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BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of the Appeal of

5 DIAMOND PROTECTION, INC.,

Appellant,

From the Decision of the

CALIFORNIA INSURANCE COMPANY,

Respondent.

File AHB-WCA-18-06

ORDER ADOPTING PROPOSED DECISION

This matter came for hearing before the Department's Administrative Hearing Bureau, on July 23, 2018, and the record was closed on October 8, 2018.

Administrative Law Judge Clarke de Maigret submitted his Proposed Decision on December 13, 2018, and recommended its adoption as the decision of the Insurance Commissioner, which the Commissioner then considered.

Now, therefore, pursuant to the provisions of California Insurance Code section 11737(f), and California Code of Regulations, Title 10, section 2509.69, IT IS SO ORDERED that the attached Proposed Decision is hereby adopted by the Insurance Commissioner as his Decision in the above-entitled matter.

This Decision shall become effective 30 days after it is delivered or mailed to the parties

unless reconsideration is ordered within that time.

DATED: February 8, 2019

RICARDO LARA
Insurance Commissioner

By: _____
GEOFFREY F. MARGOLIS
Deputy Commissioner & Special Counsel

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PROPOSED DECISION

Appellant 5 Diamond Protection, Inc. appeals Respondent California Insurance Company's decision to increase a premium multiplier in Appellant's workers' compensation policy. Appellant argues that the higher multiplier, known as the "Loss Rating Factor," unlawfully eliminated a premium reduction Respondent owed Appellant. Respondent stands behind its charges and argues it does not use the Loss Rating Factor to determine premium. Instead, Respondent contends it properly determined Appellant's premium using a lawful rating system called the "Loss Rating Plan," which does not include the Loss Rating Factor.

For the reasons discussed below, the Administrative Law Judge ("ALJ") finds that

Respondent employed both the Loss Rating Factor and the Loss Rating Plan to determine Appellant's premiums. Appellant's use of the Loss Rating Factor and Loss Rating Plan violated Insurance Code sections 11734 and 11735 and misapplied the rates Respondent filed with the Insurance Commissioner ("Commissioner"). Accordingly, Respondent must recalculate Appellant's premium without applying either the Loss Rating Factor or Loss Rating Plan.

Issues Presented

1. Did Respondent's application of the Loss Rating Factor to Appellant's workers' compensation policy during the policy period beginning June 8, 2017 (the "Policy Period") result in a misapplication of Respondent's filings under Insurance Code section 11735?

2. If so, what is the appropriate remedy?

Procedural History

This appeal arises under Insurance Code section 11737, subdivision (f).[1] Appellant initiated the proceedings on February 8, 2018, by filing an appeal from Respondent's December 14, 2017, rejection of Appellant's complaint and request for action concerning the Loss Rating Factor and Appellant's workers' compensation insurance. The California Department of Insurance ("CDI") Administrative Hearing Bureau issued an Appeal Inception Notice on February 13, 2018. After the ALJ granted a filing extension, Respondent submitted a response on March 13, 2018.[2]

[1] Section 11737, subdivision (f), provides, in relevant part: "Every insurer … shall provide within this state reasonable means whereby any person aggrieved by the application of its filings may be heard by the insurer … on written request to review the manner in which the rating system has been applied in connection with the insurance afforded or offered. … Any party affected by the action of the insurer … on the request may appeal … to the commissioner, who after a hearing … may affirm, modify, or reverse that action." Additionally, these proceedings were conducted in accordance with California Code of Regulations, title 10, sections 2509.40 et seq., and the administrative adjudication provisions of the California Administrative Procedure Act referenced in section 2509.57 of the regulations.

[2] The Workers Compensation Insurance Rating Bureau of California ("WCIRB") also filed a response on February 23, 2018, electing not to actively participate in this appeal.

On July 23, 2018, the ALJ conducted an evidentiary hearing in CDI's Los Angeles Hearing Room. Nicholas R. Andrea, Esq. of Robertson & Associates, APC represented Appellant. Amanda L. Morgan, Esq. and Joseph S. Alonzo, Esq.[3] of DLA Piper LLP (US) and Jeffrey A. Silver, Esq.[4] represented Respondent.

Andrea Todd, an account executive at Orion Risk Management, and Mohammed Sayed, Appellant's former owner, testified for Appellant. Todd Michael Brown, Respondent's director of underwriting, testified for Respondent. The evidentiary record includes the foregoing testimony and the pre-filed documents admitted in evidence, as identified on the parties' exhibit lists. The record also includes Exhibits 205 and 207, which Respondent introduced at the hearing, and ALJ Exhibit 9, which Respondent submitted after the hearing at the ALJ's request.[5]

After post-hearing briefing, the ALJ closed the evidentiary record on October 8, 2018.

Findings of Fact

The ALJ makes the following factual findings based on a preponderance of the evidence in the record:

I. Appellant's Business

Appellant 5 Diamond Protection, Inc. is a California corporation founded in 2008 or 2009.[6] Originally based in Santa Ana, California, Appellant provided security services to bars, nightclubs and hotels.[7] In late 2017 or early 2018, Appellant ceased active operations due to financial difficulties.[8]

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[3] Not admitted in California. (See Cal. Code Regs., tit. 10, § 2509.52.)
[4] Not admitted in California. (See *ibid.*)
[5] The following exhibits were admitted in evidence: Exhibits 1 through 5, 7 through 9, 100 through 103, and 200 through 207.
[6] Transcript of Proceedings of July 23, 2018 ("Tr.") at p. 93:12-20.
[7] Tr. at pp. 76:24-77:6.
[8] Tr. at pp. 90:5-10, 93:21-24.

II. Appellant's Insurance Policy

Before 2016, Appellant obtained workers' compensation insurance from State Compensation Insurance Fund.[9] In June 2016, Appellant purchased coverage from Respondent.[10] In May 2017, Appellant's broker presented Respondent's renewal quote proposal for the Policy Period (the "Proposal").[11] Appellant accepted the Proposal, and Respondent issued a renewal policy for the Policy Period, effective June 8, 2017.[12] Appellant ceased premium payments a few months thereafter because of its financial difficulties.[13] As a result, Respondent cancelled Appellant's policy, effective January 9, 2018.[14]

III. Premium Calculation

Respondent calculated Appellant's Policy Period premium using rates developed under Respondent's rating system known as the Loss Rating Plan.[15] However, Respondent did not include the Loss Rating Plan's rates in Appellant's policy.[16] Rather, the policy set out other rates, which Respondent had filed with the Commissioner. The policy modified the filed rates so that the resulting premium was as if the policy had used the Loss Rating Plan's rates.

A. Respondent's Loss Rating Plan and Model

Respondent filed a cursory description of the Loss Rating Plan with the Commissioner.[17] The description includes an example illustrating with fictitious data how Respondent calculates

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[9] Evidentiary hearing exhibit ("Exh.") 204 at p. 204-1.
[10] Tr. at p. 33:19-20; Exh. 204. Respondent is a member of the Applied Underwriters group of companies. (Exh. 2 at p. 2-3) Throughout the record, the witness and evidence frequently refer to Respondent as "Applied Underwriters" or "Applied."
[11] Tr. at p. 55:8-14; Exh. 2.
[12] Exhs. 100, 205. Exhibit 100 sets forth the estimated premium at the Policy Period's commencement. (Tr. at pp. 8:24-10:16.) Exhibit 205 sets out the earned premium that was calculated based on Appellant's actual payroll after Respondent terminated the policy. (Tr. at p. 145:7-12.)
[13] Tr. at p. 108:2-6.
[14] Tr. at p. 107:20-23; Exh. 205 at p. 205-1.
[15] Tr. at p. 116:6-7.
[16] Exh. 100, 205
[17] Exhs. 4, 5.

insurance rates under the plan's pricing model.[18] The model employs four different methods to calculate a rate.[19] Three methods are specific to the insured's particular risks. The remaining method considers risks generally applicable to the insured's industry.[20] Respondent charges the insured a rate based on a weighted average of the four methods.[21] Respondent does not file the Loss Rating Plan's rates with the Commissioner.[22]

The three methods specific to the insured's particular risks calculate rates using the insured's loss experience and aggregate historical losses of other policyholders in the insured's industry.[23] Loss experience refers the number and type of workers' compensation claims the insured has experienced in relation to its payroll, as well as the losses and expenses incurred under those claims.[24] The Loss Rating Plan model analyzes the type, frequency and severity of incurred and paid losses.[25] The model considers the insured's loss experience for a 60-month period before the policy takes effect.[26] The Loss Rating Plan further specifies that Respondent's underwriters must evaluate the insured's loss experience within 90 days before the policy's effective date.[27]

The Loss Rating Plan's filed description does not provide sufficient information to calculate an insured's rates from its loss experience and payroll data.[28] For instance, the filings show that the Loss Rating Plan uses a "Medical Only Claim Development Factor," an "Indemnity Claim Development Factor," and a "Medical Only Loss Development Factor" to

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[18] *Ibid.*
[19] Tr. at p. 113:17-20; Exh. 5 at p. 5-16.
[20] Tr. at p. 113:19-21; Exh. 5 at p. 5-16.
[21] Tr. at p. 113:21-22; Exh. 5 at p. 5-16.
[22] Tr. at p. 136:22-25.
[23] Tr. at p. 113:10-12; Exh. 5 at p. 5-16; Exh. 9 at p. 9-2.
[24] See Exh. 102 at p. 102-2. Throughout this Proposed Decision, all preceding 0's are omitted from exhibit page references. For example, "p. 102-2" refers to the page of Exhibit 102 marked as "102-02."
[25] Exh. 5 at p. 5-16.
[26] Exh. 5 at p. 5-15.
[27] *Ibid.*
[28] See Exhs. 4, 5, 9.

calculate insureds' rates.[29] However, the filings do not describe those factors, state how they are derived, or indicate their values for actual insureds.[30] Instead, Respondent determines those factors by performing actuarial calculations on aggregate historical data that is not publicly available.[31] Respondent has not filed the aggregate data or formulas for those calculations with the Commissioner.[32]

B. Actual Premium Calculation under the Policy

Although Respondent calculates insureds' rates using the Loss Rating Plan model, Respondent does not directly apply those rates to its policies.[33] Instead, Respondent applies its standard filed rates to an insured's payroll to arrive at a base premium (see subpart 1 below).[34] Respondent then multiplies the base premium by the insured's "experience modification" (see subpart 2 below) to arrive at an experience-modified premium.[35] Finally, Respondent multiplies the experience-modified premium by the Loss Rating Factor (see subpart 3 below) to arrive at the premium that would be obtained by multiplying the Loss Rating Plan rates with the insured's payroll.[36]

These calculations can be expressed by the following pair of formulas:

1. filed rates x (payroll ÷ 100) x experience modification
   = experience-modified premium[37]

2. experience-modified premium x Loss Rating Factor
   = Loss Rating Plan premium

In other words, the Loss Rating Factor simply bridges any difference between the

[29] Exh. 5 at p. 5-16; Exh. 9 at pp. 9-1, 9-2.
[30] See Exhs. 4, 5.
[31] Exh. 9 at p. 9-2.
[32] See Exhs. 4, 5.
[33] See Exhs. 100, 205.
[34] Tr. at pp. 133:5-135:7; Exh. 8; Exh. 100 at p. 100-3; Exh. 205 at p. 205-3.
[35] Exh. 8; Exh. 100 at p. 100-3; Exh. 205 at p. 205-3.
[36] Exh. 8; Exh. 100 at p. 100-3; Exh. 205 at p. 205-3.
[37] The payroll is divided by 100 because rates are charged per $100 of payroll.

experience-modified premium, which Respondent calculates using its filed rates and the insured's experience modification, and the premium Respondent calculates using the Loss Rating Plan model. The three premium components other than payroll—*i.e.*, rates, experience modification and Loss Rating Factor—are discussed in detail below.[38]

1. Rates

Like other California workers' compensation insurers, Respondent files with the Commissioner rates that Respondent uses to calculate premium under its policies.[39] Different rates generally apply to each of the approximately 500 occupation, employment and industry classifications designated in the California Workers' Compensation Uniform Statistical Reporting Plan—1995 ("USRP").[40] Appellant's policy assigned three of those classifications to Appellant during the Policy Period: Classification Code 7721 (Detective or Private Investigative Agencies), Classification Code 8742 (Salespersons-outside) and Classification Code 8810 (Clerical Office Employees-not otherwise classified).[41] The policy applied rates of $8.91, $0.86 and $0.67 per $100 of payroll, respectively, to those classifications.[42] Respondent filed those rates with the Commissioner.[43]

Respondent used its filed rates in Appellant's policy to estimate base premium, as follows:[44]

Classification:	Filed Rate	x	Estimated Payroll ÷ 100	=	Estimated Base Premium
7721	$8.91		$2,000,000 ÷ 100		$178,200
8742	$0.86		$100,000 ÷ 100		$860
8810	$0.67		$250,000 ÷ 100		$1,675
			Total Estimated Base Premium:		**$180,735**

[38] Appellant's charges also include an early cancellation (or "short rate") penalty and state-mandated surcharges, which are omitted from this discussion because they are not at issue in this appeal. (Exh. 205 at p. 205-3.)
[39] Tr. at pp. 133:21-135:7.
[40] Cal. Code Regs., tit. 10, § 2318.6. The USRP constitutes part of the Commissioner's regulations. All references to the USRP in this Proposed Decision are to the version that took effect on January 1, 2017.
[41] Exh. 100 at p. 100-3; Exh. 205 at p. 205-3.
[42] Exh. 100 at p. 100-3; Exh. 205 at p. 205-3.
[43] Tr. at pp. 133:11-135:7.
[44] Exh. 100 at p. 100-3.

However, Respondent calculated and charged different rates under the Loss Rating Plan model. Specifically, Respondent calculated Loss Rating Plan rates of $13.80, $1.33, and $1.04 for Classification Codes 7721, 8741 and 8810, respectively.[45] Respondent's Proposal uses those rates to estimate Appellant's base premium for the Policy Period as follows:[46]

Classification:	Loss Rating Plan Rate	x	Estimated Payroll ÷ 100	=	Estimated Base Premium
7721	$13.80		$2,000,000 ÷ 100		$275,939
8742	$1.33		$100,000 ÷ 100		$1,330
8810	$1.04		$250,000 ÷ 100		$2,599
			Total Estimated Base Premium:		**$279,868**

Although Appellant's policy does not mention the Loss Rating Plan rates,[47] Respondent used those rates to calculate the policy's Loss Rating Factor and thereby determine Appellant's final premium (see subpart 3 below).

2. Experience Modification

The WCIRB serves as the Commissioner's insurance rating organization.[48] Among its other functions, the WCIRB calculates insureds' "experience modifications" or "ex-mods."[49] It does so by comparing the insured's loss experience to that of other businesses in the insured's industry classification.[50] If the insured's loss experience is worse than expected for businesses of similar size within the same industry classification, the WCIRB assigns the insured an experience modification greater than 100%. If the insured's loss experience is better than expected for its size and industry, it receives an experience modification less than 100%.[51] An experience modification above 100% increases the insured's premium, while a level below 100%

[45] Tr. at pp. 135:12-136:25; Exh. 2 at p. 2-4. Respondent refers to these rates in the Proposal and testimony as "net rates."
[46] Exh. 2 at p. 2-4.
[47] See Exhs. 100, 205.
[48] See Ins. Code, § 11750.3.
[49] See Exh. 102 at p. 102-2.
[50] *Ibid.*
[51] *Ibid.*

reduces premium.[52] This system provides employers a direct financial incentive to reduce the number of work-related accidents.[53] It also helps to objectively distribute the cost of workers' compensation insurance among employers in the same industry.[54]

The data used to calculate an insured's experience modification is determined by the insured's "anniversary rating date," which is typically the inception date of the insured's policy.[55] The anniversary rating date determines the "experience period," which is a three-year period starting four years and nine months before the anniversary rating date and ending one year and nine months before that date.[56] With few exceptions, the WCIRB uses the insured's payroll and losses arising from all policies incepting within the experience period to calculate the insured's experience modification.[57]

Appellant's policy summarizes the experience modification system as follows:

> We [Respondent] must adhere to a single, uniform experience rating plan. If you [the insured] are eligible for experience rating under the plan, *we will be required to adjust your premium to reflect your claim history*. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan, which is developed by the insurance commissioner, is subject to approval by the insurance commissioner.[58]

On March 7, 2017, the WCIRB issued an Experience Rating Form stating that Appellant's experience modification was 163%, effective June 8, 2017 (the Policy Period's

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[52] For example, a 105% experience modification increases premium five percent, and a 95% experience modification reduces premium five percent. The experience modification may be expressed either as a percentage or as a coefficient (e.g., a "neutral" experience modification may be written either as "100%" or as "1.00").
[53] Exh. 102 at p. 102-2.
[54] *Ibid.*
[55] *Ibid.*
[56] *Ibid.*
[57] *Ibid.*
[58] Exh. 100 at p. 100-17; Exh. 205 at p. 205-18, emphasis added.

commencement).[59] On August 16, 2017, the WCIRB issued a corrected Experience Rating Form that retroactively reduced Appellant's experience modification to 106% as of the Policy Period's commencement.[60] This favorable reduction resulted from incorporating previously omitted 2015 payroll data in the experience modification calculations.[61] That data was omitted because it had not been audited in time for the WCIRB's original assessment.[62]

At the outset of the Policy Period, the policy applied Appellant's 163% experience modification.[63] After the WCIRB revised the experience modification to 106%, Respondent endorsed the policy to reflect the new experience modification, retroactively effective as of the Policy Period's commencement.[64] The revision reduced Appellant's estimated experience-modified premium by more than $103,000, as illustrated in the following table:[65]

Estimated Base Premium	x Experience Modification	= Estimated Experience-modified Premium
$180,735	163%	$294,598
	106%	$191,579

However, as discussed below, Respondent used the Loss Rating Factor to eliminate that premium reduction.

The policy applied Appellant's experience modification to base premium derived from Respondent's filed rates.[66] Respondent did not apply the experience modification to base premium calculated under the Loss Rating Plan.[67] The experience modification is not part of the

[59] Exh. 103.
[60] Exh. 102.
[61] Tr. at pp. 117:6-118:20 [Note that Exhibit 103 and Exhibit 200 are identical.]; Exh. 102 at p. 102-1, fn. 1; Exh. 103 at p. 103-1, fn. 1.
[62] Exh. 103 at p. 103-1, fn 1.
[63] Exh. 100 at p. 100-3.
[64] Exh. 202; Exh. 205 at p. 205-3.
[65] Exhs. 100, 205. For clarity of illustration, this table uses estimated premium. Exhibit 100, which applies the 163% experience modification, indicates estimated premium based on estimated payroll. Exhibit 205, which applies the 106% experience modification, indicates earned premium based on purported actual payroll. Appellant disputes the accuracy of Exhibit 205's payroll figures (Tr. at p. 101:9-25), and the ALJ makes no finding as to their accuracy.
[66] Exh. 100 at p. 100-3; Exh. 205 at p. 205-3.
[67] Tr. at pp. 118:18-20.

Loss Rating Plan model.[68]

3. Loss Rating Factor

Appellant's policy applies a Loss Rating Factor that increased Appellant's final premium by $182,157.[69] Respondent uses the Loss Rating Factor to eliminate any difference between an insured's experience-modified premium and its premium under the Loss Rating Plan model. Respondent calculates the Loss Rating Factor using either of the following equivalent formulas:[70]

1. Loss Rating Factor = Loss Rating Plan premium ÷ experience-modified premium
2. Loss Rating Factor = Loss Rating Plan rate ÷ (filed rate x experience modification)

The result is that the Loss Rating Plan rates and the Loss Rating Plan premium remain constant during the policy year, irrespective of whether the insured's experience modification changes.[71] Respondent simply adjusts the Loss Rating Factor to counteract the changed experience modification, so that the product of the filed rate, the experience modification and the Loss Rating Factor always equals the Loss Rating Plan rate.[72] For example, when Appellant's experience modification changed from 1.63 to 1.06, Respondent increased the Loss Rating Factor from 0.95 to 1.46.[73] As a result, the product of Appellant's experience modification and the Loss Rating Factor remained constant at 1.55[74] and Appellant's estimated Loss Rating Plan premium also remained unchanged at $279,868.[75] In other words, Appellant's Loss Rating Plan rates equaled Respondent's filed rates times a substantially worse-than-average experience modification of 155%, rather than Appellant's actual 106% experience modification. The table

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[68] Tr. at p. 116:6-9.
[69] Exh. 205 at p. 205-3.
[70] Exh. 8. The second formula omits the payroll components of premium, which divide out of the first formula.
[71] Tr. at pp. 137:1-141:24.
[72] *Ibid.*
[73] Exh. 202.
[74] I.e., 1.63 x 0.95 = 1.06 x 1.46 = 1.55 (rounded to the second decimal place).
[75] Exh. 2 at p. 2-4; Exh. 100 at p. 100-3; Exh. 202.

below illustrates this scheme with Appellant's policy data:[76]

Classification Code:	Filed Rate	x Experience Modification	x Loss Rating Factor	= Loss Rating Plan Rate
7721	$8.91	1.63	0.95	$13.80
		1.06	1.46	
8742	$0.86	1.63	0.95	$1.33
		1.06	1.46	
8810	$0.67	1.63	0.95	$1.04
		1.06	1.46	

Respondent has not filed any description of the Loss Rating Factor or its effects with the Commissioner.[77] In addition, none of Respondent's Loss Rating Plan filings indicate that an insured's premiums will be unaffected by a mid-policy period change to the experience modification.[78]

Discussion

I. Respondent's Use of the Loss Rating Plan and Loss Rating Factor Violated Insurance Code Section 11735's Filing Requirements and Misapplied Respondent's Filed Rates.

Appellant argues that Respondent failed to file the Loss Rating Factor as required by Insurance Code section 11735, subdivision (a).[79] Appellant further argues that Respondent's use of the unfiled Loss Rating Factor misapplied the filed rates in Appellant's policy.[80] Respondent argues that it was not required to file the Loss Rating Factor.[81] Respondent also contends that the Loss Rating factor did not affect Appellant's premium.[82] The ALJ finds Appellant's arguments persuasive and rejects Respondent's contentions.

A. Regulatory Framework and Applicable Law

Workers' compensation is a comprehensive benefits system that balances the interests of

[76] Exhs. 100, 202, 205.
[77] See Exhs. 4, 5.
[78] See *ibid.*
[79] Appellant's Post-Trial [sic] Brief, filed August 23, 2018 ("App. Post-Hearing Br."), at pp. 5:3-7, 5:22-7:8.
[80] *Id.* at p. 7:3-8
[81] Respondent's Post-Hearing Brief, filed August 22, 2018 ("Resp. Post-Hearing Br."), at p. 1:12-20.
[82] *Id.* at p. 2:2-3.

workers and their employers. Workers receive timely compensation for employment-related injuries but are generally barred from suing their employers. Employers receive protection from lawsuits but must provide benefits regardless of fault.[83]

California has an "open rating" workers' compensation regulatory system, in which each insurer determines its own rates, subject to certain restrictions.[84] Since workers' compensation insurance is mandatory for most California employers, the Legislature charged the Commissioner with closely scrutinizing all insurance plans to protect both workers and their employers.[85] To assist the Commissioner in carrying out this responsibility and to support employers seeking affordable coverage, the Insurance Code mandates that insurers publicly file all rate information used to set workers' compensation insurance premiums.[86] This framework is intended to curtail monopolistic and discriminatory pricing practices, ensure carriers charge rates adequate to cover their losses and expenses, and provide public access to rate information so that employers may find coverage at affordable rates.[87]

Insurance Code section 11735 lays out the statutory filing requirements. Subdivision (a) provides in part that "[e]very insurer shall file with the commissioner all rates and supplementary rate information that are to be used in this state. The rates and supplementary rate information shall be filed not later than 30 days prior to the effective date." The term "rate" means "the cost of insurance per exposure base unit," subject to certain limitations.[88] And "supplementary rate information" means "any manual or plan of rates, classification system, rating schedule, minimum premium, policy fee, rating rule, rating plan, and any other similar *information needed*

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[83] See 2 Witkin, Summary Cal. Law 11th, Workers' Compensation, § 1 (2018).
[84] See Ins. Code, §§ 11730-11742.
[85] *Nielsen Contracting, Inc. v. Applied Underwriters, Inc.* (2018) 22 Cal.App.5th 1096, 1118.
[86] Ins. Code, § 11735.
[87] Ins. Code, §§ 11730-11742.
[88] Ins. Code, § 11730, subd. (g). Rates exclude the application of individual risk variations based on loss or expense considerations, as well as minimum premiums.

to determine the applicable premium for an insured."[89]

The Commissioner and courts construe "premium" broadly to include any amounts paid to insurers for coverage.[90] "[M]oney paid by an insured to an insurer for coverage constitutes premium regardless of its name."[91] Thus, any information necessary to determine amounts owed by an insured to its insurer is supplementary rate information. As such, it must be filed under Insurance Code section 11735, subdivision (a), and remain open to public inspection under subdivision (b).[92]

Insurers may charge premium only in accordance with their filed rates and supplementary rate information.[93] As the Commissioner determined in his precedential decision *In the Matter of the Appeal of Shasta Linen Supply, Inc.*, an insurer's use of unfiled rates or supplementary rate information is unlawful.[94] That is true regardless of whether the Commissioner first disapproved the unfiled rates under Insurance Code section 11737.[95]

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[89] Ins. Code, § 11730, subd. (j), emphasis added.
[90] *In the Matter of the Appeal of Shasta Linen Supply, Inc.* (Cal. Ins. Comm'r, June 20, 2016, AHB-WCA-14-31) (*Shasta Linen*), at pp. 48-49; *Troyk v. Farmers Group Inc.* (2009) 171 Cal.App.4th 1305, 1325 ["[I]nsurance premium includes not only the 'net premium,' or actuarial cost of the risk covered (i.e., expected amount of claims payments), but also the direct and indirect costs associated with providing that insurance coverage and any profit or additional assessment charged (e.g., 'loading')."].
[91] *Shasta Linen, supra,* at pp. 48-49.
[92] Insurance Code section 11737, subdivision (b), provides in relevant part: "All rates, supplementary rate information, and any supporting information for rates filed under this article, as soon as filed, shall be open to public inspection at any reasonable time."
[93] Ins. Code, § 11730, subd. (j); Ins. Code, § 11735, subd. (a).
[94] *Shasta Linen, supra,* at p. 52. *Shasta Linen* was designated precedential under Government Code section 11425.60, subdivision (b).
[95] See *id.* at pp. 45, 52.

B. Analysis

1. The Loss Rating Plan and Loss Rating Factor Are Based on Unfiled Supplementary Rate Information in Violation of Insurance Code Section 11735.

The Loss Rating Plan includes unfiled supplementary rate information.[96] For instance, the plan's model uses a "Medical Only Claim Development Factor," an "Indemnity Claim Development Factor," and a "Medical Only Loss Development Factor" to calculate insureds' rates.[97] The pricing example that Respondent filed with the Commissioner shows it would be impossible to calculate an insured's rates—and therefore its premiums—under the Loss Rating Plan without knowing those factors' values.[98] Respondent determines those values by performing actuarial calculations on aggregate historical data that is not publicly available.[99] Because those calculations' formulas and non-public data are key components of the rate calculation, they constitute "information needed to determine the applicable premium for an insured[,]" thereby satisfying the Insurance Code's definition of "supplementary rate information."[100] If Respondent wished to calculate policyholder rates using that supplementary rate information, Respondent was required to file it and allow it to be open to public inspection under Insurance Code section 11735. However, Respondent did not file that information.[101]

Respondent also failed to file the Loss Rating Factor, as required by section 11735.[102] Respondent argues that "the Loss Rating Factor does not determine the final premium charged to

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[96] The ALJ notes that rates derived under the Loss Rating Plan model involve the "application of individual risk variations based on loss or expense considerations" and thus do not meet Insurance Code section 11730's definition of "rates."
[97] Exh. 5 at p. 5-16; Exh. 9 at pp. 9-1, 9-2.
[98] Exh. 5 at p. 5-16.
[99] Exh. 9.
[100] See Ins. Code, § 11730, subd. (j).
[101] See Exhs. 4, 5.
[102] Tr. at p. 140:14-17; Exhs. 4, 5.

the insured" and therefore is not supplementary rate information.[103] That is plainly wrong. Appellant's policy contains a line item entitled "Loss Rating Factor" that increases Appellant's final premium by over $182,000.[104] Thus, the Loss Rating Factor is unquestionably information needed to determine premium, satisfying the "supplementary rate information" definition.[105]

Respondent also argues that "the Loss Rating Factor . . . is not included in the Loss Rating [Plan] Model."[106] While that may be true, it is beside the point. The Loss Rating Factor constitutes supplementary rate information, not because it is included in the model, but because it modifies Respondent's filed rates.[107] As previously noted, Appellant's policy does not apply Loss Rating Plan rates directly.[108] It instead calculates experience-modified premium using Respondent's filed rates and Appellant's experience modification.[109] The Loss Rating Factor then adjusts the experience-modified premium to arrive at the premium Respondent actually charges under the Loss Rating Plan rates.[110] Without the Loss Rating Factor, it would be impossible to determine Appellant's final premium, since Respondent's rate filings give no indication that Respondent adjusts experience-modified premiums to match Loss Rating Plan premiums.[111] Even if Respondent's filings disclosed that information, determining final premium without the Loss Rating Factor would still be impossible because the filings omit supplementary rate information needed to calculate the Loss Rating Plan rates (see above). Since the Loss Rating Factor is necessary to determine premium, it is supplementary rate information that was required to be filed under section 11735.

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[103] Resp. Post-Hearing Br. at p. 2:2-3.
[104] Exh. 205 at p. 205-3.
[105] See Ins. Code, § 11730, subd. (j).
[106] Resp. Post-Hearing Br. at p. 2:2.
[107] Exh. 100 at p. 100-3; Exh. 205 at p. 205-3.
[108] Tr. at p. 136:19-21; Exh. 100 at p. 100-3; Exh. 205 at 205-3.
[109] Exh. 100 at p. 100-3; Exh. 205 at 205-3.
[110] Tr. at p. 136:19-21; Exh. 100 at p. 100-3; Exh. 205 at 205-3; Exh. 8.
[111] See Exhs. 4, 5.

2. Respondent's Use of the Unfiled Supplementary Rate Information Was Unlawful, Contravened Public Policy, and Misapplied Respondent's Filed Rates.

Insurers must file all supplementary rate information under Insurance Code section 11735, subdivision (a), and that information must be publicly available under subdivision (b). By failing to file the Loss Rating Factor and Loss Rating Plan's supplementary rate information, Respondent ignored the statutory mandate and frustrated the public policy concerns behind it.

Section 11735's policy aims include ensuring that the Commissioner has information necessary to determine that insurers charge amounts that are not discriminatory, cover their losses and expenses, and do not threaten their solvency.[112] By withholding supplementary rate information from its filings, Respondent prevented the Commissioner from exercising those oversight duties.

In addition, two important goals of section 11735's public inspection provisions are to enable employers to obtain coverage at the best rates and to curtail monopolistic pricing practices.[113] When rate information is transparent, policyholders are better able to compare coverage and reduce their costs. Transparency also reduces the likelihood that insurers will gain a monopolistic advantage when all carriers' pricing information is public.

In furtherance of those aims, the Legislature passed Insurance Code section 11742 establishing a mandatory online rate comparison guide. Subdivision (a) provides, in part:

> The Legislature finds and declares that the insolvencies of more than a dozen workers' compensation insurance carriers have seriously constricted the insurance market[.] . . . Unfortunately, many employers do not know which carriers are offering [workers' compensation] coverage, and it is both difficult and time consuming to try to get information on rates and coverages from competing insurance companies. A central information source would help employers find the required coverage at the best

[112] See Ins. Code, §§ 11732-11737.
[113] See *ibid.*

competitive rates.

When insurers use unfiled supplementary rate information to modify their filed rates, they frustrate the Legislature's intent behind the comparison guide and section 11735's public inspection provisions. Rate disclosure confers little value if the public does not have access to the formulas and information carriers use to modify their rates. Meaningful price comparison is simply impossible without such formulas and information.

Insurance Code section 11735 and the policy behind it required that Respondent file the Loss Rating Factor and all supplementary rate information in the Loss Rating Plan. Respondent failed to do so, rendering Respondent's use of those items unlawful. By increasing Appellant's final premium over $180,000 during the Policy Period, the Loss Rating Factor and other unfiled supplementary rate information misapplied the policy's filed rates.

II. Respondent's Use of the Loss Rating Factor and Loss Rating Plan Violated Insurance Code Section 11734's Uniform Experience Rating Plan Requirements, Thereby Misapplying Respondent's Filed Rates.

Appellant argues that the Loss Rating Factor violated the Insurance Code's uniform experience rating requirements by impermissibly offsetting Appellant's experience modification.[114] The ALJ agrees.

A. Applicable Law

Insurance Code section 11730, subdivision (c), defines "experience rating" as "a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit, or unity modification."

Section 11734, subdivision (a), requires "[e]very workers' compensation insurer to

[114] App. Post-Hearing Br. at p. 7:9-18.

adhere to a uniform experience rating plan filed with the Commissioner by [the WCIRB]." That plan is known as the California Workers' Compensation Experience Rating Plan—1995 ("ERP"), and was adopted as part of the Commissioner's regulations.[115]

The ERP applies to all policies meeting an eligibility threshold.[116] It requires an insured's experience rating to be based on data from a three year period ending 21 months before the rating date, which is typically the inception date of the insured's policy.[117] Effective on the rating date, the WCIRB must establish an experience modification or "ex-mod" for the insured using the ERP's formula.[118] The formula takes into account the insured's actual and expected losses derived from specific statistical information for the three year period.[119] Neither the Insurance Code nor the ERP allows an insurer to use experience rating that deviates from the formula.

Section 11734, subdivision (c) requires that "[e]very workers' compensation insurer shall adhere to the approved manual rules and experience rating plan in writing and reporting its business." Writing insurance includes, among other things, collecting premiums.[120]

B. Analysis

Respondent violated Section 11734's uniform experience rating requirements in at least two principal respects. First, the Loss Rating Plan is an experience rating system that fails to adhere to the Commissioner's uniform experience rating plan—the ERP. Second, Respondent's Loss Rating Factor improperly negated Appellant's experience modification.

1. The Loss Rating Plan Constitutes Unlawful Experience Rating.

The Loss Rating Plan model assesses risk by comparing a policyholder's past loss

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[115] Cal. Code Regs., tit. 10, § 2353.1. All references to the ERP in this Proposed Decision are to the version effective January 1, 2017.
[116] ERP, Section III, Rule 1. Specifically, the minimum eligibility threshold was $10,100 in expected losses during the experience period. Appellant's expected losses for the applicable experience period were $88,307. (Exh. 201.)
[117] ERP, Section III, Rule 2.
[118] ERP, Section VII.
[119] *Ibid.*
[120] 1 Couch on Ins. (3d ed. 2018), § 3:6.

experience to that of others in same industry.[121] The model analyzes the insured's incurred and paid losses, as well as the type, frequency and severity of those losses.[122] It also considers the frequency and severity of losses in the insured's industry, as well as other insureds' aggregate historical loss information known to Respondent and its affiliates.[123] The model then adjusts the policyholder's premium based on this risk assessment.[124] Consequently, the Loss Rating Plan meets Insurance Code section 11730, subdivision (c)'s "experience rating" definition.

The Loss Rating Plan deviates from the ERP's experience rating requirements. For example, the Loss Rating Plan model employs a five year experience rating period that ends no more than 90 days before the policy's effective date.[125] In contrast, the ERP mandates a three year experience rating period that typically ends 21 months before that date.[126] In addition, the Loss Rating Plan model adjusts premiums using three different methods to assess risks specific to the insured and a further method to assess risks more generally within the insured's industry.[127] Those methods differ markedly from the ERP's single experience modification formula, which is the only experience rating formula permitted by the Insurance Code.[128]

For these reasons, Respondent's use of Loss Rating Plan violates Insurance Code section 11734, subdivision (c)'s requirement that insurers adhere to the ERP when collecting premium. By charging Respondent under the Loss Rating Plan, Appellant misapplied the filed rates in Appellant's policy.

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[121] Exh. 5 at pp. 5-15, 5-16; Exh. 9 at p. 9-2.
[122] *Ibid.*
[123] *Ibid.*; Exh. 9.
[124] Exh. 5 at pp. 5-15, 5-16.
[125] Tr. at p. 132:7-9; Exh. 4 at p. 4-06; Exh. 5 at p. 5-15.
[126] ERP, Section III, Rule 2.
[127] Tr. at p. 113:19-21; Exh. 5 at p. 5-16.
[128] Compare ERP, Section VII, Rule 8, with Exhibit 5, page 5-16.

2. The Loss Rating Factor Unlawfully Negates Appellant's Experience Modification.

It is undisputed that Respondent used the Loss Rating Factor to negate any changes to Appellant's experience modification. Respondent's witness, Mr. Brown, testified as follows:

> THE ALJ: [T]o be clear, if the experience modifier changes mid policy [year], the loss rating factor will change by a corresponding amount so that there's no net change to . . . the final premium charged to the insured?
>
> THE WITNESS: That is correct.[129]

Mr. Brown further confirmed that Appellant's experience modification had no effect on premium:

> Q: . . . If the ex mod goes up or down, would that cause the premium to go up or down?
>
> A: No.[130]

When asked why Appellant's policy included an unavailing experience modification, Mr. Brown gave the following testimony:

> THE ALJ: If the ex mod doesn't affect the premium charged under the policy, why would the ex mod appear on the policy at all?
>
> THE WITNESS: It's a statutory requirement.[131]

While Insurance Code section 11734 requires insurers to include experience modifications in their policies, merely listing the experience modification in the policy is insufficient. Section 11734 and the ERP also require that the experience *modification* actually *modify* the premium charged. Specifically, section 11734, subdivision (c), requires insurers to comply with the ERP when collecting premium.[132] The ERP further requires that "[a]n experience modification promulgated in accordance with this Plan *shall be applied to the base*

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[129] Tr. at p. 141:19-24.
[130] Tr. at p. 129:12-14.
[131] Tr. at p. 139:6-9.
[132] See 1 Couch on Ins. (3d ed. 2018), § 3:6 ["writing insurance" includes collecting premiums].

premium developed in connection with the coverage provided during the effective period of the experience modification."[133] These requirements serve twin policy aims of financially motivating employers to reduce work-related injuries and objectively distributing the cost of workers' compensation insurance.[134]

Respondent acknowledged these requirements by including the following language in Appellant's policy:

> We [Respondent] must adhere to a single, uniform experience rating plan. If you [the insured] are eligible for experience rating under the plan, *we will be required to adjust your premium to reflect your claim history*. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan, which is developed by the insurance commissioner, is subject to approval by the insurance commissioner.[135]

Respondent nevertheless argues that it is legally precluded from adjusting Appellant's premium in this way, since the Loss Rating Plan's filed description includes no experience modification component.[136] According to Respondent, adjusting premium to reflect the experience modification would violate the Insurance Code by contravening Respondent's filed plan.[137] That argument is absurd. Filing an unlawful plan does not authorize Respondent to impose it on policyholders.[138]

Respondent violated Insurance Code section 11734 and the ERP's requirements, as well as the underlying public policy, by neutralizing Appellant's experience modification with the

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[133] ERP, Section I, Rule 4, emphasis added.
[134] Exh. 102 at p. 102-2.
[135] Exh. 100 at p. 100-17; Exh. 205 at p. 205-18, emphasis added.
[136] Resp. Post-Hearing Br. at p. 7:3-9.
[137] *Ibid.*
[138] Respondent also argues that the Commissioner "approved" its Loss Rating Plan filing. (*Ibid.*) But the Commissioner's failure to reject a rate filing does not indicate he approved its contents. (See Cal. Code Regs, tit. 10, § 2509.32.) In any event, the Commissioner has no authority to approve a plan that violates the Insurance Code. (See *Terhune v. Superior Court* (1998) 65 Cal.App.4th 864, 872-873 ["To be valid, administrative action must be within the scope of authority conferred by the enabling statutes."].)

Loss Rating Factor.[139] In so doing, Respondent misapplied its filed rates, since rates can be correctly applied only in conjunction with the required experience modification.

III. Appellant's Premium Must Be Calculated without Application of the Loss Rating Plan or Loss Rating Factor.

Section 11737, subdivision (f), grants the Commissioner broad authority to award remedies in workers' compensation appeals. The statute authorizes the Commissioner to "affirm, modify, or reverse" an insurer's action concerning the application of its rating system. The statute contains no language restricting remedies the Commissioner may order to modify or reverse an insurer's action. Nor has any California court inferred such restrictions from the statute. Indeed, the breadth of the Commissioner's authority is consistent with his comprehensive role to "require from every insurer a full compliance with all the provisions of [the Insurance Code]."[140]

Respondent failed to correctly apply its filed rates to Appellant's policy by unlawfully using the Loss Rating Factor and Loss Rating Plan. Respondent must recalculate Appellant's premium for the Policy Period without applying the Loss Rating Factor or Loss Rating Plan. The premium must be calculated using the policy's filed rates of $8.91, $0.86, and $0.87 for Classification Codes 7721, 8742, and 8810, respectively. Appellant's 106% experience modification that has been endorsed to the policy[141] must be applied to the base premium calculated using those rates.

Conclusions of Law

Based on the foregoing facts and analysis, the ALJ draws the following legal conclusions:

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[139] The ALJ notes that ERP, Section I, Rule 6 provides, in part: "The use of subterfuge or device in any form to evade the promulgation or application of an experience modification determined in accordance with this plan is prohibited." That rule further authorizes the WCIRB to investigate violations of the rule and to take appropriate remedial action.

[140] Ins. Code, § 12926.

[141] Exh. 202.

1. The Loss Rating Factor constitutes supplementary rate information under Insurance Code section 11730, subdivision (j). As such, it was required to be filed with the Commissioner under section 11735. Because Respondent did not file the Loss Rating Factor, Respondent's application of the Loss Rating Factor to Appellant's policy violated section 11735 and unlawfully misapplied Respondent's filed rates.

2. The Loss Rating Plan contains supplementary rate information under Insurance Code section 11730, subdivision (j), that Respondent was required to file with the Commissioner under section 11735. Because Respondent did not file certain of that supplementary rate information, Respondent's application of the unfiled information to Appellant violated section 11735 and unlawfully misapplied Respondent's filed rates.

3. The Loss Rating Plan constitutes experience rating under Insurance Code section 11730, subdivision (d), and fails to comply with the uniform experience rating plan requirements of section 11734 and the ERP. Respondent's application of the Loss Rating Plan to Appellant thereby violated section 11734 and the ERP and unlawfully misapplied Respondent's filed rates.

4. Insurance Code section 11734 and the ERP required Respondent to apply Appellant's experience modification to its policy for the purposes of collecting premium. Respondent used the Loss Rating Factor to nullify the experience modification's effect on Appellant's premium. Respondent thereby violated section 11734 and the ERP and unlawfully misapplied Respondent's filed rates.

5. Because Respondent's use of the Loss Rating Plan and Loss Rating Factor violate Insurance Code sections 11734 and 11735 and misapplied Respondent's filed rates, the Loss Rating Plan and Loss Rating Factor must be excluded from the calculation of Appellant's

premium. Appellant's premium for the Policy Period must be calculated using the policy's filed rates of $8.91, $0.86, and $0.87 for Classification Codes 7721, 8742, and 8810, respectively. Appellant's 106% experience modification must be applied to the base premium calculated using those rates.

ORDER

Within 30 days after the date this Proposed Decision is adopted, Respondent shall recalculate Appellant's charges for the Policy Period consistent with this Proposed Decision and send Appellant a revised policy and statement of account. In the event Respondent owes Appellant a refund as a result of that recalculation, Respondent shall pay Appellant the refund within 30 days after the date this Proposed Decision is adopted.

* * *

I submit this proposed decision based on the evidentiary hearing, records and files in this matter, and recommend its adoption as the decision of the Insurance Commissioner of the State of California.

Dated: December 11, 2018

CLARKE de MAIGRET
Administrative Law Judge
Administrative Hearing Bureau
California Department of Insurance

DECLARATION OF SERVICE BY MAIL

Case Name/No.: In the Matter of the Appeal of:
5 DIAMOND PROTECTION, INC.
File AHB-WCA-18-06

I, CANDACE GOODALE, declare that:

I am employed in the County of Sacramento, California. I am over the age of 18 years and not a party to this action. My business address is State of California, Department of Insurance, Executive Office, 300 Capitol Mall, Suite 1700, Sacramento, California, 95814.

I am readily familiar with the business practices of the Sacramento Office of the California Department of Insurance for collection and processing of correspondence for mailing with the United States Postal Service. Said ordinary business practice is that correspondence is deposited with the United States Postal Service that same day in Sacramento, California.

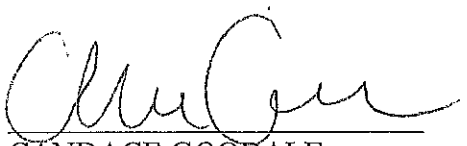
☒ On February 8, 2019 following ordinary business practices, I caused a true and correct copy of the following document(s):

ORDER ADOPTING PROPOSED DECISION; PROPOSED DECISION; NOTICE OF TIME LIMITS FOR RECONSIDERATION & JUDICIAL REVIEW

to be placed for collection and mailing at the office of the California Department of Insurance at 300 Capitol Mall, Sacramento, California, 95814 with proper postage prepaid, in a sealed envelope(s) addressed as follows:

(SEE ATTACHED SERVICE LIST)

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed at Sacramento, California, on February 8, 2019.



CANDACE GOODALE

NOTICE OF TIME LIMITS FOR RECONSIDERATION & JUDICIAL REVIEW
In the Matter of 5 DIAMOND PROTECTION, INC.
Case No. AHB-WCA-18-06

Petitions for reconsideration may be made pursuant to California Code of Regulations, Title 10, section 2509.72. To be considered, a petition for reconsideration must be made timely, and shall be based solely upon, and shall set forth specifically, the grounds upon which the decision of the Commissioner allegedly is contrary to law or is erroneous. A petition for reconsideration shall not refer to, or introduce, any evidence which was not part of the record of the evidentiary hearing. Any such evidence nonetheless provided shall be accorded no weight. Copies of documents received in evidence or already part of the records shall be referenced and attached as exhibits.

A Petition for Reconsideration must be served on all parties and should be directed to:

Geoffrey F. Margolis
Deputy Commissioner & Special Counsel
California Department of Insurance – Executive Office
300 Capitol Mall, 17th Floor
Sacramento, California 95814

Judicial review of the Insurance Commissioner's Decision may be had pursuant to California Code of Regulations, Title 10, section 2509.76, by filing a petition for a writ of mandate in accordance with the provisions of section 1094.5 of the California Code of Civil Procedure. The right to petition shall not be affected by the failure to seek reconsideration before the Commissioner. A Petition for a Writ of Mandamus shall be filed with the Court, and served on the Insurance Commissioner as follows:

Chao Lor
Attorney
California Department of Insurance – Legal Office
300 Capitol Mall, 17th Floor
Sacramento, California 95814

Any Petition for a Writ of Mandamus should also be served on the Administrative Hearing Bureau of the California Department of Insurance as follows:

Department of Insurance
Administrative Hearing Bureau
45 Freemont Street, 22nd Floor
San Francisco, California 94105

PARTY SERVICE LIST
FILE NO.: AHB-WCA-18-06

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