WCRIBMA
THE WORKERS' COMPENSATION RATING
AND INSPECTION BUREAU OF MASSACHUSETTS

May 16, 2025

CIRCULAR LETTER NO. 2445

To All Members and Subscribers of the WCRIBMA:

RATE FILING

In follow up to Circular Letter No. 2441, the Commissioner of Insurance has disapproved the WCRIBMA's rate filing to change rates effective July 1, 2025. The rates and rating values currently in effect will remain in effect. The Division of Insurance's May 15, 2025 Decision and Order on the WCRIBMA's Rate Filing is attached for your information.

Experience ratings and ARAP factors that have been issued effective on July 1, 2025 and subsequent will be revised to remove the preliminary status.

As is customary, the WCRIBMA will issue a circular letter when its next rate filing is submitted.

DANIEL JUDSON
President

Attachments

101 ARCH STREET ·5TH FLOOR, BOSTON, MASSACHUSETTS 02110-1103
(617) 439-9030, FAX (617) 439-6055, www.wcribma.org

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
One Federal Street, Suite 700 • Boston, MA 02110
(617) 521-7794 • Toll-free (877) 563-4467
www.mass.gov/doi

MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

MICHAEL T. CALJOUW
COMMISSIONER OF INSURANCE

Filing of the Workers' Compensation Rating and Inspection Bureau

For a General Revision of Workers' Compensation Rates

Docket No. R2024-01

Decision and Order

I. Introduction and Procedural History

On November 15, 2024, the Workers' Compensation Rating and Inspection Bureau of Massachusetts ("WCRIBMA"), on behalf of its members, submitted a filing for a workers' compensation general rate revision to be effective July 1, 2025 ("the WCRIBMA Filing" or "Filing"). The Filing sought a 7.1 % statewide average rate increase to be effective July 1, 2025. The Commissioner of Insurance ("Commissioner") designated Jean F. Farrington, Esq. and Matthew A. Taylor, Esq. as presiding officers for this matter. A hearing notice, issued on December 13, 2024, scheduled a public comment hearing and a prehearing conference for January 14, 2025. On December 17, 2024, the Attorney General's office ("AGO") filed a notice of intent to appear and participate.

Representatives of the WCRIBMA and the State Rating Bureau in the Division of Insurance ("SRB") spoke at the public comment hearing. Jeffrey Kadison, an actuary, submitted written comments and spoke on behalf of NAHRO, a Massachusetts Self-Insurance Group. At the following conference, the presiding officers developed a comprehensive schedule for future proceedings that included dates for cross-examination of the WCRIBMA witnesses, AGO and SRB advisory filings and cross-examination of their witnesses. We advised the parties that final briefs would be due on April 15, 2025. Following cross-examination of the SRB and AGO witnesses, the WCRIBMA elected not to submit a rebuttal filing. Briefs were timely submitted.

II. Statutory Framework

MASSACHUSETTS GENERAL LAWS, Chapter 152, §53A ("§53A") sets out the statutory requirements for obtaining approval of rates for Massachusetts workers' compensation insurance. Subsection (1) requires any insurance company writing workers' compensation insurance in the Commonwealth to file its risk classifications and premiums with the Commissioner, either directly or through a rating organization authorized to act on its behalf. The Commissioner thereafter conducts a hearing to determine whether the classifications and rates are not excessive, inadequate, or unfairly discriminatory for the risks to which they effectively apply, and fall within a range of reasonableness.

In addition to these general requirements, §53A (12) specifically states that the Commissioner shall not approve classifications or rates that provide for any of the following: 1) dividends, unabsorbed premium deposits, savings or other payments allowed or returned by the insurer to policyholders, members, subscribers or stockholders; 2) expenses that exceed the filing insurer's expense needs; and 3) commission allowances that are not demonstrated to be reasonable and to reflect the actual cost to the agent or broker of services they provide. The Commissioner, pursuant to §53A (13), also must make a finding, on the basis of information in the rate filing, that insurers employ acceptable cost control programs and techniques. If the Commissioner finds that the rates are excessive, and that the excess is the result of failure to employ adequate cost control programs, he may disapprove or limit any proposed increase in rates. Furthermore, if the Commissioner finds, after hearing, that any premiums currently in effect are excessive, he is to order a specific rate decrease, whether or not the insurer or rating organization has requested one.

Neither the statute nor the applicable procedural regulation, 211 CMR 110.00 et seq., prescribes a particular methodology for developing rates or specifies the data that the insurer or rating bureau must include in its filing. However, §53A (3) requires that the filer provide the information that supports the filing, which may include information on the experience or judgment of the filer, the experience of other insurers, and any other factors which the insurer deems relevant. The burden is on the filer to satisfy the decisionmaker that its proposed rates

meet the statutory standard.[1] As the proponent of a new mechanism or methodology, the WCRIBMA has the burden of proving its reasonableness.[2]

The Supreme Judicial Court has articulated the standard of review to be applied by the Commissioner when reviewing filings by the WCRIBMA. That standard was summarized in the Decision on August 1, 1999 Workers' Compensation Insurance Rates, Division of Insurance Docket No. R99-34, at 6, as follows:

> "It is well-settled that the Commissioner or her designee, the Presiding Officer, has the authority to analyze each element of the rate filing and each method set forth in the rate filing and may reject the proposed rates if any element or method fails to meet the statutory standard. See Workers' Compensation Rating & Inspection Bureau v. Commissioner of Insurance, 391 Mass. at 264. Accordingly, the Commissioner or Presiding Officer may reject certain "elements of a filing" if they may lead to "rates falling within a range of excess, no matter how small." Id.

The statute does not require the commissioner to approve elements of filings which would lead to rates falling within a range of excess, no matter how small. The Commissioner's decision disapproving rates needs only to be reasonably supported by the evidence that the proposed filing will fail to produce rates which are not excessive, inadequate, or unfairly discriminatory.[3]

The Supreme Judicial Court in the holding of *Workers' Compensation Rating and Inspection Bureau v. Commissioner of Insurance*, 391 Mass. 238, 245 (1984) (hereinafter "*1984*"), also considered the scope of the Commissioner's review of a filing for workers' compensation rates:

> "We have noted, however, that the scope of the commissioner's authority under G. L. c. 152, Section 52, differs from that under some other statutes. See, e.g., G. L. c. 175, Section 113B. The commissioner "may disapprove rates or withdraw his approval only if rates are inadequate, excessive or unfairly discriminatory. He does not have the power to fix rates; 'he may not require that they be at the figures he finds

[1] *Workers' Compensation Rating and Inspection Bureau v. Commissioner of Insurance*, 391 Mass. 238, 245 (1984), citing *Liberty Mutual Insurance Co. v. Commissioner of Insurance*, 366 Mass. 38, 42 (1974); See also *Blue Cross and Blue Shield of Massachusetts v. Commissioner of Insurance*, 420 Mass. 707, 709-710 (1995), in which the Court concluded that the Commissioner may disapprove rates if the filer fails to submit sufficient evidence on which he may reasonably conclude that the proposed rates will not be inadequate, excessive or unfairly discriminatory.

[2] See, In re Application of the Workers' Compensation Rating and Inspection Bureau of Massachusetts for Approval of a General Rate Revision to be Effective on or after August 1, 1999, Docket No. R99-34, at 39-40.

[3] In re Application of the Workers' Compensation Rating and Inspection Bureau of Massachusetts for Approval of a General Rate Revision to be Effective on or after August 1, 1999, Docket No. R99-34, at 39-40. See also *Blue Cross*, 397 Mass. at 119 (1986).

> reasonable.'" 391 Mass. at 245 citing Liberty Mut. Ins. Co. v. Commissioner of Ins., supra at [366 Mass. 35,] 42 [(1974)], quoting Massachusetts Medical Serv. v. Commissioner of Ins., 344 Mass. 335, 339 (1962). He must determine whether the rates are inadequate, excessive or unfairly discriminatory, based upon their falling within a "range of reasonableness." Nevertheless, "[t]he burden of furnishing evidence to enable the Commissioner to establish a range of reasonableness is on the insurers." Id. If the insurers fail to submit evidence sufficient to allow the commissioner reasonably to conclude, based on the evidence, that proposed rates will not be "inadequate, excessive or unfairly discriminatory" he may disapprove them." 1984, 391 Mass. at 245.

The Opinion, Findings and Decision on Workers' Compensation Rates rendered in October 1982 discussed, at page 2, the appropriate role of alternative proposals advanced by other parties in hearings on WCRIBMA rates:

> "The statutory standards of review, contained in M. G. L. chapter 152, section 52, provide that Workers' Compensation Insurance rates may not be made effective until approved by the Commissioner as not excessive, inadequate or unfairly discriminatory for the risks to which they apply."

A rating organization making a filing must provide sufficient information to enable the Commissioner to make such a decision. The Commissioner serves as a rate reviewer, not as a rate maker. The Commissioner reviews the filing submitted. He (or she) does not accept or reject other proposals but rather uses them as an aid in judging the filing. In their holding in 1984 the Supreme Judicial Court endorsed this language as being consistent with the proper principles to be used in WCRIBMA rate hearings.[4]

The purpose of this hearing is to determine whether the filing provides sufficient support for a finding that the proposed rate is all of the following: 1) not excessive, 2) not inadequate, 3) not unfairly discriminatory for the risks to which the premiums respectively apply, and 4) that the rates fall within a range of reasonableness. In keeping with the language of the statute, each of these criteria is separate and distinct.[5] As noted in the 1984 Case, the first three criteria are dependent on the fourth. It is therefore appropriate to articulate how a proposed rate can be considered within a range of reasonableness. As with all reasonability standards, it looks at the perspective of the reasonable, average observer. It cannot therefore be a direct comparison of the proposed rate change to some preconceived upper or lower numerical bounds, which would

[4] *1984*, 391 Mass. at 245, n. 5
[5] See M.G.L. c.152 s.53A

be unknown to this hypothetical observer. Indeed, the "range of reasonableness" need not examine absolute values at all. Instead, reasonableness, as used in §53A refers to whether it is reasonable to decide prospective rates based on the information, methods, and analysis presented in the filing. As the SJC noted in *1984*, the Commissioner can only determine excessiveness, inadequacy, and fairness of the proposed rates after determining if the filing presents a sufficient basis to form an opinion. It must therefore address two distinct criteria: burden and method. First, the burden is on the filer to provide enough information for the Commissioner to form an opinion. Second, the methodologies used to derive the prospective rate from historical data must be appropriate for doing so.[6] The inclusion of the word "range" acknowledges the prospective nature of the filing and the impossibility of predicting the future with perfect accuracy. It is possible for multiple different rate change proposals to all fall within the same range of reasonableness. The filing is expected to be much more than a shot in the dark, but reasonable minds can disagree.

The decision in *1984* reminds us that it is only after reviewing reasonableness need we address the other three tests.[7] Here, we will briefly discuss excessiveness and inadequacy to highlight their distinct criteria and clarify any confusion over the use of terms. If the filing fails to establish a range of reasonableness, and its methodology tends to overestimate the rate, it is called excessive. Conversely, if the methodology tends to underestimate the rate, it is called inadequate. However, per the holding of *1984*, the possibility exists for the proposed rates to be excessive or inadequate even when a range of reasonableness can be established.[8] For example, an inexhaustive indication of inadequacy occurs when companies must either risk insolvency or flee the market. It follows then that an inexhaustive indication of excessiveness occurs when there is no circumstance under which a downward deviation would not be granted for any book of business or risk profile (or, in other words, the rate is totally detached from the actual market experience).

The WCRIBMA's filing this year sought an overall rate increase of 7.1%; the AGO recommended an average rate decrease of -6.2 % and the SRB proposed a decrease for the

[6] See *1984*, 391 Mass. at 245
[7] See Id.
[8] See Id.

standard classifications of between -3.1 and -2.1%, depending on the Commissioner's decision on the escalation factor, and between -7.6% and -6.7% for the F-classes.

Our task is to determine whether the WCRIBMA has submitted sufficient evidence from which we may reasonably conclude that the proposed rates will not be inadequate, excessive or unfairly discriminatory and that they fall within a range of reasonableness. We conclude, after reviewing the evidence on specifically contested issues, that the evidence does not support approval of the rate increase requested in the Filing. Although our Decision does not address every aspect of the Filing, we remind the parties that failure to address an uncontested element neither constitutes approval of any party's position nor permits an inference that the element is approved.

III. Contested Issues

The advisory filings submitted by the SRB and the AGO challenged several aspects of the 2024 filing. Both address the WCRIBMA's proposals for loss development, the application to losses of an escalation adjustment, and loss trend. As was the case with the WCRIBMA's 2023 filing, expert witnesses for each party addressed various specific components of the underwriting profits provision. The SRB made a recommendation about the F-class rates. The AGO also proposed an alternative effective date for the WCRIBMA's rates and a recommendation for the period in which it would remain in effect.

A. Loss Development

The loss development factor ("LDF") incorporated into workers' compensation rates is intended to estimate insurers' ultimate losses for workers' compensation claims initiated in a particular policy year ("PY 20##" for specific policy years) until the time when they are fully paid or settled. The factor changes over time as insurers make payments and adjust reserves retained for future payments; for that reason, the ultimate value of losses cannot be determined solely from early reports. Because benefits may be paid out over long time periods, losses may not reach their ultimate value for many years. The longstanding methodology for calculating LDFs assumes that losses develop in a consistent pattern over time and that historical experience has predictive value for future development. At issue in this filing are the WCRIBMA's LDFs for indemnity (lost time) paid losses.

As in its filing for rates effective July 1, 2024, the WCRIBMA separately calculated indemnity LDFs for paid losses and for paid-plus-case losses and averaged those results. For paid LDFs it averages two years of insurer-reported losses on claims paid during two policy years (evaluated as of the end of the following policy year); the last year in that sequence is the most recent policy year preceding the Filing date. For paid-plus-case LDFs, it looks at five years of periodic insurer reports that track claim costs and loss reserves for up to 72 months. From that data it calculates a set of age-to-age link ratios. Those five ratios are averaged to produce an LDF. Age-to-age link ratios, as expected, decline as claims are resolved and no longer require reserves. The WCRIBMA's proposed LDF averages the paid and paid-plus-case values.

At the hearing on 2024 rates, the SRB and the AGO both challenged that loss development methodology, contending that it would produce excessive rates, and recommended that for both paid losses and paid-plus-case losses LDFs be derived from five years of historical data and averaged for the final LDF. After hearing arguments from all parties, the Commissioner was persuaded that the use of five years of historical data to generate LDFs both for paid and paid-plus-case losses would be reasonable. [9] The WCRIBMA declined to adopt the Commissioner's 2024 decision on the LDFs and this year continues to use the disapproved methodology. The SRB and the AGO again argue that using that methodology will continue to produce excessive rates and that the methodology approved in the Commissioner's Decision on the 2024 rates, to average five years of both paid and paid plus case data, should remain in place. The parties do not contest the data underlying the LDFs; the dispute addresses the WCRIBMAs' methodology for selecting the range of historical data to be used to calculate its LDF value for paid indemnity losses.

The WCRIBMA acknowledges that selecting historical experience for estimating losses is a matter on which actuarial judgment may differ; it defines the competing concerns as responsiveness and stability. As in the past, it observes that a shorter experience period will produce an estimate that is more responsive to changes and that a longer experience period increases stability, allegedly at the cost of responsiveness. It contends that longer periods are preferable when data change because of random variations that are not correlated with economic

[9] Filing of the Workers' Compensation Rating and Inspection Bureau For a General Revision of Workers' Compensation Rates, Docket No. R2023-03, pp. 7-12.

conditions, but that the shorter period that it chose for paid losses quickly reflects economic conditions. Characterizing PYs 2021 and 2022 as an "era of rapidly and systematically changing economic conditions," the WCRIBMA asserts that "it is intuitive that responsiveness should be approved."[10] That economic circumstances changed in those two years does not suggest that data from those years should therefore be the focus for projecting estimated future losses. The WCRIBMA's observation that change affects industries differently suggests that change is not necessarily systematic or uniformly rapid. Both the SRB and the AGO recommend that the Commissioner again, as in the Decision on 2024 Rates, approve an LDF methodology that, for both paid and paid-plus-case development factors, averages five years of historical data. Both the SRB and AGO witnesses testified that a two-year average development factor is more likely to produce excessive rates and certainly produce less stable rates. The SRB witness further observed that an LDF for paid losses based on a five-year average produces an estimate that is closer to that for paid-plus-case.

The methodology used to quantify LDFs is derived from historical data, not on conjecture about possible changes in economic conditions that may prevail in the future period in which the proposed rates will be effective. In this Filing, the WCRIBMA again proposes to calculate an LDF for paid losses using data for two policy years, 2021 and 2022, while the SRB and the AGO recommend using LDF data from PY 2019 through PY 2023 for the paid losses. For a number of reasons, we are persuaded that the use of five data points as a basis for calculating paid loss, as well as paid-plus-case LDFs is appropriate. First, a five-year experience period, the WCRIBMA's choice for paid-plus-case LDFs, provides a longer data set from which to observe variances and patterns over time. A paid loss LDF that averages only two data points, as Ms. Mays testified, demonstrates only a variance between two years. That single data point is insufficient to derive a trend.

In the introduction to its rate filing, the WCRIBMA argues that policy years 2021 and 2022 are more stable than PYs 2020 and 2022 and representative of current system conditions. The parties this year continue to address the concept of "volatility" as a characteristic of LDF data.

[10] The WCRIBMA reinforces its argument with a citation to the Commissioners' Decision and Order on the Rate Filing of the Workers' Compensation Rating and Inspection Bureau, Docket No. R2003-08. However, the issue under discussion was not indemnity losses but medical losses. As the WCRIBMA notes in its filing, medical and indemnity losses are developed separately because their development patterns differ. Exhibit I, Vol 1, Section 11-4. We do not view it as precedential.

However, for the same reasons that we found it reasonable in the Decision on 2024 rates to characterize expected numerical differences as variability rather than label them "volatile" we again refer to them as variances.[11] The SRB and the AGO argue that the link ratios in 2021 and 2022 data sets from which the WCRIBMA calculates its paid loss LDF produce are higher than those in other years. Selecting only two years with higher link ratios to calculate an LDF assumes that the conditions that generated those values will prevail in the future. Averaging five years of historical data smooths the effect of unusually high variances. This year, as it did last year, the WCRIBMA argues that losses from PY 2020 and earlier represent a significant economic discontinuity and are unrepresentative of future losses. That the Covid-19 pandemic significantly affected the workplace is unquestioned, thus we find it unreasonable to simply ignore data from that period.

The WCRIBMA further argues that using five years of data to calculate paid-plus-case losses is appropriate because random variations in company reserving practices and large claims may affect losses, especially medical losses. It offers no data to support the presence of either assumption in the data underlying the filing; we note again that medical loss development is not at issue.

1. Loss Development: Trend

In assessing the reasonableness of the parties' recommendations we consider their function as estimates of conditions in the period in which the approved rates will be in effect. The historical methodology based on calculated link ratios is consistent; this dispute is about the number of data points that should be averaged to produce indemnity paid and paid-plus-case LDFs. We are, as last year, not persuaded that it is reasonable to base the paid case LDF on two data points. The WCRIBMA contends that variances in paid loss data result from changes in economic conditions, that using two years of experience for paid case losses will prioritize responsiveness and produce rates that are predictive and therefore reasonable. It argues that incorporating data from PY 2020 or earlier into the methodology enlarges the range of variances and decreases responsiveness. That data, however, is part of the historical record and will continue to be an element in rate filings for many years. We do not find it reasonable to assume that selecting two years of exceptionally high values from a period that reflects recovery from

[11] Decision on 2024 rates at page 9

an unusual year in the workplace is the appropriate basis for calculating indemnity paid LDF. Based on this record, we conclude that the WCRIBMA has offered insufficient evidence to support its position that the two-year method of developing an LDF for paid loss data is superior to the five-year method approved by the Commissioner in the Decision on 2024 Rates.

The loss trend factor in the Filing is intended to adjust its underlying historical losses and premiums to levels expected to prevail in the period when the approved rates will be in effect, i.e. from July 1, 2025, to at least July 1, 2026, and at most July 1, 2027. In essence, it reflects expected changes in experience affecting elements such as claim frequency, claim amounts (referred to as severity) and payroll levels that affect potential premiums. Trend factors are calculated separately for indemnity and medical losses.

The SRB addresses a single aspect of the WCRIBMA's trend methodology, using in its trend factor a two-year average to estimate developed losses that is consonant with its approach to loss development. The WCRIBMA responds that the experience period used for paid loss development should be the same for loss flows and loss trend, asserting that because the Commissioner should find that two years of loss experience for LDFs is reasonable, that same conclusion should apply to loss trend. As set out above, the Commissioner has, as in the Filing for 2024 Rates, concluded that five years of loss experience is appropriate for calculating the paid loss LDF and, further, that the same experience period should be used to estimate loss trend. The WCRIBMA's argument is not persuasive.

The AGO also addresses the WCRIBMA's changed approach to estimating a trend for the State Average Weekly Wage ("SAWW") rate component, a factor that changes every year and affects workers' compensation rates in two ways. Increases in the SAWW have an upward effect on payroll, the basis for an employer's premium. Similarly, they may affect lost time claim costs. The WCRIBMA's trend calculations recognize both. In 2021, the SAWW increased by 13.9 percent, a higher increase than any historical value; the parties agree that the increase was unusual and unlikely to recur. Neither the SRB nor the AGO dispute the WCRIBMA's methodology for calculating the SAWW trend or the result. The AGO asserts, however, that the WCRIBMA should have correspondingly adjusted the indemnity severity trend because the SAWW and indemnity severity have historically been closely correlated. Its witness notes that the changed methodology for calculating the SAWW trend this year generated a value that is

lower than the indemnity severity trend, a relationship that is the opposite of that shown by actual experience. No evidence was identified that would support a conclusion that the unusual spike on the SAWW had a parallel effect of similar magnitude on indemnity severity. We are not persuaded that the 2021 rise in the SAWW, by itself, is sufficient to support a change to the indemnity severity trend calculation.

In 1985, legislation was enacted to require an annual cost of living adjustment ("COLA") for indemnity benefits paid on claims for permanent and total injuries or death. Since its effective date, November 1, 1986, such benefit payments have been adjusted annually. There are, however, open claims for injuries that occurred before that date. The WCRIBMA applies to indemnity paid losses an escalation factor of 1.044 to adjust for increases to benefits paid on those claims made before 1986. As confirmed by the WCRIBMA's witness, at this time fewer than 50 pre-1986 indemnity cases are open and subject to escalation. That value appears to be again based on a simulation model developed in 2003 that has not been run for many years, nor adjusted to reflect its current reliability as a predictor of future rate needs to cover claim costs for fewer than 50 cases. Both the SRB and the AGO question the proposed escalation factor, raising issues that persuade us that it is appropriate this year to reassess the applicability of the WCRIBMA's longstanding approach. Further, as noted by the SRB, while for indemnity paid-plus-cases, the escalation factor since 2022 has set at 1.00 (i.e., no increase), the paid case factor which, similarly, will vanish when those pre-1986 claims are closed, has not steadily declined but over the past 15 years has ranged between 1.031 and 1.045.

The AGO opposes the WCRIBMA's tail factor because, among other things, rather than adjust losses associated with pre-1986 claims, it relies on a projection associated with a simulation model that was developed and last run in 2003, has not been updated in 22 years, and no longer exists. Ms. Bergh testified that the WCRIBMA's proposed escalation factor relies not on the simulation model itself but on her opinion that escalation factor results have been stable over time and were not contested.[12] Those assumptions are not responsive to the undisputed character of escalation factors, that they are expected to decrease over time, or to the facts that the number of pre-1986 claims that are subject to escalation has diminished and that the current dollar value of those claims is unknown. Including in the tail factor an escalation factor that

[12] TR Vol. II at p19

does not reflect reliable historical data can have a substantial effect on rates because it is a value applied to all indemnity losses.

On this record, we find that the WCRIBMA has not supported its proposed 1.04 escalation factor. We acknowledge that because a few workers' compensation claims filed before 1986 are still open, it might be appropriate to include an escalation factor in the rates that focuses on data from that cohort. Because escalation factors are expected to decrease over time, we find it unreasonable to propose a factor that appears to assume, without any explanation, that they have not done so or explained why the values in the Filing for the years 2022 through 2024 are the highest in the past 15 years. The AGO suggests a value of 1.005, based on expanded critiques of other elements of estimating loss adjustments. The SRB does not propose a value but asserts that discontinuance of the WCRIBMA's escalation factor, together with adoption of other changes proposed by the SRB, could produce a -3.1% rate change. Consequently, we instruct the WCRIBMA to provide a thorough analysis of the status of the claims that underlie the escalation factor in any future filing in which it is used.

B. The F-classes

Section VIII of the WCRIBMA Filing proposes rates for risks assigned to "F-classes," business classifications covering employees whose occupations are regulated under the United States Longshore and Harbor Workers Compensation Act ("USL&HW). That statute offers benefits to longshoremen, harbor workers and other employees engaged in loading, unloading, repairing or building vessels while working on them or adjoining navigable waters, that differ from the benefits prescribed by Massachusetts workers' compensation law. For that reason, the WCRIBMA has for many years calculated rates for the F-classes independently in a section of the filing separate from the calculating rates for other class codes.

Mr. Salido described the three-step process used to estimate pure premium relativities for each workers' compensation classification.[13] That process weights data on the Massachusetts experience for each class, countrywide experience for that class, and the relativities underlying the current rate. In its filing for 2024 rates, the WCRIBMA entirely omitted a section on F-class rates principally because the National Council on Compensation Insurance ("NCCI") could no

[13] TR Vol. I at p16

longer provide to its actuary the countrywide data on F-classes that he had used from 2014 to 2022 to develop class pure premium relativities.

This year Mr. Salido determined rates for the F-classes using the same underlying methodology but assesses credibility by weighting the average of only two elements: Massachusetts experience and the relativities underlying the current rates. According to Mr. Salido's testimony, no F-class receives more than 35 percent credibility for Massachusetts data and for 10 of the 14 no more than 10 percent weight is given to Massachusetts data. The SRB is concerned that for most of the F-classes 90 percent or more weight is assigned to the relativities underlying current rates, a situation that limits the ability of the F-class rates to respond to any changes at the countrywide level affecting the relative costs among F-classes. It offers no specific antidote but recommends that the WCRIBMA continue to explore options for obtaining countrywide data.

We conclude that access to countrywide data is a significant element for determining classification rates and that it is appropriate to use the same methodology for F-class rates as is used for other classes. Although countrywide data from the NCCI is no longer available, Mr. Salido stated that "independent bureaus" exist that might be a source of data from other states.[14] In preparation for its next filing for F-class rates, we instruct the WCRIBMA to pursue all available options to obtain a broad range of data on F-class experience in other jurisdictions for the purpose of improving the accuracy of F-class rates.

C. Future Filing Dates

The AGO points out that rates effective July 1, 2025, as proposed in this Filing, will be in place for at least one year and perhaps for a second year. Because rates have recently been trending downward, they are concerned that rates approved for one year might be excessive in a second year and propose, as a remedy, that the Commissioner order the WCRIBMA to make another rate filing in November 2025 for rates to take effect on May 15, 2026.

As presented, the AGO's proposal is not limited to a decision on the frequency of WCRIBMA filings permitted by statute. For many years, workers' compensation rate filings have proposed July 1 as the effective date of a proposed rate change. Although M.G.L. c. 152,

[14] TR Vol. I at p16

§53A(7), the statute applicable to workers' compensation rate review, does not impose a filing date, it provides that, if the Commissioner does not issue a decision on those rates within six months of the selected filing date, the proposed rates will, in effect, be deemed approved. That approval, however, would not alter the effective date requested in the Filing. The AGO asserts that the Commissioner should exercise authority granted pursuant to §53A(8) to order a specific decrease in the existing rates to be effective on May 15, 2025, and order the WCRIBMA to make a second filing o November 15, 2025, for rates to be effective May 15, 2026. We have heard no persuasive argument supporting the AGO's proposal.

D. Underwriting Profits

In this Filing, the WCRIBMA again proposes to replace the long-standing standard methodology for calculating the Underwriting Profit Provision ("UPP") with the methodology disapproved in the Decision on the 2024 rates. For the reasons discussed below, they have not provided a sufficient basis to alter that decision. The goal of the UPP is to provide insurers with a fair and reasonable rate of return. As in previous years, the WCRIBMA relies on an Internal Rate of Return ("IRR") model to estimate its recommended UPP. IRR models incorporate a Discounted Cash Flow ("DCF") methodology that, in corporate and managerial finance, is widely relied on to make investment decisions. The IRR model starts with selecting a group of companies whose risks are representative of the entire regulated industry. The investment assets of these companies are then used to generate a sample portfolio from which certain factors such as leverage ratios, asset rate of return, and cost of capital are derived for inclusion in the rate calculation.

The parties to this proceeding do not oppose the use of an IRR model but their opinions differ on the various assumptions, factors, and inputs which the WCRIBMA uses to develop multiple components of that model. Historically, the methodology used industry-wide data for insurers writing casualty insurance measured in the aggregate.[15] The methodology presented uses inputs that weight data from insurers according to their Massachusetts workers' compensation net premiums when calculating cost of capital, asset rate of return and leverage ratio.[16]

[15] Ex. 1, at VII p1.
[16] Ex. 1, at VII p64.

In this filing, to calculate the underwriting profits provision, the WCRIBMA has applied a "premium weighting" to the IRR model that emphasizes companies based on the amount of worker's compensation premium they write in Massachusetts. Companies that do not write Massachusetts Worker's compensation premium are not included in the sample or any step of the calculation. In contrast, the method used by other states, the advisory filers, and by the WCRIBMA in past filings, uses an IRR model that draws upon industry aggregates as input data which, by their very nature, cannot be weighted.

As discussed above, the WCRIBMA must meet its burden to support all aspects of its filing in accordance with the SJC's holding in *1984*. For the UPP, this burden includes supporting the change away from previously reviewed methodology.[17] In its brief the WCRIBMA argues that the sample portfolio constructed in the standard model is "unacceptably unrepresentative" for use in Massachusetts rate making.[18] They contend that their premium weighting will be more accurate to Massachusetts insurers. Finally, they point to the Supreme Court case *Federal Power Commission v. Hope Natural Gas*, 320 U.S. 591 (1944), to demonstrate that their profit provision is reasonable.

The advisory filers agree that *Hope* is the case on point for analyzing return on equity and we find it useful to start the analysis there. In *Hope*, the US Supreme Court decided a challenge to an order limiting rates for a natural gas company under the Natural Gas Act.[19] The parties identify the statement in the Court's ruling that has, for decades, guided rate makings in similarly regulated industries; "…the return to the equity owner should be commensurate with returns on investments in other enterprises having corresponding risks."[20] Stated simply, if investors would anticipate higher returns on other investments with similar risks, they would not provide the capital necessary to fund the regulated entity.

This reveals the first problem with the premium weighting method; it does not provide the necessary comparison to other investments with similar risks. The SRB explains this in its

[17] Although, in some instances where events such as global pandemics have shifted the views of the reasonable observer, the opposite can be true. There, the burden is on the filer to support adherence to the old rather than adoption of the new. See *Att'y Gen. v. Comm'r of Ins.*, 370 Mass. 791, 798 (1976).
[18] WCRIBMA Brief at p 28.
[19] Hope 320 U.S. 601-603.
[20] *Hope*, 320 U.S. at 603 (explaining what is necessary to attract sufficient capital investment to sustain the regulated company).

discussion of cost of capital, also called opportunity cost. The return on investing in the Massachusetts Workers' Compensation market must be compared to investments in something other than the Massachusetts Workers' Compensation market. The standard method would compare the return on investing in the Massachusetts workers compensation industry to the return in investing in the national property casualty business, leveraged at the national rate, with an asset portfolio mix corresponding to that leverage and to that cost of capital. As a consequence of its operation, the premium weighting model limits its analysis to companies that have *already chosen to invest,* in effect, comparing their expected returns to only their own expected returns. It therefore excludes the very question the WCRIBMA asks us to examine in citing *Hope*: is the return comparable to similar *alternatives*? In limiting its model to exclude examination of alternatives, we can make no determination, and must conclude that, in this respect, the premium weighting method as presented fails to meet the burden described in the holding in *1984*.

Furthermore, when describing the differences between the sample portfolio created by the standard model and the premium weighting sample, the WCRIBMA does not explain what qualities make the standard sample unacceptable. The WCRIBMA implies that there is some essential difference between Massachusetts companies and the broader property and casualty industry, but they fail to demonstrate that assertion. As *Hope* lays out, risk is the factor by which capital investors evaluate companies.[21] Nowhere is it shown that the companies selected by the premium weighting model are subject to different risks from those included in the standard model. The WCRIBMA characterizes its approach as more representative of the insurers that are also the source of data on other facets of ratemaking, such as losses and expenses. This assertion is not a sufficient explanation to discount the use of the standard model's sample. Hope calls for a comparison to other enterprises having similar risks.[22] The WCRIBMA does not explain what risks make the broader property and casualty industry dissimilar to the Massachusetts worker's comp industry. In the absence of even a comparison of risks experienced by both groups, we cannot say that the WCRIBMA has met its burden of supporting this aspect of its filing.

[21] See *Hope*, 320 U.S. at 603.
[22] *Hope*, 320 U.S. at 603

Finally, the WCRIBMA makes no attempt to explain how their choice of premium weighting is related to the risks borne by capital. Indeed, it is likely impossible without confronting the flaw that prevents premium weighting from being a reasonable method on which to base rates. One of the major parameters of the premium weighting methodology, per company premium, rests largely within the discretion of the regulated entities. In the model, the premium weighting is applied on a *per company basis* to determine the asset mix and leverage ratio of its sample portfolio. Therefore, events totally divorced from risk, such as new market entrants, existing companies leaving the market, or mergers and changes of control, could alter the weighting of the entire model. If two companies writing Massachusetts workers' compensation premium merged, the model would produce a different asset mix and leverage ratio even if the entities' actual investment assets and total premium written remained identical. If this methodology were to be approved, companies would be pressured to alter their behavior not to address any risks they might be experiencing, but to address the methodology itself. For comparison, the standard methodology has no weighting, risk related or otherwise.

The WCRIBMA has not met its burden of submitting evidence to allow us to determine if their UPP calculation method would result in a rate that is not inadequate, excessive, or unfairly discriminatory. The filer has the burden to support every aspect of its filing, including a change from previously approved methods. We have previously rejected the premium weighting methodology as unsupported, and, despite new arguments, see no reason to change that decision. As the Supreme Court's stated in its ruling in *Hope*, the analysis turns on risk. The methodology fails to include the necessary comparison to returns on other investments of similar risks described in *Hope*. The argument for adopting premium weighting over the long-standing industry standard method fails to identify how the risks to companies writing Massachusetts workers' compensation premium differ from those of the broader property and casualty industry. Separately from the unpersuasive critique of the long-standing standard model, there is no evidence presented that per-company premium weighting is related to risk at all. As the filer has failed to meet its burden of providing us with sufficient information we cannot find that the rates determined by the Underwriting Profits Provision as presented would not be inadequate, excessive, or unfairly discriminatory in accordance with the holding of *1984*.

In closing, we note that it is not impossible for new methods of calculating the underwriting profit provision to be adopted. Indeed, the IRR model itself supplanted an earlier

methodology.[23] It is not unreasonable to think that analytical methods capable of providing demonstrably more accurate predictions of future financial rate indicators could be discovered. The adoption of those hypothetical methods for ratemaking would still require the showing that each new model answers the fundamental questions posed by *Hope* regarding comparative risk. That demonstration is absent in the methodology presented here.

IV. Cost Containment

Section XIV, volume 3 of the Filing, addresses cost containment; it contains documents submitted to support the WCRIBMA's burden to demonstrate that its member companies, as required by M.G.L. c. 152 §53A(13), "employ cost control programs and techniques acceptable to the commissioner which have had or are expected to have a substantial impact on fraudulent claim costs, unnecessary health care costs, and any other unreasonable costs and expenses, as well as on the collection of the appropriate premium charges owed to the insurers."

Since 1993, the cost containment section of the Filing has principally consisted of a survey developed by the WCRIBMA and sent to a representative group of its members; in 2024 it was sent to the ten largest NAIC insurer groups writing workers' compensation insurance in Massachusetts. Each company's response is submitted in Section XIV. The Filing also includes a report by Sharon Tennnyson, Ph.D., on Commission Allowances in Workers' Compensation Rates, the Workers' Compensation Advisory Council Annual Report for FY2023, the 2023 Annual Report of the Insurance Fraud Bureau of Massachusetts, two issues of its newsletter, "e-focusFraud" and a summary of its calendar year 2023 activities.

The cost containment survey requests information on three general areas: Claims, Premiums, and Expenses. In brief, the Claims section addresses cost control measures such as loss prevention and engineering programs, information on claims operations, including measures to control hospital and medical bills and to manage rehabilitation and return-to work programs, and asks specifically about programs and techniques to control fraud relating to claim costs and expenses. The Premiums section focuses on the company's programs and techniques to collect premiums due, identify premium fraud, and audit policies to ensure that it receives correct premium for the policy term. The Expense section requests information about the company's

[23] See SRB Brief at 17.

programs for controlling costs associated with a wide range of its business expenses utilizing, as a model for allocating those expenses, Part 1 of the Insurance Expense Exhibit that supplements annual statements that insurers file on forms prescribed by the NAIC.

As in its filing for 2024 rates, at the end of each section of the survey insurers were asked to identify and describe operational, technological or other changes that they employed during the COVID-19 pandemic, the extent to which those changes are still in place, and the impact that those changes had or are expected to have on controlling claim costs, collecting premiums, or controlling expenses.

Insurers' responses to that question as expected, uniformly report a shift during the pandemic to conducting business by virtual means. Those shifts affected many facets of their operations; in the area of claims processing, for example allowing oral approvals for medical procedures and adopting electronic communication systems that allowed earlier contacts between insurers, their insureds, and claimants. To that end, they also created templates that provided guidelines for reporting information relevant to those claims. Insurers also increased the use of telemedicine for handling claims.

Because insurers were unable to conduct onsite audits and visits to employer worksites in 2020, they adjusted their approaches to those operations, revising audit forms to make them more user-friendly for employers. When in person inspections of employers were not possible insurers allowed policyholders to video their operations, an approach that enabled the insurer's loss control experts to review the operations and recommend ways to improve the risk. Consistent with other business sectors, insurers in 2020 implemented work from home procedures that reduced their need for office space and shifted in-person meetings to virtual gatherings. Insurers noted that those changes affected matters such as travel expenses.

In the Filing for 2025 rates, insurers report that the investments in technology made five years ago successfully enabled them to maintain their level of pre-COVID business operations and simultaneously demonstrated that virtual methods can improve efficiency and save costs. For those reasons, they have retained and refined those technologies and developed protocols for identifying situations in which, for example, telemedicine may be inappropriate or an onsite audit is preferable.

The surveys uniformly acknowledge that adopting virtual means of communication has sped up claims reporting, enabled insurers to deliver services more quickly, and resulted in faster payments to claimants. To facilitate those results, insurers have developed standard templates for use by employers and claimants. Insurers also commented that the combination of technological advances and work from home polices created a flexible workforce that permitted employees to work remotely without interruption. Although hybrid work environments are now more common, digital capabilities remain the foundation for efficient claims handling.

During the pandemic companies began to conduct audits virtually; for some nearly exclusively. They developed reporting systems that enlarged the scope of information they received from employers, simplified forms for transmitting data, and expanded the use of video reporting. Post pandemic, companies have relied on that experience as a basis for developing hybrid audits and to guide decisions on when to conduct in-person audits. They uniformly recognize that more extensive reliance on virtual audits reduces expenses.

The pandemic generated a widespread shift by insurers from conducting business in an office environment to developing flexible working conditions that enabled employees to work from home. Most companies have now implemented hybrid work models that are appropriate for their operations. On an ongoing basis, they continue to evaluate their office space needs. The surveys also evidence an industrywide shift to conducting meetings virtually, thus saving travel costs, and to electronic communications with concurrent reductions in costs for office supplies and postal expenses.

On this record, we conclude that the Cost Containment section of the Filing is sufficient to support a finding that insurer cost control programs are effective.

V. Conclusion

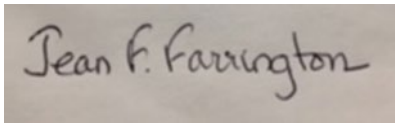
For the foregoing reasons we must disapprove the Filing. As noted, the purpose of this proceeding was to determine whether the rates presented in the Filing are not excessive, not inadequate, not discriminatory, and fall within a range of reasonableness. As the SJC explained in *1984*, the burden is on the filer to provide enough information for the Commissioner to make that determination. To understand whether the Filing contained the necessary support to enable the determination, we analyzed whether the methods used to calculate the proposed rate *could*

produce a result that fell within a range of reasonableness. For the reasons discussed above, for the elements of loss development and underwriting profits, we conclude they cannot. Any reasonable observer could see that the multi-year effect of the pandemic on loss data could not be captured in any possible two-year experience window. It is therefore unreasonable to continue using only two years of loss data for developing indemnity LDFs. For the underwriting profits provision, the premium weighting method fails to provide the necessary comparison to alternative investments as set out in Hope, does not present evidence that the sample in the long-standing method does not have commensurate risks, and does not demonstrate the link between premium weighting and risk to capital. It therefore fails both to meet its burden of providing enough information to enable the necessary determination on the proposed rates and the burden of supporting its adoption over other methods. Accordingly, we cannot determine, in accordance with *1984*, that the WCRIBMA's proposed rate is not excessive, inadequate, discriminatory, and falls within a range of reasonableness.

Having come to a conclusion under §53A(2), we must make a further determination under M.G.L. c. 152, §53A(8). That section states that if, after hearing, the Commissioner determines that a rate in effect is excessive, the Commissioner may order a specific decrease. No party has presented convincing evidence that the rate currently in effect is excessive. We therefore decline to order any specific decrease in rates under Section 53A(8). The rates currently in effect from the Decision on 2024 rates will remain in effect.

SO ORDERED

Matthew A. Taylor, Esq.
Presiding Officer



Jean F. Farrington, Esq.
Presiding Officer

AFFIRMED

Michael T. Caljouw
Commissioner of Insurance

May 15, 2025