The Privatisation of New Zealand Accident Insurance Workplace Cover 1999/2000

A Review

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This paper is dedicated to Saffron who walks through life with the wisdom
of Solomon and the patience (well some of the time) of Job

1 Summary

1.1 Debate continues

The New Zealand accident compensation regime in unique and has been subject of controversy since proposed in the late 1960's. The privatisation of the employer account for the period 1 July 1999 to 3 June 2000 was the most recent major change.

While the privatisation regime has ceased, ACC as ever continues to be a source of controversy. The weekend papers regularly feature articles about claimants seemingly not receiving benefits they are apparently clearly entitled to. The ability of ACC to operate as an efficient organisation is continually challenged. It is apparently challenged from all sides.

The objective of the paper is to note the features of the regime rather than attempt to consider whether the private regime was in anyway better or worse than the regime of the single State provider.

1.2 ACC post-privatisation

Its financial performance has improved as judged by the continuing fall in the average premium rate for workplace accident cover. A positive outcome for employers, and claimants who must be achieving positive rehabilitation outcomes to sustain the good financial result.

1.3 The year for private insurers

The insurers response to a very difficult year was extraordinary. In most cases they delivered new and innovative responses to injury prevention and claimant rehabilitation in the employer market.

They achieved good profit outcomes. They were also without doubt the beneficiaries of falling claims rates. Undoubtedly the whole privatisation move incentivised ACC to make big changes to its overall claims management approach.

1.4 Lasting legacies

- The regulatory regime put in place to monitor the private insurers was innovative and looked robust and durable. It could be a model for other long term insurance business, including life insurance.
- The legacy of all the changes in the 1990s may well be clarity of benefit entitlement under the scheme. This has seen the cost of ACC cover in New Zealand set at a competitive advantage to other countries, while providing comprehensive coverage with reasonable benefit levels.
- ACC has 6 separate accounts and all are on a fully funded basis with provision made for funding historical deficits. This will deliver transparency of cost in the future so assisting in ensuring that the cost of all benefits provided can be identified.

1.5 In summary

The view of the author is that the privatisation process delivered benefits to:

- ACC by creating a more efficient and focused organisation,
- the overall scheme by properly defining the entitlements,
- insurers who made profits from the experience,
- employers by reducing premium rates,
- employees overall through improved rehabilitation and reduction in injury rates.

2 Introduction and background

2.1 Introduction

It is important to first acknowledge the support and assistance I have received from colleagues within the firm of which I am a principal, Melville Jessup Weaver, and within the actuarial profession, during the four years I have had an involvement in the accident insurance market in New Zealand. Without their knowledge and support, my involvement in this extremely interesting area would have been much more difficult:

- Janet Lockett, who has been involved in general insurance since the 1970s, played a primary role.
- Robert Cole and Craig Lough, who like most people involved in the privatisation process, worked some extraordinarily long hours in the run up to July 1999.
- Stephen McCormack, who undertook most of the analysis of the AI Regulator data.
- Andrew Matthews, who's focused approach to all the issues which arose during that period made a lasting impression on me as to the qualities necessary for a person striving to be a very good general insurance actuary.

2.2 Other sources of information

The author would like to have produced a paper which covered all the aspects of ACC in greater detail. That was not physically or even mentally possible. The subject of ACC provision in New Zealand is a fascinating one and one on which there are a number of important sources of information available to the reader who wishes to explore the subject further. Further information on a number of valuable reference documents is included in the Appendix.

2.3 One year period

For a one year period from 1 July 1999 to 30 June 2000 the workplace accident insurance market was privatised. It was a time of great excitement and disappointment to most people directly involved and one of great controversy.

Why the subject should be a place for such apparent fierce argument from different proponents is not apparent to the author but it is a reality. Both those who are ardently in favour of the provision of the insurance cover by the state, and those who believe that better outcomes can be achieved by the private sector, have the same goal, namely the speedy and effective rehabilitation of the accident claimant and the prevention of accidents.

An important point is that the debate on private versus state is about who provides the cover, and is not about whether the cover should be provided and not about the level of the cover to provide.

2.4 Outline of the ACC Scheme

The basic features of the ACC scheme are:

- 24 hour cover for all New Zealand residents, and visitors to New Zealand.
- It is a no fault scheme, which does not require blame to be assigned before payment of benefits is made.
- Payment of a weekly income of 80% of the pre-accident level.
- Payment of all medical and rehabilitation costs, subject to due deductible amounts.

- Payment of limited lump sum levels for permanent impairment.
- Employer levy rates varying by industry, with ability to self-insure to certain levels.
- Employees pay a levy for non-workplace cover.
- Central Government is responsible for the cost of non-earners.
- The cost of motor accidents is met by a flat fee included in annual motor vehicle licence costs, and a levy included in the cost of fuel.

The investigation of the causes of accidents in the workplace and the responsibility for taking any resulting prosecution against the employer is the role of a separate agency, Occupational Safety and Health (OSH).

A basic tenet of the regime is that in virtually all cases the claimant does not have the right to sue for any form of damages.

2.5 AI Regulator data

The AI Regulator provided a comprehensive data set as at 31 March 2002. Information was provided on the contracts written by the insurers and claims made by employees (and some self-employed). While there were questions about the data, in the main we were successful in matching up contract data with claims data. The results of the analysis completed are presented in this report.

3 Historical review of the period from the inception of the ACC Scheme

3.1 Woodhouse Commission

The basis for the current scheme lies with the Royal Commission chaired by Woodhouse and completed in 1967. The outcome of the report was to move the coverage from simply accidents occurring in the workplace to all accidents irrespective of where they occurred.

The Woodhouse report was built on five overriding principles:

- *"Community responsibility (ie, community financed),*
- *Comprehensive entitlement (ie, all are included not just the workers),*
- *Complete rehabilitation (ie, to restore the injured as far as possible to their former position),*
- *Real compensation (ie, compensation for monetary and other loss to be realistic, and not time limited), and*
- *Administrative efficiency (ie to minimise delays and costs)."*

The first principle is relevant to the debate on the role of private insurers and the Woodhouse report states:

"*This first principle is fundamental. It rests on a double argument. Just as a modern society benefits from productive work of its citizens, so should society accept responsibility for those willing to work but prevented from doing so by physical incapacity. And since we all persist in following community activities which exact a predictable and inevitable price in bodily injury, so should we all share in sustaining those who become the random but statistically necessary victims. The inherent cost of those community purposes should be borne on the basis of equity by the community."*

The Woodhouse scheme was finally introduced in 1972.

The 1972 Act overruled the Woodhouse recommendation of a flat levy and continued the practice under the previous legislation with a set of industry-based rates.

Interestingly Woodhouse proposed lower compensation levels for the first 4 weeks of a claim, which compares to the current system where in the first week employees, receive their existing level of pay.

3.2 Problems in the 1980s

Quigley Committee - The committee reported in 1980 and proposed moving the scheme to a pay as you go basis, which saw the average levy reduce from $1.07 to $0.74 per $100 liable earnings by 1985. (The precise basis on which the scheme was initially funded is not apparent to the author but it was not set up on a full funding basis. Instead over the initial period the levies were set such that while they were of course greater than the expenditure it was expected that after 20 years, the costs of the scheme would be met by both the levies charged and the income on the reserves.) But the fall in the rates to $0.74 was outstripped by the rise in expenditure and the existing reserves fell substantially. To correct this rates rose by 300% in 1987.

Law Commission Report 1988 – A debate has always existed as to whether the scheme should cover incapacity to work from sickness. Woodhouse was a strong advocate for the scheme to be extended to cover this and stated at the time that while there was no logic to treat the two separately he did accept by necessity that this would have to be a two-step process. The Law Commission re iterated the proposal to extend the cover to include sickness, which was not unexpected as Woodhouse was its President at the time of the report. The 1989 Budget announced that the sickness cover would commence from 1991.

Ministerial Working Party 1991 – 1990 saw a change in Government and the establishment of a ministerial working party chaired by ex Treasury head, Bernie Galvin. The resulting report said the scheme should only cover accidents, recommended allowing private insurers into the market and recommended that employers be allowed to self insure.

Involvement of Insurers – The insurance industry was approached as part of the discussions including the Galvin Report, as to whether it wished to compete in the market place. The offer was declined.

3.3 Changes to the legislation in the 1990s

1992 Accident Rehabilitation and Compensation Insurance Bill – The reasons for the new legislation were stated as:

- the escalating costs of the scheme,
- evidence of fraud, and
- the need for greater individual responsibility.

The major changes were:

- scheme restructured into 6 accounts,
- earners required to pay for non-work cover,
- independence allowance introduced to replace discretionary grants to certain persons disabled,
- definition of personal injury narrowed,
- eligibility for certain benefits which had previously been discretionary was now defined,
- introduction of experience rating,
- work capacity test introduced, and
- lump sum benefits abolished.

1996 Amendment – The expectation of the 1992 Act was to reduce the cost of the ACC scheme and this was eventually achieved. But the National Government looked to make further changes. These covered:

- revising the work capacity test procedure into a form, which ACC was able to apply better in practice, and
- ACC could in future contract with private providers for elective surgery.

4 Premium rates and funding the Scheme 1992 – April 1999

4.1 Two outstanding problems

The funding policy agreed under the 1992 Act was a pay as you go basis while maintaining reserves at a level equal to 6 months benefits payments. It was presumed that the scheme was nearing maturity and this basis would produce stable rates over time.

Despite the policy intentions of the 1992 Act to see an immediate limitation of ACC costs, the scheme was faced with two major items of expenditure:

- the 2 year phasing out of lump sum payments saw actual payments greatly exceed the expected level, and
- a costly Court decision backdated benefits for care attenders.

4.2 Average premium rates

As a consequence premium rates did not reduce until late in the 1990s. The average premium rates up to and including the three month period for 1 April 1999 to 30 June 1999 were as follows:

	$ per $100 liable earnings (LE)
1.4.95	2.17
1.4.96	2.61
1.4.97	2.61
1.4.98	2.35

The fully funded premium rate for the period 1 April 1999 to 30 June 1999 charged by ACC was $1.47. The premium rate charged to fund the residual claims liability pre 1 April 1999 was $0.65.

4.3 Reduction in outstanding liability in the Employers' Account

The outstanding claims liability in the Employers' Account reduced significantly in the late 1990's and was essentially the result of the complete change in the philosophical basis on which the scheme was managed. The levies charged over the period included provision to reduce the unfunded liability and the resulting increase in reserves has seen the unfunded liability fall as shown by the figures in brackets.

	Value of outstanding claims $bn	**Value of unfunded liability $bn**
1996	5.2	(4.3)
1997	4.6	(3.3)
1998	3.5	(1.9)

The factors driving the reduction in the liability are:

- Improved claims management,
- Application of effective work capacity test, and

- Good economic climate.

4.4 Overall comment on the premium rates in the 1990s

While the funding policy post 1992 was to meet the costs arising in the year and build a reserve of 6 months benefit payments the evidence suggests that the rate was effectively set above this level. The reasons for this were to reduce the unfunded liability of the scheme and, it has been suggested, that it was in preparation for the privatisation of the regime ie provide the insurers scope to be seen to offer lower premium rates.

4.5 Accredited Employers Scheme (Self insurance for the larger employers)

It started in 1996 with 13 employers. By the time it was replaced by the private insurer regime it had been extended to cover around 15% of the work force.

5 Accident Insurance Act 1998

5.1 New legislation

The Accident Insurance (AI) Act 1998 replaced all the existing ACC legislation. It was a challenging piece of legislation to complete, and needed to address the following issues:

- Define the scheme's benefits.
- Establish a complete new regime to compel employers to take out a private insurance AI contract, with the self employed given the option to take out such a contract if they choose.
- Restructure ACC to enable it to continue to manage all its continuing schemes, including the Residual Claims Account established to fund the pre 1 April 1999 Employer Account liability.
- Establish a prudential supervisory regime for the private insurers.
- Address the issue of possible failure of an insurer.
- Establish a basis to ensure all employers effected cover.
- Establish a basis for registering private insurers.
- Continuing the overall legislative framework of a 24 hour no fault scheme.

Quoting from the Act itself the purpose was:

> *"To maintain a no fault comprehensive insurance based scheme to rehabilitate and compensate in an equitable and financially affordable manner those persons who suffer personal injury and to provide opportunities for the scheme to be managed and delivered in different ways."*

5.2 Milestones in the run up to 1 July 1999

From early in 1998 discussions were regularly taking place between Ministerial officials and the insurance industry, together with other interested groups. The timetable was very tight and legislation was not introduced into the House until September 1998 and did not receive its Royal Assent until December 1998. Prior to this ACC released a data set of the 3 year Employer Account data. The view of the industry was general disappointment in the quality of the data available to them upon which to make their pricing decisions. The data provided basic injury rate information but the insurers were left needing to make significant subjective pricing decisions on the cost of claims.

The timing of the release of the data was such that most insurers were well advanced in deriving their initial premium rate costings reviews prior to the legislation being passed. The impression of the author is that while the poor quality of the data was an important factor in the eventual profit results, the key driver was the approach taken on rehabilitation.

There was much interest in which insurers would enter the market and who would stay out. Those electing to enter the market were:

- Allianz New Zealand (then known as MMI),
- Farmers' Mutual Accident Care,
- HIH Workable,
- Ace Insurance New Zealand (then known as Cigna),
- New Zealand Insurance (AI), and
- Royal & Sun Alliance Accident Insurance (which was also known as Fusion).

These covered the major commercial insurers with the exception of QBE and Lumley.

In response to political pressure from its minority coalition partner, New Zealand First, the National led Government established a state owned insurer @Work. The market place needed a default insurer for those employers who on 1 July 1999 had failed to effect an insurance contract. This task was given to @work. It also provided a means by which the State could have had an influence on the price charged by the private insurers. A major feature of the regime was the absence of any form of direct price control of influence by the State.

Some insurers elected to limit themselves to marketing other insurer's policies, for example, State Insurance and Tower Insurance.

5.3 Three month period prior to 1 July 1999

The period was one of extraordinary effort by all those involved in the new regime. There are many individual stories relating to this period and the following comments are meant to give an impression of these:

- While there was apparently a 6 month period between the finalising of the legislation and the new cover commencing, in fact the period was a little over 3 months as contracts had to be negotiated and quotations for business issued, and contracts put in place by 1 July 1999. The first quotes were available in the second week of April.
- All insurers had to provide a quote on all business offered to them and one insurer appeared to delay entry into the market till late to reduce the quotation demands made of it.
- Each insurer needed to establish claims management processes to deal speedily with reported claims and commence delivery of speedy rehabilitation to claimants. Comments later from one insurer recognised that its ability to deal effectively with claims during the first 9 month period was limited.
- Two insurers chose to establish formal relationships with a health insurer to deliver rehabilitation. For both parties there were wider business opportunities if they could deliver wellness programs to employers.
- In fact most employers did not finalise their AI contracts until well into June as the brokers sought to deliver competitive quotes.
- The set up costs were substantial with the need for good comprehensive information and management systems.
- The level of information that had to be supplied to employers and employees on their new contracts was substantial and there was the opportunity to take standardised wording and allow employers to tailor it for their own company branding. This was not necessarily apparent at the time.

5.4 Accident Insurance (Transitional Provisions) Act 2000

The Act was introduced by the new Labour led Government elected in November 1999 and removed the right of the private insurers to provide cover to employers from 1 July 2000, and to the self employed from 1 April 2000.

6 Prudential regime

6.1 Defining a regulatory regime

There was considerable effort by officials in determining a prudential basis to govern the new workplace insurance environment.

Consistent with the Government's overall policy on industry regulatory regimes, the policy was to limit direct Government involvement. This meant for example it did not want to "approve" the entry of an insurer into the market place and it did not want to directly regulate the insurer's participation.

Questions were naturally raised as to whether the existing regime for supervising the solvency of general insurers was appropriate given the long term nature of AI insurance involved. The existing regime was limited to an insurer maintaining:

- a $500,000 deposit with the Public Trust Office, and
- a current rating from a rating agency.

The outcome of the discussions was to require each insurer to appoint a "prudential supervisor" (PS) to regulate its business under the Act. In practice the PS was a trustee company. The duties of the prudential supervisor were defined in Section 210 of the Act as to:

- Ensure that under the trust deed the insurer agreed to comply with a prudential solvency margin.
- Monitor the solvency of the insurer.
- Establish procedures such that the prudential supervisor controlled the assets of the insurer.
- Ensure compliance with the registration requirement.
- Ensure, if the insurer became insolvent, that the procedures set out in section (238) of the Act were followed.

Essentially, the requirement was to ensure the insurer complied with the Act.

To the trust company there was no "standard" beneficiary as per normal trust situations. Instead the trustee had duties to the Minister of Finance, and the AI Regulator.

The prudential supervisors were all trustee companies. Tower Trust acted for three insurers, Public Trust for two, and Perpetual and Guardian Trust for one each. This whole area was a new one for the Trust Companies and the author spend time discussing the subject of the paper with two of the companies concerned. One provided a copy of an internal risk assessment paper. To them it was clearly identified as an area where, given the duties and functions required of them, the risks of the business where comparatively high. In some ways the regime was almost an appointed actuaries regime with the trustee companies needing to employ a number of external advisors to ensure the proper execution of their role.

The insurers registered with the Registrar of Companies. The major requirements to obtain registration were:

- Appointment of a prudential supervisor.
- The prudential supervisor had duly certified that the trust deed complied with the provisions of the Act.
- The insurer had a current rating from a rating agency.

6.2 Cornerstone of regime

All the assets of the registered insurer were held "in trust" by the prudential supervisor. This ability of the prudential supervisor to have a charge over the AI business was the cornerstone of the regime. With two exceptions, the insurers established separate companies for their AI business. This facilitated the ability of the prudential supervisors to properly undertake their obligations.

One prudential supervisor applied the following rules:

- The assets were held by a custodian.
- The authority to release assets lay with the prudential supervisor.
- The insurer made the necessary investment decisions, and the prudential supervisor agreed to approve or otherwise every intended transaction within a four hour period.
- The payment of benefits was handled by transferring funds into an account arranged by the insurer. Transactions were approved on a monthly basis.

Reinsurance played a major part for most of the insurers who wanted to limit their exposure to the unknown risks of the new AI market. The regime did not require the prudential supervisor to hold the assets for the reinsurers. Instead the prudential supervisor looked to other advisors to sign off the security of the reinsurers involved.

6.3 Concerns of insurers

The insurers had serious reservations over the involvement of an outside party with no knowledge of the insurance industry. Apparently the insurers continue to have concerns that the ability of the prudential supervisors to continue to manage the business when it is in a run off state may be stretched. But, in the event the market had continued, all the parties would have gained more experience of their roles and it is expected that the insurers' concerns would have been met by the trustee companies and their role perhaps better understood by the insurers.

An outcome of the regime was to speed up the introduction of the mandatory accounting standard for general insurance companies FRS35, which as a consequence of the legislation needed to make full provision for the long-tail nature of AI business.

6.4 Collapse of HIH

While the one year period of the regime during which business was written means that the lessons to draw from the regime are limited, its resilience was tested by the collapse of HIH in 2001. As expected the AI Regulator kept a close eye on proceedings and the prudential supervisor concerned was left with no doubt that it was expected to manage the situation to achieve a satisfactory outcome. The regime therefore had the important feature of clear accountability of roles. This was achieved and the business was purchased by QBE. The ability of the prudential supervisor to control the assets in the run up to the demise of HIH when there must have been pressure within the HIH group of companies to assist with the financial stress of the parent was critical.

6.5 Overall comment

The basis of the regime was the Crown contracting out its regulatory role to a private sector organisation, and limited its role to policing the prudential supervisor. While it worked well in practice, its ability to manage an increasing substantial dollar liability over time is untested.

7 Accident Insurance Regulator's Office

7.1 Functions

The office was established with the following functions:

- Collect data on workplace accidents, claims and contracts by employers.
- Prosecute employers who failed to effect a workplace insurance contract.
- Oversee the management of the non-compliers fund.
- Manage the insolvent insurers fund in the event of failure by an insurer.
- To generally enforce obligations of employers, self-employed, private domestic workers and insurers under the Act.

7.2 Outcome

The AI Regulator used a number of advisers to complete audits on the insurers.

Its ability to properly exercise its role was limited when within five months of the new regime; the Labour Government announced the closure of the private regime.

Its response to the HIH issue was robust.

Its report in December 2000 was a comprehensive review of the influence of the regime and the author of this paper is heavily reliant on its contents.

7.3 Overall comment

The impression of the work of the office is that it appeared to have got off to an efficient start.

8 Non Compliers and Insolvent Insurers Fund

8.1 Introduction

The test of any regulatory regime is its ability to deal with adverse situations and in this case there were two situations that it was envisaged the regime needed to deal with.

The regime included provisions for providing cover to employees where employers had not effected a workplace AI contract and where an insurer failed due to insolvency.

8.2 Non-Compliers Fund

The Non-Compliers Fund met the payments due to claimants where the employer had not effected a contract. The fund was financed by an initial grant from the Crown of $0.55m, and funded on an ongoing basis by penalties from non-complying employers and if there was a shortfall a levy on insurers. Royal & SunAlliance was appointed to manage the fund for the AI Regulator.

The overall level of non-compliance was 1.3% of employers, representing 0.07% of the overall liable earnings. Only two employers were known to have deliberately avoided their obligations and were subject to a penalty of 5 times the premium payable. The majority of non-compliance was considered due to employers' misunderstanding the Act.

The mechanism by which the AI Regulator was able to detect non compliance where no claim was lodged was through matching Inland Revenue Department (IRD) numbers of the insured employers with the IRD's database.

8.3 Insolvent Insurers Fund

The provisions of the legislation dealing with an insolvent insurer were not tested.

The legislation provided for the following process in the event of insolvency:

- The liabilities were to be assumed by the Insolvent Insurers Fund (IIF), with the express intention that the impact on claimants was minimal.
- The prudential supervisor, administrator and AI Regulator all had prime responsibilities for the IIF.
- Future liabilities were to be limited by cancelling current contracts or transferring the contracts to another insurer. Clearly there would have been issues to deal with here where an employer had paid premiums in advance.
- Financial responsibility to correct the insolvency lay initially with the employers who could be levied up to agreed amounts. After this, calls could be made on the remaining insurers. As required the Crown would provide advances to the IIF.
- There was an expectation that the residual liability would be purchased by another insurer.

9 A review of the business written by the private insurers

9.1 Introduction

Firstly a review of the total premiums paid in the privatised year with a comparison of those paid under the ACC both before and after the period reviewed. The rates are all on a fully funded basis and exclude GST and the levy paid to OSH.

Period covered	Rate - $ per $100 LE	Provider	Total premium collected $m
01.04.99 to 30.06.99	1.47	ACC	613
01.07.99 to 30.06.00	1.20	Private insurers	500
01.07.00 to 31.03.01	1.12	ACC	372
01.04.01 to 31.03.02	0.90	ACC	376
01.04.02 to 31.03.03	0.85	ACC	353
01.04.03 to 31.03.04	0.82	ACC	353

The following qualifications apply to the figures in the table:

- The total premium paid for the 3 month period from 1 April 1999 is an annualised estimate based on the liable earnings figure for the privatised year.
- The figure for the privatised year is after adjusting for risk sharing i.e. is the equivalent gross premium.
- The figures for the period 1 July 2000 to 31 March 2002 are taken from the ACC published accounts and are in respect of the two financial years ending 30 June 2002. The figure for the period commencing 1 July 2001 is high due to the inclusion of income from the previous period. The premium for this period is also the figure for the 12 months to 30 June 2002 despite the reference to just a 9 month period. It is presumed that all the figures included in the document referred to are only in respect of premiums collected and exclude equivalent premiums for risk sharing under the Partnership Program.
- The figures for the last period namely the year commencing 1 April 2003 are taken from the recent ACC consultation document and the rates charged for this period may change for reasons which include a difference of view from the Government. The figure for the current year ending 31 March 2003 is taken from this document.

The table shows a significant reduction in the average premium rates over the 6 year period illustrated.

In this section the author provides results from the AI Regulator data on the premiums charged by the insurers.

9.2 Average premium rates charged by insurers for each of the ANZSIC codes

Like ACC the insurers primarily rated employers on the basis of the basis of their industry and not on the basis of occupation and the adopted the standard ANZSIC codes system. Table below is solely in respect of non risk sharing policies to eliminate problems with the risk sharing data

	Insurer:							
	A	**B**	**C**	**D**	**E**	**F**	**G**	**All**
ANZSIC	$	$	$	$	$	$	$	$
A	2.45	3.02	3.23	2.70	2.54	3.19	1.01	2.69
B	1.51	3.45	2.65	1.70	2.40	3.41	n/a	2.25
C	1.00	1.76	1.97	1.42	1.66	1.13	1.08	1.47
D	2.13	1.61	1.75	1.06	1.13	1.10	0.73	1.13
E	3.77	3.77	3.93	2.74	1.91	2.47	1.27	2.47
F	1.09	0.93	1.14	0.86	1.10	0.73	0.57	0.89
G	0.99	0.96	1.49	1.24	0.92	0.73	0.62	1.03
H	1.65	1.73	1.95	1.48	1.23	1.33	1.10	1.43
I	2.68	1.81	2.24	1.62	1.96	2.00	0.90	1.82
J	3.46	0.79	2.39	1.29	1.38	0.52	n/a	1.09
K	0.57	0.64	0.68	0.50	0.37	0.47	0.20	0.48
L	0.83	0.71	0.85	0.72	0.68	0.50	0.42	0.68
M	1.48	0.53	1.05	0.56	0.78	0.98	0.74	0.80
N	0.76	0.53	0.82	0.46	0.30	0.23	n/a	0.29
O	0.87	1.79	1.20	1.22	0.82	1.63	0.77	1.01
P	1.16	1.04	1.86	0.76	1.26	0.61	1.38	0.92
Q	1.35	1.54	2.24	1.28	1.16	1.55	n/a	1.59
All	1.73	1.24	1.60	1.17	1.14	0.78	0.74	1.13

Commenting on the table:

- The results are similar to those published in the AI Regulator report. For example under manufacturing the average rate in the AI report is 1.51 and for ANZSIC code C (manufacturing) the result is 1.47.
- There are some significant variations between insurers in the same ANZSIC code.
- We have not included information on the levels of business written by each insurer for each ANZSIC code and it does not follow that the lowest rates resulted in the greatest level of business written.
- The wide variety in the rates is considered surprising but presumably reflects the ability of the insurers to price individual risks as they viewed them and the acceptance of the employers to variations in rates.
- The wide variety will also reflect the variance in the risk level of the different activities within each ANZSIC class and the different markets each insurer targeted.

9.3 Comparison of individual premium rates

A comparison of the premium rates charged for a number of individual premium groups is shown in the table below. The private insurer rates shown are the overall average rate charged and the maximum and minimum average rate for individual insurers. The rates are again for non-risk sharing policies.

ANZSIC code	Policy count	Gross premium $000	Liable earnings $000	Gross premium rate	ACC 1999	ACC 2000	ACC 2001
A012300 Sheep-Beef Cattle Farming							
All insurers	8,331	6,007	239,754	2.51	1.98	2.28	2.10
Min and max insurer rate				2.25 - 4.33			
C2111000 Meat processing							
All insurers	81	5,263	299,496	1.76	4.03	3.15	2.49
Min and max insurer rate				0.69 - 2.59			
E411100 House Construction							
All insurers	2,019	5,586	123,933	4.51	3.98	3.68	2.91
Min and max insurer rate				3.84 - 5.23			
G5329 Automotive Repair							
All insurers	3,027	4,154	344,711	1.20	1.06	0.81	0.63
Min and max insurer rate				0.94 - 2.13			
H573000 Cafes and Restaurants							
All insurers	2,736	6,961	475,524	1.46	1.24	1.06	0.76
Min and max insurer rate				0.89 - 1.97			
I611000 Road Freight Transport							
All insurers	2,019	5,586	123,933	2.86	3.00	3.06	2.78
Min and max insurer rate				2.53 - 3.08			
L784100 Legal services							
All insurers	2,429	3,154	475,122	0.66	0.55	0.35	0.26
Min and max insurer rate				0.58 - 0.89			

The results show:

- With some exceptions, for the classes illustrated the premium rate under the private regime did increase although the overall average rate charged did reduce.
- Except in the cases of Meat Processing and Road Freight Transport, the ACC rate in 2000 was significantly less than the average under the privatised regime.

The minimum and maximum rates shown relate only to instances where the level of business written by an insurer was reasonable. If an insurer wrote a trivial level of business and had a very low or high average rate the figures were ignored.

9.4 Estimate of premium written by insurers

The total premium paid figure including the premium paid for risk-sharing contracts is $465m. Adjusting the figure for the equivalent premium under risk sharing contracts increases this to $500m.

The estimated split of the premium between the insurers is:

Insurer	Premium estimate $m
Ace	20
FMG	25
HIH	120
Alliance	55
NZI	50
RSA	165
@work	30
Total	465

The total figure is taken from the AI Regulator's total published figure. The variance in the market shares of each insurer is very marked. The order of the insurers shown above does not correspond to the order for insurers A to G in section 9.2 of the report.

The level of risk sharing was less than we might have expected, and is illustrated in the table below.

	% of risk sharing contracts
Full time workers	14%
Liable earnings	16%

The percentages are similar to the level of participation in the ACC Accredited Employers program immediately prior to privatisation.

9.5 How did the insurers approach the market?

The comments made below are based on the author's impression of the analysis of the data available.

General approach
The insurers appear to have used approaches based on their usual general insurance practices. Employers of small/medium size regarded as carrying on fairly general, standard type activities within clear classifications could be processed in a standard, regulation fashion. Most other employers would have some underwriting applied, to place them in relation to a theoretical average for the category.

Existing clients
The insurers used their knowledge of their existing clients when underwriting the medium sized clients. These clients could be processed to a reasonable degree based on existing information, as to nature of activities and history of other insurances as well as on the AI data supplied. For the larger clients, and others with doubtful or poor AI experience, some special consideration was usually applied. For the larger clients the brokers supplied details of the number of employees, salary, roles etc by activity and by worksite where relevant. Also data was supplied with information on safety aspects, and past accident records by site. While this would all be designed to show the employer in the best light it would also need to be correct.

Existing clients whose business had proved to be very profitable in the past could be given the benefit of the doubt in looking at their recent AI experience. There was a danger here of double discounting. But poor AI experience on top of other underwriting problems might be indicative of poor client attitude to risk. This would make a client appear less desirable for other insurances as well, and so make loading the AI rate a viable action - losing the client might not mean losing a future source of profit, but keeping them at a higher than average rate might lead to some profit.

Where an insurer was going for business growth, they had to process a lot of unknown clients with no historical knowledge of the client's other risks and offer them "reasonable" terms. They appear to have processed large volumes of proposals as being standard within a base framework of rates, with adjustment mainly for AI history. This approach reduced the effort and expense that might have been incurred with individual underwriting, and allowed attention to be focused on a reasonable but limited number of proposals from larger clients.

Protecting existing brokers
Those insurers who were mainly concerned with protecting their existing business and so did not write a high volume of business would have had a better "feel" for the business written. In the main they still imposed fairly strict rules on what AI business could be accepted at standard rates, and what had to be referred to a central underwriter. Discounting was also limited and care was applied to decisions on necessary adjustments to rates to hold business in a price-sensitive, competitive situation.

The insurers were required by legislation to quote for all business referred to them. But they could make favourable underwriting decisions for their existing client base, and charge higher rates for new business while remaining mindful of the need to balance the premium they would receive overall for the business written.

Volume insurers
The 'volume' insurers were also prepared to review the book rates in a competitive situation, and possibly allow some significant discounts. This approach could tend to lead to average/poor risks being accepted at average rates, and those risks perceived as 'better' being allowed lower than average rates. This would have led to variations in the results from apparently similar blocks of business as different insurers would have assessed the business differently. On the basis that the insurers could have slipped into giving better terms than they originally intended to clients and the assumptions underlying the base rates turned out to be invalid, losses (or lower than projected profits) might have followed. A way to counter this was to load the rates to fully allow for the manner in which they where to be applied in practice by the underwriters and monitor the underwriting carefully. This could be achieved with modelling the possible outcomes on actual business written. In practice this was not an easy task given the level of business written in a very short period.

As noted immediately above, when considering the approach taken, it must be borne in mind that the timeframe for the writing of this "new" line of business was very tight and so broad techniques needed to be applied to manage all the business involved.

9.6 Impact of the total value of the business of a client to the insurer

With the exception of @work, the insurers could consider the overall level of expected profitability of a large client or block of clients from all their insurance needs, not just the AI business on offer. The insurer/client relationship could be called on or developed by the writing of AI business.

Small/medium employers
Where a small/medium employer had had good service in recent years from an insurer, they might tend to prefer to continue placing their business with that insurer, even at a slightly higher cost. In particular, the employer could look at the total value/cost of the package of insurance they were offered. This could include assessment of the suitability of the design and limits of cover (of all types) and expected standard of service (assistance with risk management as well as claims management), as well as the premiums (maybe with possibilities for discounts or refunds for future good experience).

Large employers
Large employers are also large general insurance clients. They also tend to involve tough negotiations on insurance costs, sometimes with threats or action on self-insurance and/or shopping around. The volume of premiums usually justified extra trouble spent on investigation of risk and special pricing. Even where the level of the risk was similar to that for a smaller employer there would be an expectation that margins in the premium rates for expenses would make some reduction in rates possible. The actual recent experience of these employers could be given credibility, and terms of cover such as deductibles 'tailored' to each client. However, the muscle of a large client, and the effect of getting or losing the business of the premium income of the insurer, might easily lead to double discounting for good features and under provision for poor features. Care was necessary to identify cases where the level of risk might increase with size of the operation if this led to less direct control of employees and higher chances of accidents occurring.

9.7 Role of brokers

In the early discussions of the insurers on privatisation of the market there was a debate on the role insurance brokers could and should play. This included a suggestion that the level of commission should be controlled by legislation. In the event there was no control and the level of commission was limited in the main to 5% of premiums written. We understand there was some increase in rates in the period post 1 July 2002 when @work was actively chasing self-employed business.

The brokers did add value to the market by putting together packages of information on the risks with a client's business when broking the business around the market. Evidence also suggests that in many cases brokers enabled employers to select the best insurer for their client's needs, including achieving the best price where this was the main factor. This lead to a rush of business being placed in the 2 week period prior to 30 June 1999.

9.8 Overall comment

In the run up to 1 July 1999 there was much discussion as to the total premium rate that would apply to the market. In general, there was a real concern that the average private market rate would be higher than the equivalent ACC rate. In the event, the rate was nearly 20% less than the ACC rate and the outcome is due to the role played by brokers.

10 Claims experience – A review of the AI Regulator report

10.1 Introduction

One of the aims of this paper was to present detailed data comparing the injury incident rates and the rehabilitation rates of the private regime with that of ACC. Achieving this is difficult, not least as we only have one year of experience, and any conclusions drawn from one year would inevitably be subject to major reservations. For example, to what extent did the new regime lead to changes in reporting practices, and one-off changes in claimants' propensity to claim? Similarly how long would the impact of the employers' and insurers' ability to maintain momentum and "enthusiasm" in applying changed approaches last.

Where we have analysed the AI data available to us the results are presented in section 11, and where possible commented on the comparable ACC results.

In this section we have instead focused on presenting the results published by the AI Regulator in December 2000. One reason for just reproducing these results is the view that the report has not received the publicity it warrants.

Comment - A separate comment the author makes here is the ongoing need for an agency to collect quality ongoing data similar to that held by the AI Regulator. Currently this data is held solely by ACC and there would seem to be advantages for the data to be the responsibility of an outside agency.

10.2 Overview 1994/95 to 99/00

The table below shows the number of claims registered, number of new entitlement claims, and the number of new weekly compensation claims.

Financial Year	Claims registered	New entitlement claims	New weekly compensation claims
1994/95	280,373	54,219	32,647
1995/96	280,547	54,266	30,811
1996/97	281,294	48,300	27,214
1997/98	259,105	40,028	22,252
1998/99	242,948	29,511	17,713
1999/00	217,189	28,490	17,629

The table shows:

- a significant fall in numbers under the ACC up to June 1999,
- a significant fall in claims numbers in privatised year, and
- a significant fall in new weekly claims numbers for both 1998/99 under ACC and for the privatised year.

However a comparison of the data is subject to a number of important qualifications:

- The ACC figures are in respect of claims reported in the period shown as opposed to accident year for the privatised year.
- For the privatised year there will remain some claims still unreported.
- There is anecdotal evidence that under the private regime not all claims were reported.
- The ACC figures do not include injuries for employers in the ACC accredited employer program.

The table below shows payments on new entitlement claims. Entitlement claims are all claims involving more than payment for medical treatment:

Financial Year	Cost of new claims $m	Cost of weekly compensation claims $m	Other costs $m	Cost of other entitlement claims $m
1994/95	114.890	89.262	10.442	15.785
1995/96	107.403	87.297	14.223	16.326
1996/97	102.984	82.817	2.528	17.639
1997/98	95.577	68.043	1.340	23.195
1998/99	72.896	50.813	1.024	21.059
1999/00	57.685	45.394	1.710	10.582

The table shows:

- a continuing fall in cost for total new entitlement claims, and new weekly compensation claims,
- an increase between 1994/95 and 1998/99 for other entitlement claim costs and a fall in this amount in 1999/00.

A comparison of the data is subject to a number of important qualifications:

- Again, the ACC data is in respect of claims reported in the period, while the privatised year is in respect of accident year.
- The significant fall in the cost of other entitlement claims may be principally due to the comment immediately above as the costs involved will be incurred some time after the actual accident date.
- The figures for the privatised year are in respect of a 15 month period to 30 September 2000 and so overstate the amounts involved.

10.3 Comments made by individuals involved in claims management for the private insurers

The purpose of the following section is to take account of some of the claims management practices that arose out of the privatisation process.

- The employers had a growing sense of ownership of their workplace safety programs, as better outcomes would lead to lower premiums. Previously, except for those in the Accredited Employer Program, there was the feeling of a lack of need to have a high involvement as there was no financial incentive to do so.
- Some employers began to have a strong focus on accident prevention.
- The insurers were interested in promoting safety programs as a means of attracting business and reducing claims costs. They contracted providers to work with employers on these issues.

- NZI was recognised in the marketplace as having possibly the best rehabilitation expertise, while MMI was acknowledged as an expert in accident prevention.
- A possible outcome of the increased awareness of employers of their ability to influence the overall cost of accidents has led post privatisation to more employers joining the ACC Partnership Program.

11 Review of overall claims experience

11.1 Introduction

The data released by the AI Regulator show both the amount of claims paid and outstanding individual claim estimates, and are summarised below:

Insurer	Paid weekly	Paid other	Estimate outstanding	Total incurred costs	Gross premium	Paid loss ratio	Incurred loss ratio pre IBNR etc
	$m	$m	$m	$m	$m	%	%
Total	$57.8	$42.5m	$49.9	$150.2	$430.3	23	35

We have presumed that the data includes cost of claims paid under risk-sharing arrangements although this may not be the case. The total incurred figure amounts to $150.m, which compare to total premium estimates of $465m with risk sharing and $500m without risk sharing. There were many issues to resolve in reviewing the data from the AI Regulators office and in matching up the different fields the gross premium income amount was reduced to $430.3m, i.e. less than the figure published in the AI Regulator report.

The claims figure needs to be reduced by an estimate for claims costs paid by employers and our estimate is $1m. The basis for this estimate is it is around 40% of the premium estimate for the value of the risk-sharing contracts.

The extent to which the case estimates are realistic and will be realised in practice is difficult to determine. Allowances also need to be made for IBNR and future re-opened claims. With this business there is always the chance that claims will re open in the future. A further provision needs to be made for the cost of administering the claims.

11.2 Profitability

In assessing the overall level of profit the insurers' achieved costs need to be further allocated for establishment costs and commission paid to brokers. The latter in the main account for 5% of premiums paid. For setup costs an overall average of 10% of premiums has been taken.

The overall profitability figure estimate is shown below.

- Total incurred reduced by claims paid by employers $140 m
- Margin for under estimation by insurers of cost of claims $25 m
- Set up costs $60 m
- Administration and selling costs to date $90 m
- Provision for acute services levy $6 m
- Margin for IBNR (taken as 1.5% of total incurred) $2 m
- Margin for re-opened claims (taken as equal to IBNR) $2 m
- Provision for future administration of claims $8 m
- Total $342 m

The total cost estimate of$342 million compares to the total premium collected of $465 million. While the result is an extremely positive outcome for the insurers whether it was sustainable is open to questions.

11.3 Comparable loss ratio

The loss ratio for the business is 41%, which is similar to the loss ratio for liability classes as published in the Insurance Council Industry Review for the last three years. The results were 42% in 1999, 46% in 2000, and 43% for 2001.

12 Claims experience from AI Regulator data

12.1 Introductory comments

As shown by the results in section 11, the insurers look to have achieved a successful financial result. In this section we show the results for selected individual ANZSIC codes.

12.2 Examples of insurers' experience by ANZSIC code

We have used the same ANZSIC codes as we illustrated for the premium rate comparison. The figures do not allow for an overall understatement of the total premium due to the risk-sharing arrangements. If this factor is allowed for, the incurred loss ratio would on average reduce by 7%. Both the lowest and highest loss ratios are shown and again we have ignored results where the level of business was considered to be relatively trivial. The total premium figure is shown to give an idea of the level of business in the ANZSIC code illustrated. The total premium written was $465m.

ANZSIC code	Average loss ratio	Lowest loss ratio	Highest loss ratio	Total premiums paid $m
AO123 Sheep-Beef Cattle Farming	32.7%	8.9%	42.5%	6.564
C2111 Meat Processing	86.7%	34.9%	140.3%	7.744
E4111 House Construction	14.6%	8.3%	20.8%	5.622
G5329 Automotive Repair and Services	22.5%	12.9%	29.7%	1.107
H5730 Cafes and Restaurants	19.2%	10.3%	38.8%	7.331
I61110 Road Freight Transport	34.2%	20.4%	43.9%	14.483
L7841 Legal Services	4.6%	1.2%	5.6%	3.168

12.3 Commenting on the results

- With the exception of Meat processing the individual loss ratios are less than 40%, and the insurers achieved good financial outcomes.
- Considering the results against the premiums charged the author notes that the private insurers benefited from the downward fall in the claims rates, which resulted from the reforms of the ACC regime over the 1990'2.
- The outcome achieved by the insurers reinforces the point that the insurers by relying heavily on the data released in effect overstated the expected claims experience.

Appendix

Further sources of information on ACC:

1. Workplace Accident Insurance Statistics Report 1999/2000 by K Matthews and B Carryer of the Office of Accident Insurance Regulator Department of Labour. Available at

2. Submission by Insurance Council of New Zealand (Inc) on the Accident Insurance (Transitional provisions) Bill January 2000.

3. ACC annual reports. Available from www.acc.co.nz

4. Accident Compensation in New Zealand: A fairer scheme by Susan St John lecturer at Auckland University.