead is placed in the classification for the particular kind of manufacturing involved.

We'll get into much greater detail about the classification system in Chapter 4, but at this point just keep in mind that a company's manual rates will depend upon which particular classifications are used by the insurance company. Each classification will have a particular manual rate which is multiplied by each hundred dollars of payroll for the employees who fall into that classification. Multiplying payroll by manual rates produces ***manual premium***.

Experience Rating

Manual premium gets adjusted for most employers by various other rating factors. The most widely used adjustment is *experience rating*, which uses the **experience modification factor**. This is a multiplier that is calculated based on a particular company's reported past Workers Compensation losses. If your company's reported past losses are lower than average, you likely

will earn a credit modifier. If your past reported losses are higher than average, you will probably get a debit modifier.

Whatever your experience modifier is calculated to be, the manual premium gets multiplied by that factor. So if manual premium is $100,000 but you have a .75 experienced modifier, your *modified premium* gets reduced to $75,000. If you experience modifier were 1.25 instead, your modified premium would be $125,000.
Most employers whose annual Workers Compensation premiums exceed $5,000 qualify to be experience rated. The particular thresholds for experience rating can vary depending on which state an employer is operating in, and the thresholds also are periodically adjusted, but generally speaking all but relatively small employers should qualify for experience rating. We'll get into much more detail about this in a subsequent chapter, including how to check your experience modification factor for common errors.

Merit Rating
Some states—Alabama, Arkansas, Georgia, Oregon, South Dakota, and Vermont—have programs in place that offer credits or debits on premiums for employers too small to qualify for experience rating. These programs are known as *Merit Rating*. For example, in Alabama, an employer that is not experience rated and whose annual premium is less than $5,000 qualifies for merit rating as follows:

No claims in most recent year	10% credit
No claims in most recent two years	15% credit
One claim in most recent year	no credit or debit
Two or more claims in most recent year	10% debit

Other Premium Credits or Debits
Many states also allow discretionary credits or debits by insurers. These are generally known as *schedule credits* or *schedule debits* and they work much like experience modification factors. They are percentage discounts or surcharges that further adjust the modified premium. So a 25% Schedule Credit would further reduce premium charges by 25%. Conversely, a 25% Schedule Debit would add a 25% surcharge.
These schedule credits and debits are filed by insurers with state regulators and are supposed to be used on a rational and specified basis. That is, an insurance company will file with state insurance regulators that it wants to be approved for a maximum overall limit of credit and debit charges; if regulators approve it, the insurer can then apply up to that maximum 40% credit or debit for a particular policyholder. Within those overall limits, insurers also file sub-limits for particular criteria they propose for these adjustments. For example, if an insured filed for a 50 percent maximum credit or debit, it might use criteria like the following:

Schedule Rating Plan Credits and Debits

Criteria	**Maximum Credit or Debit %**
Premises	10%
Classification Peculiarities	10%
Medical Facilities	5%
Safety Devices	5%

Employee selection, training, supervision	10%
Management cooperation with insurer	5%
Management Safety Organization	5%

However, in actual practice, many state regulators pay little or no attention to how closely insurers actually follow these filed criteria. Insurers therefore often use schedule credits and debits with complete disregard for the criteria they file with regulators. They abide by the overall maximum amounts they have filed, but often use the debits/credits as discretionary adjustments to manipulate premiums for their own purposes. Thus when insurance markets are soft, insurers will often use schedule credits to lower premiums in order to compete for an account that they view as attractive.

When insurance markets are hard, insurers will use schedule debits to increase premiums, essentially operating on a "charge what the market will bear" philosophy. An insurance company might offer significant credits to a policyholder one year and then, just a year or two later, when the insurance market has hardened, insist on considerable debit charges for that same employer. This change in rate would not be based on any changes in the specified criteria filed with regulators—just on the fact that the insurance company wants more money, and thinks it can get away with charging more in the hard market.
Unfortunately, insurance regulators tend to allow insurance companies to get away with such behavior, so it can be difficult for employers to challenge such abuses. But I have seen instances where specific complaints to regulators about such abuses have been successful, when carriers were not able to justify their changes in schedule/debit charges based on the filed criteria.

Other Premium Credits
Many other states have enacted other premium credits that can apply to certain employers within their jurisdictions. A number of states have enacted **contractor premium adjustment plans** which can give employers in construction-related fields credits if their average hourly wages are relatively high. This can give some premium relief to construction businesses that pay high hourly wages. Other states allow credits for employers that maintain drug-free workplaces or for employers that elect to utilize managed care networks. Figure 3-1 shows the different kinds of premium credit programs offered by the various states.

One thing to keep in mind about many of these premium credit programs is that insurance companies have been successful in getting many of them set up in such a way that responsibility for filing the needed forms to qualify for the credits rests with the employers. If an employer doesn't realize that a premium credit might apply, and thus doesn't fill out and send in the appropriate forms, the employer won't get the premium credit. This is different from experience rating, which is done automatically (if not always correctly) for employers. So it can be important for employers to understand what kinds of premium credits may be available in their jurisdictions and to complete and send in the appropriate forms on a timely basis.

Standard Premium
Once the manual premium has been adjusted by the experience modification factor and any other credits and debits that apply, the resulting adjusted premium is known as the **Standard Premium**. This standard premium is used as a reference point by many loss-sensitive policies,

but on a Guaranteed Cost policy there is one last major adjustment that is made: the premium discount.

Premium Discount

A premium discount is a size discount that is applied to workers compensation insurance premiums that exceed $5,000. It's also a sliding scale discount, so that as the premium grows larger so does the percentage of the discount. These increasing discounts are figured by brackets, much like income tax brackets. The premium discount reduces premiums both on the policy and on the audit of the policy based on which bracket the premium fits in. If the premium on the audit is different than that originally on the policy, the percentage of premium discount can change.

Other Charges

There can be other, relatively small, charges that contribute to Workers Compensation premiums. An Expense Constant is often added, which is a flat charge that essentially is just a surcharge for the expense of producing the policy. There is a terrorism charge that is a rate times total payroll. Some states have introduced surcharges to fund the operation of their state Workers Compensation Commissions (agencies that adjudicate Workers Compensation claims.)

Summary of Calculating Premiums for Guaranteed Cost Policies

So we've now reviewed the major (and some minor) elements that determine Workers Compensation insurance premiums. Manual premium is computed by determining which classifications apply to an employer and then multiplying payrolls by the manual rates for those classifications. The resulting manual premium is then adjusted by an experience modification factor, schedule credit or debit charges, and any other credits that may apply (such as a contractors premium adjustment plan credits or drug free workplace credits.) Finally, premium discount, expense constant, and terrorism charges are factored in.

The following chart shows a sample premium calculation, to illustrate how these factors are used in computing premiums.

(In the experience modifier column, 1=integrates data with NCCI modifiers, 2=stand-alone modifier

Jurisdiction	Manuals	Drug Credits	Merit Rating	Contractor Credit	Experience Modifiers	Safety Credit	State Fund
Alabama	NCCI	Yes	Yes		1		None
Alaska	NCCI			Yes	1		None
Arizona	**NCCI**				1		Competitive*
Arkansas	**NCCI**	Yes			1		None
California	**Independent**				2		Competitive
Colorado	**NCCI**				1		Competitive*
Connecticut	**NCCI**			Yes	1		None
D.C.	**NCCI**				1		None
Delaware	**Independent**				2		None
Florida	**NCCI**	Yes		Yes	1		None
Georgia	**NCCI**	Yes			1		None
Hawaii	**NCCI**		Yes	Yes	1		None
Idaho	**NCCI**	Yes			1		Competitive
Illinois	**NCCI**			Yes	1		None
Indiana	**Independent**				1		None
Iowa	**NCCI**				1		None
Kansas	**NCCI**				1		None
Kentucky	**NCCI**				1		None
Louisiana	**NCCI**				1		None
Maine	**NCCI**				1		None
Maryland	**NCCI**			Yes	1		Competitive

Jurisdiction	Manuals	Drug Credits	Merit Rating	Contractor Credit	Experience Modifiers	Safety Credit	State Fund
Massachusetts	**Independent**				1		
Michigan	**Independent**				2		
Minnesota	**Independent**				1		
Mississippi	**NCCI**	yes			1		
Missouri	**NCCI**			yes	1		
Montana	**NCCI**			Yes	1		
Nebraska	**NCCI**			Yes	1		
Nevada	**NCCI**				1		
New Hampshire	**NCCI**				1		
New Jersey	**Independent**				2		
New Mexico	**NCCI**			Yes	1		
New York	**Independent**			Sort of	1		
North Carolina	**Independent**	yes			1		
North Dakota	**Monopoly**				2		
Ohio	**Monopoly**				2		
Oklahoma	**NCCI**			Yes	1		
Oregon	**NCCI**			Yes	1		
Pennsylvania	**Independent**				2		
Puerto Rico	**Monopoly**				2		
Rhode Island	**NCCI**				1		
South Carolina	**NCCI**				1		
South Dakota	**NCCI**				1		
Tennessee	**NCCI**	yes			1		
Texas	**Independent**				1		
U.S. Virgin Islands	**Monopoly**				2		
Utah	**NCCI**				1		
Vermont	**NCCI**				1		
Virginia	**NCCI**				1		
Washington	**Monopoly**			Yes	2		
West Virginia	**NCCI**				1		
Wisconsin	**Independent**			Yes	1		
Wyoming	**Monopoly**				2		

To understand why New York is shown as “sort of” for contractors’ credit, look at the detailed entry for New York in Chapter 1.

Why Guaranteed Cost Isn’t

The most basic kind of Workers Compensation insurance policy is often called a “Guaranteed

Cost" policy, but this insurance industry term can be misleading. That's because the initial premium on a policy, even a so-called "Guaranteed Cost" policy, is only an estimate, because the payrolls are, by necessity, estimated. Only after the policy has ended can actual payrolls for the policy period be determined and then a final audited premium for the policy can be calculated by plugging in the actual payroll numbers.

To illustrate this, take a look at the following charts. The first shows a sample Guaranteed Cost policy's initial estimated premium. The second chart shows how the premium for that same policy could change once the actual audited payrolls are determined.

Chart 1 Estimated premium on the initial policy

Classification	Code	Rate	Payroll	Premium
Clerical	8810	0.32	$100,000	$320.00
Outside Sales	8742	0.78	$75,000	$585.00
Machine Shop	3632	$6.75	$750,000	$50,625
Manual Premium				51,530
Experience Modification Factor				0.78
Modified Premium				$40,193
Schedule Credit	-25%			$30,145
Drug Free Workplace Credit	-5%			$28,638
Standard Premium				$28,638
Premium Discount	-10.30%			$25,688
Discounted Premium				$25,688

Chart 2: Billed Premium for same policy after audit

Classification	Code	Rate	Payroll	Premium
Clerical	8810	0.32	$88,567	$283
Outside Sales	8742	0.78	$76,875	$600
Machine Shop	3632	$6.75	$877,543	$59,234
Manual Premium				60,117
Experience Modification Factor				0.78
Modified Premium				46,891
Schedule Credit	-25%			$35,169
Drug Free Workplace Credit	-5%			$33,410
Standard Premium				$33,410
Premium Discount	-10.30%			$29,969
Discounted Premium				$29,969

So this employer purchased a policy that cost $25,688.00 in premium at the outset, but after the policy ended and an audit was done of payrolls, the actual cost for the policy was determined to be $29,969.00. The increase in premium was due to the changes in payroll. So this "Guaranteed Cost" policy didn't mean that the original premium of $25,688 was guaranteed to not increase—it just meant that premium would be determined by multiplying rates times payroll, without any additional adjustments based on the claims incurred during the term of the policy. There are other kinds of policies, generally known as "Loss-Sensitive" policies that make additional

adjustments based on the claims that are covered under the policy. We'll discuss these in more detail later.

Assigned Risk Plans

Since Workers Compensation obligations are essentially imposed upon employers by government, yet most states utilize private insurance companies as the vehicle by which most employers satisfy those obligations, the question arises: what happens when insurance companies don't want to underwrite a particular employer? After all, as private businesses, insurance companies have the right to decline to underwrite certain risks. In recognition of this possible problem, the various states have all come up with some kind of "insurer of last resort," a vehicle by which an employer can still obtain Workers Compensation insurance even if insurance companies are not willing to voluntarily insure that employer. That vehicle is generally known as "Assigned Risk" or "the involuntary market."

Not all states call their program Assigned Risk, although most do. States that have a competitive state fund usually use that fund as the insurer of last resort. States that do not have a state fund (and most don't) utilize a pooling mechanism by which employers who can't get Workers Compensation in the "voluntary market" can still get coverage—although it's often at much higher rates.

An Assigned Risk policy usually looks pretty much the same as a "voluntary market" policy. Sometimes employers are not even aware that their coverage has been written through the Assigned Risk plan, because agents sometimes don't make that clear to them. The policy still shows the name of a particular insurance company—"Amalgamated Insurance Group" perhaps—and it won't usually make an obvious reference to being an assigned risk policy.

But in many states, the premium charges for an assigned risk policy will be much higher than the premium charges for the same policy if written in the voluntary market. ("voluntary market" is the insurance industry term for policies written voluntarily, that is, not in an assigned risk program.)

The assigned risk plans in many states are pooling mechanisms, claims incurred under the policies are not the responsibility of the insurance company ("Amalgamated Insurance Group" in our fictitious example) shown on the policy. Claims and premiums are pooled among a number of insurers who write Workers Compensation insurance in the state. So even though Amalgamated Insurance Group is shown on the front of the policy, this insurance company doesn't get to keep the premiums, and they get to pass the claims costs along to the larger pool. Amalgamated just gets a servicing fee for producing and servicing the policy. That's probably why so many people covered by assigned risk policies complain that the service they receive from the insurance company is poor.

Premium charges for assigned risk policies are calculated pretty much the same as for voluntary market policies—with a few changes that serve to make premiums much higher. (At least, this is true in most states. A few don't add higher costs to their assigned risk programs.)

For starters, the manual rates in assigned risk plans are usually higher. If the manual rate for Code 3632 in a state is $6.23, the manual rate for Coded 3632 in the assigned risk plan might well be something like $7.58.
To make matters worse, in most NCCI states you lose the premium discount factor in the assigned risk plan. And assigned risk polices aren't eligible for any schedule credits that might be offered in the voluntary market. And then there's the *ARAP* charge.

In most NCCI states, there is an additional surcharge for assigned risk employers once their experience modification factor rises above 1.00. How much of a surcharge depends on how much higher than 1.00 your experience modifier is, but the surcharge can easily add another 25% or more to the premium. So often, premiums costs in the assigned risk plan can be double what they would be in the voluntary market, once you add up the higher rates, loss of premium discount factors, loss of schedule credits, and ARAP charges.
To be fair, assigned risk plans in many states have hemorrhaged money for many years, becoming a serious hidden tax on the insurance industry and their policyholders. That's because when assigned risk plans paid out more in claims than they took in as premiums, the shortfall had to be made up by assessing insurance companies. So these higher premium charges are efforts to make the overall assigned risk plans self-funding. But it also means that if your company is in the assigned risk plan, the already-high cost of Workers Compensation insurance will likely be much, much higher.

Not all states feature these higher costs in the assigned risk plans. States that use their competitive state funds as the assigned risk mechanism may not impose higher rates and other surcharges. But for most employers with assigned risk policies, moving into the voluntary market can make a huge difference in premiums. So the first order of business for employers looking to reduce Workers Compensation costs is to see if they are in the assigned risk plan, and if so, what can be done to get out of it.

Retrospective Rating Plans
A relatively recent development with NCCI assigned risk plans in many states is the imposition of a mandatory loss-sensitive rating plan for policies over $200,000 in annual premium. It's known as LSRP, or Loss Sensitive Rating Plan, and it imposes a not-very friendly version of Retrospective Rating onto those larger assigned risk policies. Retrospective Rating can lower premiums if claims are relatively low, but also have the potential to increase premiums if claims costs are not so low. Retrospective Rating plans (or "Retro" plans, as they're commonly known) are a form of Loss-Sensitive policies. That means that premiums are adjusted based on the losses that occur during the term of the policy. Since you can't know what those claims costs are until well after the policy has ended, these premium adjustments get made after the policy expiration. Usually there are a series of annual adjustments made, reflecting the changing costs of the claims over time.

Retro policies use a set formula to make further adjustments to Standard Premium. The details of the formula can vary widely, but they all "look back" (hence the "Retro" terminology) to see what the claims costs of the policy were. And since those claims costs change as time goes by, the Retro adjustments are annually revised to reflect the latest calculations of those claims costs. Claims costs evolve over time because even though a particular claim occurs at a particular date,

one can't know at the outset exactly how expensive that claim will eventually be. Thus the ultimate cost of a retrospectively rated policy won't typically be known until years after the policy has ended.

Retro policies calculate these subsequent adjustments by taking the Standard Premium and the losses for that policy year and running them through a formula that has been agreed upon in advance. Usually this formula is contained in an endorsement to the policy, although sometimes insurance companies utilize separate written agreements. We'll discuss problems with the use of these separate written agreements later.

A classic Retrospective formula works like this: There is a **Basic** charge, which is a percentage of Standard Premium. Then you take the total of all claims incurred during the policy and multiply this amount by a **Loss Conversion Factor**, or **LCF**. (The claims costs usually include not just what's been paid out by the insurance company but also that company's reserves for claims. Reserves are the insurers' estimate of what future payments on the claim will be.) Losses multiplied by the LCF produce **converted losses**. You then add the **Basic Premium** to the **Converted Losses** and multiply that total by a **tax factor**. (States charge taxes that are included in Guaranteed Cost policy premiums but broken out separately on Retro policies.)

Keep in mind that the above describes the factors of what I call a "classic" Retro --the kind that's used on the LSRP assigned risk Retro—but many insurers nowadays have added some additional factors to their Retro formulas. Other insurance companies have developed policies that mimic Retro formulas by means of written side agreements that add Retro-style adjustments to Large Deductible policies.

Let's take a look at how such a Retro plan would work. If our hypothetical policy generated $100,000 in Standard Premium (that's premium after experience modifier and other credits but without premium discount) for policy period January 1, 2004 through January 1, 2005, and had a Basic Factor of 30 percent, and losses for the year totaled $45,000 with a Loss Conversion Factor of 1.15 and a Tax Factor of 1.03, the Retro premium would be calculated as follows on the first Retro adjustment. This first adjustment would be based on incurred losses as they were valued on July 1, 2005.

(a) Basic Premium	$30,000 ($100,000 Standard Premium x .30)
(b) Converted Losses	$51,750 ($45,000 in losses x 1.15 LCF)
(c) Sum of a + b	$81,750
Tax factor	1.03
Retro premium	**$84,202.50** ($81,750 x 1.03)

So under this hypothetical Retro plan, the premium would be lower than the standard premium (which was $100,000.) It's lower even than it would have been if a premium discount had been applied to the Standard Premium, as it would have been under a non-assigned risk guaranteed cost policy.
But consider what might happen for the same policy on the subsequent retrospective adjustment, done a year later. By July 1, 2006, incurred losses for the 2004-05 policy period have changed,

and are now valued at $66,000. This is because the reserves for some open claims have been increased, and incurred losses include paid losses and loss reserves. So now this subsequent Retro adjustment would work out as follows:

(a) Basic premium	$30,000
(b) Converted losses	$75,900 ($66,000 x 1.15 LCF)
Sum of a + b	$105,900
Tax factor	1.03
Retro premium	**$109,077**

Now Retro premium is higher than the Standard Premium. And if losses increase even more on later adjustments, the premium will continue to increase—at least up to a point.

That's because Retro policies also have **Minimum** and **Maximum** premium factors. These place a floor on how low premiums can go, even if there are zero losses and a ceiling on premiums even if losses are extremely high. These are usually expressed as percentages of Standard Premium. So if our hypothetical Retro had a Maximum of 1.30, this would mean that the maximum premium that could be charged would be 130% of Standard Premium. If Standard Premium was $100,000, the maximum that could be charged would be $130,000, no matter how high losses might climb.

Conversely, if the minimum premium were .35, the lowest the premium could go would be $35,000, or 35% of the Standard Premium of $100,000.

If you haven't dealt much with Workers Compensation insurance, you might be asking why the claims costs would increase so much over time. (If you have deal with Workers Comp for a while, you probably know all too well why this happens.)

There are two reasons for this. First, many claims don't get fully settled or paid out during the term of the policy. So a year later, when our second Retro adjustment was done, the cost of those claims was higher. Second, as we mentioned earlier, many Retro policies (but not all) are based on **incurred losses.** Incurred losses include not just what's actually been paid out on a claim, but also the insurance company's estimates, or reserves, for what they think the ultimate cost of the claim will be. The estimation of proper reserves on a Workers Compensation claim is as much art as science, and they often change over time.

So in our second Retro adjustment above, not only could the paid out claims for 2004-05 be now higher than a year earlier, it might well also be that the reserves set a year ago for some claims have now been revised upwards in light of changing circumstances and information.
So one drawback to Retro plans is that until all the claims for the year are settled and paid and closed out, there can be additional charges for the policy that aren't known until years later. So our hypothetical employer in our example could be paying additional premium charges for the 2004-05 policy until 2010 or later.

The Maximum premium factor can help limit these unpleasant surprises, but only to a limited degree. Still, under the 1.30 Maximum premium we discussed earlier, this would mean that

under our hypothetical Retro incurred losses over $83,664 would not increase premiums further. Incurred losses of $83,664 would produce Retro premium of $130,000 under this plan. Since $130,000 is the plan maximum, losses above $83,664 could not increase premiums above the $130,000 maximum. So even though losses of $90,000 would, under the Retro formula, produce a Retro premium of $137,505, the most that could be charged would be 130% of the Standard Premium, or $130,000.

The other side of the coin is that, even if incurred losses were zero, the Minimum premium factor means that $35,000, or 35% of Standard Premium, is due.

Deductible Plans

Another common type of loss-sensitive plan involves the use of a deductible. These plans come in two varieties, small deductibles and large deductibles. Small deductible plans are normally set by statute in various states. That is, state law dictates that insurers must provide a certain set discount in return for the employer accepting a specified deductible. Small deductibles range from $100 per claim to $1,000 per claim typically. Large deductibles can range from $25,000 per claim up to a several hundred thousand dollars per claim or even a million dollars.

In such plans, the employer agrees to reimburse the insurer for the amount of the claims that fall under the deductible limits. This is a little different from deductibles in other kinds of insurance, where the insured is responsible for paying the deductible amount outright. With Workers Compensation insurance, regulators want to make sure injured workers have their claims paid without worrying about whether the employer can afford to pay. So in Workers Compensation deductibles, the insurer is still responsible for paying the claims, but it then has a right to demand reimbursement from the employer for those claims costs that fall under the deductible limits.

In fact, what is normally done is that insurance company requires the employer to pre-fund money for payment of claims under the deductible limit, and to replenish those funds as they are paid out. The insurance companies also normally require some additional security, such as a Letter of Credit, to make sure the employer is funding claims payments under the deductible. Thus, Large Deductible plans have many of the characteristics of self-insurance, in that the employer is really paying for the cost of most claims, and is just purchasing the claims handling services of the insurer.

The advantage of Large Deductible policies over genuine self-insurance is that the Large Deductible policy is still a valid Workers Compensation insurance policy that meets the statutory requirements of the various states. For multiple state operations, it is much less cumbersome to enter into a Large Deductible policy than to set up self-insurance programs that are approved by each of the various states.

Large Deductible plans normally have both a per occurrence deductible limit and an aggregate limit. The aggregate limit sets a maximum amount for all claims covered by the policy. In return for accepting these deductibles, the employer gets a very large discount applied to the manual premium. These large deductible discount factors are not set by statute but are individually negotiated between the employer and the insurer. The amount of discount can vary significantly from one policy to another or even between one year's policy and the next year's

policy for the same employer. In small deductible policies, the employer receives a much smaller discount that is set by statute or regulation.

This means that under Large Deductible policies, there are really two separate kinds of charges that an employer will have to pay the insurance company. The first is the discounted premium charge, and the second is the funding for the claims costs. In actual practice, insurers usually bundle both kinds of charges into a unified billing system for the employer.

One complicating factor with Large Deductible policies is that there inevitably have to be separate written agreements that govern how the employer will fund the claims costs (and associated claims handling charges.) These agreements often are very complex, and their language can make the standard Workers Compensation insurance policy (which itself is not written in user-friendly language) look straightforward by comparison. So one problem with these kinds of programs is that even large sophisticated companies may well not fully understand the details of what they have agreed to. This can lead to unpleasant surprises down the road when these programs turn out to be more expensive than the employer anticipated.

It is not uncommon for these separate side agreements to Large Deductible programs act to create payment provisions that are different from those actually set forth in the policy. The separate side agreements may act to turn a Guaranteed Cost policy into something that operates more like a Retro policy. But the provisions contained in such side agreements are often not submitted for approval by insurance regulators, the way real Retrospective Rating programs must be, and thus insurers can craft rating provisions that are more favorable to themselves.

Large Deductible policies were originally approved for use only with very large employers but over time lower premium thresholds have been approved by many states. So where once an employer had to be paying a million dollars in premium to be eligible for a Large Deductible policy, currently many states allow such plans to be offered to employers paying only several hundred thousand dollars in premium. We'll get into more detail about some of these more complicated plans later in the book and describe some of the potential benefits and pitfalls of these programs.

QUICK REVIEW

A Workers Compensation premium is almost always calculated using rates per hundred dollars of **remuneration (payroll.)**

Remuneration is largely payroll, but can also include other items of value provided by an employer.

Changes in payroll can result in significant changes in premium, even for so-called **"Guaranteed Cost"** policies.

For many employers, premium is adjusted based on prior losses and payrolls, by means of the **experience modification factor**. This is calculated yearly by a rating bureau like the National Council on Compensation Insurance and then applied by the insurance company to compute the premium.

Retrospective Rating policies make a further adjustment to the premium based on losses that occur during the term of the policy.

Deductible policies discount the premiums in return for the employer accepting responsibility for claims falling under the deductible limit. Deductible policies come in two varieties: **small deductible** policies that are set by state statute and **Large Deductible** policies whose terms are negotiated between the employer and the insurer.