Property Casualty Insurers
Association of America

Advocacy. Leadership. Results.

Written Comments of Kristina Baldwin
Property Casualty Insurers Association of America
New York State Department of Financial Services Public Hearing – June 25, 2013
Proposed Workers Compensation Insurance Loss Costs 2013

The Property Casualty Insurers Association (PCI) appreciates the opportunity to provide comments on the New York Compensation Insurance Rating Board (NYCIRB) 2013 Loss Cost Filing. PCI respectfully requests that the Department of Financial Services (DFS) consider approving this critical filing in order to maintain a competitive workers compensation market. PCI is composed of more than 1,000 member companies, representing the broadest cross section of insurers of any national trade association. PCI members write more than 38 percent of the commercial property and liability market, and 41 percent of the private workers compensation market. The companies represented by the PCI insure employers of all sizes in New York.

The NYCRIB is proposing an overall average loss cost change of +16.9%. PCI believes that insurance pricing is an important economic issue. Worker compensation premiums are directly affected by changes in the workers compensation benefits, medical costs, and system changes. Specifically, per NYCIRB, the proposed change is the result of continued adverse experience of the New York Workers Compensation carriers and is attributable to the following factors:

- Continued rise in medical claim costs;
- The average time from accident to classification has been increasing steadily, resulting in longer temporary benefits and higher overall indemnity costs;
- Transfer of costs to carriers due to the closing of the Reopened Case Fund; and
- Increase in minimum and maximum weekly benefits

Note that 4.5% of the proposed increase is related to the future workers compensation loss costs associated with the closing of the Reopened Case Fund. However, because of the hard closing date of January 1, 2014, reopened claims involving accidents from 2006 to 2013 become the responsibility of the insurer. This unfunded liability creates an additional impediment to a competitive market.

A competitive workers compensation marketplace provides employers with significant choice among insurance providers. To maintain a competitive market, insurers need to be able to charge adequate premiums so that they can provide the best services to employers. It is critical that DFS consider approving the proposed change filed by the NYCRIB, especially, in light of the fact that last year, the DFS turned down NYCIRB's request for an 11.5% increase. The NYCIRB's 2013 filing indicates that underlying costs are continuing to increase. The cost-savings from the 2007 reforms have not yet been fully realized. If this filing is disapproved in the face of increasing underlying costs, insurers may not write the marginal accounts, resulting in an increase in the NY State Insurance Fund, which already has a market share of 41%.

The Herfindahl-Hirschman Index (HHI) is a commonly accepted measure of market concentration. The U.S. Department of Justice uses the HHI for evaluating mergers. The U.S. Department of Justice considers a market with a result of less than 1,500 to be a competitive marketplace; markets in which the HHI is between 1,500 and 2,500 to be moderately concentrated, and markets in which the HHI is in excess of 2,500 to be highly concentrated. The New York WC market has a HHI of 1743, falling in the moderately concentrated range. The HHI is strongly driven by the 2012 large market share of the NY

State Insurance Fund which has a 41% market share. Again, if this filing is not approved, we anticipate that the fund's market share will continue to grow, leaving New York employers with little choice.

In the 1980's, well-meaning regulators in a number of states, tried to protect the employer community from rising costs by refusing to grant needed rate increases to cover rising losses. In some states, this resulted in carriers departing the market and a rapid growth in the residual market-which had to be subsidized by the remaining insurers and their policyholders. Eventually, rates had to be increased by very large amounts to protect insurer solvency. Instead of protecting employers, these regulators actually hurt them. PCI is very concerned that insurers will not be able to continue to write business in New York at depressed rate levels. We do not want to see the experiences that occurred in the 1980's to be replicated in New York.

Also, insurers are facing significant uncertainty regarding the reauthorization of the federal Terrorism Risk Insurance Act, scheduled to sunset on December 31, 2014. The New York Workers Compensation Act mandates coverage for terrorist acts that occur in the workplace. Inadequate premiums combined with the potential loss of TRIA may cause significant market disruption.

PCI believes it is best to allow market forces to work as freely as possible. New York employers need a healthy, competitive workers compensation market. If this filing is not approved, the ultimate outcome could be a highly concentrated workers compensation market and less insurance choices for employers.

Thank You

Kristina Baldwin
Vice President
Property Casualty Insurers Association of America
518-443-2220
90 South Swan Street
Albany, NY 12207

TESTIMONY OF DAVID DICKSON, PUBLIC MEMBER
NEW YORK COMPENSATION INSURANCE RATING BOARD
TO
THE SUPERINTENDENT OF THE DEPARTMENT OF FINANCIAL SERVICES
REGARDING
THE NEW YORK COMPENSATION INSUANCE RATING BOARD'S 2013
WORKERS' COMPENSATION LOSS COST FILING

As a public member of the Underwriting Committee of the New York Compensation Insurance Rating Board (NYCIRB), I submit the following comments regarding the 2013 workers' compensation loss cost filing.

The 2008 legislation, reconstituting the NYCIRB, as the rate service to the Department of Financial Services, included an important change to add transparency; creating voting seats of public membership, equal to the voting seats of the commercial insurance carriers.

As the purpose of this public hearing is to solicit comments regarding the submission of the NYCIRB 2013 loss cost filing, and as this filing is the result of a vote by members of the Board of Governors of NYCIRB, it is then in the public's interest that a reporting of that vote be made public and be included as part of the record of this hearing. It is that vote that led to this matter.

I would also like to again bring to the attention of the Department of Financial Services that equal voting membership on the Underwriting Committee of NYCIRB, as not been achieved. The voting chairs reserved for the Department of Financial Services as well as for the New York Business Council, remain unfilled. It is 2013, and well past the time when equal voting membership on the Committee should have been achieved.

Late last year, October 2012, New York was "embarrassed" by Bi-annual Premium Rate Ranking Study published by the Oregon Department of Consumer and Business Services. That study indicated that New York workers' compensation cost to its employers were 150% of the study's median costs for the 50 states and the District of Columbia. Only Alaska, Connecticut, California and Illinois ranked higher than New York. While there has been some explanation regarding the ranking due to differences in occupational distributions, there still remains that fact that states with similar occupational distributions to New York ranked significantly better than New York.

A comparison of New York's occupation distribution with Oregon's does not explain the differences between New York #5 ranking, and Ohio at #28, or Massachusetts at #44 or Virginia at #48. The Oregon rate study should be taken as a wake-up call.

If one were to review the record on New York's efforts regarding workplace safety as well as workers' compensation fraud, Oregon's study is not a surprise.

According to the U.S. Bureau of Labor Statistics, New York record on workplace accidents involving time away from work, exceeds national averages, as well as rates for similar states. These accident rates include private and public incidents.

The most expensive workers' compensation claim, is one which should have been avoided. Time and again New York apparently has failed to grasp that concept. The 1996 Legislation enacting incentives for the establishment of workplace safety, have never been implemented. The Workplace Safety and Loss Prevention – Industrial Code Rule 59, establishing mandatory workplace safety programs for employers with high workers' claim experience, has failed. Industrial Code 60, established to provide incentives for establishing workplace safety, drug and return to work programs, due to extensive compliance standards, as well as pitiful incentives to employers, has gone nowhere.

New York continues to play lip service to workers' compensation fraud. Employers, employees, medical providers, and all other vendors in the system know and take advantage of this "service". For the past year and a half, there has not been a single investigator in the Fraud Inspector General's Office for the area west of the state west of Rochester. There is only one full time investigator for Suffolk, Nassau Counties and the five boroughs of New York City.

The record for statewide prosecutions pursuant to Section 52 give further evidence of the level of state enforcement:

Year	Criminal Prosecutions
2009	15
2010	7
2011	6
2012	29*

*Includes 24 prosecutions brought by the Kings and New York County DAs.

New York has "earned" its ranking.

I submit that to disallow this proposed loss cost filing, will only lead to an even larger request next year. New York needs to grasp the fundamental need to have workplaces where employees can safely work. New York needs to undertake the need to re-establish a fair workers' compensation system where all can expect that "following the rules" would not be an impairment. New York needs to undertake a proper leadership role. Otherwise, New York should become used to Oregon's ranking.

Respectfully submitted,

David Dickson

The Business Council

Testimony to

New York State Department of Financial Services

NYCIRB 2013 Loss Cost Filing

Presented by

Lev Ginsburg, Esq.
Director of Government Affairs

June 24, 2013

My name is Lev Ginsburg. I am Director of Government Affairs for the Business Council of New York State and a public member of the New York Compensation Insurance Rating Board's Board of Governors. On behalf of the Business Council's more than 2,500 members – businesses large and small all across the state – I wish to submit these comments into the record as part of the consideration for the filed 2013 loss cost.

As the state's leading business organization we begin our testimony with the acknowledgement that the proposed 16.9 percent increase in loss-costs that insurers would use as the foundation of their rate-setting for 2014 premiums is obviously not the formula outcome we had hoped for. However, we firmly believe that the numbers, like the rate-settings must reflect the true costs of the system. Importantly, it has to be stressed that this loss cost analysis is a calculation of the actual cost of workers' compensation benefits, not the cause of those cost increases.

The real issues facing New York's employers are not loss-cost numbers, mathematically calculated by NYCIRB, but a comp system that remains deeply troubled, and as expensive as before the 2007 Spitzer reforms. New York's workers' compensation rates have dramatically risen over the last six years, driven by increases in maximum benefits indexed to the state's average weekly wage, increases in medical costs, growing scheduled loss of use awards, endless litigation and what was, until very recently, a slow and inefficient implementation of reform measures meant to curb costs.

It should be noted, as the Department of Financial Services contemplates this current rate increase, that last year's proposed loss-cost of 11.5% was denied in its entirety. Part of the reasoning for that denial, as articulated in DFS's opinion was that, "New York's workers' compensation system is in a state of considerable transition in light of the 2007 reforms and the subsequent steps taken by the State in furtherance of the implementation of those reforms…and that the full impact of the 2007 cost-saving reforms remains to be seen."

Unfortunately, the full impact, or any significant impact, of any cost-saving measures from the 2007 reforms still remains to be realized today. The Governor in his FY 2014 budget enacted a variety of comp system reforms that not only acknowledged the reality that comp costs are moving in the wrong direction but took some significant steps to address problems in the system.

These reforms, while welcomed, were incomplete. The administration's proposed repeal of mandatory payments to the state's aggregate trust fund, imposed only on commercial carriers, estimated to save $150 million and speed up the classification process, was strongly opposed by the Assembly Democrats, backed by the claimant's attorney bar, and did not make it into the final agreement. The ATF will therefor continue to put further upward

pressure on costs. All the while, various legislative bills attempting to undo any cost-savings measures from the 2007 reforms continue to be introduced.

The Workers' Compensation Board has recently committed to an initiative aimed at speeding up classification of permanent partial disabilities. The Business Council expects this initiative will be successful in expediting classification and the commencement of case-specific PPD durational caps. Moreover, we continue to urge the administration to reexamine the system by which scheduled loss of use awards are determined. The process currently utilizes injury recovery assumptions, many of which are nearing thirty-years old. Making these determinations based on very old and out of date medicine, coupled with a maximum weekly benefit, now over $800, is a major factor in explosive system costs.

As we remain committed to working with the administration in its ongoing efforts to implement cost-saving reforms necessary to maintain the balance intended in the 2007 reform package, the loss cost considered today must be based on the latest statistical data reported by carriers and accepted actuarial principles and methodologies and not unrealized expectations of cost savings. Making a loss cost decision based on the real costs in the system is imperative to New York's businesses because failure to do so undermines market stability, which leads to a more limited comp insurance market in the state and ultimately to severe increases in costs for employers large and small.

New York needs its policymakers to concentrate on the need for meaningful, cost-cutting worker's comp reforms to control the year-to-year loss cost increase requests highlighted by today's public hearing. The Governor recognized this reality with his reforms enacted this spring. We hope this signals a continued effort to reform the real cost drivers in the system.

TESTIMONY
OF THE
NEW YORK WORKERS' COMPENSATION ALLIANCE
AND THE
NEW YORK COMMITTEE FOR OCCUPATIONAL SAFETY AND HEALTH
TO THE
NEW YORK DEPARTMENT OF FINANCIAL SERVICES
REGARDING
THE 2013 WORKERS' COMPENSATION RATE FILING REQUEST
OF THE
COMPENSATION INSURANCE RATING BOARD

By: Robert E. Grey
Chair, Workers' Compensation Alliance
Treasurer, New York Committee for
Occupational Safety and Health

I. INTRODUCTION.

The New York Compensation Insurance Rating Board (CIRB) has submitted a Loss Cost Filing for October 1, 2013 seeking an increase of 16.9%.[1] In support of its filing, CIRB cites increased medical costs, slow implementation of the time limitations on permanent partial disability claims, closure of the Reopened Case Fund, and increases in the maximum and minimum rate.[2] Contrary to CIRB's lost cost filing, Governor Cuomo previously estimated that the portions of the 2013 budget related to the workers' compensation system would achieve savings of $800 million.[3]

The Workers' Compensation Alliance ("WCA") is a political action committee that advocates for the interests of injured workers in New York's workers' compensation

[1] NYCIRB Loss Cost Filing, October 1, 2013; see also R.C. 2235, 5/29/13.
[2] R.C. 2335
[3] http://www.governor.ny.gov/press/03292013-2013-14-budget

system.[4] The New York Committee for Occupational Safety and Health (NYCOSH) is a non-profit coalition of labor unions and individuals dedicated to ensuring that every worker has a safe and healthful job.[5] Its membership includes more than 175 local unions and over 300 individual workers, physicians, lawyers and other health and safety activists. The WCA and NYCOSH submit this testimony in opposition to the rate filing request of the Compensation Insurance Rating Board ("CIRB").

Our testimony broadly addresses four areas: (1) CIRB's lack of transparency and accountability as a rate service organization; (2) the inconsistency of the rate filing with legislative and regulatory developments; (3) the inconsistency of the rate filing with state and national trends; (4) the profit motive underlying the rate filing.

II. THE SYSTEM LACKS TRANSPARENCY AND ACCOUNTABILITY.

Despite the addition of several public members to the CIRB Board in 2007, its data continues to be drawn from the unaudited self-report of information by private insurers. Moreover, due to a variety of factors – not least of which is the failure of certain public members to fulfill their responsibility to appoint representatives to all of the relevant committees – CIRB continues to be controlled by private insurers. As a result, the inclusion of public members on the CIRB Board has failed to achieve the goal of creating transparency and accountability regarding the data that forms the basis of CIRB rate filings.

The absence of transparency and accountability by CIRB is exacerbated by the historic lack of reliability of its projections, due in part to significant inconsistencies

[4] http://www..nyworkerscompensationalliance.org
[5] http://ww.nycosh.org

between CIRB's data collection and the nature of New York's workers' compensation system. This is especially unfortunate given the fact that CIRB analyses and rate filings play a role in the development of public policy. Good public policy cannot be derived from poor or unreliable data.

The failure to create effective public participation in CIRB is detrimental to the interests of employers, injured workers, and the State of New York. The existing "rate service organization" model fails to appreciate that private insurers have an inherent interest in maintaining employer costs at a high level, because carrier profits are derived as a percentage of those costs.

These concerns are further detailed below.

A. Lack of transparency, credibility, and corroboration.

By statute, CIRB is New York's statutory rate service organization. However, its structure, data sources, and lack of accountability preclude it from functioning as a credible rate-filing entity. Prior to the 2007 statutory amendments, CIRB was composed solely of representatives of the private insurance industry. It receives self-reports from private insurance carriers regarding their claim experience, and translates those reports into "data" in support of rate applications. Said rate applications, of course, benefit the very entities that compose CIRB itself. There are a number of fundamental issues raised regarding the transparency, accuracy, and credibility of this process.

The 2007 amendments added several public members to CIRB in an effort to encourage transparency and accountability. Regrettably, the addition of the public members has failed to alter the dynamic of the CIRB Board, which results in retention of

control by the private insurers. This situation is exacerbated by the failure of certain public members to designate participants in all stages of CIRB's processes.

There continues to be no evidence that CIRB effectively audits or verifies the accuracy of the information it receives from insurers. As a result, the reliability of CIRB data has been previously criticized by the Department of Financial Services (and its former component, the Insurance Department). For example, in 2006 the Insurance Department disapproved CIRB's filing for a rate increase based on skepticism about the accuracy of insurer claims.[6] The Insurance Department observed at that time that insurers are not intended to have "underwriting profit" in which premium collected exceeds claims paid. The target number in that regard is 0%, and insurers are expected to profit solely through "investment return." In 2011 CIRB's rate filing was significantly reduced based on its inability to explain the divergence between the alleged experience of private insurers and the experience of the State Insurance Fund, and in 2012 its rate filing was again disallowed in the entirety by the Department of Financial Services.[7]

B. CIRB data cannot be verified by or compared to data from other sources.

CIRB receives data only from private insurers and the State Insurance Fund, which together amount to about two-thirds of the market in New York.[8] The self-insured sector of the market (the other one-third) does not report data to CIRB or to any other

[6] In the Matter of Workers' Compensation Insurance Rate Application of the New York Compensation Insurance Rating Board, Opinion and Decision of New York State Insurance Department, 7/17/06, available at http://www.ins.state.ny.us/wc/wc_index.htm.

[7] Opinion and Decision of the Department of Financial Services, July 16, 2012, available at http://www.dfs.ny.gov/insurance/hearing/wc_06252012/wc_06252012_Opinion_Decision.pdf

[8] Report to the Governor from the Superintendent of Insurance Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy, NYS Insurance Department, at pp. 21-22, available at http://www.ins.state.ny.us/wc/wc_index.htm.

source. The lack of reporting by self-insurers represents a loss of invaluable data that could be used as to verify the accuracy and credibility of CIRB rate filings.

Similarly, the Insurance Department previously found it to be difficult, if not impossible, to compare CIRB's data to that collected by the Workers' Compensation Board ("the WCB") because the systems used by these entities are fundamentally incompatible.[9] As a result, the accuracy of the information collected and reported by one cannot be cross-checked by reference to that of the other.

For example, in its 2008 Report to the Governor, the Insurance Department found that CIRB had reported 154,598 claims for 2003. The Department therefore added one-third to that figure in order to account for the self-insured sector, arriving at the conclusion that there were 206,079 claims in 2003.[10] The WCB, however, had indexed only 149,808 claims in 2003.[11] In short, CIRB (accounting for two-thirds of the market) had more claims reported to it than the WCB (covering the entire market) indexed.

Clearly there is a significant variation between the data collection and reporting mechanisms of CIRB and the WCB. This variation, like the absence of data from the self-insured sector of the market, deprives the Department of critical information that could be used to verify CIRB's data.

In addition, the manner in which CIRB collects data is not compatible with relevant workers' compensation practice. The most relevant example is CIRB's claim about the cost of permanent partial disability claims, which was a fundamental basis of the 2007 legislation time-limiting permanent partial disability benefits. Prior to the enactment of the legislation, the method by which CIRB calculated the cost of permanent

---

[9] Report to the Governor at pp. 21-23.
[10] Id. at p. 24.
[11] Summary Annual Report of the Workers' Compensation Board, 2003.

partial disability awards was not generally available. In 2008, the Insurance Department found that CIRB does not distinguish between schedule loss of use awards (which are finite awards for permanent injury to extremities) and permanent partial disability awards. "Instead, CIRB splits PPD into major and minor categories. Separating PPD data as scheduled and non-scheduled is critical information."[12] The Insurance Department further observed that CIRB's determination of whether a "PPD" claim was "major" or "minor" depended on whether the carrier's reserves on the claim were more or less than $22,000.[13] Assuming that CIRB has continued to use the same methodology, a worker earning $900 per week who was injured after July 1 2009 would be entitled to an award of $22,000 or more with a schedule loss award for 11.5% of an arm, or 12.5% of a leg. It is therefore apparent that counting all "major PPD" claims as permanent partial disabilities results in a vast overestimation of the cost of permanent partial disabilities.

The lack of reliability, transparency, and accountability in CIRB data, which is compounded by the inability to easily compare and corroborate it with information from other data sources, calls into question the extent to which it should be utilized by the Department in setting workers' compensation loss costs. We continue to believe that authorization for CIRB to function as a rate service organization should be permitted to sunset and that the Department of Financial Services should assume those functions.

III. THE RATE FILING IS INCONSISTENT WITH LEGISLATIVE AND REGULATORY DEVELOPMENTS.

There are four areas of legislative and regulatory development that significantly impact CIRB's rate filing: permanent partial disability claims ("PPDs"),

[12] Report to the Governor at p. 22.
[13] Id. at p. 22, footnote 24.

increases in the maximum and minimum rate, medical costs, and closure of the Reopened Case Fund. Each is discussed below.

A. PPD claims.

The 2007 reforms related to time limitations on permanent partial disability benefits (the PPD caps) became effective on March 13, 2007. If a worker was injured on that date, was found to be permanently partially disabled precisely two years later,[14] and was assigned the shortest available cap period of 225 weeks, that worker would still be entitled to workers' compensation benefits until July of 2013. This example represents the shortest conceivable time frame in which a permanently partially disabled worker could have his or her benefits terminated as a result of the 2007 amendments. It was apparent to all private and public actors at the time of the 2007 legislation that the full cost savings related to the "PPD caps" would not materialize until at least 2015.

It was also clear at the time of the 2007 amendments that there would be a significant staged increase in the maximum weekly benefit rate from 2007 through 2010, and that the maximum weekly benefit rate would thereafter continue to rise incrementally.

Thus, insurers were able to predict in 2007 that (1) no injured worker would have his or her benefits terminated until mid-2013 at the earliest, and that the broader impact of the PPD caps would not occur until at least 2015; and (2) the maximum benefit rate would nearly double by 2010.

[14] Two years is generally the shortest time frame to classification under the 1996 Workers' Compensation Board Medical Guidelines.

In possession of this information, CIRB submitted premium reductions of 18.4% in 2007 and 6.4% in 2008, a total premium reduction of 24.8% in two years. These decreases were not based on the expectation that the PPD benefits of any worker would actually be terminated in 2007 or 2008, but rather were based on the impact of the PPD caps on reserves and settlements. Insurer exposure was further reduced by the advent of "indemnity only" Section 32 settlements, which permit the transfer of medical liability to the Special Fund for Reopened Cases (the 25-a Fund).

Despite these facts, CIRB continues to refer to the "slow pace" of implementation of the time limitations ("caps) on PPD claims that were imposed as part of the 2007 workers' compensation reform legislation. In its rate filing, however, CIRB acknowledges "that most carriers now set reserves based on their estimates of post-reform benefits, within one or two years of the date of injury, and that no carriers reflect lifetime benefits for PPD claims."[15] This undermines the claim that slow implementation of the PPD caps has significantly increased costs. Notwithstanding the concession that all carriers set reserves based on the caps, however, CIRB's loss cost filing inexplicably calculates PPD costs based on one-third of current claims being for lifetime benefits.[16] CIRB offers no justification for this obviously artificial inflation of PPD costs.

In addition, CIRB's longstanding claim that PPDs are a significant cost-driver remains dubious. It must be observed that from 2007 – 2012 the maximum weekly benefit doubled, yet employer premiums in 2012 are still slightly lower than in 2006 – notwithstanding the assertion that the PPD caps have not been implemented. There are only two possible conclusions that can be drawn from this set of facts. One possibility is

[15] NYCIB Loss Cost Filing October 1, 2013 at p. 4
[16] Id.

that the existence of the supposedly unimplemented PPD caps has had a downward impact on costs, thus offsetting the increase in the maximum benefit. This would disprove CIRB's claim that slow implementation has driven costs up. The other possibility is that PPDs are not and never have been a significant cost-driver, which would disprove CIRB's contentions to the contrary. In either event, CIRB's contentions are unsupported by actual experience.

B. Increased maximum and minimum weekly benefit rate.

Insurer contentions about the impact of the increase in the maximum workers' compensation benefit rate are overstated. Department of Labor data has demonstrated that the maximum benefit rate impacts only a small number of injured workers, and that this number is further diminished as the maximum rate rises.

The chart below is drawn from the 2009 and 2010 Annual Safety Net Reports of the Commissioner of Labor and demonstrates the wage distribution of permanently partially disabled claimants. Over two-thirds of injured workers have average weekly wages below $800, which limits their maximum workers' compensation benefit to $533.33 per week or less. Therefore, increases in the maximum benefit rate beyond $533.33 per week are relevant to less than one-third of injured workers.

Average Weekly Wage for PPD NSL Claimants
(with Degree of Disability and Duration Cap Established)
(Accident Dates March 13, 2007 – June 30, 2009)

	2009	2009	2010	2010
Average Weekly Wage	No. of Claimants	% of Total	No. of Claimants	% of Total
Less than $200	5	4.4%	12	2.1%
$200 - $299	11	9.6%	32	5.5%
$300 - $399	11	9.6%	55	9.5%
$400 - $499	17	14.9%	77	13.3%
$500 - $599	9	7.9%	70	12.1%
$600 - $699	21	18.4%	99	17.2%
$700 - $799	11	9.6%	58	10.1%
$800 - $899	7	6.1%	38	6.6%
$900 - $999	4	3.5%	26	4.5%
$1,000+	18	15.8%	107	18.5%
Total	114	100.0%	577	100.0%

It is critically important to recognize, however, that even the minority of injured workers who earn enough to receive the maximum benefit rarely do so for any appreciable length of time. The law provides reduced benefits for partial disability. In cases of temporary disability, insurer use of so-called "independent medical examinations" generally results in benefit reduction within two months of the date of accident. In cases of permanent disability, virtually no workers are found to be permanently totally disabled. Thus, there is a significant discrepancy between the existence of an increased maximum rate and its actual utilization in the system.

It is therefore clear that increases in the maximum benefit rate beyond $533.33 per week have had an extremely limited impact on costs in cases involving permanent partial disability. The increased rate is not available to over two-thirds of injured

workers, and even those to whom it is theoretically available do not receive increased compensation benefits for significant periods of time.

CIRB's filing recognizes that the current incremental increase in the maximum rate accounts for a mere .5% increase in loss costs.[17] Even this figure likely overestimates the impact of the increased maximum rate. CIRB similarly recognizes that the increase in the minimum rate is insignificant from a cost standpoint, variously estimating it at 0.3% and 0.4%.[18]

We respectfully submit that the overall impact of increased maximum and minimum benefit rates is negligible.

C. Medical costs.

While asserting that medical costs are rising slightly, CIRB's rate filing fails to assess the impact of the Workers' Compensation Board's Medical Treatment Guidelines. The Medical Treatment Guidelines (MTG), which were proposed by insurers and which were projected to reduce costs through the limitation of medical treatment, were issued three years ago and were recently expanded to cover additional diagnoses and chronic care. The MTG have resulted in the submission of 20,000 "variance requests" per month, each of which requires a response by the liable insurer and in most cases also requires adjudication by the Workers' Compensation Board.[19] A WCA analysis of the available information has resulted in a conclusion that the implementation of the MTG results in administrative and litigation costs that are potentially double the cost of the medical

[17] Id. at p. 8
[18] Id, see also NYCIRB Analysis of Proposed Bills to Reform the Workers' Compensation System, 3/14/13 at p. 1
[19] Workers' Compensation Board FOIL response is available at: http://www.nyworkerscompensationalliance.org/uploads/file/MTGFoilResponse.pdf

treatment involved.[20] In short, the implementation of this particular "reform" has increased costs. To the extent that its implementation occurred at a "slower pace," the delay may have actually reduced costs.

It is likely that a portion of the increased costs are not attributable to medical treatment, but rather are due the administrative and regulatory costs associated with the Medical Treatment Guidelines. It is difficult to assess the accuracy of CIRB's projections for medical costs absent a more detailed assessment of the cost of the Medical Treatment Guidelines.

D. Closure of the Reopened Case Fund.

CIRB asserts that closure of the Reopened Case Fund accounts for a 4.5% increase in loss costs.[21] Once again, this estimate appears to be unrelated to actual system experience regarding claims against the Reopened Case Fund. Fewer than 2% of the hearings held by the Workers' Compensation Board are concerned with the issue of claims against the Reopened Case Fund, and according to the chief executive officer of the Fund 80% of the claims against it are "medical-only."[22] It therefore appears that the reincorporation into premium of costs that were previously funded through assessments will be significantly less than the 4.5% estimated by CIRB. Moreover, from an employer perspective, assessments should decline in an amount equal to or greater than any increase in premium.

[20] WCA analysis is available at: http://www.nyworkerscompensationalliance.org/uploads/file/MTGCostUpdate3-9-12.pdf
[21] NYCIRB Loss Cost Filing, October 1, 2013 at p. 10
[22] "Alliance Calls on Lawmakers to Shut Down Reopened Case Fund," WorkCompCentral 9/24/12

IV. THE RATE FILING IS INCONSISTENT WITH STATE AND NATIONAL TRENDS.

Exhibit EE to CIRB's loss cost filing demonstrates that there are no fundamental claim trends that justify the request for a 16.9% increase. Exhibit EE, Sheet 1 demonstrates a steady decline in claim frequency since 2007, which is itself consistent with long-term trends.[23] Exhibit EE, Sheets 2 and 3, show only mild increases in indemnity severity and medical costs, which may well be offset by the decline in frequency.[24]

By way of comparison, NCCI reports significantly decreased frequency in lost time claims (5%) and only minimal increases in indemnity claim costs (1%) and severity (2%).[25]

These trends are entirely inconsistent with CIRB's loss cost filing seeking an increase of 16.9%, and again call into question the credibility of the rate filing.

V. THE RATE FILING IS DRIVEN BY INSURER PROFITS, NOT SYSTEM COSTS.

The present loss cost filing is also inconsistent with available information about workers' compensation costs and insurer profits. Nationally, NCCI recently reported that workers' compensation combined ratios are improved, loss ratios have declined, loss adjustment expenses have declined, policyholder dividend ratios are up, investment returns are stable, operating results are improved, and pre-tax operating gain ratios are

[23] NYCIRB Loss Cost Filing, 10/1/13, Exhibit EE, Sheet 1
[24] NYCIRB Loss Cost Filing, 10/1/13, Exhibit EE, Sheets 2 and 3
[25] NCCI State of the Line, 2013 Annual Issues Symposium, May 16, 2013 at pp. 39, 42-43

up.[26] The chief executive officer of AmTrust, a large national workers' compensation insurer, has said that it is "seeing tremendous growth in the workers' compensation market," especially in New York.[27] Liberty, Hartford, and AIG also reported significant growth in business in workers' compensation lines.[28]

A variety of provisions in the 2013 budget impacted the State Insurance Fund ("SIF") and are expected to increase the SIF's costs comparative to private insurers. This will in turn make private insurers more competitive with the SIF. According to Fred Buse, a former member of CIRB's Board of Governors, "[t]he State Insurance Fund ahs been able to give its policyholders a real price advantage, and the private carriers have been complaining about it."[29] The impact of the budget is to eliminate that price advantage, which insurers "have been complaining about for years."[30]

There is no economic evidence that a major increase in loss costs is required in New York's workers' compensation marketplace. There is no evidence that claim costs are undergoing any appreciable increase. Instead, insurer profit and loss in workers' compensation lines is attributable to market conditions and interest rates.[31] Insurer failure to properly manage reserves and investment portfolios should not be remedied by passing on increased costs to New York's employers, or through benefit cuts for New York workers.

---

[26] Id. at pp. 16-18, 21-23, 25
[27] "Comp Rates Outpacing Losses for 7 Quarters Straight," WorkCompCentral 3/20/13
[28] Id.
[29] "Builders, Nonprofits Oppose Cuomo Raid on SIF Reserves," WorkCompCentral 3/8/13
[30] Id.
[31] "Analysts See P&C Insurance Rate Increases Continuing in 2014," WorkCompCentral 6/7/13

VI. CONCLUSION.

The WCA and NYCOSH submit that CIRB's application for a 16.9% increase in loss costs should be rejected. The WCA and NYCOSH also call the Department's attention to the provisions of the 2007 Workers' Compensation Reform Act that were intended to remove CIRB from data collection and rate-making functions. These provisions remain unfulfilled, and each annual rate filing makes it clear that this is an oversight that should be rectified.

Dated: June 12, 2013
New York, New York

Respectfully submitted,

Robert E. Grey
Chair, WCA
Treasurer, NYCOSH

ANDREW M. CUOMO
GOVERNOR

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
328 STATE STREET
SCHENECTADY, NY 12305
(518) 408-0469
FAX (518) 473-1415

ROBERT E. BELOTEN
CHAIR

JEFFREY FENSTER
EXECUTIVE DIRECTOR

July 1, 2013

Benjamin M. Lawsky, Superintendent
Department of Financial Services
One State Street
New York, New York 10004-1511

Dear Superintendent Lawsky:

As you know, the enacted 2013-14 Budget fundamentally changed the assessment process in New York State beginning 2014 and closed the Fund for Reopened Cases (Fund) effective January 1, 2014. It is our expectation that the closure of the 25-a Fund will result in a reduction in assessments and administrative costs and it will also shift future liabilities to payers better equipped to assess long term liability and control costs over the life of the claim.

2014 Assessment Changes

The enacted 2013-14 Budget drastically changed the way New York State workers' compensation assessments will be billed and collected. Historically, the Workers' Compensation Board has billed the various statutory assessments individually. The basis for payers assessment bills varied depending on coverage type. Private insurers were billed as a percentage of premiums, the State Insurance Fund and self-insured employers were billed based on indemnity payments.

The new law dramatically simplifies the assessment calculation and billing process. While the exact process will be announced by official regulation later this year, what follows is a summary of the new assessment process. First, all statutory assessments, with the exception of the so called Self Insurers Assessment, will be combined into one assessment. By November 1, 2013, and every year thereafter, the Workers' Compensation Board will publish an assessment rate, as a percentage of premium or premium equivalent for self-insured employers, to be used by all payers beginning January 1 of the upcoming calendar year. Private carriers and the State Insurance Fund will collect the assessment from their insureds and pass those funds on to the Workers' Compensation Board.

Fund for Re-Opened Cases Background

The Fund was established in 1933 and provides payments directly to claimants and health providers when the claimant's case is reopened under certain circumstances:

- The case was previously disallowed or closed without compensation and is reopened after a lapse of 7 years from date of accident;
- The case is reopened 7 years after the date of accident and at least 3 years after the last compensation payment; or
- Death occurs after 7 years from the accident in non-compensated cases or after 7 years from the date of the accident and at least 3 years after the last compensation payment.

Supplemental benefits are also paid out of the Fund and reimburse for payments to totally disabled individuals or the spouses of deceased individuals where the date of accident or death occurred on or before 12/31/78; the Fund reimburses the supplemental portion of the payment. Finally, the Fund also reimburses payments to totally disabled volunteer firefighters and ambulance workers where the date of accident occurred on or before 12/31/98.

Chapter 57 of the Laws of 2013 enacted on March 29, 2013 states that "no application…for transfer of liability of a claim to the Fund for Reopened Cases shall be accepted by the Board on or after the first day of January, 2014….".

Assessment History

Historically, as per WCL 25a(3), the Fund is to be fully reserved and funded, including an additional reserve equal to 10% of the sum of future claims liabilities. Pursuant to the statute, as soon as practicable after 1/1 of each year, the condition of the fund is reviewed and whenever the assets fall below the prescribed minimum, the WCB assesses and collects from carriers, self-insured employers and the State Insurance Fund.

Based upon the statutory formula, the annual assessments for the past five years have been as follows:

Fund for Reopened Cases
Annual Assessments

Year Billed	*Amount*
2009	$181,717,835
2010	$267,022,251
2011	$322,752,373
2012	$249,808,526
2013	$314,280,175

As discussed, the statutory formula for maintaining the Fund for Reopened Cases requires assets at least equal to reserves. Therefore, assuming the reserves are adequately stated, the assets of Fund should theoretically be sufficient to pay existing claims without further assessments/collections given the 10 percent cushion. However, without the benefit of a full actuarial review it is unclear if the cases will develop as currently projected, if the current funding levels are adequate or if additional assessments will be necessary.

Impact on 2014 Assessment Year:

The WCB has taken steps towards selecting a vendor to conduct a full actuarial review of the Fund and based upon the results of that review will determine the adequacy of the current

reserves. This review is expected to be complete sometime in 2014. Therefore, in the interim, and at least for the 2014 rate year, additional assessments for the Fund will not be included in the assessment rate. This will result in a reduction in the overall assessments for 2014 of roughly $300 million or approximately 5% of what the assessment would have been had it not been for legislative action this year. Additionally, increases in the overall statewide premium base resulting from a loss cost increase could reduce the assessment further, equating to an approximate 1% assessment reduction for every 5% increase in loss costs.

It is important to note that these projected assessment decreases are only estimates. The enacted 2013-14 Budget requires the Workers' Compensation Board to promulgate a single assessment rate for all employers regardless of coverage type by November 1, 2013 and every year thereafter. We are currently analyzing payer data to publish the rate this fall. Given the historic variations in assessment by coverage type, until that analysis is complete it is not possible to predict precisely what the 2014 assessment rate will be.

Future Fiscal Impact

The proposed legislation contemplates the potential for reserve adjustments going forward and states that the amounts collected (via the assessment rate) to maintain the financial integrity of the Fund may be paid over a period of time at the discretion of the chair. Therefore, if a restatement of claims indicates a funding shortfall, the deficit can be addressed in subsequent rate years. The chair can direct that the assessment rate be incrementally adjusted to address the shortfall over a period of time to avoid any dramatic spikes in the rates going forward. Overall, however, the future fiscal impact on the employers is still expected to be significantly less than the current assessment level of approximately $300 million per year.

Sincerely,

Jeffrey R. Fenster
Executive Director

NEW YORK COMPENSATION INSURANCE RATING BOARD (NYCIRB)

October 1, 2013 Loss Cost Filing

Response of Ziv Kimmel, FCAS, Vice President and Chief Actuary

In addition to the testimony I provided verbally at the hearing, this response is specifically addressed to several of the items described in the testimony provided by Mr. Humowiecki of the Workers' Compensation Board (WCB).

PPD Assumptions

In his testimony, Mr. Humowiecki questions the Rating Board's assumption with respect to the reflection of duration caps versus lifetime benefits in reported loss amounts. While we acknowledge that the increase in the percentage assumed to reflect the duration caps from 27.5% in the 2012 to 66.7% in the 2013 filing is significant, the 2013 figure is a better reflection of the true benefit levels underlying the reported losses. In fact, at this point, six years after the reform and a full year after the implementation of Loss-of-Earning-Capacity Guidelines, no carrier reflects lifetime benefits, and a 100% "post-reform" assumption would be even more accurate. However, the 66.7% was selected in order to address the stability concerns Mr. Humowiecki raised.

Mr. Humowiecki also asserts that the overall loss cost level change, if the same assumption - 66.7% of PPD losses are assumed to be at post-reform level – was made at the time of the 2012 loss cost filing, would be over 40%, leading to great volatility in the workers compensation rates. This assertion is inaccurate and misleading. The source of this 40% figure in unclear and questionable.

In fact, had the Rating Board used the 66.7% assumption with the 2012 Loss Cost Filing, the indication would have been just about 30%. If such a filing had been approved, and if the Rating Board then made a gradual adjustment to 100% assumption with the 2013 filing, the indication would have been a small decrease, and indicating a relatively stable pricing environment, and nothing like the extreme volatility Mr. Humowiecki suggests. However, the foregoing scenarios, including the one presented by Mr. Humowiecki, are hypothetical. The reality is that the Rating Board strives to strike the right balance between responsiveness to changing market conditions and the stability consideration, which we recognize is of great importance. This is the reason that the filing does not reflect the 100%, but chose, for stability purposes, to go with the 66.7%.

Mr. Humowiecki describes the steps the WCB is taking to address the "slower than expected" classification process. While it is possible that this will work, the time that it takes to implement such administrative changes needs to be recognized. It is our understanding that more than two years since the implementation of the Medical Treatment Guidelines, there are still many system participants, including physicians, who are not well versed in the various details of the Guidelines and the associated administrative process. Similarly, it is possible that implementation of these classification expediency steps may take an undetermined amount of time to implement, and even when implemented, it is unclear how effective these may be. Mr. Humowiecki quotes questionable figures regarding "classifications or settlements" without specifying the actual numbers of classifications only occurring since the enactment of these changes. It should be noted, too, that the new process was announced by the WCB on May 28, two weeks after the submission of the loss cost filing. If the new classification process will work, and claims would be classified faster than they are today, reducing temporary benefit payments and total loss amounts, this information would be reflected in the carriers' data as of 12/31/2013,

and thus, will be accounted for in next year's loss cost filing. This would also apply to the assumption with respect to the percentage of claims affected by duration caps in the calculation of the loss development adjustment. The assumptions in the filing are based on current conditions. If, in the future, the Rating Board will obtain evidence that classifications are happening earlier in the claims' maturity than at present time, these assumption can be revised in future loss cost filings.

Special Disability Fund

There are several problems with some of the arguments made by Mr. Humowiecki with respect to the reserving practices by carriers on claims that were eligible to Special Disability Fund relief, and their impact on the loss cost indication.

Mr. Humowiecki asserts that a significant percentage of claims are accepted by 15-8 prior to the 5 year relief waiting period. Consider the following excerpt from a report on the Special Disability Fund prepared by Milliman (consulting firm) for the New York State Division of the Budget in July of 2007:

> In 1996, the New York State Legislature extended the period during which the employer/insurer is required to pay all benefits from 104 weeks (two years) to 260 weeks (five years). The change was enacted retroactively for claims with injuries on or after August 1, 1994. The intent of this change, presumably, was to moderate the steeply rising annual pay-out of the SDF. The law change had, however, an unintended consequence of substantially changing the claim handling strategies of insurers and self insured employers.
>
> When the waiting period for reimbursement was only two years employer / insurers generally attempted to get the claim established for SDF reimbursement as quickly as possible in hopes of avoiding expensive medical treatments, especially surgeries, which frequently occur after 104 weeks from the injury. When the waiting period changed to 5 years this incentive for early establishment was gone and the entire process slowed down significantly. Currently claims may take up to 10 years or more to get established.

Thus, it is clear that many claims may have taken a long time to get established by the Fund.

That said, even if it were the case that a significant number of claims were accepted by the Fund at earlier maturities, consideration must be given to the types of claims that were accepted by the Fund at such an early maturity, their impact on the overall development factors, and to the observed difference in development factors in years before and after the reform. If a group of claims were to accurately reflect 15-8 relief at, say, two years of maturity, then there would be no development on these claims in subsequent years, i.e. they would all be reserved at 260 weeks of indemnity payments. Thus, the ultimate development factors on this group of claim would be unity, and putting downward pressure on the overall loss development factors at the earlier maturities. If this were true, we would expect to see higher loss development factors in earlier maturities in post reform policy years than in pre-reform policy years. This, however, is not the case. An examination of the loss development factors for the private carriers, for example, as are included in the filing document, shows no signs of higher loss development factors in the post reform years compared to pre-reform. A possible reason for this is that the types of claims that may be accepted by the Fund at the earlier maturities are the ones that are easier to determine and reserve, and are not expected to result in significant development in the post reform environment. Therefore, these claims are not being overestimated in the analysis.

In addition, even if we had seen an increase in the development factors as a result of the closing of the SDF (which we don't), the ratemaking procedures utilized by the Rating Board would mitigate such increases, as from 1st to 10th report, we are excluding the highest and lowest factors, to prevent large volatility.

In addition, note that the closing of the Special Disability Fund also resulted in an impact on medical costs. However, no adjustment was made to the medical on-level factor. A medical on-level adjustment for the closing of the SDF, would result in an additional loss cost increase that is likely to offset some, if not all, of the proposed adjustments suggested by Mr. Humowiecki.

Finally, Mr. Humowiecki suggests in his testimony that the carrier survey conducted by the Rating Board is not reliable because of the "low response rate". It should be noted that the carriers responding to the survey represent approximately 80% of the market premium volume, which cannot be considered a low response rate.

<u>Trend</u>

Mr. Humowiecki is correct when arguing that the indemnity trend would be flatter if the PPD assumption had not been revised. However, the difference would be very small, and, if the PPD assumption were not changed from last year's filing, the overall trend would then be higher than the filed trend factor, because medical losses would represent a larger percentage of overall costs and the medical trend would receive greater weight.

<u>25-A</u>

Mr. Humowiecki implies that some savings may be generated by the elimination of the expenses associated with the transferring of the claims to the Reopened Case Fund. However, these savings may be offset and surpassed by additional expenses associated with the carrier keeping the files open for possibly many more years.

Note too, that a 10 year average was selected to determine the average amount that will be shifted back to the carrier. The impact resulting from this change would have been higher if a lower number of years were used in the average, and significantly higher had just the most recent few years were selected.

With respect to the change in loss costs to policies in force, we recognize the fact the impact will vary by policy based on the effective date. In theory, the full impact of this change should apply to in-force policies in their entirety, since they will fully incur the additional liabilities generated by this change. However, since ratemaking is prospective in nature, many employers will benefit since the Rating Board requests that the change apply only to the unexpired portion of the policies.

Thank you for the opportunity to submit this reply.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

WRITTEN COMMENTS FOR PUBLIC HEARING

REGARDING NEW YORK COMPENSATION INSURANCE RATING BOARD PROPOSED WORKERS' COMPENSATION INSURANCE 2013 LOSS COST INCREASE OF 16.9 PERCENT

ON

TUESDAY, JUNE 25, 2013

AT

DEPARTMENT OF FINANCIAL SERVICES, 25 BEAVER STREET

ROOM 510

NEW YORK, NEW YORK

ELLEN MELCHIONNI
PRESIDENT
NEW YORK INSURANCE ASSOCIATION, INC.

130 Washington Avenue • Albany, NY 12210 • (518) 432-4227 • (518) 432-4220 fax
info@nyia.org • www.nyia.org

I am submitting these comments on behalf of the New York Insurance Association, or "NYIA." NYIA is the state trade association that has represented the property and casualty insurance industry in New York for more than 130 years. NYIA's membership is broad and diverse, consisting of stock, mutual and cooperative insurance companies writing in every county of New York State. Many of our member companies write workers compensation insurance in New York. For the reasons that follow, we strongly support the New York Compensation Insurance Rating Board (NYCIRB) proposed workers' compensation insurance 2013 loss cost increase of 16.9 percent.

Loss costs are crucial to setting actuarially appropriate workers compensation insurance rates. If costs are rising in the system then the rates must reflect this reality or solvency can become an issue. Solvency of insurance companies is of prime importance for the Department of Financial Services (DFS) as well as protection for business and workers. A related problem that should be avoided is rate suppression. The practice of mandating unjustified rate decreases or lower rates is not sound public policy but rather political tactics which thwart insurance competition. There is a long-standing practice of artificial rate suppression occurring on an almost yearly basis. This does not benefit policyholders in the long run, nor does it encourage insurers to enter the New York market.

Turning to the proposed NYCIRB loss cost increase of 16.9 percent, there are several real world factors resulting in higher workers compensation costs reflected in this loss cost increase proposal. Although slowing in recent years, medical costs in New York continue

to increase at a rate greater than inflation. As noted by NYICRB on page 6 of their proposal, the medical costs are increasing at a yearly rate of 4.9%. Second, the enacted state budget for 2013-14 eliminates the reopened case fund with the costs of such cases now being transferred to workers compensation insurance carriers. The result of this cost transfer is a 4.5% increase. Third, the continuing yearly increase in the weekly maximum workers compensation benefit and this year's budget action increasing the minimum weekly benefit from $100 to $150 combine to increase loss costs by 0.9%. A fourth factor is the trend where the average time from accident to final classification of the injury has been steadily lengthening, thereby inevitably leading to longer temporary benefits and greater overall indemnity costs. One of the reasons for this increasing length of time spent on temporary total disability before receiving a disability rating is the practice of some claimants delaying the disability rating assignment because once this occurs the duration caps on permanent partial disability (PPD) takes effect. This means the expected savings in the workers' compensation system from the 2007 reforms establishing a maximum cap of ten years on PPD are not being fully realized.

According to our members, the New York workers compensation insurance market has been characterized for the past few years as one with rising claim costs without concomitant expense relief. The current New York workers compensation system is burdened with escalating medical costs and wages. It is stretched even thinner by the cost of complying with increased regulation and the costs of fraud pile onto the problem. Couple these negative developments with the low interest rate environment we have been in for over five years now and the impact on New York workers compensation insurers' financial health has been very stressed. This does not encourage more carriers to enter the New York

workers compensation insurance market and hence expand the competitive nature of the market. Less competition in the marketplace inevitably results in harm to the workers compensation policyholders due to less choice.

In conclusion, NYIA maintains that rates must reflect the actual risk and the facts demonstrate there are numerous cost drivers in the New York workers compensation system. These costs must be reflected in the loss cost filing for New York's workers compensation premium rates and NYCIRB has properly justified the need to increase the loss costs for next year's premiums. NYIA accordingly respectfully requests DFS approve the NYCIRB loss cost proposal in its entirety and without any modifications. This action would ensure the health and vitality of the workers compensation insurance market in New York, a market that employers and injured workers rely on to provide benefits in a timely and cost-effective manner.

Thank you for consideration of our comments. Please feel free to contact us with any questions regarding these comments.