NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES

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PUBLIC HEARING IN RE:
WORKERS' COMPENSATION RATE

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One State Street
New York, New York

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Reported By
Stefanie Krut

A P P E A R A N C E S:

DFS PANEL PRESENT:
MARIA VULLO, Superintendent

MAURICE MORGENSTERN, Deputy Bureau Chief

ALEXANDER VAJDA, Principal Casualty Actuary

SPEAKERS:
Ziv Kimmel - New York CIRB

Kenneth Munnelly - Workers' Comp Board

Elizabeth Heck - Greater New York Insurance Companies

Thomas Nowak - AIG Property Casualty

Robert Grey - Workers' Comp Alliance and NYCOSH

Nadia Marin-Molina - NYCOSH

Kelly Jay McLaughlin - The Hartford

Nancy Treitel-Moore - Liberty Mutual

Ken Pokalsky - Business Council of New York

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MR. MORGENSTERN: Good morning. We would like everyone who's here today to sign in at the door, so if you haven't had the chance to do that, please do so. I would welcome you here this morning, but that job belongs to the person presiding over me, and it's my privilege and pleasure to introduce the Superintendent of Financial Services.

SUPERINTENDENT VULLO: Good morning, everybody. Thank you, Moe. Welcome this morning to the Department of Financial Services. As you know, we are here for a workers' compensation rate hearing.

Workers' compensation insurance is a vital and indispensable element of our State's economy. No business can function without it. And it serves as a safety net for every worker who may suffer injury during the course of performing.

A vibrant, competitive insurance

Workers' Compensation Rate market depends on coverage that is readily available and fairly priced. We, at the Department of Financial Services, are committed to ensuring that workers are protected properly while we maintain healthy competition for workers' compensation insurance providers.

Today's hearing concerns a proposal for workers' compensation insurance loss cost increase filed by the New York Compensation Insurance Rating Board, otherwise known as CIRB, beginning with a C, which was submitted on May 13th, 2016.

CIRB is a nongovernment rate service organization licensed pursuant to Section 2313 of the New York Insurance Law, and it provides services to New York workers' compensation insurers. Every New York workers' compensation insurer must be a member of CIRB and must report statistical data to CIRB. In turn, CIRB compiles

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and evaluates the data submitted to it, develops the loss costs, and then files on behalf of its members and subscribers. When placed in effect, those loss costs are used by the workers' compensation insurers in New York in setting rates for their policyholders.

Loss cost changes for workers' compensation insurance are subject to this Department's prior approval. Section 2305 of the Insurance Law requires that I hold a public hearing if a rate service organization, such as CIRB, makes a filing for workers' compensation insurance that proposes to increase loss costs by seven percent or more above the approved loss cost of the prior year.

In its filing, CIRB has proposed to increase workers' compensation base loss costs by 9.3 percent. Therefore, this hearing has been convened.

I would note from the outset that

the proposed increase is significant. I am also aware that the Governor has proposed legislative initiatives that would have gone a long way towards resolving the increase proposed today. Unfortunately, the legislature did not support those initiatives and we are here today evaluating a rate increase request.

This hearing was noticed on June 15, 2016 in the State Register and provided that the purpose of this hearing is to determine whether DFS should approve CIRB's approved proposed 9.3 percent increase or some other amount.

We will be hearing testimony today from individuals representing a wide spectrum of stakeholders in the workers' compensation market, which we expect will assist us in our review of the filing. The procedures today will provide that CIRB, as the applicant, will present first. Thereafter, other

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interested parties will be entitled to make limited presentations, and Mr. Morgenstern will be calling people up after each witness.

There are a number of individuals we are happy to see have registered to submit oral testimony. Some have also provided written testimony as well. If there is anyone who wants to testify who has not yet registered, please do so immediately. The forms are over there.

We will also accept written comments from any interested parties for the next five business days. So we will not close the record until five business days after this hearing. And then all comments, as well as the oral testimony presented today, will be made part of the public record and considered by DFS in rendering its decision, which we must make by July 15th.

The stenographer here will be

taking a verbatim transcript of today's hearing. We request that those who are providing oral testimony keep their comments pertinent to the issue and limit them to no more than five minutes so that we can get through. Where there was written testimony submitted, it's not necessary to read that written testimony into the record, and because we have it, it will be part of the record and it will be fully considered. We ask that you just highlight those items in the testimony that you wish to emphasize to our attention today.

And we are the panel; myself and Mr. Vajda, our actuary, and Mr. Morgenstern, if he would like, are free to ask questions of the witnesses. We appreciate everybody sticking to the time limit so we can run the hearing smoothly. And I assure you, again, we will consider all the comments and the testimony in rendering our decision.

So with that, I think we want to

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call the first witness, Moe?

MR. MORGENSTERN: Yes. New York Compensation Insurance Rating Board, Ziv Kimmel.

SUPERINTENDENT VULLO: Mr. Kimmel, you can start when you are ready.

MR. KIMMEL: Good morning, members of the hearing panel and all other attendees and participants. My name is Ziv Kimmel. I am Senior Vice President and Chief Actuary of the New York Compensation Insurance Rating Board. I am a fellow of the Casualty Actuarial Society and a member of the American Academy of Actuaries.

The hearing testimony I provide to you today is presented on behalf of the Rating Board's membership and is specifically in reference to the Rating Board's request, current filing application for a 9.3 percent average increase in the overall loss cost level.

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Actuarial examination of workers' compensation cost levels in the state over the past several years suggests that the costs of paying for workers' compensation claims, including medical and indemnity benefits, have been relatively stable after the Compensation Board increased wage levels and decrease in claim frequency. However, premiums charged by insurance carriers to pay for these claims have been insufficient. This insufficiency originates from an inadequate loss cost level. The loss costs represent the benchmark in insurance carriers' use to determine the final premium rate.

Loss cost inadequacy can result in an unhealthy marketplace where carriers may be more reluctant to renew policies or accept new risks. This trend is apparent in New York State and the State Fund's increasing market share is evidence of that trend. According to statutory Annual Statement

Workers' Compensation Rate figures submitted to the Department of Financial Services, direct written premium of the State Insurance Fund now represents over 44 percent of the entire premiums in the State. As a point of reference, their market share in 2011 was 36 percent. When a single carrier writes close to half of the statewide premiums, and there are more than 300 carriers out there, it's a clear indication that the marketplace is unhealthy with insufficient competition.

When there is less competition in the market place, resulting from the inadequate loss cost level and the reluctance of carriers to write at these levels, employers may find it more difficult to shop around for the best possible rate. While approval of the loss cost filing will cause a one-time increase in costs to employers, in the years following it is expected that the workers' compensation

Workers' Compensation Rate market will be more stable and competitive, a climate that benefits employers and carriers.

The proposed loss cost level change is based on the latest data reported to the Rating Board member carriers and reflects the application of accepted actuarial principles and methodologies.

The filing indication consists of the following elements: First, actual carrier experience, which is based on two policy years of data, with premiums and losses developed to ultimate value, and premiums adjusted to the current loss cost levels, and losses adjusted to the current benefit levels. This component contributes 6.8 percent to the requested increase.

The next component is a trend factor which contributes an additional 1.6 percent to the indication. This is a result of separate analyses of claim frequency and claim severity, and

Workers' Compensation Rate reflects projected wage increases to the prospective filing period.

Next is a change in the loss adjustment expense provision increasing the indication further by 0.5 percent based on standard analyses of defense and cost containment, expense -- and adjusting and other expenses. And finally, benefit level changes, contributing an additional 0.5 percent to the total indication.

In addition, when deriving the overall change, consideration was given to the fact that the catastrophe provisions are proposed to remain unchanged. Combining all of these elements results in the overall indication of 9.3 percent. The full details of the analysis are described in the filing document, which has been made available on our website, www.nycirb.org.

I do, however, want to elaborate on a few of the filing components.

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First, I would like to address the reflection of past reforms in the actuarial analysis. I would like to discuss specifically the 2007 reforms. The experience used in this filing is from policy years 2013 and 2014. Paid losses and case reserves from these years certainly reflect the post-reform benefit level structure, including the duration caps on nonscheduled PPD claims and the closing of the special disability fund. However, when developing losses to ultimate value, we use information from years that preceded the reform, and we anticipate that post-reform years would develop in a different manner because of the revised benefit structure. The method to determine the necessary adjustments has been thoroughly reviewed by the Rating Boar's Actuarial Committee and has been previously approved by the DFS. It involves restating the reported development from the

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pre-reform years to post-reform levels. The process is being performed separately for each of the reform elements, and an adjustment factor for each of the reform elements is being calculated as the ratio of the ultimate development factor after the restatement to the ultimate development factor before the restatement. These adjustment factors are shown on Exhibit D, sheet two of the filing document, which shows the benefit level adjustment factors. The final factors are 0.93 for the duration caps component, and 1.157 for the closing of the special disability fund. Note that the adjustment factor for the special disability fund is lower than what was used in last year's filing and is expected to gradually decrease in future years as a smaller portion of the development comes from pre-reform years. The complex details involving the restatement of the loss development

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link ratios are described in the filing document.

Second, a new procedure we are introducing in this year's filing is an adjustment to premium amounts in the experience period to a consistent impact of experience rating. The goal of this procedure, which is an accepted procedure which is used in other jurisdictions, is to ensure that neither the experience indications nor the trend factors are impacted by fluctuating effects of the experience rating plan. The impact of this procedure in this year's filing is a very small decrease in the experience indication. The new procedure, however, does put upward pressure on this year's frequency trend.

I would like at this point to say a few words about trend. We continue to use the same methodology of utilizing five years of financial data in selecting trend factors based on

Workers' Compensation Rate exponential regression of claim frequency and claim severities for medical and indemnity. We believe that a five-year trend strikes the right balance between stability and responsiveness. Based on the analysis, we have determined that claim frequency is expected to decrease by 1.5 percent per year, indemnity average cost per case, or severity, is expected to increase by 5.3 percent per year, and medical severity is expected to increase by 5.1 percent per year. The total annual loss trend, combining the frequency and severities, is 3.6 percent per year. Much of that increase, however, is caused by increased wage level in the State, which also generates more premiums. We, therefore, offset the total annual loss trend by a projected increase in the average wage level in the State. The projected annual wage level increase is 3.1 percent. After

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applying the wage offset, the net annual trend is 0.5 percent per year. When projecting this trend from the experience period, which is policy years 2013 to 2014, to the prospective filing period, which we have a prospective effective date of October 1st, 2016, the total trend used in this year's filing is 1.6 percent, or a factor of 1.016.

With respect to the benefit level changes, the only change included in this year's filing is the automatic increase in the maximum weekly benefits, which is tied to the State average weekly wage. This increase, as I mentioned earlier, contributes 0.5 percent to the overall indication.

The remaining technical details of the proposed changes are, as I mentioned, contained in the filing document. The methodology and data used to derive the resulting indication of 9.3 percent were reviewed and

Workers' Compensation Rate approved by the Rating Board's Actuarial Committee. Given these results, the 9.3 percent requested increase in the loss cost level is necessary and reasonable in order to maintain an adequate loss cost level and a healthy, competitive workers' compensation system.

This concludes my prepared testimony for this public hearing. I will be happy to address any questions that the hearing panel may have regarding my statement, or any other component of the Rating Board's requested loss cost file.

SUPERINTENDENT VULLO: Thank you, Mr. Kimmel. I have just a few questions. I don't want to get into the gritty details of the numbers. I will refer to Alex for those. But you did mention, both in written testimony as well as orally, the State Insurance Fund and its percentage of the market, and obviously DFS is concerned about

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competition in the market. I did notice, however, that the State Insurance Fund's share of the premiums in the market has experienced a slight decrease from last year, and if you look at -- and that's based on premiums, and if you look at written policies, that slight decrease may be even a little bit larger. One could conclude that indicates some positive trend in private carriers' willingness to write into this market. Do you have a comment on that?

MR. KIMMEL: Well, as you mentioned, the decrease from 2014 to 2015 has been very slight, and usually from year to year you do see a slight fluctuation in market share. That's why I mentioned in my testimony the point of reference 2011, and you could see that over the past several years there's been a steady growth, and I think that's the important point to focus us.

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SUPERINTENDENT VULLO: Okay. But, like you said, there has been, at least in one year, and you sort of mentioned certain reforms, and one of the things that I also want to ask you about is this schedule rating plan. Are you familiar with that?

MR. KIMMEL: Yes.

SUPERINTENDENT VULLO: So that gives insurers some flexibility, I think, within five percent. Have you seen any efforts to, you know, insurers, you know, because of that to, you know, enter the market more? I mean, it seems like a positive way of encouraging insurers on the private side to come into the market, if you can comment on that. I think that is a recent, January 2015, endeavor.

MR. KIMMEL: Privateering is ever pushing to have more pricing tools and scheduled rating is definitely a necessary tool for them to have some pricing flexibility that may encourage them to enter the market, which may have contributed to the slight decrease in the State Fund's market share.

SUPERINTENDENT VULLO: So that's a positive development --

MR. KIMMEL: That's a positive --

SUPERINTENDENT VULLO: -- if you will, in the competition in the marketplace.

MR. KIMMEL: That's certainly a positive development. That said, the schedule rating limits our plus or minus five percent, which is still much lower than these generally accepted in other jurisdictions.

SUPERINTENDENT VULLO: But still not zero so...

MR. KIMMEL: Still better than zero.

SUPERINTENDENT VULLO: One other thing, and I think it was a comment in some of the other testimony that we received, CIRB, as part of its filing process, has reviewed information

Workers' Compensation Rate received pursuant to financial data calls. And, you know, I assume CIRB performed certain reasonability checks? And if so, can you comment on that? Because there was a comment being received, so I just want to give you the opportunity to address that.

MR. KIMMEL: Certainly. There are several levels of data validation that we perform at the Rating Board. When the carrier submits data, the data is not automatically downloaded to the database that we use in the filing. It goes through a rigorous testing and validation process, which is, in large part, automated. In other words, when the carrier submits data, the automated data loading system checks for data anomalies and could potentially reject data files which are entered if they don't meet certain criteria.

In addition, some data anomalies are allowed to get into the database, but carriers are expected to either

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There are literally hundreds of e-mails between the Rating Board and the member carriers to validate and to verify many data points that are entered into the system. And in some cases the carriers do provide explanations as to those anomalies are legitimate, they are real, and in some cases the carrier says that there is some inaccuracies in the data and they need to submit a data correction and we afford them the opportunity to submit those data corrections before we finalize the data for use in the filing.

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In addition, we perform several data reconciliations. We reconcile the data that is in the financial data polls to the annual statements that are submitted to the Department of Financial Services to make sure that the data as a whole is -- agrees with the data that was submitted to the Department.

And finally, we perform another set of reconciliations between the financial data that is submitted that was used to determine the overall loss of level and the unit statistical data, which is a little older, but still gives us an idea if the carriers appropriately aggregated their data for submission in the -- for the financial data that we used in the loss cost filing.

SUPERINTENDENT VULLO: Thank you. And just you know, the Department obviously doesn't just accept the rate filing. We do our only internal

Workers' Compensation Rate review. Other than that, I will turn it over to Mr. Vajda for questions that he may have.

MR. VAJDA: Good morning.

MR. KIMMEL: Good morning.

MR. VAJDA: I just wanted to start by asking about the estimated impact of the closure of the reopen case file. In the 2013 filing, there was a 4.5 percent estimated impact increase in loss cost rate over the funds and that's what you filed and the Department had approved. And currently the estimated impact of that closure is 6.2 percent. And we would like for you to explain what's changed and why that this change in, estimated change in legislative impact shouldn't flow through, just simply flow through like other differences between legislative impacts and actual.

MR. KIMMEL: So there's a couple of questions and I will address one at a time. First, the difference between

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the 4.5, which was included in the 2013 filing. The original analysis that the Rating Board performed to determine the impact of the closing and the reopen case fund was during the days where the bill was proposed, this was part of the 2013 budget bill, and we had data through 2011. We collected data from external sources, such as the Workers' Compensation Board, to determine what the assessments were, and the assessment information that we had at the time we originally estimated the impact was through 2011. Based on that information, we determined that the impact would be 4.5 percent.

Later that year, a new data point came in which had the 2012 assessment, and as actuaries -- as an actuary, I like to use the most recent available data, and the data from 2012 did indicate a very high level of assessment, suggesting that the cost of the reopen case fund was higher than

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originally estimated. And based on data, including the 2012 assessment, the actual impact was 6.3 percent. So that explains sort of the differences. As more data came in, we had to reevaluate the impact.

To your other question, because of the unique features of the reopen case fund where claims have to be at least seven years old before they enter into the fund, the experience that we have right now in the filing is for policy years 2013 and 2014 so -- but the development that we use is from years prior to the closing of the fund. So much of the development is quote/unquote suppressed because it reflects the shifting of claims from the carriers to the fund.

Right now that the fund going forward, the fund is closed so those developments are expected to be higher. And we employ a similar procedure to the one we employed for the special

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disability fund when we calculate the impact based on this original 6.3 percent. Most of it is not in the experience, but some of it -- a very tiny fraction of it is in the development already, so that caused a reduction of impact from 6.3 to 6.2.

MR. VAJDA: Okay. Thank you. Just moving to trends. We have noticed that the indicated severity trends for private carriers, that you included in the summary filing, that those indicated trends that are decreased from 7.2 percent in the 2014 filing to 5.4 percent in 2015 to the current 4.7 percent. What factors do you think are responsible for this trend? And what implications, if any, are there for the medical severity trends going forward?

MR. KIMMEL: Some of the reasons for the decreasing -- the medical trend is still increasing, but it's increasing in a lesser amount than it was in the past. Some of the causes

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may be the medical treatment guidelines and other tools, we have medical fee schedules in place, some control on the medical going forward. So medical treatment guidelines played a certain parts of body were implemented in 2010 I believe. So as -- over the first few years when they were first implemented, it was still hard to gauge what would be the impact and how well they would work. Right now, a few years down the road, it is possible that they are starting to take hold and are putting more control into what is being penned out.

MR. VAJDA: Okay. Just moving to loss development generally. You have used a straight five-year average for each point ratio to develop losses. You do review this for reasonability and I know at one point for one particular evaluation you used a five-year excluding high and low because of an anomalous value. The

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question I have pertains to, I guess, in your finding, you have explained the use of the five-year average to smooth variation from them that you will see from year to year. I guess my question concerning this moving variation, when does that get overwritten by potentially changing conditions, looking at the State Insurance Fund's development triangles for indemnity, for first to second, second to third and third to fourth? The link ratio for the oldest policy year is the highest of the five and sometimes significantly so, and yet the Actuary Committee opted to use the five-year average for those particular points, and if you could provide any further descriptions as far as what the Committee evaluated in coming up with including the five-year average for this reporting.

MR. KIMMEL: Certainly. The actuaries and Actuarial Committee

Workers' Compensation Rate reviews those data points thoroughly and we have what you might call a default methodology from which we deviate if we find anomalous value that necessitated a change in that procedure for one link ratio. That said, case reserving practices can be very cyclical and trying to pinpoint when the cycle is going to start and when it's going to end can be very challenging. Using a long-term average does cover the possibility of the many years of the reserving cycle.

So in other words, in one year -- like in the earlier year, you had some high link ratios because those totals were the reserving practices at the time, those reserving practices can resume at any time. The fact that they are currently not at that level does not mean that they're not going -- cannot go back to those levels down the road.

MR. VAJDA: Okay. And do you

look at any other sort of metrics besides these ratios?

MR. KIMMEL: Absolutely. We examine -- first of all, we examine different types of metrics. In addition, we looked at claim settlement rates to make sure that if there is a significant clear evidence that there's significantly more claim settlements or significantly less claim settlements, that may necessitate a change in procedure, but we have not seen it to date, not in a significant enough way to justify changing the methodology.

MR. VAJDA: And then just my final question would involve a similar explanation for the medical development factors for going back -- say if you look at the triangles for up through I think seven, you will note, again, that the highest development factor in the set of five is from the earliest year, and if you go back, that factor for a few of those reports is actually the

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highest in the last 10 years. In the past 10 months you have set the triangle back five years and I think -- so given all that, does this similar logic hold for the medical case development --

MR. KIMMEL: Yes.

MR. VAJDA: -- even though --

MR. KIMMEL: Yes. We are looking at all these items and all these elements and we examine them, and there was just not enough evidence to justify a change in the methodology for this year's filing.

MR. VAJDA: In the Committee's estimation.

MR. KIMMEL: Yes.

MR. VAJDA: Thank you. I don't have any other questions.

SUPERINTENDENT VULLO: Great. Thank you, Mr. Kimmel.

MR. MORGENSTERN: Our next speaker is Kenneth Munnelly, the Chair of the Workers' Comp Board.

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MR. MUNNELLY: Good morning, Superintendent Vullo, members of the panel. My name is Ken Munnelly. I am the newly appointed Chair of the Workers' Compensation Board. The Governor designated me Chair last Wednesday, so I appear before you with four day's worth of experience and ready to testify.

In reality, though, I did serve on the Board as a Commissioner for three years and prior to that was the General Counsel of the Board for five years, so I do have some knowledge of the workers' compensation system.

The New York State workers' compensation system represents a bargain between employers and employees that was consummated approximately 100 years ago. Workers injured on the job received necessary medical care and healthcare and loss wages paid by the employers, but in return employers are relieved from the risk of litigation.

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Workers' compensation actually is a no-fault system, but nevertheless we do have our fair share of litigation within the system. In order to provide protection for their employees, New York employers procure workers' comp insurance typically through a private carrier, the State Insurance Fund or self-insurance. How much these employers pay for this insurance is largely influenced by the type of employees they have, their own loss cost experience, and the overall experience in their industry.

New York workers' compensation program delivers medical and loss wage benefits to thousands of injured workers. In 2015 the Board assembled over 264,000 claims, held over a quarter of a million hearings, and received and processed more than 14.7 million forms. With such a workload, the Board is always in search of ways to ensure the system will provide more

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timely and appropriate medical care and wage replacement to workers.

As you know, the Compensation Insurance Rating Board's recent rate filing indicated that loss cost rates were insufficient by 9.3 percent on average. This rate increase is supremely frustrating because as part of the 2016/17 executive budget, the Governor proposed, with the Board's support, extensive workers' compensation reform that would have prevented such a significant rate increase and provided other beneficial coverage options besides traditional carrier coverage.

The Governor's recommended reforms included benefits for workers, such as improving claim and access to medical care and paying benefits quicker to claims. It also provided benefits for public and private employers, such as including reduced assessments by approximately 40 million

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dollars to employers throughout New York State, saving 100 million dollars by eliminating mandatory deposits into the aggregate trust fund, improving the municipal employer and county plan member access to public self-insured pools, and freeing up three billion dollars to self-insured employers throughout New York State.

Unfortunately, neither the legislature nor key stakeholders were interested in engaging in meaningful discussions despite the fact that many of the Governor's legislative proposals were based on the recommendations made by the stakeholders within the workers' compensation system.

Despite the legislature's failure to engage in workers' compensation reform, the Board, as part of its ongoing efforts to best serve the people of the State of New York State, is in the process of instituting administrative and structural changes

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that are expected to help reduce costs in future years. It must be clearly noted that any administrative changes will only result in minor reductions in the loss costs. Ultimately, significant legislative remedies are needed to achieve the systematic workers' compensation reform that we all believe is necessary.

So what is the Board doing? Well, one of the things the Board is doing is we have engaged in a business process reengineering program, and right now we are in the middle of this initiative, and as part of this, what we call a BPR program, we have established focus groups that represented the various stakeholders in the system. We have groups that represent business, labor, injured workers, carriers. And over the course of a year we gathered recommendations from them on how best to realign workers' compensation system to meet their needs. In the end, we had dozens, dozens of recommendations. These recommendations were split into two main categories; legislative changes and administrative changes.

Many of the Governor's executive budget recommendations that I spoke about earlier were the legislative recommendations that came out of this BPR initiative. But in addition, there are the administrative recommendations that the Board can do on their own.

And we know that sometimes legislative changes are not always achievable. Therefore, the Board has continued its focus on several administrative changes. We have identified several projects that will result in a better overall experience for our stakeholders, and some of the more significant projects that we are undertaking include a medical portal.

We are designing a medical portal that will enable healthcare providers

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Users will no longer need to know which paper form to complete and will be walked through an interactive process that determines the proper path based upon the answers provided. This web-based process will make medical treatment authorization requests easier and faster, enabling patients to have better outcomes. We anticipate that electronic submission will also accelerate the approval process, reduce errors, improve data quality and replace paper authorization forms.

We are also undertaking virtual

Workers' Compensation Rate hearings. The Board is investing in state-of-the-art virtual hearing equipment and related technology. The vision for virtual hearings comes out of a continued focus on improving the experience claimants have before the Workers' Compensation Board and delivering to them the medical and indemnity benefits that they deserve. This will enable attorneys, claimants, carriers, doctors to appear remotely from offices, even their home, instead of coming to the Board, which can be a very time consuming and costly process.

We are redesigning our claims information system. We are building a new claims system with current technology, making it better performing, more accessible and easier to use, resulting in faster resolutions and greater efficiency. We have an EK system that enables our stakeholders to see their files within the Board, and we are trying to enhance this with new

Workers' Compensation Rate technology, which would be beneficial to both employers and the claimants.

The cost of operating the workers' compensation system ultimately is borne by employers. This year Governor Cuomo's budget offered a significant opportunity to ease these costs by grabbing a foothold on systemic advances, while addressing some of the most critical needs of injured workers and employers. Unfortunately, these measures failed to make it into the final executive budget. Despite legislative disappointment, the Board is continuing to build on its past administrative efforts and will be exploring new initiatives to find more administrative efficiencies but also maintaining the quality of care within the system.

Specifically, I would like to talk a little bit about the Business Relief Act that was passed in 2013 as part of the Governor's executive

Workers' Compensation Rate budget. That legislative initiative reduced costs for employers by simplifying the workers' compensation assessment process and closing the reopen case fund. These savings were accomplished by simply assessing costs in a more efficient, unified manner, and by closing a vehicle that had long outlived its usefulness. These administrative changes had no impact on the lives of injured workers. They were process improvements, which we will continue to do.

Prescription drugs is another area that the Board is taking some initiatives in. The Board will be releasing a discussion document shortly to gather comments regarding the implementation of a new drug formulary with the goal of ensuring claimants receive quality pharmaceutical care.

Currently the prescription drug guidelines are extremely limited and have resulted in drugs being utilized

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in ways for which they are not federally approved. For example, a recent trend is the compounding of topical creams with pharmaceuticals that were not approved for this purpose. This has been an extremely dangerous and sometimes fatal practice that we see at the Board all too often.

Impairment guidelines update. The impairment guidelines for the schedule loss of use awards have not been updated in over 30 years. There have been significant advances in medical treatment and patient outcomes as a result of medical advances that need to be incorporated into our guidelines. Therefore, we are working on updating the guidelines to more accurately reflect modern medicine. These scheduled losses of use account for a significant portion of the overall system costs, and revising these guidelines will provide much needed relief to businesses while

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ensuring claimants' rights are still protected.

Special parts for permanent partial disability. In 2011 the Board introduced new guidelines for determining permanent impairment and loss of wage earning capacity and a classification process that took effect in January of 2012. The measures included a revised form, which requires documentation of the medical impairment, and specific functional abilities using these guidelines, and a vocational data form to document the claimant's education, work history and other relevant nonmedical factors so we could more accurately ascertain the loss of wage earning capacity for these claimants.

The Board has implemented special hearing parts to deal with these PPD cases and to resolve these issues and achieve faster results on permanency, which was a main goal of the 2007

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workers' compensation reform.

In closing, I would like to say that the legislature's failure to pass the Governor's proposed reforms, in our opinion, is a missed opportunity, and we think we need to continue to work with the legislature to adopt meaningful legislative changes that will make our system better.

Thankfully the Governor is strongly committed to reforming the workers' compensation system and will pursue legislation again next year. Both the Governor and the Board will continue to push for critical legislative reforms that balance the rights and needs of both injured workers and employers.

Additionally, the Board continues to be committed to maximizing administrative efforts to mitigate cost increases and improve quality. Thank you for the opportunity to testify today, and I will be more than happy to answer any questions you may have.

SUPERINTENDENT VULLO: Thank you, Mr. Munnelly. I appreciate that. You mentioned a number of times about proposed legislative reform and you described some administrative reform. Do you have an opinion as to whether that reform, if enacted, would have obviated the large rate increase that we have before us today?

MR. MUNNELLY: You know, it's difficult to say, Superintendent, but, you know, legislative reform in our system is absolutely necessary. And I will give you a couple of examples. One of the provisions in the bill was just to simplify section 14 of the workers' compensation law, which was how we calculate the average weekly wage. It's a very, very old statute. It's very convoluted. It involves litigation to figure out something as simple as a claimant's average weekly wage. We needed to simplify that

Workers' Compensation Rate statute and we can save time and money. Now, will that result in a decrease in rate increase? Not that alone, but it's an aggregation of all these things. So I guess I can say to you that it would have a positive impact in the direction we all want to go.

SUPERINTENDENT VULLO: Which is lower rates.

MR. MUNNELLY: Yes.

SUPERINTENDENT VULLO: And part of that is saying part of this amalgamation of legislative reform is some of the administrative things that the Workers' Compensation Board is doing, but I think you said those administrative remedies have sort of a minor reduction on it, but you didn't say -- I don't think you said is when do you expect those administrative remedies to take effect which might have an impact on the rates?

MR. MUNNELLY: We are currently working on that and we anticipate, you know, the end of this year, beginning of next year, so very soon.

SUPERINTENDENT VULLO: So it's not for the one that we are seeing now, perhaps next year.

MR. MUNNELLY: Absolutely.

SUPERINTENDENT VULLO: And one of the things that you talked about is this business process reengineering and can you -- and you explained that, but what's the overall goal of that project from the Workers' Comp Board perspective?

MR. MUNNELLY: It's to update the Board systems and processes. BPR is something we have been working on for many, many years, and what we are doing is we are looking in the mirror and seeing what can we do better, what can we do more efficiently, and if we do that, that's going to save time, it's going to save resources and it's going to save money, and ultimately be reflected in rate increases. So the goal is to be more efficient without jeopardizing the rights of claimants to get benefits that they are statutorily entitled to.

SUPERINTENDENT VULLO: So efficiencies that won't impact the claimant's rights but could hopefully result in benefits, financial benefits to the system via these efficiencies while helping the rate increase scenario.

MR. MUNNELLY: That's the goal.

SUPERINTENDENT VULLO: You said you were frustrated by the sort of lack of legislative reform. Can you explain that, why you think the support wasn't there to pass the legislative reforms, if you know?

MR. MUNNELLY: There's just so much the Board can do because a lot of the -- many things are set in statute, so we need legislative changes. And the problem is, and it's nobody's fault, it's that we have a system where

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we have claimants on one side, businesses on the other side, and they have different interests. Neither have a monopoly on being right and neither have a monopoly on being wrong. So we have to balance the two. So what it may be beneficial to claimants, businesses may see as detrimental, and vice versa. Many manu stakeholders and they're all interested, and because of that sometimes things don't get done because they just couldn't reach, you know, a compromise on what needs to be done.

The 2007 reform, I was working in the legislature during that time. That took over 10 years to pass that 2007 workers' compensation reform because there's interests on both sides. But that doesn't mean we don't strive to find the result and do the reforms. It's just that it's a difficult path.

SUPERINTENDENT VULLO: Well, 10 years from 2007 is 2017, so we will get there. One final question for me and then I will turn it over to Alex, is you mentioned pharmaceutical, and one piece of legislation that did pass the legislature and the Governor has signed this week or last week is the heroin opioid legislation. And specific to, I guess, workers' comp might be the provision of the legislation that limits the initial amount of opioids that a physician can prescribe to seven days. Do you have a view as to the impact of that on the workers' comp system?

MR. MUNNELLY: We were very happy to see that legislation pass, but in reality we adopted nonacute pain medical treatment guidelines a couple of years ago, which had in them some of the same things that were passed in this legislation. So the Board was a little bit ahead of the curve on this. But it's very, very positive, what was done there. We are --

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SUPERINTENDENT VULLO: Positive for the workers's comp system.

MR. MUNNELLY: Yes. Yes. We are implementing special parts for prescription drugs and opioids because it's a big issue and, you know, our guidelines call for weaning of claimants off of opioids when appropriate. And, you know, it's very, very costly, these prescriptions, and sometimes detrimental to the health of claimants so, you know, there is a balance there. But I think what was in that heroin reform bill is consistent with what's in our guidelines, so it is a net positive and we will continue to monitor prescription drugs, especially the opioids, and make sure that claimants are getting the drugs they need but are not becoming addicted to these drugs with long-term negative consequences.

SUPERINTENDENT VULLO: Terrific. I was on that task force so it's

Workers' Compensation Rate obviously a major New York issue and it's a Workers' Comp Board issue as well. Alex, anything?

MR. VAJDA: I don't have anything.

SUPERINTENDENT VULLO: Great. Thank you.

MR. MUNNELLY: Thank you very much.

MR. MORGENSTERN: As we move onto our remaining speakers, I would like to repeat the Superintendent's request that you keep your comments limited, and if you have written testimony that you are presenting, it's really not necessary to read it. You can just highlight whatever points you want to emphasize. So our first next speaker is Elizabeth Heck of the Greater New York Insurance Companies.

MS. HECK: Members of the Hearing Committee, thank you for the opportunity to make a statement at this hearing with regard to the proposed

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workers' compensation loss cost filing. My next name is Elizabeth Heck, and I am President and Chief Executive Officer of the Greater New York Mutual Insurance Company.

Greater New York Mutual is a 100 year property and casualty insurance company domiciled in New York State. My company has continuously written workers' compensation since the early 1950s and at times workers' compensation has been the principal line written by my company, representing as much as 53 percent of our direct premium.

In recent years, because of inadequate rates which produced unprofitable results in this line, we elected to cutback our workers' compensation writings. So they now stand at less than four percent of our direct written premium.

I respectfully submit that the workers' compensation rate increase

Workers' Compensation Rate filed by the New York Compensation Rating Board of 9.3 percent to be effective October 1, 2016 is necessary and essential for the health and well-being of the New York State economy.

While claim and medical costs have been relatively stable country-wide, they continue to increase in New York, despite efforts to control costs, which places an undue burden on the New York business community and strains the ability of insurance companies operating in New York State to meet the demand for workers' compensation insurance. The extended period of very low interest rates compounds the problem because it is no longer possible for insurance carriers to offset underwriting losses with investment income.

You look confused. Do you want me to explain? Okay. Because, you know, that's something, if you think

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about going back into the '70s and '80s, that's something that was pretty common for insurance companies where they can operate at an underwriting loss but they were able to earn investment income, and now with Brexit I think we're going to have even a longer period of low interest rates.

The workers' compensation calendar year combined ratios in New York State continue to be unprofitable and lag behind the country-wide average. As a point of reference, the average country-wide combined ratio for private carriers for the five-year period ended 2014 was 110 percent compared with 123 percent for New York State. When the very low interest rate environment is factored into the equation, the magnitude is even greater on the bottom line than the reported results.

The benefit levels have more than doubled since the reforms were enacted

Workers' Compensation Rate during 2007, but those increases have been at a rate that is out of step with the premium levels. The elimination of the special funds, the reopen case fund and second injury fund, also adversely impact loss costs.

While the increased benefit levels have an obvious impact on required pricing levels, there are additional factors that should also be considered when determining whether a rate increase is warranted.

And what I have done is I have submitted written testimony where I list several, you know, factors that should be considered, but I will only mention two. There are several people that want to testify.

So the first relates to the impact on loss experience of the high medical costs driven by prescription drugs. Everyone is talking a little bit about that, and I just want to mention a few things. You know, the

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medical trend factors have begun to stabilize country-wide, but they continue to grow at a rate that's faster than the consumer price index. And there are several reasons for that, and some of them have been mentioned already. We all know that there's new and expensive drug therapies and procedures, and there has been a greater reliance on those procedures, but physicians, when determining, you know, how to treat an injured worker. Obesity is an epidemic that we see that are impacting claims, both in medical costs and also the time it takes to settle a claim, and also the prognosis as to whether or not and how long somebody can -- when they are able to get back to work because it really impacts the outcome.

The other thing that we see is something that it sounds like, you know, everyone's completely aware of this, but the pain management drugs.

You know, that has a very big impact. They tend to be expensive and overprescribed.

The second -- the thing that I wanted to mention about the medical treatment guidelines, they have helped. I mean, what we have seen is that they have helped to standardize treatment for workers' comp claims in New York, but the guidelines and the fee schedule doesn't apply in every case. So there are several exceptions that we see as a practical matter. One of them relates to out-of-state treatment. So we find that claimants that are residents of New Jersey, they were injured but, you know, working for a New York employer, when they're treated in New Jersey, the cost of that treatment is multiple to what it would be in New York. And what's interesting is we also write workers' compensation in New Jersey. New Jersey has different rules. But for these New York employers, when they treat in New Jersey, they are not subject to any of the rules. So, you know, that has an impact on the costs. And there's some other exceptions as well that we see what happens, you know, in practical application.

The second factor that should be considered is, again, it's the time that it takes to settle a claim, and there are several factors that contribute to the delay, and it sounds like some of them the Workers' Comp Board is trying to address. But one that relates to the prescription drugs, and it's an ancillary thing that you may not be aware of is the fact that when an injured worker is actively treating and they are -- say, for example, they are on pain medicine, and we all know that that's an issue. Until the pain management protocol is stabilized, you can't even approach settlement because we need to protect Medicare's interest and we need to go

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through CMS in order to get a Medicare set aside. And if a drug prescription -- like I will give you an example. Say a claimant is injured and they are taking some sort of opiate, you know, to manage the pain and the doctor prescribes, you know, a certain regimen that they take three times a day. But in actuality he is only taking it one time a day and ultimately, hopefully, he will be off the drugs because it's not healthy. Well, what Medicare does when they are evaluating the future costs of the claim, they assume that whatever he is doing at that point in time is going to continue forever. So it becomes impossible to settle the claim at that juncture and that automatically adds onto the time. So, you know, that's something that's adding onto the cost and it's adding onto the time, both to the medical and the indemnity.

The second thing that was

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mentioned is the fact that, you know, relates to the PPD caps. What we see is that, you know, on the surface, that should reduce costs, but what we find is that it doesn't always because there is an incentive to seek a total disability. So what that means is there is a lot more activity on the file. So, you know, there's many more IMEs, there's more hearings, there's litigation costs. All of that adds to the cost of the claim and also adds to the time it takes to settle the claim.

You know, I have some other things that I mentioned in my written testimony relating to some, you know, other benefits, you know, things that private carriers do on behalf of the community to help create a safer work place, and all of that, you know, is expensive. And, you know, even though that isn't related to the loss cost, it's just, you know, an added expense, you know, to do business in this State.

So for all of those reasons, I firmly believe that the loss cost filing is appropriate and necessary to maintain a viable voluntary market for workers' compensation in New York. Thank you.

SUPERINTENDENT VULLO: Great. Thank you. And also, thank you for the written testimony. I just had one question. From at least information that we have at the Department, it appears that your company has actually increased its written premiums over the past two years, and most specifically I think a greater than 50 percent increase from 2014 to 2015 in terms of written premium. And I recognize that it's not back to where you were in the 1950s but --

MS. HECK: You mean for workers' comp?

SUPERINTENDENT VULLO: For workers' comp.

MS. HECK: It is true. We --

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SUPERINTENDENT VULLO: But you increased it, so that's a good thing.

MS. HECK: Well, and I will explain, and what I will tell you is that as a company, we have always loved workers' compensation. It happens to be a good line because as an underwriter there is a lot of available information so it makes it easier to do. The problem is that it -- you can't do it if it doesn't make sense. If you can't -- if you can't have the other lines of business that you write subsidize the workers' compensation. So it is true. We selectively look in the market because we would love to get back in. So what we have been doing is really sort of watching the pricing. You know, we are a New York company where we do a lot of business in the State. In fact, you know, we write in 15 states, 50 percent of our writings are in New York, and we would love to be, you know -- to provide a

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competitive market in the State, but we can't do it at a loss. I guess that's the bottom line.

SUPERINTENDENT VULLO: Understood. Thank you. Good? Great. Thank you.

MR. MORGENSTERN: Just one question. Can your combined ratio for workers' comp in the area of the average New York combined ratio?

MS. HECK: No, it isn't, and I will tell you why. What we have done is we made a decision, I will tell you, several years ago, 20-- 1-1-2004. At that point in time we were writing probably about 35 percent of our corporate work was workers' comp and we brought it way down, and it was because the rates were inadequate. And during those years, our combined ratios were horrendous in that line, and we realized we needed to do it because it's very important, you know, that the company remains -- you know, have a

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strong balance sheet and remain solvent. And so we made that decision to cut way back. Now we will selectively, you know, entertain certain accounts and we make sure we are going to do it, you know, on the ones that make sense.

You asked a question before about the scheduled rating. And I will say that that is something that is helpful but it's not enough. So if you have the ability to see an account and it's one that is operating, you know, sort of so-so, it gives you some flexibility but it isn't quite enough. It only gives you five percent, and this loss cost indication is nine, you know, so on average you can see rate away it's only half of what you need. So it's something.

SUPERINTENDENT VULLO: Good. Thank you.

MS. HECK: Okay, thanks.

MR. MORGENSTERN: I would like

Workers' Compensation Rate to call Thomas Nowak of AIG Property Casualty.

MR. NOWAK: Good morning, Superintendent. My remarks will be brief. I do intend to submit written testimony within the next couple of days, but I am here today to support, personally as well as to share the support of my colleagues at AIG Property Casualty, to the loss cost filing that has been made to increase the loss cost level change to 9.3 percent.

As we draw to a close of the first decade post 2007 reforms, private carriers continue to face profitability challenges here in the New York State workers' compensation marketplace. Combined ratio data for private carriers, while improving dramatically since those early post-reform years, continue to demonstrate a fundamental insufficiency in the underlying loss cost structure.

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While a number of good things have taken place post-reform, for example, medical treatment guidelines, these took longer to implement and for us to see the results and then were initially promised. Likewise, the cumulative impact of benefit changes have in fact far exceeded the improved loss cost level changes during that period of time.

So for us, and I think for all stakeholders, it's important that we're treated equitably, and that includes the ability of private carriers to continue to contribute to a vibrant, innovative and competitive marketplace in which the solvency of all market participants is preserved. So we do encourage you to seriously consider and approve the 9.3 percent change that's been indicated. Thank you.

SUPERINTENDENT VULLO: Thank you. And you said you were going to submit written testimony? Just make sure to do it in the next five days.

MR. NOWAK: We will. Thank you.

MR. MORGENSTERN: The next speaker is Robert Grey of the Workers' Compensation Alliance.

SUPERINTENDENT VULLO: Mr. Grey, you have already submitted testimony, which we appreciate greatly, so we were able to read it in advance.

MR. GREY: I was planning on reading all 140 pages, actually.

SUPERINTENDENT VULLO: I appreciate you submitting it in advance.

MR. GREY: Thank you. As you know, my name is Robert Grey. I am the Chair of the Workers' Compensation Alliance. I have been a practicing attorney and before that a licensed representative in the workers' compensation system for going on 30 years now.

The testimony, which I submitted on behalf of the WCA, was also adopted

Workers' Compensation Rate by the New York Committee For Occupational Safety and Health.

Our view is that the loss cost filing should not be about the insurance industry making up for what it feels were inadequate rate increases in the past or making up for what it feels were inadequate profits in the past, but instead is a projection of what they're anticipated costs will be in the upcoming year.

To that extent, as I think the Department has already observed, the data that CIRB relies on is of some interest, but in some ways it's also of limited value because it looks back to a period of time in the workers' compensation system when the trends were different than they are now. And what I'm hoping to do briefly is point out about two of those areas.

The largest part of the NYCIRB rate filing, as far as we can tell, relates to permanent partial disability costs, both nonscheduled permanent partial disability and scheduled permanent partial disability. If I read the NYCIRB filing correctly, they estimate that 60 percent of the claims are medical only and that those only account for four percent of costs, which would leave 40 percent of the claims as being indemnity claims, and that would account for 96 percent of the costs.

NYCIRB then, I think, observed that two-thirds of the indemnity claims, excuse me, about 85 percent of the indemnity costs relate to permanency, and that would leave only 15 percent, actually less than that, that relates to temporary disability. And then of the permanent disability, NYCIRB breaks it down two-thirds to nonscheduled PPDs and a third to scheduled PPDs.

So when we broke all of that down what we get to is about 55 percent of all of the claim costs are related, according to NYCIRB, to nonscheduled PPDs and about 27 percent are related to schedules, and that leaves you about 10 percent for temporary disability.

So to take the largest chunk of that first, the question is what's going on with permanent partial disabilities. As the Department knows, those claims were capped in 2007. Probably all or virtually all of the uncapped accident dates are already out of the system. So all new claims that you are dealing with and most of the remaining claims in the system are what we call capped PPDs.

If you look at, and I'm sure you did, in the testimony we submitted, the data from the Workers' Comp Board, you can see that the numbers of classifications spiked in 2013, and that was because there was, without question, a five or six year slowdown in the rate of classification, which is

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due to multiple factors. Some of it was that the Board didn't issue guidelines until 2012, some of it was that the carriers did not push classifications because, likely, they were concerned about the impact of the aggregate trust fund, which in our view, was an unwise economic decision on their part, but there was, regardless of the cause, a slowdown in classification.

You will see that the Workers' Compensation Board in 2013 addressed that, and the numbers show that there was a significant spike in the rated classification in 2013 and '14, which has now begun to retrench a little bit. And really, the only conclusion you can draw from the retrenchment is that the Board is cleaning out the backlog. And what that means is two things: One is that the number of classifications is going to continue to drop. I do not have pre-2007 data, but it should in

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the next year or two fall back to the same rate that it was before 2007 as the inventory of backlogged classifications goes away. And the other thing that it means is that the period of time from date of accident to date of classification will drop.

You know, the Board is, by its own administrative or judicial action, largely reducing the degrees of wage earned capacity that it's finding, which reduces the cost per claim of every classification, and the Board is, as the Chairman told you, expediting these cases to the maximum extent of its ability. In the data that we gave you, which you will also see, is that a large percentage in the private insurance market of permanent partial disabilities now eventually settles. And any time a case settles, there is a savings to the carrier from that.

So our view is that based on the data that you see in current trends,

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from 2013 through 2015 and where that is clearly going to continue to go, PPD costs are going to continue to drop for private carriers.

With regard to schedule loss, which Chairman Munnelly mentioned, what a worker gets in schedule loss is a function of three things: One is the Board's guidelines, two is the workers' wage, and three is the date of the accident due to the rate change. These guidelines, as others have observed, have not changed since 2007. The Board reissued them in 2012, which we take it as the Board approving them as viable in 2012.

The guidelines, as they presently exist, absolutely promote resolution of claims. They either assign a definitive value to an injury based on the diagnosis or they assign a limited range of possibilities, which encourages resolution. And in my experience, probably 85 or 90 percent

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of schedule loss claims are resolved by agreement without litigation. And this, by the way, stands in contrast to the permanent partial disability claims, which are subject to, sometimes excessive litigation, but lots of litigation. So that does go to show you the value of a good guideline as opposed to a less good guideline.

The guidelines haven't changed. The Board's administration of schedule loss claims hasn't changed. The medical treatment guidelines are supposed to promote better treatment and better recovery. So that should, if they work as advertised, depress schedule loss costs over time.

So the only thing that has changed is the impact of increases in the rates from 2007 to 2015. If you take a look at 2007 to 2009 when the workers' comp rates went from 400 a week to 600 a week, that affected 74 percent of the claims in the system.

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26 percent of workers earn $600 a week or less if they were unaffected, and their benefits have not changed to date. And by the way, if the Board were to revise the schedule loss guidelines, these workers who earn less than $600 a week, it's not to take an increase away from them, it would be that you would be diminishing their benefits, which has not increased since 1992.

But that change aside, 74 percent of workers did get a benefit between 2007 and 2009 when rates went up, and that benefit was up to a third increase, although that full third only applied to 48 percent of workers who earned $900 a week or more. When you go to 2010 to 2012, when the workers' comp rates went from 600 to 792.07, the now affected 48 percent of claims, which would be people who earned more than $900 a week, and those workers got up to, depending on their wage, a 25

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percent increase.

However, from 2012 through 2015 we are now down to workers' comp rates going up incrementally over a four year period from 803.21 to 844.65 per week for the maximum rate. 72 percent of claimants are unaffected by that because they do not earn enough money to benefit from the increased rates. Of the 28 percent of the claims that are affected, you are looking at a total of a six percent increase over that four-year period of time in the value of those claims.

So I have to admit, I became a lawyer because I can't do math, but I spent a fair amount of time looking at this and what I concluded was that if the increase in schedule loss is the six percent that applies to 28 percent of your scheduled loss claims, which are 27 percent of all of your claims, it works out to about a half a percent increase in carrier costs in the last

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four years due to schedule losses, which I cannot square with a 9.3 application based largely on alleged increases in scheduled loss claims that are not verified.

Just briefly, the other couple of issues that I pointed out in the written testimony are that essentially every time there is a third-party action related to a workers' compensation claim, there is a cost savings for the compensation carriers, whether it's by lien and recovery, by credit or by some combination of both, and we have never been able to find where those cost savings are built into any NYCIRB rate filing or into any premium.

I have heard some anecdotal evidence that the carrier will only give the employer an adjustment in their loss costs if the third-party recovery occurs in the same year as the accident, which, of course, never

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happens. So that appears to us to be a hold that perhaps should be looked at.

In terms of the various complaints about profitability, I attached to my written testimony to the State Insurance Fund data, the State Insurance Fund, as far as I can tell, not being an actuary, is doing very well, has an underwriting profit, has a wonderful combined ratio. We understand that the State Fund operates on a slightly different economic footing than the private carriers, but you know, historically there has not been an enormously wide divergence between the two, and that also, we think, calls it into question.

Just to briefly address Chairman Munnelly's comments, we believe that some of the items from the Governor's executive budget could potentially be implemented and could potentially result in some small cost savings, although not anything significant, in the system. I think the issue that bogged that down legislatively is that those cost savings came at the potential expense of due process rights of the litigants in the system. It's certainly much more efficient to run a system without due process, but there has to be a compromise that can be reached on that, that makes the Board run more efficiently but still gives people an opportunity to be heard and present their claims. And although I am no defender of the insurance industry, they have a right to defend their claims and to be heard as well. So, you know, I do think that some of those initiatives can potentially be moved forward with buy in from stakeholders and from the legislature.

The medical treatment guidelines, while they clearly had a what we will call a positive impact on medical costs for carriers are a bureaucratic disaster, and I don't think that the

Workers' Compensation Rate Board would disagree with me on that. The Board is now getting something like 270 thousand variance applications every year to be processed, which means that doctors' offices are preparing a quarter of a million forms, the insurance companies are reviewing a quarter of a million forms, the Board gets probably half a million forms as a result of that and then there are further processes that spin off from there. We had to pass on a paper pointing out that it's likely that the administrative costs of the medical treatment guidelines is greater than the costs of the medical treatment that's being saved.

It is entirely possible that the medical portal will resolve a lot of that, so that may be a very beneficial thing in terms of reducing the administrative burden for everyone, and we are, I would say, cautiously positive and optimistic and supportive of that.

I do disagree with the Board's position that the executive budget would not have had an adverse impact on the benefits for injured workers. There were provisions in there that would have definitely had an adverse and depressing impact on benefits for injured workers, and that we cannot support, in part because we do not think the loss costs are out of control and we think that the loss cost filing, rather than being based on what costs really are and really will be going forward, is more an effort to recapture money that carriers believe they lost in 2008 and 2009 and 2010. But as someone pointed out, we are now 10 years past the 2007 reforms, and at some point we have to start talking about what's happened in the last two or three years as opposed to in the last 10.

So I properly overstayed my

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welcome. In summary, our position is that the permanent partial disability costs are declining and will continue to decline as a result of the impact of the caps and the beneficial impact that they have on settlements, that schedule loss costs have essentially been flat for four years, and there is no expectation that they will increase significantly going forward. We don't see where third-party recoveries are factored in anywhere here. We think the workers' comp is clearly profitable both for the State Insurance Fund and for the private insurance industry.

And by the way, the State Fund's market share is fairly in line with what its market share has been within limits over many, many years. And we oppose the rate filing submitted by NYCIRB. I would be happy to take any questions.

SUPERINTENDENT VULLO: Thank you, Mr. Grey. I know that you oppose

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the rate filing. Are you saying that there should be no rate increase at all or you're just opposing the amount of the increase, or maybe you haven't done the analysis for some number below the nine percent.

MR. GREY: I am not an actuary and I am not qualified to recommend to the Department what an appropriate rate increase should be. To the extent that there are legitimate increases in costs for carriers and to the extent that there might be slight increases going forward because of the raise in minimum wage and the raise in workers' compensation benefits, I certainly agree that the carriers should be able to take in enough premium to pay their claims. However, as I outlined, to -- our analysis is that 85 percent of NYCIRB's rate filing is due to PPDs and schedules, and we can't find justification for that in the actual trends that are going on in the system.

So off the top of my head, that would work out to something like a two percent rate filing, but that's just a non-actuarial seat of my pants --

SUPERINTENDENT VULLO: Yeah. I don't want you to come in up with a number. You also mentioned maybe indemnity and you said PPD carrier were in the 85 to 90 percent. That's all a good thing for the system. I mean, it's certainly, you know -- for both sides of the system. I practiced law for a long time. Settlement doesn't necessarily mean that one side only benefits from settlement. I mean, everybody benefits from a settlement because you avoid litigation costs and that's sort of on both sides of the --

MR. GREY: Madam Superintendent, I decry the PPD caps. I mean, you are dealing here with -- my clients are people who are permanently disabled. The data shows that the vast majority of them, regardless of whether the

Workers' Compensation Rate Board says they have a 30 percent loss of wage earning capacity or a 90 percent loss of wage earning capacity, or any number in-between, the vast majority of these people never go back to work, frankly, because they are not able to go back to work. There is a mismatch between what the system thinks they can do and what they can actually do in the real world.

So the impact of the PPD caps is to put these folks in a financial straightjacket. They can either collect their weekly benefits until they are terminated or they can settle the case and take the money upfront. So the whole situation is an unfortunate situation. The only thing that preserved the value of their benefits, frankly, is the ATF deposit requirement, which most of the people in the room want to get rid of, because eliminating the ATF deposit would transfer the leverage from the injured worker to at least get the value of their benefits to the carrier to pay whatever the carrier chooses to pay. So that would be a second taking from these people who have already been capped.

Having said all of that, when we are presented with two bad choices and one of them is settlement, that's a totally legitimate choice under the circumstance. There is, when appropriate, benefit to the claimant. There is certainly a benefit to the carrier.

To go back to my written testimony, if you -- it's interesting, I think, to take a look at the State Insurance Fund settlement rate compared to the private carrier settlement rate. The private carriers are settling like 80 something percent of their PPD and the State Insurance Fund is not, and that's because the private carriers are subject to the ATF and the State

Workers' Compensation Rate Insurance Fund isn't, and possibly also because of policy decisions by the State Insurance Fund. It would probably be healthier policy to impose the same requirement on the State Insurance Fund as there is in the private carriers. That would even out the marketplace and would also be beneficial to my clients.

SUPERINTENDENT VULLO: Thank you. Thank you.

MR. GREY: Thank you.

MR. MORGENSTERN: Our next speaker is Nadia Marin-Molina of the New York Committee on Occupational Safety and Health.

MS. MARIN-MOLINA: First, thank you for the opportunity to speak here today. My name is Nadia Marin-Molina. I am an Associate Director of the New York Committee on Occupational Safety and Health. I am here to speak today on behalf of NYCOSH and the Workers' Protection Coalition.

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The New York Committee For Occupational Safety and Health has worked to extend and defend every person's right to a safe and healthy workplace, including the protection of the workers' compensation system. And the Workers' Protection Coalition is fighting for a fair and just workers' compensation system for all injured workers in New York State. The Coalition is comprised of a broad group of individuals and organizations, including injured workers, the health and legal community, labor affiliates and workers' rights advocates.

Today I am here to speak in opposition to the New York Compensation Insurance Rating Board's request to increase the loss cost filing for October 1st, 2016 by 9.3 percent. The CIRB proposal is based on the premise that the costs of workers' compensation are continuing to rise and that as a result the employers must pay more as

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well.

But real cost savings to the workers' comp system can be found by addressing the issue of misclassification. Every day low wage workers in New York State are misclassified as independent contractors. This misclassification costs six billion dollars a year. In the construction industry alone, this cost is estimated to be a half billion dollars in New York City.

But misclassification is not limited to the construction industry. NYCOSH's healthy nail salons campaign confirms that many employers evade paying workers' compensation premiums by underreporting their payroll. And just a little bit more on this, we have worked with the State on the monitoring and enforcement of, it can be wage theft or a health and safety violations in nail salons, and there has been a close correlation between finding wage

Workers' Compensation Rate violations and a lack of workers' comp insurance or misreporting for workers' compensation premiums.

But in addition to that, the employers that intimidate and misinform workers about whether they have the right to workers' compensation at all if they are sick or injured, and as a practical matter that means that workers who are mostly low wage immigrant workers and don't know their rights are exploited in order for employers to keep their premiums low. And this is the same story not just in construction but in the nail salon industry.

There is a report from the National Employment Law Project which found that this intimidation and lack of information is a serious issue for workers and that as a result the workers' comp system is not functioning for workers in the low wage labor market. This is a quote, "of the

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workers in our sample who experienced a serious injury on the job, only eight percent filed a workers' compensation claim." And when workers told their employer about the injury, 50 percent experienced an illegal employer reaction, including firing the worker, calling immigration authorities, or instructing the worker not to file for workers' compensation. About half of the workers injured on the job had to pay their bills out-of-pocket or use their health insurance to cover expenses. Workers' compensation insurance paid medical expenses for only six percent of the injured workers in our sample.

Another area of misclassification that I would mention is the on-demand economy, or the so-called gig economy, characterized by companies that use online portals to connect customers and workers with short-term jobs. This is a small sector of the economy but it's

Workers' Compensation Rate increased exponentially in the past and is likely to continue growing. Because many of these companies classify their workers, again, as independent contractors, they are evading paying workers' compensation premium and shifting the cost burden towards the employers who seek to play by the rules.

Raising insurance rates is going to have the effect of increasing costs for good employers and pushing marginal employers towards more misclassification and worker exploitation. And it could be justified if the services to workers were to increase along with them. But while workers are seeing less benefits and fewer of them are able to access workers' compensation at all, as I mentioned, raising costs is nothing more than overburdening the system without providing a benefit to workers.

So we are here because we believe

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the focus should be on New York's workers who need a strong and effective workers' compensation system, including respect for the human rights of injured workers, just and timely compensation, quality healthcare, an accessible process, justice for low wage workers and freedom from retaliation. Thank you for the opportunity to testify.

SUPERINTENDENT VULLO: Thank you very much. Obviously serious concerns and certain issues with respect to leave or enforcement into some of these areas as well. I appreciate that.

MR. MORGENSTERN: Next is Kelly McLaughlin from The Hartford Group.

MR. MCLAUGHLIN: Hi. Thank you. Thanks for having me. I am Kelly McLaughlin. I work for Hartford Insurance Group. I also sit on the Underwriting Committee and the Board of Governors. We would like to stress the faith we have in the process of the New York CIRB and our participation in it.

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This proposal that you have before you today was approved unanimously by the Underwriting Committee. There are 11 members on that committee. It was then passed to the Underwriting Committee, on which I sit. It passed with five votes in the affirmative -- I actually abstained because I didn't want to vote twice -- on the Board of Governors, with two votes opposed, both by State agencies. And then at the Board of Governors it was approved unanimously with abstentions by two of the State boards.

I would like to point out for the group here that the New York CIRB and the Board of Governors is made up of a broad spectrum of consistencies. It includes insurance, labor and the business communities, and all the members of the Board, whether they abstained or voted, participated in a robust discussion of the merits of this filing, what you have before you, and

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we believe that the approval by the recommended rate filing by the DFS is an important step in the right direction to address the inadequacies in the State.

SUPERINTENDENT VULLO: Thank you.

MR. MORGENSTERN: Would you be able to comment on the previous speaker's discussion of misclassification are appropriate ways to make sure that the classification of employees is accurate and --

MR. MCLAUGHLIN: Yes. We have robust processes to make sure that employers are classifying their employees as appropriate. I think one of the issues and concerns that were raised by the prior speaker was that a lot of these entities are classifying these contractors as sole proprietors, in which case we wouldn't be able to participate in the insurance program for them. Most of the sole proprietors

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are not required to have insurance. We don't get to look at that business because they are not looking to purchase business from us. But when we're looking at general contractors, we do have thorough underwriting questions and guidelines to evaluate whether or not they are using subcontractors and if they are doing that appropriately. We also audit risks and also the rating bureau looks at risks as well. Good? Thank you.

SUPERINTENDENT VULLO: Thank you.

MR. MORGENSTERN: Next is Nancy Treitel-Moore from Liberty Mutual.

MS. TREITEL-MOORE: I do have some copies of more or less what I am going to say. Thank you all for giving me the opportunity to testify in support of CIRB's filing for a 9.3 percent increase in loss cost. My name is Nancy Treitel-Moore. I am the Director of State Strategy and Bureau

Workers' Compensation Rate Relations for workers' comp at Liberty Mutual. I also serve on the NCCI's Actuarial Committee and serve the Board of Governors.

Liberty Mutual is one of the largest writers of workers' comp in the country and is currently 10th in New York. Back in 2012 we were actually third in the New York workers' comp. Although New York workers' comp premium has dropped by almost 190 million dollars since 2012, we are still a major player in the State and we have a vested interest in having adequate loss costs approved, as we want to write in the State.

Those loss costs times a loss cost multiplier determine the rates that companies charge. The loss cost multiplier is made up of an expense multiplier and a loss cost departure factor, or modifier. In New York that modifier has historically been limited plus 10 percent, minus 25 percent

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around the approved loss costs. It's also been the practice in the State to not allow a positive underwriting profit provision for workers' comp to be included in the expense multipliers, despite the prolonged low interest rate environment that we are in. So actuarially sound loss costs reflective of expected costs are critical to a healthy marketplace, and especially in a state like New York who we don't have as much pricing flexibility as elsewhere. I didn't mention schedule rating here, but even that just gives us another plus or minus five. It doesn't give us the range that we have in other states.

So the inadequate loss costs in New York over the last few years are one reason why Liberty Mutual has chosen to reduce our market share in this State. And I think it's also a key driver of one of the State Fund's market share has gone from 36 percent

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back in 2011 to around 45 percent today.

Having analyzed the loss cost filing CIRB submitted, I think the 9.3 percent is actually sound and reflects the best estimate of what's needed to get loss costs to an adequate level in this State.

I wanted to share with you what I think some of the key drivers of that 9.3 percent increase are. I think we are still dealing with a significant deterioration in loss experience post the 2007 reforms and that the approved loss costs having kept pace with that deterioration. The 2013/14 policy losses are almost seven percent, worse than the losses covered by the approved loss costs. Loss costs are also trending faster than wages, and frequency is down, which is a really good thing because it means safer workplaces and fewer injured workers. But both medical and indemnity severity

Workers' Compensation Rate in New York has increased by over five percent a year on average from policy year 2010 to '14. That's faster than wage inflation and it's faster than an increase in the medical CPI. It's not so much higher than the increases we are seeing country-wide, which NCCI reported to be under two percent over a five-year period on average.

I believe the reason we are seeing experience coming in worse than expected in New York has a lot to do with the changes and incentives as a result of the 2007 reforms. Maximum weekly benefits increased from $400 a week to $844 today. That increase in benefits was factored into the loss costs. However, it's also made it more attractive to remain out on workers' comp than it used to be. Pre-reform, about half of injured workers had their weekly benefits capped by the maximum. After the reforms the Workers' Comp Research Institute reports that only 16

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percent of injured workers now have their weekly benefits capped by the maximum. There's also been some increase in the minimum benefits and we are seeing temporary total disability durations increase, and I think that the higher benefit levels are a likely driver of that.

Additionally, for nonscheduled permanent partial benefits is 225 to 525 week caps don't kick in until the claims are classified. That creates incentives to delay classification, which we have seen take place post 2007 reforms, adding costs to the system. We are also seeing more scheduled loss of use claims, since in some cases those benefits can be greater than the nonscheduled PPDs and then paid as a lump sum and paid out sooner.

Doctors also play a greater role in this system now than they did prior to the 2007 reforms. That combined with a lack of ability for employers to

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direct injured workers to New York doctors with quality outcomes contributes to added system costs. The treatment guidelines are definitely helping, but we still incur costs dealing with variances and challenges when the treatments are outside the guidelines. The doctors also drive the determination of MMI impairment ratings and scheduled loss of use. Again, challenging these doctor's determinations when we believe they're overly generous, in cases where that happens we have added costs for IMEs, more hearings, more delays in bringing cases to closure.

The above mentioned items, you know, are driving delays, frictional costs and in some cases added benefits being paid while we wait to bring a claim to a disposition all add to the system's costs.

The bottom line is that current loss costs in New York are

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significantly less than they need to be to cover projected losses. The industry needs the 9.3 percent increase for loss costs to be adequate to cover what we think the costs will be in the upcoming policy year and to help determine profitability and keep the marketplace healthy and competitive. Thank you. Any questions?

SUPERINTENDENT VULLO: You are the 10th largest writer. Do you know what's your percent, your company's percentage of the workers' comp market in New York? Because I read there were 300 carriers, so I am curious as to the 10th --

MS. TREITEL-MOORE: Yeah. We're about, I think it's about four percent or so now. Yeah, I can get you the exact number --

SUPERINTENDENT VULLO: So that's four percent of the entire market or --

MS. TREITEL-MOORE: Maybe it's five percent, yeah. We had 146 million

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in premiums in 2016. Yeah. Another 2.4 billion.

SUPERINTENDENT VULLO: That's great. Okay, thank you.

MR. MORGENSTERN: Do you agree with the comments that the treatment guidelines are easier?

MS. TREITEL-MOORE: Of the treatment guidelines? Yeah. I don't know that. I think I would have to talk to the claims folks about the administrative costs associated with them. I know that we do find in New York way more than frictional costs than we have in some other states in terms of the number of hearings and multiple hearings and stuff that we often have to go to to resolve a case. We do have a lot of variances. Not as many as when the guidelines first came out, where there were a lot of questions. So, you know, the number of variances have -- as the doctors have gotten moral familiar with the

Workers' Compensation Rate guidelines they have gone down a bit but there's still a bunch of them and still costly. And although net benefit, the treatment guidelines are definitely an improvement in the system to have them.

SUPERINTENDENT VULLO: Thank you.

MR. VAJDA: No questions.

MS. TREITEL-MOORE: Thanks.

MR. MORGENSTERN: Okay. Our last scheduled speaker is Lev Ginsburg, Business Council of New York.

MR. POKALSKY: Good afternoon. Actually, my name is Ken Pokalsky. I am the Vice President of The Business Council of New York State.

SUPERINTENDENT VULLO: So you are not Lev Ginsburg.

MR. POKALSKY: I am not Lev Ginsburg. Lev is our staff workers' comp analyst and he also has a seat as a public member on NYCIRB's Board of Governors, but he could not be here

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today for family reasons, so I am pinch hitting.

Business Council New York State is New York's largest statewide employer association. We represent about 2,300 private sector employers across New York. Our membership does include some of the State's comp carriers, but the majority of our members are consumers, if you will, of the workers' compensation system, in fact, on behalf of those members who are testifying today.

We often are involved in issues impacting the State's economic competitiveness, including business costs that are driven by State policy actions, including workers' compensation. Excuse me. The proposed 9.3 percent increase in loss costs that insurers would use as the foundation of their rate setting for 2017 premiums is obviously not the formula outcome for which we had hoped. However, we firmly

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believe that these numbers, like the rate-setting process, must reflect the true costs of the workers' compensation system. This loss cost calculation results from an analysis of the actual cost of workers' comp benefits, not an analysis of the cause of those cost increases.

In our view, the real issues facing New York's employers are not loss cost numbers, which are mathematically calculated by NYCIRB, but a comp system that remains deeply troubled and that is now more expensive than before the 2007 reforms. New York's workers' compensation rates have dramatically risen over the last eight years, driven by a variety of factors, and we talked about already today, maximum benefits increases, medical costs, growing scheduled loss of use awards, extensive litigation and others.

It should be noted that the

Workers' Compensation Rate proposed loss costs in the last several years were either dramatically decreased or rejected entirely, leaving the system today in a perpetual state of deficit. Making a loss cost decision based on the real costs in the system is imperative to New York employers because failure to do so undermines market stability, leading to a more limited private insurance market for our members, as evidenced in the continued growth of State Insurance Fund's market share. This system, left unchecked, will ultimately lead to severe increases in costs for employers, large or small.

In recent years, in its rate settings, the Department of Financial Services has relied on the opinion that the Stat's compensation system is in a state of considerable transition in light of the 2007 reforms and the subsequent steps taken by the State in furtherance of the implementation of

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those reforms and that the full impact of the 2007 cost-saving reforms remains to be seen.

Unfortunately, for a variety of reasons, the cost-savings expected in the '07 reforms that were to balance the significant increase in benefit levels that were part of the package have never been fully realized.

New York's workers' compensation system remains a drag on New York State's business cost competitiveness. As has been discussed earlier today, the executive budget proposal earlier this year acknowledged this reality by offering a number of reforms that were rejected by various interest groups and obviously were not enacted into law. While some of those were supported by our organization, including the repeal of the ATF deposit mandate, the creation of a self-insured employer guaranteed fund and others, one of the major cost savings that we had -- that

Workers' Compensation Rate had been discussed for possible inclusion in the executive budget was not included, was not even on the table in a formal way, and that was addressing the maximum medical improvement, the definition of MMI and how to works into the classification of PPD claims.

So as a result, we saw no relief through the legislative process. To address our cost concerns, we have asked the Workers' Comp Board and the Governor's office to reexamine the system by which scheduled loss of use awards are determined. Making such determinations based on old and out of date medicine coupled with a maximum weekly benefit now over 840 has proven to be a major cost factor in growing system costs and usually adding hundreds of millions of dollars annually, as reflected in this filing.

Further, there continues to be a compelling need to fix a glaring

Workers' Compensation Rate loophole in year '07's reform legislation by applying permanent partial disability ratio caps from the date of injury thus ending the practice of extending payments to claimants for many years beyond the intent of the '07 law. Doing so would have an immediate impact on compensation cost savings, significantly more than the requested loss cost percentage now before DFS.

In summary, NYCIRB's requested 9.3 increase is justified by actual system costs, but we also stress that the Department's consideration of this proposed loss cost cannot be based on some hope of future savings but on the latest statistical data reported by carriers and accepted actuarial principles. As we said earlier, making a loss cost decision based on the real costs in the system is imperative because failure to do so will lead to a more limited comp insurance market in the State and ultimately more

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significant increases for our members.

Business Council remains committed to work to convince policy makers on meaningful cost savings workers' comp reforms. Achieving this goal is the only way to ensure that future loss cost requests will be significantly lower. Until that time, we argue the data on workers' comp costs supports approval of the current loss cost filing. Thank you.

SUPERINTENDENT VULLO: Thank you. So did you a submit written statement?

MR. POKALSKY: We will.

SUPERINTENDENT VULLO: I didn't see it. That's why I was asking.

MR. POKALSKY: We gave a version of our comments to the court reporter, but we will submit it.

SUPERINTENDENT VULLO: That's great. Because not always the case that the Business Council supports the workers' comp increase because lawyers

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will pay for that increase. So that's why your written testimony to see what your position is --

MR. POKALSKY: Sure. And our point is that the system's costs are what the system's costs are. Our real concern is that we have -- the '07 reforms were intended to be a careful balance between things like significant increase and maximum benefits that would obviously add to system costs, some administrative cost savings, but also significant cost controls, such as duration caps, and, frankly, the implementation of the medical treatment guidelines. The guidelines were adopted -- I think yet to be fully adopted, but we're -- the first group of four major ones were adopted I believe, you know, five plus years after '07 reforms. And as others have testified today, we still see the application of the PPD caps to be somewhat ineffective, leading to, you

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know, continued delays in the system.

So our point is the costs of the system are what the costs are. The costs should be addressed through legislative and regulatory reforms.

SUPERINTENDENT VULLO: And I think you said something that the rates should be based upon, I guess, the existing costs and not future savings. Why not consider some of the future --

MR. POKALSKY: Well, our experience is after the '07 reforms there was a significant reduction in the following year for cost savings that simply did not materialize, and we know this firsthand because at the time we had a self-insured trust and we know what our premium losses were for the '08 premium year. Those savings certainly did not materialize on the timetable that was anticipated or perhaps hoped for when the rates were set for '08. That's our concern, that there would be some expectation of cost

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savings for next year reflected in these premiums of cost savings don't materialize.

SUPERINTENDENT VULLO: You're saying wait for the actual changes and then you can actually reduce the rates if that happens.

MR. POKALSKY: Yes, ma'am.

SUPERINTENDENT VULLO: Okay. Thank you. Good?

MR. POKALSKY: Thank you.

SUPERINTENDENT VULLO: Is there anyone else? That was all we had.

MR. KIMMEL: I would like to make a couple of more statements, if that's possible.

SUPERINTENDENT VULLO: Sure. People are probably getting hungry for lunch so...

MR. KIMMEL: I will keep it short. I will keep it short.

MR. MORGENSTERN: This is the second bite at the apple so...

MR. KIMMEL: Thank you for the

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opportunity to say just a few words in response to some of the comments that were raised earlier.

Contrary to the accusation that was made that insurance carriers are trying to make up for past losses, I just would like to stress that the science of rate making is prospective in nature. So the loss costs we are going to propose are intended to be appropriate for policies that will be written effective -- become effective between the dates of October 1st, 2016 and September 30th, 2017. We do use historical information to make the projections, but the intent is not to make up for some past losses that, you know, loss costs were inadequate for.

The second comment I would like to make is with respect to some of the numbers that were raised here by, specifically by Mr. Grey, who first questions the quality of the data that the Rating Board is using but then goes

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ahead and quotes several numbers from the loss cost filing. And the numbers that he did quote, having considered that he is not an actuary, were taken primarily out of context, and I would just say that some of the numbers that he spoke with respect to the percentage of cases that are scheduled or nonscheduled. The overall loss cost filing is intended to be an aggregate number. 9.3 percent is for all claims, not just for scheduled or for nonscheduled. And the numbers that he quoted from our filing were specific, very specific technical aspects of the calculation to adjust some of the loss development factors that I described in my testimony.

So with that in mind, I think we will also submit something additional comment in writing, but I just wanted to clarify those points.

SUPERINTENDENT VULLO: Everyone is entitled to -- I would just say I

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wouldn't call anything anybody said here today an accusation or anything. Everything is taking their point of view as advocates as Mr. Grey did here, as everyone else did. So we will be happy to take some additional comments.

MR. KIMMEL: Thank you.

SUPERINTENDENT VULLO: Thank you. Anyone else? So as I said at the beginning, we are keeping the record open for five business days. I guess that means until next Monday.

MR. MORGENSTERN: Tuesday.

SUPERINTENDENT VULLO: Tuesday. No. That's July 5th. So it's July 5th. So close of business July 5th. And we appreciate greatly everyone who has testified here and the submission of the written comments, and we will bear everything in mind in arriving at our decision, which is required by July 15th, and we will make our decision by July 15th. So thanks again, and I look forward to greater transparency and engagement with all of you. Thanks.

(TIME NOTED: 1:03 P.M.)

CERTIFICATION

I, STEFANIE KRUT, a Notary Public in and for the State of New York, do hereby certify:

THAT the foregoing is a true and accurate transcript of my stenographic notes.

IN WITNESS WHEREOF, I have hereunto set my hand this 30th day of June 2016.

Stefanie Krut

STEFANIE KRUT