Portland Airport Limousine Co., Inc., *d/b/a* PALCO AIR CARGO	]	
	]	
***v*.**	]	
	]	
MAINE EMPLOYERS' MUTUAL INSURANCE COMPANY, *et al*.	]	**ORDER ON CROSS-MOTIONS FOR SUMMARY ADJUDICATION**
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	]	
	]	
Docket NO. INS-04-109	]	
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This adjudicatory proceeding arises out of a petition filed with the Superintendent pursuant to 24 A M.R.S.A. §§ 229 and 2320(3) by Portland Airport Limousine Co., Inc., doing business as Palco Air Cargo, contending that it is being overcharged for workers' compensation insurance by the Maine Employers' Mutual Insurance Company ("MEMIC") because it has been inappropriately assigned to the high-risk program established pursuant to 24-A M.R.S.A. § 3714(7). For the reasons set forth below, I find that MEMIC's assignment of Palco to the high-risk program is appropriate unless Palco can prove that its loss reserves for the current rating period are demonstrably and materially excessive.

Issues to be Addressed in this Order

On March 29, pursuant to procedures agreed upon by the parties in prehearing conferences, the parties filed a stipulation of facts and jointly presented the following three contested issues of law for resolution by the Superintendent:[1]

1. Was MEMIC's assignment of Palco to the high-risk program under 24-A M.R.S.A. § 3714(7) inconsistent with the Superintendent's Decision and Order in *Palco II*?[2] If so, what shall the remedy be?
2. What does the statutory phrase "incurred loss" in 24-A M.R.S.A. § 3714(7) mean? Does it mean actual losses paid to the policy beginning date exclusive of budgeted, projected, or reserved losses? What does the statutory phrase "loss ratio" in 24-A M.R.S.A. § 3714(7) mean? Does it mean actual paid losses divided by actual premiums as opposed to budgeted, projected, or reserved losses divided by actual premium?
3. With regard to Palco's "incurred losses" as reported to MEMIC by the prior carrier, does MEMIC have a duty to examine those losses and determine that those reported losses are reasonable, and not arbitrary, capricious, or abusive, and is MEMIC required to adjust those reported losses by any subrogation recovery which has been made or is reasonably certain to be made?

Having reviewed the joint stipulations and the written arguments filed by the parties on April 5, I make the following conclusions of law, as applied to the stipulated facts:

Whether* Palco II *Prohibits Assignment to the High-Risk Program

MEMIC's high-risk program provides mandatory deductibles and premium surcharges for certain employers with adverse loss experience. Pursuant to 24-A M.R.S.A. § 3714(7)(A), "An employer must be placed in the high-risk program if the employer has at least 2 lost-time claims, each greater than $10,000 of incurred loss, and a loss ratio greater than 1.0 during the previous 3 year experience rating period.'

Palco contends, however, that even if it meets this description, it is exempt from placement in the high-risk program because "the Superintendent's prior Order in *[Palco II]*directed that Palco receive a recalculated experience modification factor *and no surcharge*." *(Emphasis in original)* This is the inconsistency alleged by Palco between MEMIC's action and the decision in *Palco II*.

Palco acknowledges that the respondent in *Palco II* was its previous insurer rather than MEMIC, but contends that the replacement of coverage should not be decisive. I agree with Palco that MEMIC should not be permitted to impose any rating adjustments that would have been prohibited if MEMIC had actually been a party to *Palco II*. However, assigning Palco to the high-risk program is not inherently inconsistent with the *Palco II* decision. Palco's claim that the decision prohibited all surcharges was inaccurate. The actual text of the order in question did not refer to surcharges in general, but specifically to the removal of a schedule rating surcharge that had previously been applied to Palco.

The *Palco II* proceeding arose out of the prior insurer's efforts to reclassify Palco's trucking operations from "Mail or Parcel Delivery" to "Local Hauling," which is subject to a higher premium rate. While the less expensive "Delivery" classification was in use, the insurer had imposed a surcharge under its schedule rating plan. Schedule rating is a program under which insurers may negotiate (or in some cases in the involuntary market may impose) discretionary surcharges or credits of up to 25% if the insurer determines, based on various possible reasons described in the rating plan, that a particular employer's classification and experience rating do not by themselves accurately measure the insurer's risk exposure. I served as the hearing officer in *Palco II*, and found that an on-site inspection demonstrated that the reclassification was appropriate, but I also found that "since Palco's experience modification and schedule rating were both based on the more favorable classification, the experience modification factor should be recalculated and the schedule rating debit should be removed."[3] Therefore, I ordered that the prior insurer could only reclassify Palco to a higher-risk classification for rating purposes "provided that as of the effective date of any reclassification, no schedule rating debit is applied."[4] *(Emphasis added)*

This order was narrow in scope, and was imposed for the limited purpose of making sure that in the transition to the new classification, Palco was not being charged twice for what were essentially the same risk factors, especially on a policy that was already in force at the time of the decision and had been negotiated on a different basis. The order did not alter the application of any nondiscretionary surcharges or credits in accordance with the terms of the insurer's rating plan. To the contrary, the order expressly required the use of an appropriate experience modification factor, even if that results in a surcharge, as it has for Palco's 2004–05 policy. Likewise, if Palco's loss experience is sufficient to define it as a high-risk employer, then Palco can and should be placed in the high-risk program. However, if Palco is assigned to the high-risk program, the resulting surcharges, if any, must be based on the expected losses for its current classification rather than the lower expected losses for its former classification, consistent with the corresponding adjustments ordered to its experience modification factor in *Palco II*.

The Meaning of "Incurred Loss"

Next, Palco argues that even if a surcharge may properly be imposed if it "has at least 2 lost-time claims, each greater than $10,000 of incurred loss, and a loss ratio greater than 1.0 during the previous 3-year experience rating period," MEMIC uses incorrect definitions of "incurred loss" and "loss ratio" for purposes of deciding whether an employer triggers the statutory criteria. The parties have stipulated that Palco has at least two lost-time claims with incurred losses in excess of $10,000, and have stipulated to the appropriate premium figure to be used as the denominator in calculating Palco's loss ratio, so the incurred loss figure to be used as the numerator in the loss ratio is the only material factual issue in controversy.

The issue arises because many workers' compensation claims result in payment for an extended period of time after the date of injury. In these cases, it is the policy that is in force on the date of injury that is responsible for the payments, not the policy in force at the time of payment. Therefore, when an injury occurs that is expected to require future payments, the insurer must recognize its best estimate of the total cost of the claim (known as the "reserve" for that claim) as a liability. MEMIC includes such reserves when calculating an employer's incurred losses, but Palco contends that this is erroneous, arguing as follows:

> The correct interpretation of the words "incurred loss" in the first sentence of 24 A M.R.S.A. § 3714(7) is "actual loss," not budgeted, projected, or reserved loss. The word "incurred" is in the past tense; it does not refer to amounts which may or may not be paid out in the future. It does not refer to projected future losses. The past is not the future.

That argument borders on the frivolous, because the term "incurred loss" has a settled and unambiguous meaning.[5] The distinction between "paid" and "incurred" losses is one of the most fundamental concepts of insurance accounting. A loss is incurred as soon as the event giving rise to the obligation has taken place. The phrase "incurred losses" is used to include both paid losses and reserves for future payments wherever that phrase appears in the Maine Insurance Code,[6] in the approved NCCI rating plans, and in the *National Association of Insurance Commissioners Accounting Practices and Procedures Manual* which the Superintendent is required to follow pursuant to 24-A M.R.S.A. § 901 A(1)(A).[7] Indeed, as discussed below, Bureau of Insurance Rule 450 expressly provides that a workers' compensation insurer has a duty to estimate an employer's incurred loss.

In essence, therefore, Palco is arguing that for public policy reasons, the use of the term "incurred loss" must be regarded as a drafting error and that the Legislature obviously meant to say "paid loss." The fallacy in Palco's argument is that just as a bill I pay on credit is every bit as "actual" as a bill I pay by cash, an insurer's obligation to make future payments on a claim is every bit as "actual" as the payments that have already been made. This is true even though the exact amount of those payments can only be estimated and must be re-evaluated from time to time. Indeed, 24 A M.R.S.A. § 2386, which recodifies the former Accident Prevention program on which the MEMIC high-risk program was based, expressly distinguishes between a particular employer's "actual incurred losses" and the "expected incurred losses" for an employer in the same rating classification.

Although paid loss figures are, as Palco observes, less open to dispute than reserves for future payments on incurred losses, the tradeoff is that paid losses are more objective but less relevant. For example, the criteria for assignment to the high-risk program look primarily to the severity of an employer's lost-time claims, and one of the major factors determining the severity of a claim is the length of time for which benefits are expected to be paid. Paid losses measured after one or two years cannot distinguish at all between a claim that pays indemnity benefits for thirty years and a claim where the employee recovered fully and returned to work two years after the date of injury. A variety of actuarial techniques can be used to convert paid loss data to more useful information. However, they are just as dependent on estimation as the methods to which Palco objects, they are better suited to aggregate data for large groups of employers than to measuring the experience of one mid-sized individual employer,[8] and they are not what the statute or the approved filings direct MEMIC to use.

In short, MEMIC acted correctly when it included reserves for open claims in calculating Palco's loss ratio.

Correction of Excessive Reserves

Next, Palco argues that even if it is proper for MEMIC to consider reserves on open claims in calculating an employer's incurred loss history for rating purposes, MEMIC has a legal duty to conduct its own independent review of all reserves reported by prior insurers. To the contrary, MEMIC participates in the uniform experience rating plan and uniform statistical plan as required by 24-A M.R.S.A. §§ 2382-D and 2384-C, and is not only permitted but required to use the incurred loss data from the uniform statistical plan for rating purposes.

If the reported reserve is inaccurate, it is the prior insurer, not the subsequent insurer, that has the responsibility for correcting it. This is appropriate, because when an employer changes carriers, the new carrier does not come in and take over the responsibility for servicing and paying open claims. It is the old carrier that has the necessary information, and uses that information when there are any further decisions to be made on the claim.

In general, the uniform statistical plan relies on the good faith business judgment of the personnel actually responsible for paying the claim. A limited exception is set forth in Bureau of Insurance Rule 450, Article I, § 4(A), which requires a corrected report if "the insured can demonstrate that the information used by the insurer in estimating the incurred loss was incorrect and the insurer knew or should have known at the time of the required valuation date that the information was incorrect." If the employer and the prior insurer cannot agree, the burden is on the employer to prove that the prior insurer's report is demonstrably incorrect. *See New Meadows Abatement v. MEMIC,* No. INS-99-16 (Me. Bur. Ins. May 1, 2000). While a dispute is pending or its resolution is in progress, the new insurer's duties are limited to forbearance in pursuing the collection of any portion of the premium that depends on the outcome of a request for correction in which the employer has a reasonable likelihood of prevailing.

It is premature to rule on the merits of any particular claim or establish definitive legal standards for any possible exception to the general rule that subrogation recoveries need not be credited against incurred loss until paid, because American Interstate Insurance Company, the prior carrier responsible for the claims in question, and the National Council on Compensation Insurance, Inc. ("NCCI"), the advisory organization designated by the Superintendent pursuant to 24 A M.R.S.A. §§ 2382 B(2) and 2382-C(5) to administer the uniform statistical plan and uniform experience rating plan, would be necessary parties to any dispute that might arise over a request for a corrected incurred loss report and should have an opportunity to speak to the questions presented.

Scope of the Dispute

At this point, with most of the legal issues resolved and some key factual issues stipulated, the question that remains is what relief might Palco still be entitled to and what would it have to prove in order to obtain that relief.

Since Palco has stipulated that it incurred at least two significant claims, and the stipulated earned premium for the subject rating period is $285,321, Palco belongs in the high-risk program if and only if its incurred losses for the same period are at least $285,321.01. Since the reported incurred losses are $395,089, Palco is entitled to reassignment out of the high-risk program if and only if it can prove that it is entitled to corrections to its case reserves that total at least $109,768.

If Palco is in the high-risk program, its premium surcharge is based on the ratio of incurred losses to the expected incurred losses for its (current) classification and loss history. The parties appear to have stipulated that the expected incurred losses are $189,409. If so, the maximum surcharge of 20% applies whenever the incurred losses exceed 1.5 × $189.409 = $284,113.50. Since this is less than the earned premium, this means that if Palco is in the high-risk program at all, the applicable premium surcharge will be 20%.

Finally, Palco is subject to the mandatory $1000 indemnity deductible if it is in the high-risk program and its "threshold loss ratio" exceeds 1.0; i.e., if its "limited losses" exceed its premium. The limited losses are calculated by discarding the difference between the largest single loss (currently evaluated at $179,986) and the earned premium for that year ($135,293), in cases where one or more single losses exceed earned premium. Thus, if Palco remains in the high-risk program, it is entitled to relief from the $1000 deductible (retroactive to the inception of the current policy) if and only if it can prove that it is entitled to corrections to its case reserves that would decrease its limited loss by at least $65,075.

Order

It is therefore *ORDERED* that:

1. As to Palco's claims that it is categorically exempt from assignment to the high-risk program and that MEMIC may not include estimated future claim payments in calculating Palco's "incurred loss" for rating purposes, the Petition is *DENIED*.

2. As to Palco's claim that MEMIC must conduct an independent review of the loss reserves established by Palco's prior insurers, the Petition is *DENIED* except to the extent that MEMIC shall not require payment of the disputed surcharge before May 15, 2005, and shall defer its collection efforts beyond that date if Palco has by that time provided MEMIC with credible evidence that American Interstate's reserves for Palco claims are demonstrably erroneous by a net amount of at least $109,768 and that Palco has been diligently pursuing a request for corrective action by American Interstate.
3. Nothing in this Order shall be construed as requiring MEMIC to revise its billing unless and until NCCI has revised the underlying loss data, nor as requiring MEMIC to defer its collection efforts indefinitely if Palco initially qualifies for relief under Paragraph 2 but subsequently ceases to pursue its request for corrective action or it becomes apparent that its request for corrective action is unlikely to prevail.
4. The parties shall advise the Superintendent as soon as reasonably possible whether
    1. the matter has been resolved;
    2. further proceedings are required, and if so, whether American Interstate must be joined as a party; or
    3. this Order is dispositive of the merits of the proceeding but is contested and should be reissued as an appealable final agency action.

This Order is an interlocutory order and is not final agency action. The Superintendent retains jurisdiction over this matter and will hold a hearing or other appropriate proceeding if requested by any party consistent with the terms of this Order.

[1] Pursuant to 24-A M.R.S.A. § 210, the Superintendent has appointed Bureau of Insurance Attorney Robert Alan Wake to serve as hearing officer, with full decisionmaking authority.

[2] *Palco Air Cargo v. American Interstate Insurance Co.*, No. INS-04-102 (Me. Bur. Ins., July 15, 2004).

[3] *Palco II* at page 10.

[4] *Palco II* at page 11, paragraph 3.

[5] Unfortunately, this actually makes the argument harder rather than easier to refute definitively, since we are dealing with fundamental terminology. Any insurance glossary or dictionary will define the distinction between paid and incurred losses in a manner consistent with this Order, but Palco could plausibly argue that few if any legislators are in the habit of reading insurance dictionaries. One could take a passage of writing and substitute the word "dog" for the word "cat" wherever it occurs, and the result would still be syntactically correct and in many cases would even make sense. Nevertheless, the distinction between cats and dogs is what it is, and so is the distinction between incurred losses and paid losses.

[6] As discussed in Note 5, *supra*, many of these references presume some basic understanding of what incurred losses are, and therefore do not actually resolve the question raised by Palco. However, there are a number of passages in the Insurance Code in which "incurred" could not possibly mean "paid," including but

not limited to 24-A M.R.S.A. §§ 750(3), 784(4)(L)(1)(b), 1495(2), 2304 C(1), 4134(5), 4204(4), and 6707(3).

[7] SSAP 55.

[8] It is not clear exactly what Palco means when it proposes redefining incurred loss ratio to mean the ratio of the amount "actually paid out" to actual premiums. Does it mean the losses on the same policies, in which case three years is far too short a period for the losses to possibly "'even out' any actual premium and actual payment variations"? Or does Palco simply mean a calendar year paid loss ratio, in which the losses paid on old policies are being compared to the premiums collected on the current policy? Aside from the vocabulary problem that the statute says "incurred loss ratio," which is something completely different, the use of calendar year paid loss ratios could doom employers with a single catastrophic incident to high experience modifications and high-risk surcharges far beyond the statutory limits on considering old claims for rating purposes, and would also give insurers a strong disincentive to settle claims.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

APRIL 14, 2005

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ROBERT ALAN WAKE
DESIGNATED HEARING OFFICER