1 STATE OF NEW YORK
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4 PUBLIC HEARING ON NEW YORK COMPENSATION
5 INSURANCE RATING BOARD LOSS COST FILING
6 ----------X
7 25 Beaver Street
8 New York, New York
9
10 June 25, 2013
11 11:00 A.M.
12
13 P A N E L:
14 ROBERT EASTON, Chair, Executive Deputy Superintendent,
15 Insurance Division
16 JEAN MARIE CHO, Deputy Superintendent for Property and
17 Casualty Insurance
18 ALEXANDER VAJDA, Principal Casualty Actuary, Property Bureau
19 MAURICE MORGENSTERN, Deputy Chief, Property Bureau
20
21
22
23
24 Reported by
25 Edward Leto

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1 MR. EASTON: Good morning. My name is Robert Easton.
2 I'm the Executive Deputy Superintendent of the Insurance
3 Division at the Department of Financial Services. I will be
4 chairing this hearing today.
5 Today's public hearing concerns the proposed workers' comp
6 insurance loss cost increase. The New York State Department of
7 Financial Services has received a rate filing from the New York
8 Compensation Insurance Rating Board, known as CIRB, for a workers'
9 compensation loss cost increase of 16.9%.
10 The approved loss costs are used by the workers' comp
11 carriers in the New York marketplace in setting rates. The rate
12 application was submitted by CIRB to the DFS on May 14. CIRB is
13 a non-government rate service organization for workers'
14 compensation in New York State. All workers' compensation
15 insurers must send statistics to CIRB which compiles and
16 evaluates the data and files the resulting overall loss cost
17 change on behalf of its members and subscribers.
18 Loss cost changes are subject to the Department's prior
19 approval. Section 2305 of the Insurance Law requires that the
20 Superintendent of Financial Services hold a public hearing if a
21 rate service organization makes a loss cost filing for workers'
22 compensation that seeks an increase of 7% or more above the approved
23 loss cost. The 16.9% increase requested, therefore, requires
24 this hearing.
25 I understand that we have at least six individuals today

1 registered to submit oral testimony. If there is anyone who
2 wants to testify but who has not yet registered, please register
3 with the Department representative over there, please
4 (indicating).
5 We will call individuals to testify in the order in which
6 they're registered. We will also accept written comments for
7 five business days from today from any interested parties. For
8 the record, DFS, as of this morning, has received written
9 testimony from Mr. Lev Ginsberg of the Business Council,
10 Mr. David Dickson, who's a public member of the underwriting
11 committee of CIRB, from Kristina Baldwin of the Property and
12 Casualty Insurers Association of America, and from Mr. Robert
13 Grey of the Workers' Compensation Alliance and New York
14 Committee for Occupational Safety and Health.
15 All comments, the oral testimony presented today, and any
16 written comments received will be made part of the public record
17 and posted on the Department's internet site, www.dfs.ny.gov.
18 The stenographer will be taking a verbatim transcript of today's
19 hearing. We're not going to set a firm time for speakers to
20 testify, but we do request that you keep your comments brief and
21 pertinent, where possible. Where there is written testimony, it
22 is not necessary to read the written testimony into the record.
23 We have your written testimony. We only ask that you highlight
24 those items in the testimony that you want to emphasize or bring
25 to our attention.

1 Members of the Panel can and may ask questions during the
2 testimony. We do not invite questions from the audience. I
3 will let my colleagues introduce themselves and describe their
4 roles here at the Department. Starting to my right.
5 MS. CHO: Good morning. My name is Jean Marie Cho. I'm
6 the Deputy Superintendent for Property and Casualty Insurance.
7 MR. VAJDA: I'm Alexander Vajda. I'm the Principal Casualty
8 Actuary for the Property Bureau.
9 MR. MORGENSTERN: Maurice Morgenstern, Deputy Chief of
10 the Property Bureau.
11 MR. EASTON: And now, without further ado, we'll begin
12 with the testimony presented by Mr. Ziv Kimmel from the New York
13 Compensation Insurance Rating Board. Would you please step up
14 to the podium.
15 Z I V K I M M E L, having first been duly sworn by a Notary
16 Public of the State of New York, was examined and testified as
17 follows:
18 MR. KIMMEL: Good morning members of the Hearing Panel,
19 and all other attendees and participants. My name is Ziv
20 Kimmel. I'm Vice President and Chief Actuary of the New York
21 Compensation Insurance Rating Board. The hearing testimony I
22 provide to you today is presented on behalf of the Rating
23 Board's membership, and is specifically in reference to the
24 Board's current filing application for 16.9% average increase in
25 the overall loss cost level, and a 4.5% increase on outstanding

1 policies as of 10/1/2013.
2 MR. VAJDA: Ziv, can we just make sure your microphone is
3 on?
4 MR. KIMMEL: The proposed loss cost level change is based
5 on the latest statistical data reported by the Rating Board's
6 member carriers and reflects the application of accepted
7 actuarial principles and methodologies.
8 The filing indication consists of the following components:
9 Actual carrier experience, based on two policy years of data,
10 contributing 16.1% to the requested increase.
11 A trend factor which reduces the indication by 2.6%. This
12 resulted from separate analyses of claim frequency and claim
13 severity, and reflects projected wage increases to the
14 prospective filing period.
15 Change in Loss Adjustment Expense provision reducing the
16 indication further by 1.4%, based on standard analysis of
17 Defense and Cost Containment and Adjusting and other expenses,
18 and benefit level changes contributing 5.4% to the total
19 indication, which I'll address in detail later on.
20 In addition, when deriving the overall change,
21 consideration was given to the fact that the catastrophe
22 provisions are proposed to remain unchanged.
23 Full details of the analysis are described in the filing
24 document, which has been made available on our website at
25 www.nycirb.org.

1 I do, however, want to elaborate on a few of the filing
2 components.
3 First, as always, in the calculation of the experience
4 component of the indication, reported losses are adjusted to
5 ultimate value and to the current benefit level. The procedure
6 to adjust losses to ultimate value was modified in the filing
7 that was submitted to the Department of Financial Services last
8 year. We are reintroducing an enhanced version of this
9 methodology change this year. This methodology no longer
10 considers Incurred-But-Not-Reported, or IBNR, loss experience
11 when determining the tail portion of the loss development
12 factors. This procedural improvement was intended to increase
13 the stability over time of the loss development factors, as
14 carriers, from time to time, might revise the methodology by
15 which IBNR losses are derived, and the manner in which these
16 losses are allocated to the different policy years.
17 The overall impact of this methodology change is to reduce
18 the overall impact by 2.7%. In other words, holding everything
19 else equal, the loss cost indication using the previous
20 methodology would have been over 20%.
21 Losses are also adjusted to the current benefit level.
22 This means that all final adjusted losses that are used to
23 determine the experience indication are at the post-reform
24 level. We continue to assume, however, that a portion of the
25 losses are reported at pre-reform levels, specifically with

1 respect to the implementation of duration caps, and that a
2 portion of losses are reported at the post-reform levels. Losses
3 that are assumed to be reported at pre-reform levels are
4 adjusted downward to reflect the anticipated savings from the
5 implementation of duration caps. Losses that are assumed to be
6 reported at post-reform level are not adjusted downward for the
7 full impact of the duration caps, as these losses are already
8 reflecting the caps. These losses, however, are subject to a
9 smaller downward adjustment to reflect the fact that they are
10 not expected to develop to ultimate as pre-reform losses.
11 This method is the same procedure that has been used in the
12 last several approved filings. In 2011 it was assumed that 75%
13 of the losses are at pre-reform level, and that 25% are at
14 post-reform level. Last year, the filing reflected an
15 assumption that 72.5% are at pre-reform level and 27.5% are at
16 the post-reform level. This year, the filing reflects an
17 assumption that one-third is at pre-reform level, and two-thirds
18 are at post-reform level. Increasing the percentage that are
19 assumed to be at post-reform level makes sense for the following
20 reasons: First, it is now six years after the enactment of the
21 reforms, and carriers are not reserving PPD cases at lifetime
22 benefit levels. This is because carriers, based on the
23 condition of the claimant, are able to estimate relatively well
24 the PPD duration claimants would be entitled to. In addition,
25 PPD loss of earning capacity guidelines have been implemented

1 effective January 1, 2012, and the losses used in the filing
2 analysis are valued a full year subsequent to this
3 implementation. Finally, an analysis of paid losses, which does
4 not consider the reserve condition, resulted in an indication
5 significantly higher than the proposed 16.9%. This also
6 supports a significant increase in the percentage of losses that
7 is assumed to reflect post-reform benefits in the paid plus case
8 analysis.
9 The obvious question that needs to be asked is, therefore,
10 why are we not reflecting the fact that with respect to duration
11 caps, 100% of losses are at post-reform levels? The answer is
12 that while a 100% assumption would constitute a better
13 reflection of the reserve levels and would be more responsive to
14 current market conditions, it was the Rating Board's decision to
15 select two-thirds, in order to contribute to stability in the
16 market.
17 I would like, at this point, to say a few words about
18 trend. We continue to use the same methodology of utilizing
19 financial data, and selecting trend factors based on exponential
20 regression of claim frequency and claim severities for medical
21 and indemnity. We believe that a five-year trend strikes the
22 right balance between stability and responsiveness. Based on
23 the analysis, we have determined that claim frequency is
24 expected to decrease by 1.3% per year, indemnity average cost
25 per case, or severity, is expected to increase by 2.0% per year,

1 and medical severity is expected to increase by 4.9% per year.
2 With respect to the benefit level changes, as I mentioned,
3 there are three components: The automatic increase in the
4 maximum weekly benefits, which is tied to the state average
5 weekly wage, contributes 0.5% for to the overall indication. In
6 addition, the 2013 Budget Bill provides for an increase in the
7 minimum weekly benefit from $100 per week to $150 per week. We
8 determined that this change would result in an additional 0.4%
9 increase.
10 The other provision with a significant impact on loss costs
11 included in the enacted Budget Bill is the closing of the Fund
12 for Reopened Cases effective January 1, 2014. The calculation
13 of the impact is described in the filing document, as well as in
14 the document issued by the Rating Board in March of this year.
15 The impact results from a shift of costs that have been borne by
16 the fund and paid for by policyholder assessments back to the
17 insurance carriers. The estimated overall impact included in
18 the filing for this change is an increase in loss costs of
19 4.5%. However, we expect that this increase will be offset by a
20 reduced assessment percentage. Also, with respect to the
21 closing of the Fund, because it accepts claims that are at least
22 seven years old, costs of claims that would have been
23 transferred to the Fund on policies that have expired and
24 policies that are currently effective would be incurred by the
25 carriers, even though the pricing on these policies did not

1 reflect this possibility and assumed such claims would be
2 transferred to the Fund.
3 While we are not suggesting loss costs be revised on
4 expired policies, because ratemaking is prospective in nature,
5 we are proposing that this change, a loss cost increase of 4.5%,
6 because of the closing of the Reopened Case Fund, apply to
7 policies in force as of October 1, 2013 on a pro-rata basis.
8 This is also known as an outstanding loss cost change, and such
9 a change has been approved by the Department in the past when a
10 change in benefit levels occurred during a policy period.
11 The remaining technical details of the proposed change are,
12 as I mentioned, contained in the filing document.
13 Now, some might ask, what are the underlying reasons for
14 this increase? What is going on in the workers' compensation
15 system that might be causing this need?
16 To put things in context, I would like to mention a couple
17 of points.
18 First, there are increased lags in PPD classification
19 activity. The duration caps that were implemented as part of
20 the 2007 reform start to kick in only after a claim is
21 classified as a PPD by the Workers' Compensation Board. When
22 the reform savings were originally estimated, it was assumed
23 that the waiting time for classification would remain
24 approximately the same. However, it appears that the timeline
25 from the date of injury to the date of classification has

1 substantially increased. There is no question that this is
2 happening, and it has been acknowledged by the Workers'
3 Compensation Board. Costs are increasing as claimants continue
4 to receive temporary benefits while awaiting classification.
5 For example, if a claimant has a wage loss of $900 a week,
6 they would be getting a temporary benefit of $600 a week. Each
7 additional year of temporary benefits, while awaiting
8 classification, would add more than $30,000 to the cost of the
9 claim, which is very significant.
10 There are different explanations as to the reasons for the
11 increased lag. It is clear that claimants have an incentive to
12 delay the classification, as they would keep receiving temporary
13 benefits and may not want to "start the clock" on the capped PPD
14 duration, which happens at classification. While some argue
15 that carriers may contribute to the delays, this argument is
16 weak, as they keep paying temporary benefits and the clear
17 economic incentive is to get the claims classified as soon as
18 possible to start the clock on the duration caps and minimize
19 their losses.
20 While in the first couple of years after the reform it may
21 have been true that there were some concerns regarding orders to
22 pay the Aggregate Trust Fund, at this point, six years after
23 reform, these concerns are greatly diminished. Carriers observe
24 claimants and their attorneys doing everything they can to delay
25 classifications, and the costs of paying temporary benefits are

1 mounting. Remember, the bottom line is that these delays are
2 real, they're happening, and they are pushing costs upward.
3 Also, to put the proposed loss increase in context, I would
4 like to review the relationship between the increases in the
5 maximum weekly benefits and the recent loss cost filings. The
6 maximum weekly benefit has increased from $400 a week prior to
7 the reform, to the current level of $792, which on July 1 will
8 increase to $803. That is more than double the pre-reform
9 maximum benefit.
10 To account for those increases, the Rating Board's filings
11 since the enactment of the reform included increases of about
12 15% just for this component. The overall cumulative impact of
13 rate and loss cost changes that became effective since the
14 reform was implemented is a decrease of more than 6%. In other
15 words, employers today pay 6% below what they did prior to the
16 reform. If we remove the 15% that is due to the increases in
17 the maximum weekly benefit, we would be at 21% below the
18 pre-reform values. In other words, but for the increases in the
19 maximum weekly benefits, employers would be paying 21% less
20 today than they would have paid prior to the reform.
21 Finally, the requested increase should come at no surprise.
22 Last year, the Rating Board filed for an increase of 11.5%.
23 Because that filing was disapproved by the Department, going
24 into this year's filing our starting point reflected a major
25 loss cost inadequacy in the state. This inadequacy, combined

1 with the new benefit level changes, gets us to where we are
2 today, in a situation where we now need a higher increase.
3 From that perspective, and taking into consideration the
4 combination of the poor loss experience and the benefit level
5 changes, the 16.9% requested increase in the loss cost level is
6 necessary and reasonable in order to maintain an adequate loss
7 cost level, and a healthy, competitive workers' compensation
8 system.
9 This concludes my prepared testimony for the public
10 hearing. I would be happy to address any questions the Hearing
11 Panel has regarding my statement, or any component of the Rating
12 Board's requested loss cost increase. Thank you.
13 MR. EASTON: Thank you. I'll start with a few questions.
14 Are you aware that the Workers' Compensation Board has recently
15 taken proactive steps to ensure that claims get classified in a
16 timely manner?
17 MR. KIMMEL: Yes, we are aware of those changes.
18 MR. EASTON: And what impact, if any, would that have on
19 the suggested recommendation that you're putting forth today?
20 MR. KIMMEL: These changes were just recently put into
21 place by the Workers' Compensation Board. No impact for these
22 changes has been incorporated in the filing. However,
23 implementation of such major changes takes time.
24 MR. EASTON: But could the implementation of those
25 changes have an impact on the rate structure?

1 MR. KIMMEL: To the extent that the classification
2 activity would start happening at a faster pace, yes, it would
3 potentially cause --
4 MR. EASTON: Are you in any position to quantify what the
5 impact would be?
6 MR. KIMMEL: I cannot quantify at this time. But to the
7 extent that there will be some savings as a result, they would
8 be reflected in the data as of 12/31/2013, and in the loss cost
9 filing that we will submit to the Department next year.
10 MR. EASTON: Would it be appropriate for us, in your
11 estimation, to take into account currently the fact that the
12 Workers' Comp Board has taken these proactive steps geared
13 towards expediting classification?
14 MR. KIMMEL: Without an ability to quantify what this
15 thing would do and how long it would take to implement, I think
16 it would be very difficult to put in a quantitative number on
17 what these changes would be.
18 MR. EASTON: But you're not in a position to offer a
19 number today, correct?
20 MR. KIMMEL: No, I'm not.
21 MR. EASTON: What effect, if any, do you see on workers'
22 comp rates from the implementation of the Federal Affordable
23 Care Act?
24 MR. KIMMEL: The Federal Affordable Care Act is slowly
25 getting implemented by the federal government, with a major

1 component of it to be implemented in 2014. There are different
2 forces that are working in different directions, and it is very
3 early to say what impact it will have on the workers'
4 compensation system.
5 MR. EASTON: So are you able to quantify the impact
6 of what's popularly known as ObamaCare?
7 MR. KIMMEL: I am not in the position to quantify that.
8 MR. EASTON: Does the rate filing reflect any of the
9 changes in the marketplace that may be wrought by virtue of
10 federal health care reform?
11 MR. KIMMEL: No, it does not.
12 MR. EASTON: The catastrophe provision --
13 MR. KIMMEL: Let me just add, it does not reflect them,
14 but it is, like I said, it's very early to say if it will cause
15 an increase or a decrease in the workers' compensation system.
16 MR. EASTON: Is it your view or your understanding that
17 the federal health care reform won't begin to be implemented
18 until 2014?
19 MR. KIMMEL: Well, different aspects of the reform are
20 already underway, such as requirements on health insurers to
21 have certain loss ratios. That's already in place. But I
22 believe the requirement that each individual would have to have
23 health insurance, otherwise they'll be subject to some sort of a
24 tax, I think that's subject to implementation in 2014. So
25 different components of the act are to be implemented over time.

1 MR. EASTON: Okay. But currently, the rate filing
2 doesn't take account of any of them?
3 MR. KIMMEL: No.
4 MR. EASTON: Thank you. The catastrophe provision as a
5 percentage of loss increased from 2.4% in last year's filing to
6 3.6% in this year's. What's the basis for that change?
7 MR. KIMMEL: The 2.4% that was in last year's filing and
8 the prior several filings was based on a study that was done
9 several years ago, and the Rating Board took it upon itself to
10 do an update of that study and recalculated that percentage of
11 premiums.
12 MR. EASTON: Who performed the study years ago that you
13 just referenced?
14 MR. KIMMEL: The Rating Board staff.
15 MR. EASTON: And so that was updated, and that accounts
16 for the change?
17 MR. KIMMEL: Yes.
18 MR. EASTON: Are you familiar with the Terrorism Risk
19 Insurance Act?
20 MR. KIMMEL: That is due to expire next year?
21 MR. EASTON: That will be up for debate as to whether or
22 not it will be reauthorized after 2014.
23 MR. KIMMEL: Yes.
24 MR. EASTON: But it will be debated, I presume, in the
25 Congress if not this year, then certainly next year.

1 MR. KIMMEL: Yes. I can make a comment about that. Why
2 don't you ask the question.
3 MR. EASTON: Thank you. So to what extent does CIRB's
4 filing reflect the fact that there's uncertainty as to whether
5 or not the act will be reauthorized by Congress?
6 MR. KIMMEL: At this point, the rate filing proposes no
7 change in the catastrophe provision, which the underlying
8 assumption for the no change is that the act will be
9 reauthorized.
10 To the extent that there are changes and Congress fails to
11 extend the protection of the insurance industry, we will have to
12 look into that and examine how much or what changes are made and
13 potentially file with the Insurance Department the changes in
14 the catastrophe provision based on what transpires in
15 Washington.
16 MR. EASTON: And if what transpires in Washington is that
17 it is reauthorized, but that there is a higher retention on the
18 part of carriers before they can avail themselves of the federal
19 backstop that's provided, what impact would that have on the
20 rate?
21 MR. KIMMEL: At that point, we will have to study it.
22 We'll have to examine those new retention levels and adjust the
23 catastrophe provision accordingly, and again, file with the
24 Department of Financial Services for your approval.
25 MR. EASTON: So the increase from 2.4% to 3.6% has

1 nothing to do --
2 MR. KIMMEL: That has nothing to do.
3 MR. EASTON: How do you attempt to measure the impact of
4 the 2007 reforms? You've described how it has changed for six
5 years on and you gave other explanations, but how is it that you
6 measure, you know, how do you figure out whether the right
7 number is 75% or 72.5% or some other number?
8 MR. KIMMEL: Is your question regarding the percentage
9 that we assume to be reflecting the reform?
10 MR. EASTON: Correct.
11 MR. KIMMEL: In the past several years, the Rating Board
12 has conducted a survey of carriers, including this year, that at
13 this point, pretty much supports 100% of carriers -- of the
14 carriers that responded to the survey, are saying that they are
15 not reserving lifetime levels for permanent partial disability.
16 In other words, they all reflect the duration caps.
17 So in the filing, we chose to include -- we reflect the
18 fact that two-thirds of the carriers or the losses do represent
19 post-reform duration caps and keep one-third as presumably still
20 reflecting lifetime benefits.
21 But the selection of those percentages was meant to
22 stabilize the increase in the loss costs, because if we assumed
23 100% still reflecting the duration caps, the increase would have
24 been significantly higher.
25 MR. EASTON: But the information and your estimates are

1 based on the carrier survey alone; is that right?
2 MR. KIMMEL: No. The carrier survey indicates 100% of
3 the carriers are at post-reform levels. We selected two-thirds
4 in order to stabilize the loss cost increase.
5 MR. EASTON: Okay. The State Insurance Fund is the
6 residual market in New York. Their indications are more
7 favorable than those of the private carriers. That's driven by
8 both lower reported loss ratios and lower development factors.
9 Last year, you couldn't really offer an explanation as to why
10 that would be the case.
11 Are you now aware of any reasons for the difference in the
12 loss cost indications?
13 MR. KIMMEL: Usually I'm always asked this question and
14 I'm always -- I'll give you my usual answer, and it is that we
15 are making loss costs that should be appropriate for all risks
16 in the state, and when we get data from all carriers, some
17 carriers might have significantly better results and some
18 carriers might have significantly lower results or worse
19 results. And the State Fund happens to consistently show better
20 results. And you just see it because we present their results
21 differently, but --
22 MR. EASTON: But why do you think that would be if it's a
23 market of last resort?
24 MR. KIMMEL: That question probably should be addressed
25 to the State Fund, because they know better what some of their

1 practices are, and I know they're not technically subject to the
2 regulations of the Department of Financial Services, but this is
3 something that needs to be explored.
4 MR. EASTON: Okay. But you don't have any empirical
5 explanation for the distinction?
6 MR. KIMMEL: Not really.
7 MS. CHO: I just wanted to go back to the post-reform and
8 pre-reform assumption. On your on-level calculations, there
9 reflects an assumption that 66.7% of the losses are reserved at
10 post-reform levels. However, as you pointed out, the assumption
11 in last year's filing was 27.5%, the year prior was 25%, the
12 year prior to that was 20%. So the assumption of 66.7 is a
13 significant increase in only one year's time, and clearly has an
14 impact to the proposed loss cost change.
15 Now I know you had cited the paid loss experience as
16 contributing to some of that big jump, but is there anything
17 else that would contribute to such a marked change in the
18 reserving assumptions?
19 MR. KIMMEL: The reserving assumptions probably would
20 begin last year and two years ago supported a higher percentage,
21 and the selections do include lower percentage reflecting cost
22 reform levels were intended to stabilize the increase in loss
23 costs. At this point, it has been probably more than a year
24 where carriers are fully reflecting post-reform duration caps,
25 and we really need to start having better reflection of reality

1 in the loss costs. So I think this increase is justified and it
2 is appropriate.
3 MS. CHO: So you had mentioned 100% response -- 100%
4 reserving at 100% at post-reform. So is the 100% response
5 reflective of 100% of the market or just 100% of responses?
6 MR. KIMMEL: The carriers that responded to the survey
7 represent over 80% of the market. And none of -- 0% of those
8 say that they're reflecting lifetime benefits. So it's a very
9 credible sample on which to base the assumption.
10 MS. CHO: But you've already pointed out that part of the
11 reason why it's an adjusted lower number is to stabilize the
12 loss cost increases. So here it does seem like it's quite a
13 jump in a four-year span to go from 20% to 25%, to 27.5%, and
14 then to 66.7%.
15 MR. KIMMEL: It's a big jump, but it's a better
16 reflection of reality.
17 MS. CHO: Also, last year we talked a little bit about
18 how the accident year indications tend to -- or at least last
19 year and much like this year, it seems to be much more favorable
20 than the policy years. Do you have an explanation on why this
21 would be?
22 MR. KIMMEL: It could be due to some sort of
23 stabilization as we see some of the indemnity -- I'm looking at
24 the trend, the indemnity trend, and I see that it's started to
25 stabilize. It's still increasing, but at a much lower rate than

1 in the past, so that could be part of the reason that impacts
2 the latest accident year, and we see some more favorable results
3 at that point.
4 MS. CHO: So, I mean, I understand it's not quite the
5 same thing as policy year, but it is more recent data. Does it
6 seem to be that it is indicating an improving trend, though?
7 Because we saw an improving trend from policy year 2011 versus
8 policy year 2010.
9 MR. KIMMEL: Yes, it does indicate an improving trend.
10 However, accident year data is extremely immature, and loss
11 development factors associated with accident year information
12 are much higher and highly leveraged, which could contribute to
13 some inaccuracies. So it's important to stay away from accident
14 year stuff. I know it's been used in the past, but there have
15 been studies that show that using the one policy one accident
16 year indication could potentially mislead, because, again, it's
17 immature. And in addition, one policy one accident year doesn't
18 overlap of the experience, and a portion of the experience is,
19 therefore, double counted or given extra weight.
20 And countrywide, across the nation, different states that
21 you see have moved away from using accident year information.
22 So we are conforming to that methodology.
23 MS. CHO: In the pricing of the closure of the Special
24 Disability Fund in 2000, I think there was an 85% efficiency
25 factor that was used. My understanding is this factor reflects

1 a belief that carriers would have more incentive to control the
2 costs of the claims over the life of the claim as opposed to
3 just the five years. Why wasn't the comparable efficiency
4 factor used in the estimation of the impact for the Closure of
5 the Reopened Case Fund?
6 MR. KIMMEL: The Closing of the Reopened Case Fund was
7 estimated based on a 10-year average assessment amounts relating
8 to average loss amounts. The usage of 10 years in determining
9 that average is at the very low end of possible estimates. If
10 we had used the most recent three years, the impacts would have
11 been much higher, and we believe that putting an additional
12 factor to offset that indicated impact would understate it.
13 In addition, there could be additional expenses associated
14 with transferring those costs back to the carriers, so those
15 extra expenses of keeping the files open for much longer as
16 opposed to transferring them over to the fund could actually
17 result in additional expenses. So we didn't include a safety
18 factor, but we also did not include an expense factor. So we
19 just went with a midpoint of the impact without putting a factor
20 in any direction.
21 MS. CHO: Okay. So there wasn't any specific research or
22 analysis done to explain why there wouldn't be an efficiency
23 factor when it does contribute to controlling claim costs for
24 this particular --
25 MR. KIMMEL: It would not necessarily contribute to

1 claim costs, because like I said, it could be significantly
2 higher expenses associated with transferring the file back to
3 the carriers. It is different than the Special Disability Fund
4 where the carriers would keep the claims anyway. The Reopened
5 Case Fund, the claims would completely transfer over to the Fund
6 and basically closing the books on them and not handling them
7 anymore. Once you transfer those claims back to the carriers,
8 there are extremely high expenses associated with it, and we
9 have not accounted for those higher expenses.
10 MS. CHO: Right. But unless there wasn't --
11 MR. KIMMEL: But we haven't accounted for those higher
12 expenses and we haven't accounted for any efficiencies.
13 MS. CHO: Also in the filing, you described how private
14 carrier premium development triangles were adjusted to remove
15 several anomalous policies from the data?
16 MR. KIMMEL: Yes.
17 MS. CHO: Can you describe what other edits you may have
18 performed on the data that's the basis for this filing?
19 MR. KIMMEL: We are -- every year when we receive the
20 data, we go through quite an enormous effort of contacting
21 carriers, asking them about different anomalous values that they
22 report. In some cases they are responding to us explaining the
23 anomalies, and it appears to be legitimate and we accept the
24 data. In some cases, they indicate to us that they are -- that
25 there's something wrong with the data and they resubmit the

1 data.
2 The data that's reflected in the filing is based on the
3 latest resubmitted information after all those edits, and I can
4 give a couple of examples where some carrier reported very large
5 development factors from sometime in the mid '90s. I don't
6 remember exactly what year it was. We contacted that carrier
7 after observing that anomalous value, and they indicated to us
8 that this was due to a very specific claim, employers' liability
9 claim, and which resulted in a much higher development, and they
10 had to book a higher amount for the case, which affected the
11 factor. So we accepted that as reasonable.
12 MS. CHO: Do you have any formal process or controls that
13 are in place to prevent fraud or anomalous data from being
14 reported?
15 MR. KIMMEL: We review the loss development triangles.
16 We review the claim. We review the claim counts reported. We
17 have some automated processes and some manual processes that
18 check the automated processes and review the data. And, again,
19 I'll just say that there's been like hundreds and hundreds of
20 emails going back to carriers, phone calls to examine several
21 data points, and I believe the data is correct and reasonable.
22 MR. EASTON: I'm sorry, but is it your view that in
23 making the determinations as to what is anomalous and valid and
24 what is anomalous and not valid, involves a measure of judgment
25 that you end up or your team ends up exercising?

1 MR. KIMMEL: I wouldn't call it judgment. I would call
2 it actuarial expertise. Because when you examine loss
3 development triangles, I should say -- well, we have some
4 automated processes, so a lot of judgment is being taken away
5 from the process. But in addition to the automated processes,
6 we do have actuaries that look at the information, examine it,
7 and find things that the automated processes may have missed.
8 Some tolerance values may have been too narrow in catching only
9 extreme stuff. But sometimes a trained actuary can identify
10 some things that are not so extreme, but are still exceptional
11 and could be defined as anomalous.
12 MR. EASTON: I'm not suggesting that actuaries don't have
13 experience, but it sounds to me like what you just said does
14 involve a measure of professional judgment, but it's judgment
15 nonetheless. Do you disagree?
16 MR. KIMMEL: If you want to call it judgment, I want to
17 call it expertise.
18 MR. EASTON: Okay.
19 MS. CHO: And in that process that you were talking
20 about, the automated and manual process, does it include a
21 reconciliation between the aggregate data that you received and
22 the policy level data?
23 MR. KIMMEL: We have done a study several years ago to
24 examine the matching between the policy data and the financial
25 data. This exercise resulted in many carriers -- contacting

1 many carriers where we find some differences. Some of those
2 differences were explained. Some of the differences resulted in
3 some data resubmissions, and we are planning to undergo a
4 similar process in the coming year.
5 MS. CHO: Have you looked at -- is the process similar to
6 what some of the other states have started to require, like
7 California? Massachusetts?
8 MR. KIMMEL: Yes. I know in New York we don't have a
9 requirement, but we are being proactive about it and are
10 attempting to reconcile between those two data sources.
11 MS. CHO: And the prior study, how long ago was that
12 done?
13 MR. KIMMEL: That was done in 2009 I believe.
14 MS. CHO: Thank you.
15 MR. VAJDA: I'd like you to clarify some of the methods
16 and underlying assumptions used to adjust the historical losses
17 to a post-reform basis. Regarding the duration caps for the
18 non-scheduled permanent partial disability claims, you assume
19 that 40% of the cases are affected by 9th Report by the duration
20 caps, and I believe you do have a distribution for different
21 reports going out for different maturities, and would just like
22 to ask you, how did you derive that distribution?
23 MR. KIMMEL: The distribution has been derived based
24 on -- the original distribution was derived based on information
25 from the Workers' Comp Board on pre-reform claims and what's in

1 the original estimation of the impact of the duration caps.
2 Subsequent to the reform, the safety net report that was
3 issued by the Department of Labor included a distribution of a
4 loss of earning capacity percentages and resulting duration
5 caps, and that formed the basis to that duration. To that
6 distribution.
7 MR. VAJDA: Okay. Looking at the filing that 40% of
8 claims affected by duration cap at 9th Report, that would seem to
9 imply that the average time it takes for a claim to be impacted by
10 the duration caps before the reserves would come down would be at
11 least nine years. And how does --
12 MR. KIMMEL: That is -- I disagree with that statement.
13 I don't think that that's what we're saying. What we're saying
14 is that there's a lag to classify, and I believe that the
15 assumption is right now in the filing, five to six years.
16 That's where -- in that exhibit, you could see all the zeros up
17 to six years I believe?
18 MR. VAJDA: Yes.
19 MR. KIMMEL: 0% impacted. And at that point, we start
20 seeing certain claims impacted by durations having loss of
21 earning capacity of I believe up to 15%, getting four years of
22 benefits, and using the distribution from the safety net report,
23 those percentages are gradually increasing, getting to nine years
24 about 40% being impacted by the duration caps.
25 MR. VAJDA: Okay. But wouldn't a carrier adjust their

1 reserves downward once a claim has been classified? I mean, if
2 you're looking at adjusting a paid development triangle based on
3 an unadjusted distribution similar to the safety net report,
4 that seems appropriate to me, but I would think carriers, if
5 they were able to take down reserves on a claim, because they
6 know they're only going to be responsible for 250 weeks or 300
7 weeks or however, instead of putting up lifetime benefits, I
8 think they would want to do that.
9 MR. KIMMEL: However, the loss development factors are
10 from years prior to the reform and are still reflecting lifetime
11 benefits. Which is why we're making this adjustment.
12 MR. VAJDA: Understood. But, I mean, but if you're
13 saying that -- if you're saying that it takes -- okay. So --
14 MR. KIMMEL: And when you talk about -- I think we both
15 agree that it makes a lot of sense to do this. On paid plus
16 case, we're not looking really at payments, but payments plus
17 case reserves, meaning unwinding of the discounts of the
18 reserves on those claims that is being adjusted for.
19 MR. VAJDA: That's the one adjustment you're making for
20 that --
21 MR. KIMMEL: Yes.
22 MR. VAJDA: That adjustment for the -- that reduction in
23 loss -- that portion in the loss development factors is only for
24 underlying the discount? It's not for anything else? It's not
25 for the fact that some claims aren't going to be developing as

1 long as others?
2 MR. KIMMEL: Well, that's exactly why we have those
3 percentages, 40%, 50% up to 95%, to say that certain percentage
4 of claims are not going to be affected by it, and certain
5 percentage of claims are going to be affected by it, and that's
6 why they're getting the adjustment.
7 MR. VAJDA: Okay. Let's go back, just when you say like
8 5% of the claims at 6th Report and there are zeros before that,
9 so you're saying that no claim through the first five years
10 would have any case reserve differences --
11 MR. KIMMEL: Right.
12 MR. VAJDA: -- pre and post-reform with the
13 implementation of the duration caps?
14 MR. KIMMEL: Right. Because this adjustment applies to
15 the claims that are assumed to be already reported at
16 post-reform levels.
17 MR. VAJDA: Okay. I think --
18 MR. KIMMEL: They're reported at post-reform levels.
19 That's the two-thirds of the claims that we assume this applies
20 to. So they're already reported at the lower value reflecting
21 the duration caps. We're just saying they're going to develop
22 differently because of the unwinding of the discounts of the
23 lifetime benefits in the loss development chart. So they're
24 already reflecting the duration, so they're already lower
25 reflecting the duration caps.

1 MR. VAJDA: So you're saying that the claims that are
2 reported are already at -- are already being reserved at a
3 lower --
4 MR. KIMMEL: Correct.
5 MR. VAJDA: -- level? Okay. And I guess the next
6 question I would have would be regarding the Special Disability
7 Fund. That in 2007, that it was estimated that the closure of
8 the Second Injury Fund would increase indemnity loss cost by
9 17.8%, and there's an adjustment to the indemnity on-level
10 factor that fully -- I believe reflects that full 17.8%. If you
11 can just confirm that for us.
12 MR. KIMMEL: That is correct. And I will elaborate. The
13 Special Disability Fund has been eliminated effective July 1,
14 2007. Reimbursements from the Fund are only paid after five
15 years. Therefore, losses from 2011 and 2010, which are the
16 years that are used in filing and are at an early maturity, the
17 reserve levels are similar to where these reserves would have
18 been set in a pre-reform environment with respect to the
19 reflection of the potential reimbursements from the Special
20 Disability Fund.
21 This is because carriers historically reflected potential
22 reimbursements in the incurred losses after the claim has been
23 accepted by the Special Disability Fund, which has had been
24 approximately at five years after the date of accident.
25 Now since the reported losses are then developed to

1 ultimate value using the pre-reformed development patterns,
2 which reflects subrogation from the Special Disability Fund, an
3 adjustment is needed to bring the ultimate value of the losses
4 to post-reform level. In other words, reflecting the
5 elimination of the Fund. And the adjustment is included in the
6 indemnity on-level factors, as you mentioned, which is equal to
7 the impact of closing the Fund, which was estimated in 2007.
8 MR. VAJDA: Thank you for that. But now that we've -- I
9 mean, I think that looking at the historical triangles, you
10 know, the indemnity development triangles for the State
11 Insurance Fund, it seems like that phenomenon is happening where
12 you see negative development factors from 6th to 7th Report, 7th
13 to 8th, and 8th to 9th on a five-year average, which seems to
14 support the assumption that carriers are reserving -- that the
15 State Fund is reserving on a lifetime basis and then only taking
16 down the reserves once they get relief.
17 It's hard to see such -- you really don't see that in the
18 private carrier triangles, and that's one thing that we're
19 struggling with to try to figure out. You know, we can see it
20 from one company, and you know, we can see it from the State
21 Fund, but we really -- we're having difficulty discerning it in
22 the private carrier triangles, and we're just wondering if you
23 had any other support as far as how other of your members are
24 reserving for those claims, because it doesn't seem to show up
25 in the data as clearly as it does for the State Fund?

1 MR. KIMMEL: I don't have a great explanation for this.
2 This is one of those differences between the State Fund and the
3 private carriers that we've observed and contributes, in part,
4 to the difference in indication that was asked about before.
5 Some things that you clearly see when you look at a
6 specific carrier and you don't have a combination of the rest of
7 the carriers in the market, which could affect some of the
8 results.
9 MR. VAJDA: I mean, granted, the combination of many
10 different carriers, you know, would tend to make discerning
11 patterns more difficult if companies -- if the companies have
12 different reserving practices. But still, you expect to see
13 something by now I would think.
14 MR. KIMMEL: At this point, we're not seeing that yet.
15 MR. VAJDA: Okay. I’ve got one more question for you. In
16 the calculation of the impact of the projected increases in the
17 maximum weekly indemnity benefits used throughout the
18 prospective period, the old minimum weekly indemnity benefit of
19 $100 was used for non-death claims instead of the $150 minimum
20 that's currently in effect.
21 What impact, if any, would the use of the $150 minimum
22 indemnity weekly benefit have on the indication of the -- on the
23 maximum weekly benefit?
24 MR. KIMMEL: If we had used in calculation of the maximum
25 weekly benefit a minimum of 150, that would result in impact of

1 1/10th of a percent, which would bring the indication down from
2 the proposed 16.9% to 16.8%.
3 MR. VAJDA: Thank you.
4 MR. MORGENSTERN: Can you comment on the decrease in the
5 indicated loss trend from last year's filing?
6 MR. KIMMEL: Last year we have started to see some
7 flattening, especially with the indemnity curves, and we still
8 have used a five-year trend which brings -- which last year was
9 from 2006 to 2010.
10 This year we are truly getting much further into the
11 post-reform era. So from 2007 to 2011, we are continuing to see
12 that flattening, and we're not having this increase from 2006 to
13 2007 that impacted the trend last year.
14 MR. MORGENSTERN: Yes, but the indemnity severity
15 especially seemed to come down more than everything else in the
16 five-year period.
17 MR. KIMMEL: Yes. And we believe that five years strikes
18 the right balance between responsiveness and stability. And
19 like I said, last year we had 2006 to 2010. That was our
20 five-year period which we project. From 2006 to 2007, there was
21 a significant increase. That no longer is in that five-year
22 period. So the five years are becoming flatter as a result,
23 which results in a negative overall trend factor.
24 MR. MORGENSTERN: When the Department first approved
25 large deductible programs, the experience for large deductibles

1 was considerably better than for the rest of the business, but
2 that has reversed in the last few years, and it seems that it's
3 both on an incurred and a paid basis. So I don't think that you
4 could attribute that to reserving practices.
5 Do you have any insight into why things are worse for the
6 large deductible programs?
7 MR. KIMMEL: Large deductibles have deteriorated in the
8 past years. We're seeing it in the data and we report the data
9 as we see it. I don't have any information as to why this is
10 happening. I'm not sure if any of the carriers that are going
11 to testify later may have insight on why they're seeing this.
12 But I can confirm that we're seeing it as well.
13 MR. MORGENSTERN: Do you think that perhaps some carriers
14 are unable to recover the deductible from the insureds? Do you
15 think there could be some problems with that?
16 MR. KIMMEL: That should not affect the results as we
17 report them, because we are analyzing the results on the gross
18 of the deductible basis.
19 MR. MORGENSTERN: So you don't count what's actually been
20 paid on?
21 MR. KIMMEL: No.
22 MR. MORGENSTERN: Okay.
23 MR. EASTON: Ziv, I think those are all the questions we
24 have at the moment. Thank you.
25 MR. KIMMEL: Thank you.

1 MR. EASTON: We'll next invite Elizabeth Heck from
2 Greater New York Mutual to testify.
3 E L I Z A B E T H H E C K, having first been duly sworn by a
4 Notary Public of the State of New York, was examined and
5 testified as follows:
6 MS. HECK: Members of the Hearing Committee, thank you
7 for the opportunity to make this statement with regard to the
8 proposed workers' compensation rate filing. My name is Elizabeth
9 Heck, and I am the president and chief operating officer of
10 Greater New York Mutual Insurance Company.
11 Greater New York is a property and casualty insurance
12 company domiciled in New York State, which has been operating
13 since 1914.
14 My company has continually written workers' compensation
15 since the early '50s, and at times, workers' compensation has
16 even been the principal line of my company, representing as much
17 as 53% of our direct written premium. But in recent years, we
18 have made a decision to cut back on our writings of workers'
19 compensation because inadequate rates have made the line very
20 unprofitable for our company.
21 So I respectfully submit that the workers' compensation
22 rate increase filed by the New York Compensation Rating Board of
23 16.9% to be effective October 1, 2013 is necessary, and it's
24 essential for the health and well-being of the New York State
25 economy.

1 Rising claim costs and medical costs have placed an undo
2 burden of the New York business community, and have strained the
3 ability of insurance companies operating in New York to meet the
4 demand for workers' compensation insurance.
5 And what I want to add to the information that Mr. Kimmel
6 was talking about is that the extended period of very low
7 interest rates is something that really has to be considered,
8 because what it does is it compounds the problem, because it's
9 no longer possible for insurance carriers to be able to offset
10 underwriting losses with investment income.
11 The countrywide workers' compensation calendar year
12 combined ratios have been unprofitable for several years, and
13 when the very low interest rate environment is factored into the
14 equation, the magnitude is even greater on the bottom line than
15 the reported results. And there's a general rule of thumb that
16 for every 1% decline in investment yield, a carrier would need
17 to improve their combined ratio by 5.7 points in order to
18 achieve the same return on equity when writing a long tail line
19 like workers' compensation.
20 So when you add that to the reported combined ratios, it's
21 clear that the line can't support itself to the current pricing
22 levels, and what I've included in my written testimony, both the
23 countrywide and New York State industry combined ratios, and you
24 know, I won't go over them, but when you look at them, what you
25 can see is that the New York experience has been extremely

1 unprofitable. In fact, the 2012 preliminary calendar year
2 combined ratio for workers' comp is 131.6%, and it was 22.6
3 points worse than the countrywide ratio.
4 And you'll also note that the NCCI states that the
5 countrywide ratios that I have included, you can see that the
6 countrywide improved from 2012, but the New York State combined
7 ratio worsened. And it's clearly an indication that the New
8 York rates are not keeping pace with the increasing loss costs.
9 Now, Mr. Kimmel did a very good job talking about some of
10 the reasons, you know, that went into the factors for the
11 increase in the loss cost, and obviously the increase in the
12 benefit levels and the closure of the Special Fund, both the
13 Special Disability Fund and the Reopened Case Fund, have had a big
14 impact on the total loss cost, and what I'm going to do is I'm
15 just going to mention a couple of other things that he didn't
16 mention, that I think that we see on the carrier side that
17 should be considered.
18 You know, medical costs and prescription drugs obviously
19 have a very big impact on the cost of claims. There are new and
20 expensive drug therapies, and they are continuing to be relied
21 on by physicians, and it has caused a very big cost driver over
22 the years. According to the NCCI, medical now comprises close
23 to 60% of the total workers' compensation loss costs, whereas 20
24 years ago it was only 47%.
25 And the above statistics reflect the general state of

1 workers' compensation, but with regard to New York State, I do
2 want to comment that the medical treatment guidelines have had
3 an impact, and what we've seen is that there has been some help
4 in standardizing the treatment with regard to workers'
5 compensation. However, pain management guidelines have not been
6 formalized yet, and pain management drugs are the biggest
7 component of the drug costs that we see.
8 And what we see with regard to pain medical management, you
9 know, these are very expensive drug therapies. We find that
10 they're often over-prescribed, and they, again, are one of the
11 higher cost drivers. So what happens with those drugs is that
12 they add to the overall cost of the claim, but then they also
13 make it difficult to settle a claim, because if a claimant is
14 actively treating and there is a feeling that, you know, either
15 from the doctor or from what's happening with regard to the
16 claim, that some of those medications will subside and they
17 won't be necessary. It doesn't make sense to settle the claim
18 as quickly. You know, it makes much more sense to wait until
19 that treatment is stabilized, because what happens with the
20 Medicare set aside is those expensive prescription drugs are
21 assumed to be taken for the balance of the claimant's lifetime.
22 So that could increase the cost of the claim significantly.
23 With regard to the Aggregate Trust Fund, I want to just
24 comment that just like Mr. Kimmel said, what we found is that
25 the ATF does encourage faster settlements, and we certainly

1 support that. What we have found is that claims classified with
2 lifetime benefits generally settle higher than they had before,
3 because the attorneys are aware that we must turn over our claim
4 to the ATF unless we make a quick settlement, and sometimes what
5 that does is it pushes the leverage, you know, in the other
6 direction, and it could make those costs increase.
7 With regard to increased time to classification and
8 settlement, we have seen that with regard to the permanent
9 partial disability caps, that they really should reduce the cost
10 of the claim, but we have seen, you know, what you have seen and
11 what the Rating Board has seen, is that there is a motivation by
12 the claimants and their attorneys to try and find a total
13 disability finding which wouldn't be subject to the cap. And so
14 as a result of that, there are greater hearings. There is a
15 greater number of hearings. There are more IMEs. There are
16 more expenses associated with litigation, and it extends the
17 life of the claim, because if ultimately the claim is found to
18 have settled with the PPD cap, the longer the claim is paid
19 under temporary benefits, it's going to increase the value that
20 the claimant will ultimately receive.
21 MR. EASTON: So you don't disagree that the Workers'
22 Compensation Board's initiative to expedite the classification
23 of claims will be anything but prudent for the ratemaking
24 process and for industry, correct?
25 MS. HECK: You mean the changes that are just coming out?

1 MR. EASTON: That they announced two months ago. Yes.
2 MS. HECK: Yes. I think it was the end of May, right?
3 MR. EASTON: Okay.
4 MS. HECK: So it was just very recent. You know what the
5 question is? The way I view it, you know, on the carrier side,
6 in 2007, a lot of big reforms were announced, and some of them,
7 you know, looked like they could really help. You know, the whole
8 idea was to reduce the cost of the claims I believe, and to
9 answer all the questions that were out there, it does take time
10 to see whether or not that's going to happen.
11 Now there were some changes that were introduced I think it
12 was the end of May, and you know, we welcome to see, you know,
13 if that will expedite the claims process and allow a claimant
14 who is truly a PPD claimant to be subject to the cap, I think it
15 would help. But we haven't seen it to date. And it's a
16 question of whether or not the provisions that went through with
17 those changes, you know, will make a difference.
18 In addition to -- the other thing that we see that could
19 extend the time that it takes with the claim, again, it relates
20 to the drugs and having to get a CMS approved Medicare set
21 aside. And what we have seen is that a claim will be
22 classified, and you know, we want to be able to handle the claim
23 appropriately, and of course, you want -- the best way to handle
24 a claim is to settle both the indemnity and medical
25 simultaneously. You know, it's the most efficient, it's the

1 best for the claimant, it makes the most sense. It gets it off
2 the books of the company.
3 But what happens is if a claimant is still -- the drug
4 protocol is not -- it's not stabilized, and a claimant is taking
5 some of these very expensive drugs, and I think you know which
6 drugs they are. Some of them, you know, they add significant
7 amounts to the ultimate cost of the claim.
8 What happens with the Medicare set asides is that a drug, a
9 physician would need to rewrite a prescription. There has to be
10 a certain amount of time before Medicare would agree that the
11 drug is not going to be considered in the lifetime benefits.
12 And what would happen is if a set aside is -- if Medicare is
13 approached too soon, then the cost of the claim is going to be
14 exaggerated.
15 Just to give you an example, if you have a claimant that's
16 taking one of those expensive narcotic drugs, you know, those
17 drugs that, you know, we all know what they are, that they
18 really increase the cost of the claim, and a physician
19 prescribes the drug to be taken three times a day, if the
20 injured worker is only taking the drug once a day and Medicare
21 gets that information, what they're going to do when they
22 calculate the set aside, they're going to assume that the
23 claimant is going to take that drug three times a day for the
24 balance of his lifetime.
25 So what ends up happening is, you know, it means that the

1 claim will be overstated. The set aside -- you know, the amount
2 that needs to go into the set aside is going to be overstated by
3 two-thirds, you know, one time per day versus three times per
4 day. So in order for CMS to actually consider the change in the
5 drug protocol, the doctor needs to go through this process, and
6 it somewhat extends the time with regard to CMS. And once all
7 that's completed, the approvals do take some time. It adds
8 another three to six months into the process of settling the
9 claim.
10 The other items that I want to mention, I wanted to mention
11 terrorism, because as a carrier, it's very important. It's a
12 high-profile issue. Especially for a New York, you know, a
13 company that's providing insurance in urban areas like New York
14 City.
15 We continue to face the problem of purchasing terrorism
16 reinsurance. We actually buy, you know, standalone reinsurance
17 to cover us and to help us manage aggregation issues, and it's
18 extremely expensive. There are large net retentions and
19 triggers under TRIPRA, and of course, with it set to expire in
20 2014, we think that -- we do think that an extension is
21 essential to the New York economy, but even without the
22 government backstop, the terrorism exposure coupled with the
23 inadequate rates is really an impediment to writing business in
24 urban areas. It's very important when you are providing
25 workers' compensation insurance and there is a risk, that, you

1 know, you can have all of these deaths, you have the deaths -- a
2 terrorist attack, there's a huge exposure that you need to be
3 able to manage in terms of aggregation to keep everyone solvent.
4 The last two items that I just want to mention is some of
5 the expenses on the carrier side that aren't represented in loss
6 costs, but carriers do very well and it's expensive.
7 One is fighting fraud. We work diligently to investigate
8 and detect fraudulent claims, and we believe that the New York
9 Fraud Bureau has done an excellent job in helping us do that.
10 New York is one of the states that really does an excellent job.
11 We can't say that about every state, but we do say that about
12 New York.
13 But we have seen, as a result of difficult economic
14 conditions, that we've seen an uptick in the workers'
15 compensation related fraud, and that does increase overall loss
16 costs. And I point it out because just handling fraudulent
17 claims and the expenses associated with taking care of them and
18 making sure that we keep them to a minimum is expensive.
19 The other item that I want to mention that is something
20 that insurance carriers do as a matter of course is we do a lot
21 of safety engineering, and we believe that it really adds to --
22 it helps the business community and it helps both the insureds.
23 We believe that the safety engineering that we provide -- and
24 it's not reflected in the loss costs calculation that's done by
25 the Rating Board -- is incredibly helpful, and the ultimate

1 beneficiary for that is really the injured worker in the
2 business community, and all of that is extremely expensive.
3 So it's for these reasons that we fully support the Rating
4 Board's increase of a 16.9% rate increase. We think it's
5 necessary to maintain a viable, competitive market in New York
6 State for workers' compensation.
7 MR. EASTON: Thank you. Does anyone on the Panel have
8 any questions?
9 MR. MORGENSTERN: You say that at one point your company
10 had 53% of your premium written in workers' comp?
11 MS. HECK: Yes.
12 MR. MORGENSTERN: What is it now?
13 MS. HECK: It's less than 2%. And what happened was --
14 it's been a few years. Beginning in 2004, we saw that the rates
15 were really very inadequate. So we made a conscious decision to
16 cut back on our workers' compensation writings, because we
17 couldn't write it at a loss.
18 MR. MORGENSTERN: So when was it 53%?
19 MS. HECK: Well, I would say in the '90s. I'll tell you
20 in 2003 it was closer to 40%. So we really did, you know, we
21 provided a viable market. We think it's a very important line
22 of business. It's something that we fully support. We just
23 need to have enough premium to be able to pay the claims and
24 expenses.
25 MR. MORGENSTERN: Thank you.

1 MR. EASTON: Okay. Thank you. Next we'll invite Steve
2 Bennett from AIA to testify here today.
3 S T E V E B E N N E T T, having first been duly sworn by a
4 Notary Public of the State of New York, was examined and
5 testified as follows:
6 MR. BENNETT: My name is Steve Bennett. I'm Associate
7 General Counsel of the American Insurance Association. I want
8 to thank you for the opportunity to comment here today on the
9 loss cost proposal.
10 The American Insurance Association endorses the
11 Compensation Insurance Rating Board's filing, requesting a loss
12 cost increase of 16.9% effective October 1, 2013 on new and
13 renewal policies.
14 AIA members write a substantial share of the private market
15 for workers' comp insurance in New York, and therefore, have a
16 significant interest in the stability of the workers' comp system in
17 the state. AIA, a national property and casualty trade
18 association, is a public advocacy organization, supporting its
19 members' legislative, regulatory, and judicial interests
20 throughout the nation. Thus, AIA does not have an actuarial
21 role with respect to rates in any state. That responsibility is
22 vested among the various rating or advisory organizations
23 licensed by state insurance commissioners, and in New York, the
24 CIRB.
25 However, we do have a strong and abiding interest in the

1 health of the workers' comp marketplace generally, and in the
2 stability that is required to maintain a healthy balanced
3 market.
4 The universal standard of review is that rates not be
5 excessive, inadequate, or unfairly discriminatory. This
6 standard guides insurance departments nationwide, in meeting
7 their obligations under the law and to safeguard the solvency of the
8 insurers operating in their states, and to protect the benefits
9 owed to injured workers. Although there may be an actuarial
10 disagreement between a rating organization and an insurance
11 department in any given year of what a rating need is, over
12 time, insurers hope to have confidence in the overall adequacy
13 of rates, rates sufficient to cover expected losses, and to earn
14 a reasonable return on capital.
15 AIA's endorsement of CIRB's filing, thus, should be viewed
16 in the context of deference to CIRB as the New York workers' comp
17 insurance industry's institutional actuary. Although actuarial
18 opinions may differ, the members of CIRB, insurers writing workers'
19 comp insurance in the State of New York, will look to their
20 institutional actuary in forming their individual business
21 judgments about deploying capital to the New York workers' comp
22 marketplace.
23 Thus, the rating organization's actuarial judgment sends an
24 important signal to the industry about the adequacy of rates,
25 and the Insurance Department's decision, an equally important

1 signal about the regulator's support for a well-financed workers'
2 comp system.
3 And, regardless of actuarial or policy differences, in the
4 end, the system needs to be adequately financed, and employers
5 need to pay for the system they have, or risk distortions that
6 will carry with them seeds for a marketplace dysfunction.
7 Indeed, this is what occurred over 20 years ago in many
8 states, with what was then a national workers' comp financial
9 crisis, a crisis born of combined escalating losses stemming
10 from benefit delivery system excesses and of chronically
11 inadequate rates. Insurers withdrew from voluntary markets
12 because they determined they could no longer write coverage
13 without incurring extensive losses. Combined ratios soared.
14 In states with traditional assigned risk plans, the result
15 was significant increases in residual markets, along with ever
16 higher losses in those markets, themselves without adequate
17 rates, and, again, with soaring combined ratio.
18 For example, in Texas, in 1989, the residual market deficit
19 was one-half billion dollars, requiring insurers reinsuring pool
20 losses to cover that deficit before writing a single dollar of
21 new workers' comp coverage. The deficit was so large as to drive
22 into insolvency that state's largest writer of workers' comp
23 insurance. In other states, voluntary markets evaporated, with
24 residual markets comprising upwards of 90% of the entire market.
25 In states, with state funds such as New York's, serving as

1 the market of last resort, the result was significant increases
2 in state fund market share, along with their far higher
3 financial exposures. Insurers lost billions of dollars over
4 this period, both in voluntary market and residual market
5 losses. It was only following an extensive effort over several
6 years by employers and insurers in amending the laws to reduce
7 costs and in providing greater rating flexibility that the
8 system recovered balance.
9 New York State Insurance Fund also could suffer adverse
10 consequences of a chronic rate inadequacy. Market share could
11 soar if the private market were to contract, with SIF taking on
12 far higher levels of risk. SIF already is the largest writer in
13 the state by far, with 41% of the market in 2012, up from 36% in
14 2010 and 2011. The rest of the private market is in single
15 digits.
16 A market share even higher with commensurate increased risk
17 is especially worrisome with enactment of legislation this year,
18 diverting 1.75 billion from the SIF. Whatever the rationale for
19 that transfer, the fact is that those are assets the SIF will no
20 longer have to cushion losses.
21 With the SIF already capturing a large share of the market,
22 what are the policy implications of an even larger market share?
23 Is there an implicit recognition of some equilibrium between the
24 so called public and private markets? What effect would this
25 outcome have for New York's employers and the relative degree of

1 market concentration and competition?
2 The extent of rate inadequacy also can interact
3 synergistically with elements of the rating law that may affect
4 market competition. For example, New York significantly
5 restricts insurers' ability to compete based on risk
6 characteristics apart from experience. Schedule rating credits
7 are prohibited, and deviations are permitted, but only within a
8 narrow range of negative 20% to positive 10%.
9 All of which is to suggest that, aside from debate over the
10 actuarial credibility of any estimated future losses, the
11 Department's decision can have an indirect but profound effect
12 on the health and stability of the workers' comp insurance market.
13 As to the current filing, a comment relative to last year's
14 filing and decision denying any increase -- this is a comment
15 relative to last year's filing and decision denying any
16 increase: We don't intend here to reargue last year's decision
17 itself, but insofar as the apparent premise behind that decision
18 may be guiding this year's decision, it is relevant. Last
19 year's decision denying any increase appeared to rest largely on
20 the transition in which the system was and is experiencing from
21 the 2007 reforms.
22 The Department noted that New York's workers' comp system is in
23 a state of considerable transition in light of the 2007 reforms,
24 and the subsequent steps taken by the state in furtherance of
25 those reforms. The decision and order then listed issues with

1 the clear potential to alter the workers' comp landscape. The
2 decision and order then noted the agreement by both the
3 CIRB and the workers' comp board actuaries that the 2007 cost-saving
4 reforms remain to be seen.
5 If the test for approving a proposed rate increase is
6 perfect system stability and the absence of transitions, no
7 increase can ever be granted, because any workers' comp system is
8 always in transition. It may be in transition from recently
9 enacted reform, perhaps from regulatory initiatives in the wake
10 of those reforms, perhaps Case Law developments whether or not
11 the result of reforms, or perhaps a myriad of other decisional
12 points within a workers' comp system.
13 A workers' comp system is always transitioning. There are an
14 incalculable number of moving parts to the engine. However,
15 predictions with actuarial credibility need to be made, not
16 based on promises of improved results, but on experience. That
17 is what CIRB is tasked to do. That is what it did last year and
18 what it has done this year.
19 Finally, to return to the point made previously, regulatory
20 decisions do not exist in a vacuum. There is context, and
21 affected parties will choose to interpret those decisions as
22 they see fit, regardless of whatever gloss the regulator uses to
23 justify his or her decision. Insurers will rely on their
24 individual business judgments in viewing the Department's
25 decision, informed by CIRB's analysis, and their own internal

1 actuarial judgment, notwithstanding whatever might be the
2 Department's stated rationale underlying the decision.
3 We trust the Department will carefully consider CIRB's
4 recommendation in this light. Thank you very much.
5 MR. EASTON: Thank you, Mr. Bennett. I have one question
6 for you.
7 MR. BENNETT: Sure.
8 MR. EASTON: And it's this, do you agree that there is a
9 range of reasonableness where actuaries on say both sides of an
10 issue could probably be right, and yet, as a regulator, a
11 decision needs to be made, and there's not necessarily a monopoly
12 on correctness in that situation, because actuarial work is
13 based on assumptions, and the kind of determinations on which
14 reasonable people can differ?
15 MR. BENNETT: First, I'd have to phrase my answer first
16 by saying I'm not an actuary, so I'm not well versed in that.
17 But I would believe reasonable actuaries could differ. I guess
18 my only point would be as long as they're basing it on the
19 experience and judgment and not on what may or may not happen in
20 the future. But as long as they're looking at the numbers of
21 the loss history, I assume that reasonable actuaries could
22 disagree.
23 MR. EASTON: Thank you. Does the Panel have any other
24 questions? Thank you, Mr. Bennett.
25 MR. BENNETT: Thank you.

1 MR. EASTON: We'll next here from Laurie Barkhorn of The
2 Hartford.
3 L A U R I E B A R K H O R N, having first been duly sworn by a
4 Notary Public of the State of New York, was examined and
5 testified as follows:
6 MS. BARKHORN: Good morning. I'm Laurie Barkhorn. I'm
7 the northeast division executive at Hartford Insurance Company.
8 Thank you for having me here today.
9 The Hartford is one of the top five insurers of workers'
10 compensation in the State of New York. As a member of the New
11 York Compensation Insurance Rating Board, we participated in the
12 actuarial and underwriting committee process, and in the
13 development of the original loss cost recommendation that went
14 to the New York CIRB Board of Governors earlier this year.
15 The loss cost recommendation used actuarial standard
16 ratemaking techniques to derive a reasonable indication, and in
17 our opinion, was at the lower end of range of loss cost
18 estimates that we analyzed. This indication was presented to
19 the Board of Governors of the New York CIRB for their
20 consideration.
21 While The Hartford is not represented on the Board of
22 Governors this year, our rotation ended in 2012, based on past
23 experience on the Board, we are familiar with the deliberative
24 process that takes place to review the recommended indication.
25 The members of the Board make up a broad spectrum of

1 constituencies in the state, including insurance, labor and
2 business communities. Members of the Board engage in a review
3 of this original loss cost indication and come to an adjusted
4 conclusion which results in the filing before you today. The
5 final loss cost filing reflects the significant input of all
6 constituencies represented on the Board.
7 We believe that approval of this recommendation before you
8 by the DFS is an important step in the right direction to
9 address rising system costs in the state. We remain committed
10 to a dialogue with the Department -- excuse me -- with the
11 Department of Financial Services, as well as the Workers'
12 Compensation Board, to ensure a competitive environment for New
13 York businesses.
14 I apologize in advance that I've been asked only to read
15 the statement and not to respond to questions, but I would like
16 to reiterate that The Hartford remains very committed to a
17 dialogue with the parties who are represented here, and will
18 entertain those at a later time. So thank you.
19 MR. EASTON: Sorry. I do have one question.
20 MS. BARKHORN: Okay. I will try to answer it.
21 MR. EASTON: Is it your understanding that the CIRB Board
22 of Governors suggested unanimously that 16.9% was the proper
23 loss cost increase, because that's what it sounded like from
24 your testimony?
25 MS. BARKHORN: No. I'm sorry, Mr. Easton. Number one,

1 I'm not on the Board of Governors, so I'm not privy to that
2 dialogue and the vote. And even if I were, I'm not sure that
3 we're able to share that information. I would only say that
4 based on past experience, there's a lot of dialogue that happens
5 from the underwriting and actuarial committees to the actual
6 representation, and certainly is not always a unanimous vote.
7 MR. EASTON: So you don't know this year whether or
8 not --
9 MS. BARKHORN: Correct.
10 MR. EASTON: -- there were any dissenters?
11 MS. BARKHORN: That is absolutely correct.
12 MR. EASTON: Thank you.
13 MS. BARKHORN: Thank you.
14 MR. EASTON: We'll next invite Mr. Thomas Nowak from AIG
15 to testify.
16 T H O M A S N O W A K, having first been duly sworn by a
17 Notary Public of the State of New York, was examined and
18 testified as follows:
19 MR. NOWAK: Good afternoon. My name is Thomas Nowak.
20 I'm a senior vice president of workers' compensation for AIG
21 Property Casualty Group. I am also a member of the Governing
22 Committee of the Rating Board, and I'm pleased and privileged to
23 serve as its chair this year.
24 As chair of the Rating Board, and as a carrier writing I
25 believe in excess of 9% of the market in the state, I am here to

1 support the workers' compensation rate filing made by the Rating
2 Board on behalf of its member carriers.
3 That filing was prepared by the Rating Board actuarial
4 staff, it was subject to the review of the Rating Board's
5 actuarial committee, and represents a critical and necessary
6 action to preserve the financial stability of the workers' comp
7 insurance marketplace here in the State of New York.
8 Using standard and time tested actuarial techniques, the
9 Rating Board has identified and quantified changes in loss costs
10 due to the following: automatic increase in maximum and the
11 legislated increase in minimum weekly benefits, the impact of
12 the closure of the Reopened Case Fund, and loss experience
13 projected to ultimate value, both of private carriers and of the
14 State Fund.
15 Coupled with the decision of the Department of Financial
16 Services last year that no change in loss costs take place, we
17 believe that the need for loss cost adequacy is urgent and
18 compelling.
19 The enactment of workers' compensation law reforms in 2007
20 was an important step forward in addressing long-term issues
21 affecting the State's workers' compensation marketplace. The
22 benefits of these reforms were estimated and were reflected in
23 previous Rating Board filings. We believe these promised
24 benefits are emerging, but implementation of reforms have
25 evolved over time, and so, too, has their financial impact as

1 demonstrated in carrier financial data. Achievement of loss
2 cost adequacy remains a work in progress.
3 In addition to overall loss cost adequacy, last year's
4 decision by the Department of Financial Services for no change
5 in loss costs may have an unintended consequence of creating
6 anomalies within industry groups and individual classification
7 pure premiums. Rating Board procedures allow for the equitable
8 distribution of overall loss cost level changes, while
9 recognizing reported Unit Statistical Plan data. Maintenance of
10 a responsive classification process and loss costs is necessary
11 for the competitive marketplace for New York employers.
12 We urge the Department of Financial Services to approve the
13 filing as submitted. Thank you.
14 MR. EASTON: Thank you, Mr. Nowak. I have a question for
15 you.
16 MR. NOWAK: Sure.
17 MR. EASTON: Your testimony references standard and time
18 tested actuarial techniques. Do you agree that there is, even
19 using those techniques, a range of reasonableness where
20 competent actuaries could come out differently on issues such as
21 the impact of the closure of the Reopened Case Fund?
22 MR. NOWAK: Yes.
23 MR. EASTON: Thank you. Next we'll invite Nancy
24 Treitel-Moore from Liberty Mutual to testify.
25 N A N C Y T R E I T E L - M O O R E, having first been duly

1 sworn by a Notary Public of the State of New York, was examined
2 and testified as follows:
3 MS. TREITEL-MOORE: Thank you for giving me the
4 opportunity to testify in support of CIRB's loss cost filing.
5 My name is Nancy Treitel-Moore. I work as the Director of State
6 Strategy in Liberty Mutual's Workers' Compensation Product
7 Management Department. I'm an actuary and have been involved in
8 the workers' compensation claim analysis for most of my 31 years
9 with Liberty Mutual, both in New York and countrywide.
10 I regularly serve on workers' comp actuarial and governing
11 committees, and I'm currently serving on NCCI's Actuarial
12 Committee and CIRB's Actuarial and Board of Governors, and I'm
13 also on a number of other independent rating bureaus.
14 Liberty Mutual is the largest writer of workers' comp in
15 the country and the third largest writer in New York. As a
16 major player in New York, we have a vested interest in having
17 adequate loss costs approved for use by the industry. The rates
18 we file are based on these loss costs times a loss cost
19 multiplier, and that multiplier is made up of an expense
20 multiplier and a loss cost departure factor.
21 The practice of the Department is to only allow carriers to
22 depart from the approved loss costs by a range of plus 10% to
23 minus 20%. So regardless of pricing flexibility that exists in
24 a state, we want the loss costs that form the basis of our rates
25 to be actuarially sound and reflective of expected costs.

1 However, in a state like New York where carriers have a lot more
2 limited pricing flexibility in the rates they charge, it's even
3 more critical that we get adequate loss costs approved.
4 It's important that we have adequate loss costs approved in
5 the state to maintain a healthy, competitive marketplace. The
6 reported calendar year combined ratios in New York have been
7 running close to 130% the last several years, meaning losses and
8 expenses are running 30 points higher than premium. That's one
9 sign that the industry is not profitable and that we do not have
10 a healthy marketplace for workers' comp in New York right now.
11 Additionally, we saw the State Insurance Fund grow from 36
12 to 41% of the workers' comp insured market from 2011 to 2012.
13 There's no doubt in my mind that concerns with the profitability
14 of the New York workers' comp marketplace and the Department's
15 decision last year to approve no loss cost increase contributed
16 to that growth in the State Fund's market share, as employers
17 find it harder to get workers' comp coverage from private
18 carriers.
19 Having analyzed the loss cost filing that CIRB submitted, I
20 believe the 16.9% increase requested, is the minimum needed to
21 get loss costs to an adequate level in the state. This level of
22 an increase, while large, comes as no surprise to me, given that
23 the 11.5% loss cost filing made last year was disapproved, and
24 given that on top of that shortfall, we also now have to fund
25 for the prospective impact of shutting down the Reopened Case

1 Fund. The prospective impact of that law change, plus some
2 minor changes in the minimum and maximum weekly benefits, are
3 expected to increase insurers' loss costs by at least 5.4%.
4 Mr. Kimmel talked about the assumptions underlying the
5 16.9, so I won't go back through them. It is, however,
6 important to realize that if CIRB had given 100% weight to what
7 I'll call the post reform indication, we would be looking at a
8 loss cost filing of closer to 27%. By the way, that was the
9 recommendation of the actuarial committee, and it's not in my
10 written testimony, but the reason why we went up to 100% weight
11 being given to the post reform indication at the actuarial
12 committee is it's now been over a year since the implementation
13 of the treatment guideline -- the impairment guidelines. So a
14 year ago when we made the filing, they had just come out in
15 December. Now they've been out for over a year. In addition,
16 the guidelines -- the treatment guidelines have been out for
17 over two years now. So the actuarial committee felt pretty
18 strongly that we should now give 100% weight to the post reform
19 indication.
20 In addition, it was consistent with the indication had paid
21 losses been used, and by giving some weight to that assumption
22 that carriers are not yet fully reserving claims based on the
23 2007 reforms, the indication was tempered and 16.9% was filed.
24 So why do we need such a large increase in the state? The
25 simple answer is that the experience has deteriorated

1 significantly post 7/1/2007, and that the loss cost changes
2 approved has not kept pace with that deterioration. The worst
3 experience is coming through in the reported losses for policy
4 years 2010 and 2011, the years used in the indication. While
5 trends are starting to moderate and we've factored that
6 improvement into the indication by using a -2.6% overall trend,
7 we still need to raise loss costs by 11.5% to cover the change
8 in experience, trend, and loss adjustment expenses. And on top
9 of that, we have the legislative changes that are adding another
10 5.4%.
11 I believe that some of the drivers of the high losses that
12 we see in New York are as follows: First, the increase in the
13 maximum weekly benefit from $400 pre 7/1/2007 to almost $800
14 today, has driven up the indemnity costs. Some of this was
15 expected and factored into loss costs. However, it is more
16 attractive nowadays to remain out on workers' comp than it used
17 to be, and those higher benefits, coupled with a recession,
18 drove higher increases in frequency than anticipated, and there
19 is also some evidence that TTD durations have increased.
20 Second, caps on nonscheduled permanent partial disability
21 only kick in once a claim gets classified. Therefore,
22 claimants have an incentive to delay getting classification, and
23 as already mentioned, that lag has increased. However, getting
24 an agreement that MMI has been reached so that a claim can get
25 classified, can be challenging, with added delays and costs if

1 we need to get an IME and go through multiple hearings for that
2 to take place.
3 Third, the increased role that doctors play in the system,
4 combined with the lack of ability for employers to direct
5 injured workers to doctors with quality outcomes, contributes to
6 the added systems cost. While the treatment guidelines that
7 have been enacted should reduce costs, and we factor that
8 expected reduction into the loss costs, we routinely get
9 requests for variances from the guidelines. We also see doctors
10 treating outside the guidelines and incur costs challenging
11 those treatments.
12 Additionally, when dealing with scheduled loss of use
13 awards, we have to stay on top of providers that routinely
14 assess excessive percentages for the loss of use of scheduled
15 body parts. Again, challenging these, which we do, means added
16 costs for IMEs, more hearings, and more delays in bringing the
17 claims to resolution.
18 Fourth, the overall process for bringing a claim to closure
19 in New York is fraught with delays, frictional costs, and in
20 some cases added benefits being paid, while waiting to bring a
21 claim to closure. For example, my claims people tell me that it
22 frequently takes six to eight weeks just to get a hearing date
23 scheduled once we file the paperwork for a Section 32
24 settlement. The turnaround for appeals can be close to a year.
25 Additionally, we often need multiple hearings to bring a claim

1 to closure, particularly when there's issues that arise between
2 the time when a hearing is scheduled and the date of the actual
3 hearing.
4 The bottom line is that the current loss costs in the state
5 are significantly less than what they need to be to cover
6 projected losses. The assumptions included in CIRB's filing are
7 reasonable, and if anything, are on the optimistic side.
8 Workers' comp calendar year combined ratios in New York confirm
9 that the industry is clearly losing money in the state. The
10 policy year data used by NYCIRB is a more reliable starting
11 point for setting loss costs than the calendar year reported
12 results. However, all indications point to the need for a
13 sizable loss cost increase in New York workers' comp.
14 In summary, I support CIRB's filing. The industry needs at
15 least a 16.9% increase filed for loss costs to be adequate to
16 cover costs in the upcoming policy year, to help return New York
17 to profitability, and to keep the marketplace healthy and
18 competitive. Thank you for letting me testify.
19 MR. EASTON: Thank you.
20 MR. VAJDA: I have one question.
21 MS. TREITEL-MOORE: Sure.
22 MR. VAJDA: Going back to your item seven, talking about
23 the increase in benefits from 400 to 800, and it's now more
24 appealing to be out on workers' comp than working. If I
25 remember, there was a 10% benefit utilization factor that is

1 part of the -- it's part of CIRB's methodology to try to account
2 for increased frequency of a system when indemnity benefits are
3 increased?
4 MS. TREITEL-MOORE: Yes.
5 MR. VAJDA: It's your opinion that that 10% was
6 inadequate, given the change in the financial condition?
7 MS. TREITEL-MOORE: Yes. I think the timing of the
8 increase in benefits, when you look at that combined with the
9 recession that we underwent, we saw a much larger spike in
10 frequency than anything we had anticipated. And then also TTD
11 durations have gone up in the state.
12 MR. VAJDA: Okay. Thank you.
13 MS. TREITEL-MOORE: Any other questions?
14 MR. EASTON: One more.
15 MS. TREITEL-MOORE: Okay.
16 MR. EASTON: Has Liberty Mutual availed itself of the
17 expedited classification process that the Workers' Comp Board
18 has put into place recently?
19 MS. TREITEL-MOORE: So it only came out the end of May,
20 and you know, we're hopeful that it will be effective, but it
21 still requires that claims have to reach maximum medical
22 improvement. So we still have to deal with the doctors and
23 getting them to agree that MMI has been reached. And it's also
24 going to take time to see if the law judges adhere to the
25 guidelines. I know they're supposed to, but we don't find that

1 everywhere.
2 And the other thing is we don't know what other loopholes
3 they might find. So it's all -- it's very hard to anticipate
4 what kind of impact that's going to have --
5 MR. EASTON: That wasn't my question. My question was,
6 has Liberty Mutual availed itself of this process? You started
7 to say it was only recently implemented. My question is, has
8 Liberty Mutual started to avail itself of the process?
9 MS. TREITEL-MOORE: Yes. We have someone from our claims
10 department in the audience, and she's shaking her head yes.
11 MR. EASTON: Okay. Thank you.
12 MS. TREITEL-MOORE: You're welcome. Anything else?
13 Thank you very much.
14 MR. EASTON: Next we'd invite Robert Grey from the
15 Workers' Compensation Alliance to offer testimony. Mr. Grey, if
16 you could give a copy, if you have an extra copy, to the court
17 reporter, that would be helpful. If not, it's not a big deal.
18 But I note that we have your testimony, so it's not necessary to
19 read it into the record. We'd ask you only to highlight those
20 points that you want to.
21 R O B E R T G R E Y, having first been duly sworn by a Notary
22 Public of the State of New York, was examined and testified as
23 follows:
24 MR. GREY: Good morning. I'm here on behalf of not only
25 the Workers' Compensation Alliance, but also the New York

1 Committee for Occupational Safety and Health. These are, of
2 course, not groups that are positioned to address any technical
3 actuarial sorts of issues, and I'm certainly not going to get
4 into that territory, but what we do have is firsthand experience
5 with regard to how claims are actually handled in the system,
6 and we have a sense of the correlation or lack of correlation
7 between the claims that have been presented by various insurance
8 industry speakers today and the actual practice.
9 I'd like to start by reiterating a point that we have made
10 in our testimony for the last several years, and which continues
11 to be our view, which is that there is a fundamental lack of
12 transparency and credibility that accompanies CIRB's filings.
13 This year, we listened to Mr. Kimmel advise that CIRB is using a
14 new methodology, and that the new methodology has diminished
15 what the rate filing would have been were it not for the new
16 methodology, and that calls to our mind a question as to whether
17 this means that all of CIRB's past rate filings for the past
18 several years, which did not use this methodology, were
19 inflated.
20 We have difficulty understanding how CIRB can conduct a
21 survey of its members, discover that not one of its members is
22 reserving any case to anything other than caps, and to then
23 submit a rate filing that assumes that one-third of current
24 claims are not capped. We feel that that likely results in an
25 artificial overinflation of PPD costs.

1 We question the use of a five-year trend. We question that
2 because although the 2007 legislation is now six years old, as
3 the Department is well aware, many of the aspects of the 2007
4 legislation were not implemented until subsequent years, and
5 have not become more fully effective for the past three years,
6 and we would suggest that a more accurate period of time to look
7 at would be a three-year period and not a five-year period. It
8 would be interesting to see how that would diverge.
9 In its analysis for the Legislature and the Governor with
10 regard to the state budget, CIRB estimated the impact of the
11 increase in the minimum rate at .3%. In its filing for the
12 Department it has estimated that at .4%. While certainly a
13 difference between .3% and .4% is trivial, to us it calls into
14 question the credibility and accuracy of CIRB's filings. We
15 would think that actuaries would get it right the first time, or
16 at least stick with the same number and not adjust it. We did
17 not observe any explanation for the adjustment.
18 We continue to feel that in its calculations, CIRB does not
19 have accurate data with regard to the cost of PPD claims. As
20 the Department is aware, in 2007, the Insurance Department interacted
21 with CIRB, and determined that CIRB uses a dollar value limit
22 for determining what is a permanent partial disability
23 non-schedule, as opposed to a permanent partial disability which
24 is scheduled. We think that this precludes CIRB from having an
25 accurate estimate of what non-schedule permanent partial

1 disabilities are.
2 It is our view that the loss cost filing dramatically
3 overstates the impact of closing the 25-A Fund. The loss cost
4 filing estimates 4.5%. We do not find it in any way credible
5 that 4.5% of carrier costs are attributable to the tail end of
6 what we call 25-A cases.
7 About 2% of the hearings that the Workers' Comp Board holds
8 are regarding this issue, and about 80% of those claims are
9 medical only. Certainly there should be an increase in carrier
10 costs, because they'll be internalizing into premium that which
11 was funded through assessments, but we do feel that 4.5% is
12 excessive.
13 On a visceral level, the simple fact is that New York has a
14 healthy marketplace for workers' compensation, as evidenced by
15 the fact that you have many private carriers that are still
16 functioning in the state, and you have many private carriers who
17 have been quoted as saying that this is a healthy marketplace,
18 and they are expanding their lines of business in the field in
19 New York State. Several of which carriers are present.
20 As the gentleman from AIA pointed out, the 2013 budget
21 removed 1.75 billion dollars from the State Insurance Fund, and
22 operated in several other ways to reduce the competitiveness of
23 the State Insurance Fund, and we think it is to be anticipated
24 that this will, in the near and intermediate future, result in a
25 reduction of the State Fund's market share, which should create

1 a more competitive environment for the private carriers.
2 Were that not to occur, and if instead, some of the prior
3 speakers were correct and the State Insurance Fund's market
4 share were to increase, in the view of the organizations that I
5 am here on behalf of, that would not be a negative thing in any
6 way. It is our view that the State Insurance Fund is, and has
7 been for a long period of time, the best insurance option for
8 New York employers and insurers, and is a far, far preferable
9 option to any of the private carriers. So we would not lament
10 an increase in the State Insurance Fund's market share.
11 Several of the speakers have taken the position that the
12 delay in classification is attributable to claimants and
13 claimants' attorneys delaying classification. The simple fact
14 is that the statute became effective on March 13, 2007, and
15 there has been not one obstacle for the past six years that
16 would have prevented any private carrier at any time from
17 pursuing a permanency finding in any case.
18 The Workers' Compensation Board has made it clear in a
19 number of decisions that it would always have been perfectly
20 happy to classify, and it is purely and simply the private
21 insurance industry's own failure to pursue and classify
22 claimants that has resulted in the delay of the classification
23 process.
24 We do not feel that the appropriate corrective action for
25 the Department is to grant the private carriers an increase in

1 rates, which we think works out to about a billion dollars in
2 increased costs for New York employers to remedy the carriers'
3 failure -- own failure to avail themselves of the statute and
4 the administrative remedies that have always been present for
5 them. All that would do would be to provide a disincentive to
6 the carriers to follow the law as it's written.
7 We object to all of the characterizations of the maximum
8 rate as resulting in a significant increase in costs. As the
9 Department is aware, the bulk of the increase in costs
10 attributable to the maximum rate occurred in the first several
11 years after the reform. Everything since then has been
12 incremental. There is an incrementally smaller number of
13 workers who benefit as the rate increases going forward, and
14 even those workers who achieve some benefit from the maximum
15 rate, do not achieve it for any significant period of time
16 because of the nature of partial disability and reduction in
17 weekly rates in the workers' compensation system.
18 The last two points that I'd like to address are one of the
19 prior speakers made a reference to an increase in fraud. We
20 find the conversation about fraud in the workers' compensation
21 system to almost invariably be an entirely one-sided
22 conversation, and that very little attention is paid to what
23 efforts, if any, carriers make to remedy the issue of employer
24 fraud with regard to misclassification of employees,
25 underreporting of payroll, and other vehicles that employers use

1 to cheat carriers out of the premium that carriers should be
2 charging.
3 Regrettably there is, in our observation, very little
4 effort that's made by carriers to remedy that problem, because
5 obviously if Liberty is to aggressively pursue its insureds for
6 fraud, those insureds will then take their policies to AIG.
7 This is, however, a situation that does increase costs for
8 employers unjustifiably and should be corrected.
9 We would be remiss given that AIG has been a speaker here
10 today, in not mentioning the issue of insurer fraud as also a
11 significant contributor to costs in the system.
12 Lastly, since two of the speakers brought up the issue of
13 the composition of the CIRB Board and the recommendation of the
14 CIRB Actuarial Committee, we would like to see some transparency
15 in disclosure about the actual recommendation of the CIRB
16 Actuarial Committee, and we think it would be in the public
17 interest to have disclosure by one of the public members, if by
18 no one else, of what the actual vote was on the CIRB Board of
19 Governors with regard to the proposed loss cost filing.
20 We think it would be valuable information for the
21 Department to know whether this is a unanimous vote by all of
22 the members of the CIRB Board, or whether there was a
23 significant disagreement among the CIRB Board, because we think
24 that might influence the Department's judgment in this matter.
25 We also think it would be a matter of some public interest.

1 Thank you.
2 MR. EASTON: Thank you, Mr. Grey. We'll next hear from
3 Mark Humowiecki of the Workers' Compensation Board.
4 M A R K H U M O W I E C K I, having first been duly sworn by a
5 Notary Public of the State of New York, was examined and
6 testified as follows:
7 MR. HUMOWIECKI: Good afternoon. My name is Mark
8 Humowiecki. I'm Deputy Executive Director for Policy and
9 Program Development of the New York State Workers' Compensation
10 Board. I'm also a public member of the Board of Governors of
11 the Compensation Insurance Rating Board.
12 I'm here on behalf of the Workers' Compensation Board to
13 speak against the proposed rate increase. I believe that the
14 assumptions underlying this year's filing overstate current and
15 future costs.
16 As you know, last year the CIRB filing requested a loss
17 cost increase of 11.5%. The superintendent disapproved the
18 filing because insufficient weight had been given to the savings
19 from the 2007 reform, and more time was required to evaluate the
20 full impact of the reform.
21 This year, CIRB requests an even greater increase. It's
22 important to note, however, that the higher number is driven not
23 by significant changes in the underlying financial data received
24 by CIRB, but rather by changes in the actuarial assumptions that
25 are applied to that data.

1 The most significant change in actuarial assumptions
2 involves the application of duration caps to non-schedule
3 permanent partial disability claims. The 2007 reform instituted
4 duration caps on PPD claims whose date of accident occurred on
5 or after March 13, 2007. Since 2007, CIRB has applied an
6 on-level adjustment to address the fact that claim reserves and
7 development in pre-reform years would not be reflective of PPD
8 claims once duration caps were in place.
9 Over the last few years, CIRB has assumed that some portion
10 of PPD claims were being reserved in the same manner as
11 pre-reform PPD claims. Each year, that assumption has been
12 modified, gradually increasing the proportion of claims that
13 were reserved for post-reform caps. Last year, the CIRB filing
14 assumed 27.5% of PPD claims were reserved for post-reform caps.
15 This year, the filing makes a dramatic change by assuming that
16 two-thirds of claims are reserved for post-reform caps.
17 This change has a significant impact on the ultimate
18 indication. If the same assumption had been made last year, the
19 filing would have been for more than 40% of an increase. Had
20 that been granted, this year's filing would actually call for a
21 significant reduction in loss costs. That level of fluctuation
22 in workers' compensation rates borne by New York employers is
23 not at all desirable. Similarly, if this year's filing
24 continued to assume the 27.5% ratio, the indication would be for
25 less than a 5% increase.

1 I concede that the pace of classifications of post-reform
2 claims has been slower than expected. The causes of this may be
3 multiple. Carriers have been trying to settle PPD claims,
4 rather than moving them to classification, because once
5 classified, the carrier has six months to settle or deposit the
6 full amount of the claim with the ATF. Claimants have resisted
7 classification by disputing that they have reached MMI. As a
8 result, the time to classification has grown to more than six
9 years. However, this number can be somewhat misleading, as it
10 excludes all cases that are settled by Section 32 agreement.
11 Pre-classification Section 32 settlements likely occur earlier
12 in a claim than PPD classifications.
13 Regardless, the Board has recently taken proactive steps to
14 ensure the timely classification of PPD claims. In May, the
15 Board established special hearing parts with seasoned judges for
16 classification hearings. The Board also issued new guidance
17 regarding parties' use of the 2012 Permanent Impairment and Loss
18 of Wage Earning Capacity Guidelines, and the requirement to
19 submit evidence as directed using appropriate forms.
20 Claims that are two years old that involve non-schedule
21 injuries, and where the claimant continues to be out of work,
22 are reviewed and assigned to the classification calendar.
23 The heightened attention to classification is already
24 producing an impact. In the last two months, more than 1,450
25 non-scheduled PPD claims were either classified or settled by

1 Section 32. At that rate, the Board will classify or settle
2 more than 8,700 PPD claims annually, which is significantly more
3 than occurred prior to the reform. This suggests that the Board
4 is now reducing the backlog of PPD claims and will begin
5 bringing down the time it takes from injury to classification.
6 By speeding up classifications, and the corresponding
7 application of duration caps, the Board expects to see lower
8 incurred indemnity costs over the current experience. The
9 adjustments that the filing makes to LDFs to reflect the impact
10 of the classifications are overly pessimistic about when the
11 caps are applied and should be modified accordingly.
12 The second major actuarial assumption that generates the
13 request for a double digit increase involves the on-level
14 adjustment made for the closing of the Special Disability Fund,
15 also known as 15-8. The 15-8 Fund assumed liability for claims
16 in which the claimant had a prior permanent impairment and
17 experienced a subsequent workplace injury that resulted in a
18 permanent disability substantially greater than would have been
19 experienced without the prior impairment.
20 The Fund assumed liability for payments after acceptance
21 into the Fund and after five years of payments. The 2007 reform
22 closed the Special Disability Fund to claims occurring after
23 July 1, 2007 and to any claim for which an application for 15-8
24 relief was filed after January 1, 2010.
25 At the time, the CIRB estimated that the closure would

1 increase indemnity costs by 17.8%. In each of the six filings
2 since 2007, the CIRB has included the same on-level adjustment
3 to reflect the increased cost of closing 15-8. This adjustment
4 accounts for much of this year's loss cost increase.
5 Essentially, the CIRB filing assumes that the elimination
6 of 15-8 has not produced any change in the incurred amount of
7 PPD claims over the last six years. This is based on the
8 assumption that prior to the reform, all carriers reserved
9 potential PPD claims for full lifetime benefits, no matter how
10 likely the chance of 15-8 relief, and did not adjust the
11 reserves downward until after at least five years. This means
12 the carriers put up a lifetime reserve, well before the claim
13 was classified as having a PPD, but would not adjust that
14 reserve downward no matter how confident they were that the
15 claim would receive relief.
16 While some adjusters in some carriers may have followed
17 this approach, there's very good reason to believe that many did
18 not. The availability of 15-8 relief was often apparent very
19 early in a claim. Prior workers' compensation claims or other
20 documentation of previous injuries was often easy to locate.
21 15-8 relief was very valuable in a context of lifetime benefits,
22 so examiners had a strong financial incentive to develop the
23 medical evidence for 15-8 relief as quickly as possible.
24 From 1998 to 2007, more than one quarter of 15-8
25 applications were made within one year of the accident, and more

1 than half, 54%, were made within two years of the accident.
2 Experienced adjusters report that it was common to set the
3 initial reserve for only 260 weeks of indemnity if a viable 15-8
4 claim existed. While practices varied from carrier to carrier,
5 at least some carriers and TPAs did not put up lifetime reserves
6 in claims where 15-8 relief was likely.
7 While only 15% of carriers in the CIRB survey admitted that
8 15-8 relief was reflected prior to formal acceptance by the
9 Fund, the survey is not highly reliable, given the low response
10 rate and the self-serving nature of the answers.
11 As Mr. Vajda noted earlier today, historic loss development
12 factors, particularly those of private carriers, suggest that
13 lifetime reserves were not consistently put up in all PPD
14 claims. In the first five years of the claim, the indemnity
15 development factors are consistently significant. Moreover,
16 incurred indemnity costs continued to develop through years five
17 through eight, suggesting that carriers were not taking down six
18 figure reserves in year six, but rather, often did not establish
19 the lifetime reserve in the first place.
20 Second, even assuming that reserves weren't adjusted until
21 15-8 relief was awarded, most claims received 15-8 relief well
22 before five years. While the Special Disability Fund didn't
23 begin paying the claims until the carrier had paid five years of
24 indemnity, the determination of whether a claim qualified for
25 15-8 relief could be made by the Special Funds or the Workers'

1 Compensation Board at any point. In fact, from 1998 to 2011,
2 64% of the 15-8 claims were accepted into the Fund in less than
3 five years from the date of accident. More than one-third of
4 new 15-8 claims were established in less than three years.
5 Since the CIRB survey responses discuss reserves being
6 adjusted at the time 15-8 relief is determined, and not at the
7 time 15-8 begins making payments, the impact of 15-8 occurred
8 well before the five-year point.
9 These flaws in CIRB's assumption around 15-8 have
10 significant consequences. The fact that historically 15-8
11 relief was reflected in a claim reserve prior to five years,
12 means that claim reserving and development for post-reform
13 claims, now up to six years old, are already different than they
14 were in pre-reform claims. As a result, the data already
15 reflects higher incurred values for PPD claims as a result of
16 the closure of 15-8. To continue to apply the same 17.8%
17 on-level factor, significantly overstates the loss costs.
18 So it's important to note that the trend picture is
19 improving, as has been noted earlier today. Claim frequency has
20 resumed its historic downward trend. Moreover, medical and
21 indemnity trends have continued to flatten. The indemnity trend
22 would be even flatter were it not for the change in actuarial
23 assumptions about PPDs discussed above. The recovering economy
24 and continued wage growth also signal improvements for the
25 workers' compensation market.

1 Turning to the issue of 25-A, the 2013 Business Relief Act
2 closes the Fund For Reopened Cases or 25-A Fund effective
3 January 1, 2014. This Fund allowed carriers and self-insured
4 employers to shift to all employers the costs of reopened claims
5 that are at least seven years old and have had three years since
6 a true closing. Over the last several years, the Fund has
7 required an increasing assessment on employers. By law, the
8 25-A Fund is fully funded.
9 With the closure, employers will realize a $300 million
10 annual assessment savings. Though the costs of reopened claims
11 will now be borne by the primary payer, the change produces
12 efficiencies that resulted in reduced overall costs. Carriers
13 and the employer community will no longer have to pay the costs
14 associated with applying for 25-A relief, developing the record,
15 and the attorneys' fees and hearings associated with this
16 transfer of liability.
17 Moreover, the original payers will handle the claims more
18 efficiently throughout the claim history, knowing they cannot
19 escape liability through 25-A.
20 CIRB requests the ability to charge 4.5% additional loss
21 cost to employers for the unexpired months in the current
22 premium year to recoup some of the costs of closing 25-A. This
23 request should be rejected, as its impact on employers is
24 arbitrary. Those employers whose policies renewed later in the
25 filing coverage period are subject to a significant increase on

1 their existing policy, even though they pay the same 16.9%
2 employer assessment.
3 In contrast, those policies that renew in October or
4 shortly thereafter, will have avoided the additional increase
5 and will pay a much smaller assessment on the 2013 to 2014
6 policy.
7 In summary, the request for a 16.9% increase is largely
8 premised on a set of actuarial assumptions that overstate future
9 costs. The filing assumes that the current data reflects most
10 of the savings from the 2007 reform, but none of the increased
11 costs from closing the 15-8 Fund. A more prudent approach would
12 be to gradually unwind both assumptions about savings from the
13 caps and additional costs from the 15-8 closure. This would
14 produce greater stability in workers' compensation pricing,
15 which is good for everyone. Thank you, and I'll take any
16 questions.
17 MR. VAJDA: I'd just like one clarification. When you're
18 talking about the review of historic loss development factors,
19 about, you know, that the reserves do not indicate that, you
20 know, that the Special Disability Fund's relief was coming at
21 5th or 6th Report from private carriers, I just want to say,
22 just to clarify, that that's suggestive of that. It doesn't
23 necessarily confirm it or prove it, because without looking at
24 all sorts of individual company triangles and reviewing claim
25 files, we don't really have proof one way or the other. But it

1 is suggestive of that. I just wanted to clarify that.
2 MR. HUMOWIECKI: Agreed.
3 MR. EASTON: Any other questions from the Panel? Thank
4 you, Mr. Humowiecki.
5 MR. HUMOWIECKI: Thank you.
6 MR. EASTON: That concludes everybody who had
7 pre-registered to testify. Is there anybody who hasn't had an
8 opportunity to speak today who wishes to be heard? Mr. Kimmel?
9 MR. KIMMEL: Can I get up there and respond for a couple
10 of minutes?
11 MR. EASTON: I would invite you to submit written
12 testimony within the five-day period, if you would like to be
13 heard further.
14 MR. KIMMEL: Okay.
15 MR. EASTON: And that goes for anybody else as well.
16 Otherwise, we will conclude this hearing, and thank you all for
17 your participation today.
18 (TIME NOTED: 1:04 P.M.)
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1 CERTIFICATION

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5 I, EDWARD LETO, a Notary

6 Public in and for the State of New

7 York, do hereby certify:

8 THAT the foregoing is a true and

9 accurate transcript of my stenographic

10 notes.

11 IN WITNESS WHEREOF, I have

12 hereunto set my hand this 26th day of

13 June, 2013.

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17 EDWARD LETO

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