Workers compensation market practice and premiums guidelines

For premium filings on or after XX January 2018

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XX December 2017

NSW GOVERNMENT

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1. Commencement

1.1 These *Workers compensation market practice and premium guidelines* (Guidelines) commence on XX January 2018 and will apply until rescinded or replaced.

2. Definitions

2.1 These Guidelines adopt the definitions provided in the *Workers Compensation Act 1987*, the *Workplace Injury Management and Workers Compensation Act 1998* and the Workers Compensation Regulation 2016.

2.2 The terms used in these Guidelines have the following meanings:

Term	Definition
1987 Act	*Workers Compensation Act 1987*
1998 Act	*Workplace Injury Management and Workers Compensation Act 1998*
Authority	State Insurance Regulatory Authority (SIRA) constituted under the *State Insurance and Care Governance Act 2015*.
Basic tariff premium	The basic tariff premium for an employer is to be calculated by multiplying the wages payable to workers in respect of the period of insurance by the relevant rate as defined by the insurers against the WIC codes. Where an employer is engaged in more than one business activity and pays wages to workers in more than one class, the proportion of the wages for each class is to be multiplied by the rate applied against each relevant WIC code. If the policy concerned relates to per capita rates in respect of some or all workers, the relevant numbers by which those rates are to be multiplied (for example the number of boxing matches or taxi licence plate) should be substituted for wages in respect of those workers.
Break-even premium rate	The expected cost for the portfolio divided by wages for the premium renewal year where expected costs include estimated incurred claims costs, investment earnings and expenses, and levies, but exclude profit margin.
Cost of claims	The claims costs included within the premium formula as per each insurer's premium filing.
Cohort	A sub-set of a licenced insurer's portfolio that exhibits claims experience that is statistically different from other sub-sets. Examples include size (small and large employers) and industry (as defined by the WIC system).
Employer	The actual premium rate charged for a particular employer. For experience rated employers, the employer premium rate is weighted

Term	Definition
premium rate	between the tariff premium rate and their experience premium rate plus any other loadings or adjustments made to the premium.
Licensed insurer	An insurer who holds a current licence granted under Division 3 of Part 7 of the 1987 Act.
Nominal Insurer	The workers compensation Nominal Insurer established by section 154A of the 1987 Act.
Per capita rate	The rate specified for a WIC code that is represented in a way other than a percentage.
Policy or policy of insurance	A policy of insurance as detailed in the 1987 Act.
Portfolio	All workers compensation policies expected to be written in the premium renewal by a licenced insurer.
Premium filing	A report of the premiums that the insurer proposes to charge to each employer which includes the formula, parameters and premiums per industry (including applicable rate per industry).
Rating structure	A licenced insurer's methodology for calculating an employer's workers compensation premium. It will normally consist of formulae, parameters, tariff rates, loadings and discounts.
Regulations	Workers Compensation Regulation 2016
Specialised insurer	An insurer whose licence is endorsed with a specialised insurer endorsement.
Tariff premium rate	The rate defined for a particular NSW WIC code which reflects the underlying claims cost of a particular industry.
Target premium rate	The total premium expected to be collected for an insurer's portfolio (including all loadings, discounts and adjustments) divided by total portfolio wages for the premium renewal year.
Ultimate premium rate	The total premium that is expected to be collected for an insurer's portfolio when factors such as capping, safety incentives and other external factors are taken into consideration, divided by total portfolio wages for the premium renewal year.
Wages	Wages as defined in section 174 (9) of the 1987 Act, but does not include a motor vehicle allowance or accommodation allowance to the extent that the allowance is required to be excluded from wages by Annexure D of these Guidelines.
WIC codes	The codes specified in the NSW Workers Compensation Industry Classification (WIC) System (see Annexure A) issued by SIRA as part of the *Workers compensation market practice and premiums guidelines*.

3. Guideline-making powers

3.1 These Guidelines are made under section 168 of the 1987 Act.

Explanatory note:

Section 168 (1) of the 1987 Act allows the Authority to issue guidelines with respect to policies of insurance (the Workers compensation market practice and premiums guidelines).

The Guidelines specify the minimum requirements for policies of insurance as per the 1987 Act and the Regulations and set out how insurers are to present premium filings to the Authority and how the Authority will assess those filings.

4. Scope of guidelines

4.1 These Guidelines form part of a suite of regulatory instruments available to the Authority when regulating insurer financial and prudential arrangements. As per the 1987 Act and the Regulations, the Guidelines specify:

- the minimum requirements for policies of insurance
- how insurers are to present premium filings to the Authority, and
- how the Authority will assess those filings.

4.2 These Guidelines apply to all 'licensed insurers' as per the 1987 Act, including the Nominal Insurer and specialised insurers.

To clarify, the following entities are exempt from the requirements outlined in these Guidelines:

- self-insurers
- Self-Insurance Corporation (SICorp) (including any Government employer covered by the Government's managed fund scheme under section 211B of the 1987 Act), and
- Coal Mines Insurance (the workers compensation company (within the meaning of the *Coal Industry Act 2001*).

4.3 These Guidelines apply to premium filings for policies commencing on or from 4:00pm, 30 June 2018 until the Guidelines are rescinded or replaced.

4.4 Section 3 of the 1998 Act states that the purpose of the workers compensation legislation is to establish a workplace injury management and workers compensation system with the following objectives:

a) to assist in securing the health, safety and welfare of workers and in particular preventing work-related injury

b) to provide:

- prompt treatment of injuries
- effective and proactive management of injuries, and
- necessary medical and vocational rehabilitation following injuries.

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c) in order to assist injured workers and to promote their return to work as soon as possible

d) to provide injured workers and their dependants with income support during incapacity, payment for permanent impairment or death, and payment for reasonable treatment and other related expenses

e) to be fair, affordable, and financially viable

f) to ensure contributions by employers are commensurate with the risks faced, taking into account strategies and performance in injury prevention, injury management, and return to work, and

g) to deliver the above objectives efficiently and effectively.

4.5 These Guidelines are aimed at enabling the achievement of these objectives by ensuring insurance policies and premiums are fair, affordable and commensurate with each employer's risks.

4.6 The Authority will apply these Guidelines in conjunction with relevant legislation, NSW Government policy and other policies and guidelines issued by the Authority as appropriate in the public interest.

4.7 Annexures A, B, C, D and E form part of these Guidelines.

5. Premium principles

Licensed insurer premium filings are required to demonstrate the following principles:

5.1 Principle 1: Premiums are fair and reflective of risk

Employer premiums should be fair and reflective of risk as indicated by the employer's industry, size and previous claims experience and risk management.

In general, fairness can be assessed relative to other similar cohorts of employers. The intention is that all employers engaged in the same or similar industry or business activities should have premium rates that are the same or similar unless influenced by the individual employer's previous claims experience and its risk management and return to work practices. Insurers should not deliberately introduce cross subsidies between cohorts of employers.

Where an employer's previous claims experience is taken into account, the fairness of its premium will be assessed under Principles 2 and 3.

The insurer will need to provide justification that its proposed target average premium rate for a particular cohort fairly reflects the expected claims costs, expenses and suitable profit margin for that cohort.

5.2 Principle 2: Balance between risk pooling and individual employer experience

Employer premiums should strike a reasonable balance between risk pooling (for example, through the pooling of the experience of all employers) and individual employer experience.

For small employers, their primary requirement is insurance cover which provides certainty of protection against the costs of workers compensation claims. When dealing with small employers, insurers are required to apply industry-based rates in accordance with Principle 1, with limited premium adjustments for claims experience, return to work and risk management consistent with Principle 3.

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As employer size increases, they generally have more influence over the management of their risk and return to work. Insurers can take into account the employer's own claims experience and risk management practices in addition to industry-based rates increasingly according to the employer's size. The largest employers can be rated almost entirely on their own claims experience, return to work management and risk management practices.

5.3 Principle 3: Premiums should not be unreasonably volatile or excessive

This principle builds on the objective that the workers compensation system be fair, affordable, and financially viable.

At a system level, employer premiums should not be excessive. In general, they should be reasonably stable from year to year, fairly reflecting individual employer risk, but at the same time not endangering the financial viability of the system.

Affordability in this context relates to the premium burden on employers in general, and the subsequent impact on the NSW economy.

Protecting employers from excessive and unreasonably volatile premiums is particularly important for small employers. The claims experience of a small employer can be volatile from period to period and can be unduly affected by one large claim.

A small employer's individual claims experience should not have an unreasonable impact on their premium. From this perspective, small employer premium stability is consistent with the affordability objective in the legislation and the risk pooling principles articulated in Principle 2. For example, a small employer's premiums (in one year or collectively over a few years) should not increase as a result of a claim by more than the value of the claim.

Large employers have a greater capacity to influence their own claims experience. The fairness of the system is more clearly served if the premiums of larger employers are more directly reflective of their claims experience.

To the extent that financial viability is not unduly impacted (see Principle 5), premium stability includes consideration of the staged implementation of changes to claims experience, premium loadings, discounts and investment earning rates. This will enable employers to adjust injury risk management and return to work practices to mitigate against expected future premium expenses.

5.4 Principle 4: Incentives for risk management and good claims outcomes

Individual premiums should provide incentives for employers to undertake effective risk management aimed at improving health and safety in the workplace and work opportunities for injured employees.

Employers can have their premiums discounted or loaded on the basis of their previous claims experience and the effectiveness of their return to work and risk management practices. Such discounts and loadings, which must also conform to Principles 1, 2 and 3, should be designed (as much as possible) to generate incentives for the employer in the form of premium rebates or reducing future premiums for good or improving performance.

At the same time, perverse incentives or incentives that might compromise the objectives of the scheme in relation to the effective treatment and rehabilitation of injured workers must be avoided.

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5.5 Principle 5: The premium basis needs to be consistent with the insurer's capital requirements

Insurers are required to have a capital management plan that recognises the substantial financial and insurance risks inherent in workers compensation portfolios. An insurer's premium basis needs to be consistent with its capital management plan and current capital position.

For the Nominal Insurer, the premium rates as a whole are to be set so as to achieve (as far as can be estimated) an overall target premium pool for the year. The target premium pool is to be linked to the Nominal Insurer's funding plan which will take account of its overall capital management plan, current capital position and target capital position over three forward years.

For each Specialised Insurer, the premium rates as a whole are to be subject to an annual total premium revenue plan that accords with the insurer's capital management plan.

For those insurers authorised by the Australian Prudential Regulation Authority (APRA), the insurer's capital management plan is to be presented to the Authority and is required to be consistent with capital management plans that the insurer has submitted to APRA.

For all licensed insurers, the filing is required to justify the difference between:

- the target premium rate
- the breakeven premium rate (including cost of claims, expected investment earnings and expenses), and
- show how this difference impacts on the insurer's projected capital position.

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6. Policies of insurance requirements for licensed insurers

6.1 All policies of insurance must comply with Part 7 (Insurance) of the 1987 Act and the Regulations.

6.2 Exemption limit

Section 155AA(8) of the 1987 Act

The exemption limit for the 2017/2018 financial year is fixed at $0 for the following employers:

a) an employer who carries on a business that is covered by Annexure A classes 612310, 612315, 612320, 612322, 612324, 612326, 612330, 931120, 931130, 931930, 931940 or 931950 (being classes that refer to a per capita rate), regardless of whether the employer carries on any other business

b) an employer who carries on a business in the thoroughbred racing industry and who is required by the Rules of Racing (within the meaning of the *Thoroughbred Racing Act 1996*) to hold a policy of insurance with Racing NSW, regardless of whether the employer carries on any other business.

Note: Fixing the exemption limit for the specified employers at $0 means that those employers will not be exempt employers within the meaning of section 155AA (exempt employers not required to obtain policy of insurance) of the 1987 Act.

6.3 Recovery of excess from employer

Section 160 of 1987 Act

The following prescribed excess amount is specified:

a) $0 – if an employer notifies the relevant licensed insurer of an injury that led to the weekly compensation claim within five days of becoming aware of it

b) in all other cases—the lesser of the following:

i. the amount that is the weekly payment of compensation to which the worker is entitled as determined by section 36 of the 1987 Act

ii. the amount as per Annexure B for the applicable policy year.

Note: Under section 160(2) of the 1987 Act, an employer is required to repay the prescribed excess amount to the insurer under an insurance policy in respect of each weekly compensation claim that the insurer has paid under the policy. However, if the amount that the insurer has paid in respect of any such claim is less than the prescribed excess amount, the amount the employer must repay is that lesser paid amount.

6.4 Late payment prescribed rates

Section 172(5) of 1987 Act

The prescribed rate is as defined in Annexure C and is the rate applied per month and compounded monthly.

6.5 Mine safety contribution

Mine and Petroleum Site Safety (Cost Recovery) Act 2005

Licensed insurers are required to comply with the provisions of the *Mine and Petroleum Site Safety (Cost Recovery) Act 2005* by making the determined contribution to the Mine Safety Fund and advise in the premium filing the rate payable by employers whose wages or a part of their wages are attributable to WIC codes 120000 to 152000.

6.6 Dust diseases contribution

Licensed insurers are required to comply with the Notice published by the Authority and issued pursuant to the *Workers Compensation (Dust Diseases) Act 1942*, which determines the contributions for insurers under section 6 of that Act.

6.7 Employer definitions

Part 18, Division 2, clause 138 of the Regulation

a) For the purposes of this Guideline:

Experience-rated employer means an employer whose total wages

i. are greater than $750,000 (where the period of insurance to which the premium relates is 12 months), or

ii. would be greater than $750,000 (where the period of insurance to which the premium relates is not 12 months) if that premium was calculated using a period of insurance of 12 months.

Small employer means an employer whose total wages:

i. are not greater than $750,000 (where the period of insurance to which the premium relates is 12 months), or

ii. are not greater than $750,000 (where the period of insurance to which the premium relates is not 12 months) if that premium was calculated using a period of insurance of 12 months.

If an employer is a member of a group, a reference to the basic tariff premium of the employer or to total wages payable by the employer to workers (however expressed), is taken to be a reference to the sum of the basic tariff premiums of all members of the group or to total wages payable to workers by all members of the group, respectively.

Note: A reference to the term "group" in this section has the same meaning as defined by section 175D of the 1987 Act.

6.8 Wages and motor vehicle allowances

Section 174(9) of the 1987 Act

The definitions and calculations regarding the extent to which motor vehicle and accommodation allowances are to be excluded from wages as defined in Annexure D.

6.9 Treatment of prior businesses

6.9.1 For the purpose of these Guidelines, a person is the **predecessor** of an employer if there is:

a) **an acquisition of the predecessor's business** - the employer has acquired or otherwise come into the possession of the business of the person, or

b) **a transfer of all or the majority of the predecessor's workforce** - the employer has, during any policy period, employed workers who at any time constituted all or a majority of the workers employed, during any policy period, and those workers have carried out activities or performed services for the employer that were the same or similar to activities carried out or services performed by those workers for the person.

6.9.2 The claims and basic tariff premium history of an employer's predecessor must be used in the calculation of the employer's workers compensation insurance premium.

6.9.3 Sub-clause 6.9.1(i) applies when the business acquired is the whole or main part of the business of the person, or is the whole or main part of a separate and distinct business of the person, and whether or not the business acquired is carried on at the same location.

6.9.4 Sub-clause 6.9.1(ii) applies whether or not the activities carried out or services performed for the employer were carried out or performed at the same location as those carried out or performed for the person.

6.9.5 In this clause, **business** has the same meaning as in Division 2B of Part 7 of the 1987 Act.

6.10 Apprentice incentive

Each licensed insurer must provide details of an apprentice incentive rebate available to employers in the premium filing. As a minimum, the apprentice incentive rebate must be equal to the premium payable on remuneration payments to apprentices by the employer, ie apprentice wages x Employer Premium Rate.

6.11 Retro-paid loss policies – calculation of required deposit

Under section 172A of the 1987 Act

The required deposit for an employer is to be:

1. an amount or calculation method proposed by the Nominal Insurer and provided in a premium filing
2. approved by the Authority.

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6.12 Transitional arrangements

Where a licensed insurer amends the premium formula methodology from their previous premium filing, the licensed insurer must not apply a premium rate for experience rated employers which is greater than 30 per cent more than the employer premium rate determined at the prior policy renewal where the increase occurs solely as a result of the amendment to the methodology.

6.13 Premium volatility due to claims impact

Where an insured employer is subject to being experience rated in accordance with section 6.7 of this Guideline, licensed insurers must ensure that the employer's premium rate does not exceed an increase of more than 50 per cent from the previous policy year as a result of the employer's own claims experience within the claims reporting period used in the calculation of their premiums.

6.14 Premium instalments

6.14.1 As per Part 18, Division 6 of the Workers Compensation Regulation 2016 licensed insurers may offer premium payments by instalment plans.

6.14.2 Each type of instalment plan must be approved by the Authority in the licensed insurer's premium filing.

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7. Premium filing process

7.1 A licensed insurer must not charge an insurance premium that has not been filed with and not rejected by the Authority except in the case of a provisional premium within section 169(5) of the 1987 Act. A licensed insurer must not charge a premium that is above or below that specified in the premium filing.

7.2 Frequency of submission of premiums

7.2.1 Licensed insurers are to provide their premium filings for the next year beginning 4:00pm, 30 June by no later than 15 March each year.

7.2.2 If a licensed insurer proposes charging premiums other than the premiums previously filed and not rejected by the Authority within a 12-month policy year, the licensed insurer is required to submit a revised premium filing.

7.2.3 A licensed insurer may submit a revised filing to the Authority at any time.

7.3 Premium filing meetings

7.3.1 Each licensed insurer is encouraged to meet with the Authority for a pre-filing meeting. The Authority anticipates that licensed insurers could present:

a) proposed significant changes to premium formula from previous filings

b) material differences with the most recent valuation assumptions

c) implementation plans based on the effective date of the premium filing, including systems testing and scheduling.

7.3.2 Each licensed insurer is encouraged to meet with the Authority when it submits a premium filing. At this meeting they can present the highlights of the proposed filing, including the context, material changes from the previous filing, and any variations to the proposals indicated at the pre-filing meeting.

7.4 General principles that SIRA will apply when assessing filings

7.4.1 The premium filing is to be submitted on a prospective basis, with all discretionary elements described with well-defined objective triggers and actions. That is, what objective triggers allow an insurer to alter an element of the premium basis and what actions/changes are allowed to that element (eg magnitude or boundaries).

7.4.2 Actuarial statement confirming that the proposed rating structure complies with SIRA's pricing principles, including an assessment of how the rating structure meets each of the five principles.

7.4.3 The premium filing must contain sufficient information so that SIRA can assess that the filing and premium structure:

a) all parameters and assumptions need to be justified. That is, assumptions must be based on objective analysis and where assumptions differ from objective evidence a sound explanation must be provided

b) the data and information supplied in the filing must be presented in such a manner as to allow SIRA to perform analysis and comparison between insurers

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c) the data and information supplied in the filing must be sufficient for SIRA to fully understand the premium pricing and rating model, and to determine whether the premium for any given employer is consistent with the filing

d) explain how each of the pricing principles have been satisfied.

7.4.4 When considering the level of detail to be included in the premium filings, insurers should include sufficient information within the filing such that an informed reader can draw the required conclusions. This level of detail is comparable to the detail required for a full valuation report subject to Actuaries Institute PS300.

7.4.5 The insurer needs to explain the cross-subsidies within their premium system and why those cross-subsidies are reasonable

7.5 Proposed rating structure

7.5.1 The filing must set out in detail the proposed rating structure including the premium formula and all parameters. The derivation of the parameters with supporting evidence must be included.

7.5.2 Where the premium formula contains industry tariff rates then the derivation of these tariff rates for each industry from first principles must be included.

7.6 Experience rated policies

7.6.1 Where an insurer utilises an experience rating mechanism, the filing must include:

a) the principles behind experience rating mechanism

b) the derivation of the parameters to be used in the experience rating mechanism

c) the definition of claims costs to be used for experience rating

d) the impact that experience rating is expected to have on the target premium rate

e) demonstrate that the formula complies with the pricing principles.

7.6.2 An insurer must illustrate the impact of an employer's claims experience on the premium as a result of the experience rating mechanism (that is compare the current premium to the expected premium taking into account the latest claims experience). This must be completed on an individual policy basis and then summarised into bands showing increases/(decreases) of 0 to 10, 11 to 20 per cent, etc. Where the impact of the experience rating loading is not commensurate with the employer's claims experience the insurer must justify the increase.

7.7 Portfolio profile

7.7.1 An outline of the portfolio expected to be written in the premium year including:

a) wages and number of policies split by experience rated and non-experience rated policies and by industry WIC code

b) the expected target premium to be collected (split between experience rated and non-experience rated policies) by WIC code

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c) comparison between this expected portfolio and the portfolio written in the previous two years (by wages, policies and premium).

7.7.2 Sufficient detail should be included so that SIRA can derive the target premium from the above information (ie SIRA should be able to use the rating structure and portfolio profile to derive the dollar amount of premium that is expected to be collected in the policy year).

7.8 Breakeven premium rate

7.8.1 The expected breakeven premium rate for the premium year with supporting evidence for the different components of the breakeven premium rate including:

a) claims cost

b) derivation of projected claims costs for the premium year including key assumptions used in the derivation. Appropriate heads of damage should be used in the derivation and this detail included in the filing

c) claims costs by accident year and actuarially determined ultimate claims costs for the last five years and how these estimates have developed over time (for example, incurred development table as per accounting disclosures)

d) assumed inflation rates (normal inflation and superimposed inflation) and discount rates

e) any differences between the assumptions used in the premium bases and the actuarial valuation bases and justification for the differences

f) a copy of the latest outstanding claims actuarial report upon which the above projections are based

g) the link between these claim costs and any tariff rates (at WIC level) that are used in the premium formula must be explained.

7.8.2 Expenses:

a) derivation of the expense loadings used in the derivation of the breakeven premium rate

b) expense loadings must be split between acquisition, policy administration and claims handling expenses

c) the split of total expenses between WC department direct expenses and apportioned overhead expenses – IT, finance and accounting, HR and general management

d) the expense loadings must be supported by management accounts showing sufficient detail to allow SIRA to consider if expenses loadings reflect a best estimate of an efficient policy and claims handling process

e) at least two years of actual past expenses must be included

f) for overheads that have been apportioned to workers compensation, an explanation of the apportionment process must be included.

7.8.3 Other loadings:

a) Any other loadings included in the breakeven premium rate (such as costs of reinsurance) must also be included with supporting evidence.

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7.9 Profit margin

An insurer must explain the proposed percentage of gross premiums (excluding GST) intended to be retained as profit, before tax, to provide a reasonable rate of return on the capital supporting the business, and the actuarial basis for its calculation.

7.10 Capital projection

7.10.1 A three-year projection of the insurer's capital position including projected balance sheet, APRA required capital (if relevant) and profit and loss statement. The projected profit and loss statement must reflect the proposed premium structure and expected portfolio to be written.

7.10.2 The link between the profit and loss statement and the balance sheet must be clearly demonstrated and explained.

7.10.3 The key assumptions supporting the projections must be stated and the sensitivity of the projections to the key assumptions must be illustrated.

7.10.4 For multi-line insurers, a projection showing the NSW workers compensation portfolio and the total entity level should be included.

7.11 Assessment and rejection of premium filing in accordance with section 169 of the 1987 Act

7.11.1 The Authority will assess a licensed insurer's premium filing (submitted as per Part 7 of these Guidelines) against the following criteria:

a) compliance with the premium principles as described in Part 5 of these Guidelines

b) compliance with the Policies of Insurance requirements as described in Part 6 of these Guidelines, and

c) compliance with the requirements described in Part 7.4 of these Guidelines.

7.11.2 Failure to demonstrate compliance to a reasonable degree with these Guidelines, and in particular, any of the abovementioned criteria may result in a rejection of the premium filing.

7.11.3 The Authority will complete an assessment of a licensed insurer's premium filing within eight weeks. The Authority may request additional information or amendments to the premium filing in order to ensure that the criteria of the Guidelines are met. Insurers are required to respond to requests for additional information or amendments promptly.

7.11.4 The Authority will advise a licensed insurer in writing once the assessment is complete, advising that the premium filing has not been rejected.

7.11.5 Once the Authority confirms that an assessment is complete and the premium filing has not been rejected, a licensed insurer must apply the rates and rating structure from commencement of the premium filing period without discretion.

7.11.6 Where a premium is rejected, the Authority will provide written notice of its rejection of a premium and the reasons for the rejection.

7.11.7 Where a premium is rejected, the Authority and the licensed insurer will adhere to the process defined in section 169 of the 1987 Act or as prescribed by the Regulation.

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8. Market practices

8.1 General market practices

8.1.1 A licensed insurer must:

a) observe proper standards of market conduct

b) pay due regard to the interests of its customers and treat them fairly

c) pay due regard to the information needs of its clients, and communicate information to them in a way which is clear, fair and not misleading

d) manage conflicts of interest fairly, both between itself and its customers and between a customer and another client

e) have adequate arrangements in place to secure compliance with these guidelines.

8.1.2 Licensed insurers must not engage in conduct that is misleading or deceptive, or likely to mislead or deceive, in relation to an employer or the market.

8.1.3 Where an insured employer has advised their licensed insurer, prior to the policy renewal that they wish to transfer their workers compensation insurance to another licensed insurer, the licensed insurer holding the policy must not hinder or delay the transfer.

8.1.4 A licensed insurer must not make a false or misleading representation about whether an employer can or cannot obtain workers compensation insurance from that insurer or from any other insurer.

8.1.5 A licensed insurer must act towards insured employers and beneficiaries under their workers compensation insurance policy, in respect of any matter arising under or in relation to the workers compensation insurance policy, with the utmost good faith. If reliance by an insurer on a provision of the policy would be to fail to act with the utmost good faith, the insurer may not rely on the provision.

8.1.6 Licensed insurers must notify insured employers of the renewal of their policies no less than six weeks prior to the date of renewal.

8.2 Premium compliance assurance programs

8.2.1 Each licensed insurer must maintain a program of premium compliance assurance to ensure that insured employers within their portfolio of insurance are compliant with their premium obligations in accordance with the relevant NSW workers compensation legislation, guidelines and rulings as issued and maintained by the Authority.

8.2.2 Each licensed insurer must report quarterly, to the Authority, all premium compliance assurance activities, findings and outcomes. The Authority may specify, from time to time, the format and reportable items required from each licensed insurer.

8.2.3 Each licensed insurer must provide the Authority with the files, data or any other relevant information in relation to the premium compliance assurance activities, as requested from time to time.

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8.3 Regulator premium information requirements

When requested by the Authority, each licensed insurer must provide the Authority with employer and policy information that is compliant with the requirements of the Policy technical manual issued by the Authority or as otherwise specified by the Authority.

8.4 Premium information for employers

8.4.1 Licensed insurers must make available to employers within their portfolio of insurance, a premium calculator which can be utilised to accurately estimate or reconstruct the premium charged to that employer.

8.4.2 The premium calculator must be accessible by employers at all times where possible.

8.4.3 Upon request, licensed insurers **must** provide to an employer, or their representative, information used in the calculation of the insurance premiums for that employer within five working days.

8.4.4 Information to be provided to employers must include all inputs into the calculation such as, but is not limited to:

a) claims costs information

b) remuneration used

c) industry classification

d) industry classification rate

e) any penalties, rebates or discounts applied (including capping or transitional provisions), or

f) any other information which is relevant to the calculation of the insurance premium.

8.4.5 Licensed insurers must make available the terms and conditions as per Schedule 3 of the Workers Compensation Regulation 2016 of their workers compensation policy to employers and potential employers on a publicly accessible website at all times.

8.5 Employer premium dispute process

8.5.1 Licensed insurers must have a published process in place where an employer may request review of aspects of their premium determination. The dispute process must as a minimum:

a) include contact details (department, address, email and telephone number) for the licensed insurer so that insured employers may lodge their complaints, reviews and appeals

b) advise of clear timeframes for lodging disputes

c) specify actions required by the employer and actions to be undertaken by the licensed insurer in order to expedite the dispute process

d) ensure that licensed insurers must acknowledge the employer's application within five working days

e) specify a reasonable timeframe in which the licensed insurer's review process will be completed, and

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f) specify how the licensed insurer will treat a review that requires additional information or where the insured employer or licensed insurer requires an extension of time.

8.5.2 The determination of a complaint, review or appeal must set out a detailed explanation of the basis for the decision and the reasons for arriving at that determination.

8.5.3 A licensed insurer's internal complaints handing and dispute resolution process must be consistent with *Australian/New Zealand Standard AS/NZS 10002:2014 Guidelines for complaint management in organizations*.

8.5.4 Insured employers may seek a further review by the Authority within 28 days of the licensed insurer's determination if a resolution is not reached with the licensed insurer to the satisfaction of the insured employer.

8.5.5 The licensed insurer must provide the contact details of the Authority to the insured employer so that they may seek a further review where they are not satisfied with the outcome of the insurer's determination.

8.5.6 Where the insured employer remains unsatisfied with the licensed insurer's determination, the Authority will investigate any complaint or request for review to determine if a premium has been written that is not compliant with the premium filing of the licensed insurer. The licensed insurer must provide the Authority with any information as requested by the Authority in the investigation of the employer's complaint, review or appeal.

8.5.7 Each licensed insurer must report quarterly, to the Authority, all complaints, reviews and appeals activities, findings and outcomes. The Authority may specify, from time to time, the format and reportable items required from each licensed insurer.

8.5.8 The Authority may audit a licensed insurer under section 202A of the 1987 Act regarding compliance with the Guidelines where it is considered appropriate.

9. Annexures

Annexure A – NSW Workers Compensation Classification System

Annexure B – Recovery of excess from employer

Annexure C – Late payment prescribed amount

Annexure D – Motor vehicle and accommodation allowance

Annexure E – Review of Primary Activity Guideline

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Disclaimer

This publication may contain information that relates to the regulation of workers compensation insurance, motor accident third party (CTP) insurance and home building compensation in NSW. It may include details of some of your obligations under the various schemes that the State Insurance Regulatory Authority (SIRA) administers.

However to ensure you comply with your legal obligations you must refer to the appropriate legislation as currently in force. Up to date legislation can be found at the NSW Legislation website legislation.nsw.gov.au

This publication does not represent a comprehensive statement of the law as it applies to particular problems or to individuals, or as a substitute for legal advice. You should seek independent legal advice if you need assistance on the application of the law to your situation.

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Workers and Home Building Compensation Regulation

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