

NEW YORK WORKERS COMPENSATION

October 1, 2007 Rate Revision

Explanatory Memorandum

This memorandum, together with the attached actuarial exhibits, provides supporting documentation for an overall premium level change of -13.6%, to become effective on October 1, 2007.

The proposed rate level change is based upon the latest statistical data reported by the Rating Board's member carriers and includes the estimated measurable effects of Governor Spitzer's 2007 workers compensation reform initiatives.

The elements contributing to the overall change are summarized below and are presented in detail on the following pages.

| | |
|--|-------|
| 1. Change indicated by Policy Year 2005 experience | .948 |
| 2. Change indicated by Accident Year 2006 experience | .954 |
| 3. Average change indicated by experience $[(1) + (2)]/2$ | .951 |
| 4. Change in prospective claim cost, frequency and wage levels | 1.055 |
| 5. Change in expense provisions | .987 |
| 6. Change due to reform legislation | .867 |
| 7. Proposed Rate Level Change $(3) \times (4) \times (5) \times (6)$ | .859 |
| 8. Change in catastrophe provision | 1.000 |
| 9. Total Premium Level Change $[(7) \times .961 + (8) \times .039]$ | .864 |

A listing of the actuarial exhibits follows the explanatory portion of this memorandum in order to provide easy reference for reviewing the underlying support for this filing.

1. Experience of Policy Year 2005

The calculation of the indicated change in rate level derived from the experience of policy year 2005 is presented as Exhibit B.

The experience of Policy Year 2005, valued as of December 31, 2006, has been compiled from the latest available statistical data submitted by the Rating Board's member companies. Similar to recent years, large deductible experience is included in the determination of the indicated rate level change. Although this experience is still viewed as unique and similar to self-insurance, its inclusion reflects the Insurance Department's long held position that this data should be included in the annual rate revision. The methodology used to include the large deductible experience takes into account the relative net earned premium volumes of the non-large deductible and large deductible business, respectively. This methodology is the same procedure that was used in the approved October 1, 2005 rate revision. The net ratios are appropriate since they represent the actual premium levels that are

being charged for the respective New York business. Furthermore, at the previous direction of the Insurance Department, the policy year indication also includes the experience of the State Insurance Fund.

Losses emanating from the September 11, 2001 terrorist attacks have been excluded from the ratemaking data. Both policy year 2000 and policy year 2001 losses have been adjusted to remove the effects of the September 11, 2001 experience that was identified and reported under Catastrophe Code 48. The definition of Catastrophe Code 48 encompasses claims directly arising from the commercial airline hijackings of September 11, 2001 and the resulting subsequent events with accident dates of September 11, 2001 through September 14, 2001.

Similar to previous filings, the Rating Board has utilized case basis losses for the policy year loss evaluation. Indemnity and medical losses were analyzed separately in recognition of the significant differences in their respective development patterns.

Two, three, four and five-year average link ratios, as well as a three-year average, calculated after excluding the highest and lowest points, were analyzed for both indemnity and medical. Changing development patterns were observed at various report levels, especially at the more immature valuations. Consequently, the methodology uses the three of five factors for the first to tenth reports and three-year average factors from the tenth to ultimate in order to smooth the impact of the variations in the observed development patterns. Separate development factors were derived for the non-large deductible and large deductible experience using this same methodology.

The Rating Board has used the methodology from the 2006 filing for determining the tail factor portion of the ultimate loss development factors. This method utilizes three reports of data, and averages these results with the tail factors calculated in the prior year's filing submission. The incorporation of the previous factors is felt to be appropriate in order to further smooth the effect on development of reserve changes occurring in older policy years.

Premium development factors, similar to previous filings, are based on five-year averages which minimize fluctuations in the observed development patterns.

The private carrier non-deductible development data can be found in Exhibits BB, Sheets 1 thru 2D. For large deductible development, exhibits labeled as Appendix D, Sheets 1 thru 5 are provided.

Appendix F contains the experience of the State Insurance Fund. These pages include premium development factors for the policy year, and separate indemnity and medical loss development factors on both a policy year and accident year basis. Because of the large volume of State Fund data, it is appropriate that projections of ultimate losses reflect this experience's own development patterns.

Policy year losses for the private carrier non-large deductible, State Fund experience, and the large deductible experience are separately adjusted to an ultimate settlement basis, as described above, and are converted to the level of benefits in effect prior to the date of the 2007 reform legislation. The estimated rate level effect of the legislation is provided in Exhibit F. The premiums are converted to the current rate level and are adjusted to an ultimate level which assumes there is no development beyond the sixth report. Loss ratios are then calculated for indemnity and medical based on the adjusted premiums and losses, and total developed on-level loss ratios are produced.

The developed on-level loss ratios are adjusted to include a loss adjustment expense factor of 1.163 which is a slight decrease in this factor from the 1.164 that underlies the current rates. The derivation of this factor can be found on Exhibit EE, Sheet 3.

The total adjusted loss ratio is then compared to the expected loss and loss adjustment expense ratio underlying the October 1, 2005 rates to determine rate level indications separately for the non-large deductible and large deductible experience. These indications are then weighted on the basis of their respective net earned premiums to arrive at a decrease of 5.2% in rate level based upon Policy Year 2005 experience.

2. Experience of Accident Year 2006

The calculation of the change in rate level indicated by the experience of accident year 2006 is presented in Exhibit C.

Consistent with the policy year experience, large deductible data, as well as the experience of the State Insurance Fund, has been included in the accident year experience base. The Rating Board has also utilized case basis losses for the accident year evaluation and has excluded losses attributable to the September 11, 2001 event from the accident year 2001 experience.

Case basis losses have been analyzed separately for medical and indemnity and traditional loss development factors have been derived. Similar to the policy year experience, three of five factors from first to tenth and three-year average link ratios from tenth to ultimate were used to determine the proposed loss development factors through twentieth report. For both indemnity and medical, an average of three reports, further averaged with the prior year's tail factor, was utilized in the determination of a twentieth report to ultimate, or tail, loss development factor which is consistent with the policy year methodology.

Accident year losses are developed to an ultimate settlement basis and are converted to the benefit level prior to the reform legislation. Calendar year premiums have been adjusted to the current rate level. The resulting on-level loss ratios are also adjusted to include loss adjustment expense as previously described.

The private carrier non-deductible loss development data can be found in Exhibits CC, Sheets 1 thru 1D. The large deductible development is included in exhibits labeled as Appendix D, Sheets 6 and 7. State Fund development is shown in Appendix F.

The total adjusted loss ratios are compared to the expected loss and loss adjustment expense ratio underlying the October 1, 2005 rates separately for the non-large deductible and large deductible experience. The subsequent weighted average indicates a decrease of 4.6% in rate level based on Accident Year 2006 experience.

3. Average Experience Change

With equal weight being given to the 5.2% decrease indicated by the policy year experience and the 4.6% decrease indicated by the accident year experience, the average effect of experience on rate level is a decrease of 4.9%.

4. Trend Factor Analysis

The presentation of the loss portion of the trend factor is similar to previous years in that indicated trends are expressed in terms of average annual changes in claim costs and claim frequencies. Exponential and linear regression lines are used in analyzing the severity and frequency trends, and are calculated using both five years and eight years of data. The loss trend analysis utilizes a weighted average of private carrier and State Insurance Fund (SIF) claim costs and frequencies as the basis for calculating the trend factors. The determination of the wage trend utilizes five years of actual New York wage data, analyzed on both a linear and exponential basis.

For the indemnity trend, historical average claim costs by injury type were derived separately for the private carriers and the SIF by the application of observed claim and loss development patterns. The average severities for the private carriers and the SIF are displayed as information in Exhibit DD, Sheets 5 and 6, respectively. The injury type severities are weighted together on the basis of the actual frequencies for each injury type for each policy year. This methodology recognizes any shifts in the claim frequencies between injury types over time and ensures that the appropriate weights are given to the respective average claim costs in the final trend analysis.

Total medical costs, including both medical only and medical on compensable cases, is used as the basis for the medical claim cost trend calculation. The use of separate private carrier and SIF data has also been used as described above. Compared to last year, there is an increase in the annual medical claim cost trend. Medical costs have continued to produce a clear and recognizable upward trend in New York over the past several years, with this year's trend being slightly greater than observed in previous revisions.

Exhibit DD, Sheets 2-6 show the derivation of the indicated claim cost trend for both indemnity and medical losses.

Similar to the procedure utilized for claim costs, separate private carrier and SIF claim frequencies are calculated, and then combined, to produce indicated frequency trends. Consistent with prior revisions, premium at present rates is the exposure base used in the frequency calculations. Indicated frequency trends continue to be negative, although at a lower annual rate compared to last year.

Exhibit DD, Sheets 7-11 show the details underlying the change in both indemnity and medical claim frequencies as calculated in the traditional manner.

A wage trend analyses procedure, using both an exponential and linear regression of the latest five years of wage data from the New York State Department of Labor (DOL), is used in the wage trend calculation which is the same methodology as used in previous years. The average weekly wages are derived directly from published DOL statistics for all industries. Exhibit DD, Sheet 12 shows the calculation of the wage trend factor produced by this methodology.

The methodology described thus far would be applicable to the entire trend projection period in the absence of reform. However, the 2007 reforms are significant and it is highly likely that any trend after implementation of the reform legislation will be different from that indicated by pre-reform experience. Although an analysis of post-reform trend is customarily measured after actual experience under the reform has been compiled, recognition of potential effects on trend of the 2007 reforms is being given in this filing by reducing the otherwise calculated trend factor by 50%. Consequently, the final trend reflects the full indicated trend projected to 7/1/07 and the reduced trend projected from 7/1/07 to the average date of accident for policies effective October 1, 2007 and thereafter. The pre-reform trend factors, selected on the basis of the regression line with the best fit (R^2) can be found on Exhibit DD, Sheet 1. The derivation of the post-reform trend factors and the calculation of the final overall trend factor are contained in Exhibit D.

5. Expense Analysis

The proposed expense provisions and underlying calculations are shown on Exhibit E and Exhibit EE, Sheets 1 through 3. The expense provisions derived here are based on private carrier data as reported on each carrier's Insurance Expense Exhibit and Statutory Page 14 exhibit of the Annual Statement.

Consistent with prior revisions, the underlying data in the expense analysis are on an all private carrier direct basis with acquisition costs reflecting actual expense experience. The impact of large deductible policies continues to be reflected in the determination of the general expense and other acquisition expense provisions.

Furthermore, in keeping with the Department directive issued as a result of the rate hearing held on May 30, 1991, this filing contains no allowance for profit and contingencies. Elimination of the profit factor results in effectively lowering the overall indication by approximately three percentage points.

The indicated total expense provision of .241 results in a 1.3% decrease in overall rate level.

Loss adjustment expense continues to be analyzed separately for allocated and unallocated expense. Due to the oftentimes unstable calendar year results, four years of experience are reviewed in this portion of the expense analysis. The impact of large deductibles is also taken into account in the determination of the unallocated loss adjustment expense factor. The indicated total loss adjustment expense factor of 1.163 is included in the calculation of the policy year and accident year experience indications.

6. 2007 Workers Compensation Reform

New York Legislative Bill A. 6163/S. 3322 is a comprehensive reform bill that has been designed to increase benefits for injured workers, while at the same time, reducing the overall costs of the workers compensation system.

The Rating Board, together with its Actuarial Committee, and assisted by the consulting firm of Tillinghast/Towers Perrin, has estimated that the cost impact of those provisions of the new law that are quantifiable is a decrease of 13.3% in overall rate level. The derivation of this estimate can be found in Exhibit F, Sheet 1. The following narrative and the attached Exhibit F, Sheets 2-4 provide support for this evaluation.

Four major provisions of the reform have been actuarially determined in this analysis: the elimination of the Special Disability Fund, caps on permanent partial disability duration, benefit increase and the enactment of several medical-related provisions. The requirement for permanent partial claims to be transferred to the Aggregate Trust Fund, the establishment of medical and impairment guidelines and the strengthening of fraud provisions are major system changes, but cannot be quantified with any degree of certainty at this time. Nevertheless, commentary has been provided in this memorandum regarding the perceived direction that these provisions could have on future costs to the carriers.

The actuarial analysis begins with a compilation of loss data by injury type on a pre-reform basis. From this base, the methodology builds in the effect of the elimination of the Special Disability Fund, applies the effects of the duration limits on permanent partial claims, adjusts for the increase in the maximum benefit and considers the changes in the medical-related provisions to arrive at an overall estimated claim cost impact. The claim cost effect is then converted to an overall manual rate level change by utilizing the expense ratios underlying the 2007 rate revision.

I. Elimination of the Special Disability Fund

The reform bill closes the Special Disability Fund (SDF) to new claims with accident dates of July 1, 2007 and later. As a result, the loss amounts previously reimbursed by the SDF will now be retained by the carriers.

The methodology, illustrated in the exhibit labeled Exhibit F, Sheet 2, estimates the effect of this provision of the law by utilizing the three latest years of actual SDF reimbursements and relating these reimbursements to actual carrier paid losses for the same calendar year time periods (2004-2006). Separate indemnity and medical impacts are calculated for each of the three individual years and are then averaged to obtain the respective loss cost effects. This analysis indicates that, before other provisions of the law are considered, the loss amounts previously paid by the SDF will add an additional 20.9% to the carriers' indemnity losses and 5.4% to medical losses, or an average of 15.7% to total losses.

However with, the elimination of the SDF, the carriers will now have more accountability and incentive to more aggressively control, manage and settle these cases since they are now responsible for the full loss payments on all of these claims. In other states in which second injury funds have been eliminated, a "mitigation" factor of .70 has often been used to adjust the otherwise determined additional losses that are to be retained by the carriers in recognition of the carriers' ability to better manage these full cases. However, in many other states, the second injury funds had actively participated in determining claimant benefits which added considerable administrative expense to their systems. Thus, the .70 factor reflects both a loss savings and an administrative cost savings for the carriers. In New York, the SDF does not participate in determining a claimant's benefits so that the administrative expense savings seen in other states will not materialize to the same magnitude in New York. Nevertheless, some savings are expected once the SDF is eliminated. In recognition that there should still be a reduction in costs, an average of 1.0 and .70, or .85, was selected as a mitigation factor for New York. When the mitigation is taken into account, the carriers' total losses are expected to be increased by 13.3%.

The total loss cost effect is then distributed by injury type. Since the former SDF cases are long duration cases, all of the indemnity impact is distributed to death, permanent total and major permanent partial injury types in such a manner that the total indemnity effect is maintained.

II. Limitation of Permanent Partial Disability Duration

The limitation on the duration of permanent partial disability (PPD) claims is based upon a specified number of weeks relative to the claimant's loss of earnings. In the analysis, a loss of earnings distribution based on actual data from the Workers' Compensation Board (WCB), as compiled by Milliman, was used to distribute the statutory benefits across all PPD claims. However, due to the subjective nature of establishing the appropriate loss of earning for each PPD claimant, an upward "drift" in the underlying distribution could be seen as an inevitable consequence under the new legislation. It also appears that this drift might be prevented by the establishment of statutorily required rules and regulations whose intent is to effectively eliminate much of the subjective aspects of benefit determination. Consequently, no adjustment has been made to the Milliman distribution.

Actual PPD claim data from the WCB was used to determine the percentage of losses that would be eliminated at the various number of weeks specified in the legislation. It should be noted that this calculation includes the effects of mortality separately for male and female, and is on an undiscounted basis. Since the underlying loss costs in the rates are intended to be undiscounted and the fact that the PPD cases will no longer be lifetime, an undiscounted basis is appropriate.

From a limited survey of carriers on the Rating Board's Actuarial Committee, it was determined that approximately 35% of PPD cases are currently settled and that these cases currently represent about 40% of the full lifetime values. However, Milliman also analyzed settlement rates and determined that only 7% of the cases are currently settled. Since the survey results are anecdotal, but current, and the Milliman results are factual, but reliant on limited historic WCB data, an average of the two sources was used to estimate the PPD settlement rate of 20% that is used in this part of the analysis. Based on this percentage, the elimination of the number of weeks was split between settled and non-settled cases. On the exhibit labeled as Exhibit F, Sheet 3A, the separate effects of the PPD caps for the settled and non-settled cases can be found.

In addition, the law allows for claimants with an 80% or greater loss of earnings to apply for permanent status if it can be shown that there is financial hardship. This provision will erode some of the otherwise calculated cap savings since a person with an 80% or greater loss of earnings may experience significant financial hardship and qualify for this consideration. Based on WCB wage data for claimants with PPD benefits established in 2005, an average annual wage for these claimants in 2007 would be approximately \$41,350 (795 x 52). According to the federal government, the poverty level for a family of 4 in 2006 was \$20,444, which projects to \$21,037 (1.029 x 20,444) in 2007. Comparing an average PPD claimant's annual wage to the poverty level indicates that, at a 50% loss of earnings level, an average claimant would be at the federal poverty line and, most likely, be able to demonstrate financial hardship. Consequently, at the 80% loss of earnings level, a claimant would be well below the poverty line, making it likely that financial hardship can be proven. However, the reform law also contains various provisions for strengthening the administration of the workers compensation system so that the granting of hardship exceptions could be restricted. Consequently, since the number of hardship cases cannot be determined in advance, a conservative 50% offset was applied to the indicated savings for intervals of 80% and greater.

Exhibit F, Sheet 3 summarizes the above described calculations. The percentage reduction in PPD losses for the settled and non-settled cases are weighted together based on the previously mentioned 20/80 split. Since the resultant reduction applies just to non-scheduled injuries, this effect is weighted with scheduled losses and the portion of PPD that is pre-PPD (temporary) to arrive at the overall effect of a 50.5% reduction in PPD costs.

III. Benefit Increase

The maximum benefits for injured workers will increase from \$400 per week to \$500 per week on July 1, 2007, with additional annual increases, effective on July 1 of subsequent years.

The determination of the rate level impact resulting from statutory benefit changes that raise the maximum weekly benefit is based on a universally accepted actuarial methodology developed by actuary Barney Fratello in a paper entitled *The Workers Compensation Injury Table and Standard Wage Distribution Table – Their Development and Use in Workers Compensation Insurance Ratemaking*, published by the Casualty Actuarial Society. This publication, or portions thereof, has been used for over fifty years by actuaries in all jurisdictions to price the effects of changes in the maximum weekly benefit that are either proposed or enacted by their respective state legislatures. The incorporation of a state's current statutory maximum weekly benefit, the new maximum weekly benefit, the state's average weekly wage and the 'Standard Actuarial Wage Distribution Table' enable an actuary to produce an accurate estimate of the rate level effect when changes to the maximum are proposed or enacted.

The actual methodology used by the NYCIRB to calculate the effects of changes in the maximum weekly benefit is a Limit Factor Analysis, as set forth in Mr. Fratello's actuarial paper. For a better understanding of the method, the following should be especially noted:

- While the methodology refers to average benefits and wage levels, these are expressed in terms of ratios for use with the Wage Distribution Table and are not intended to be actual values.
- The methodology only measures changes in the minimum and maximum benefits or percentage that these benefits bear to an employee's wages, and nothing more. It assumes that the current administrative functions within the workers compensation system and the level of disability or impairment of the injured workers that determines these benefits are at the current level.
- The methodology also reflects potential increases in utilization of the system as a result of the large increase in benefits. In other states, when large benefit changes were enacted, it was often seen that more claimants applied for the more generous benefits, which resulted in higher actual effects than the actuarial estimates were able to predict.

The calculation of the impact in New York of increasing the maximum weekly benefit from \$400 to \$500 per week can be found on the attached Exhibit F, Sheet 4. The methodology is performed separately for each major injury type [death, permanent total, permanent partial major (>22,000 per claim), permanent partial minor (<22,000 per claim) and temporary] to recognize any variation in the maximum, as a percent of wage, that is provided for by statute. Recognition has also been given to the lower wage levels of PPD claimants and the manner of determining benefits that is used by the WCB for PPD cases.

Once the indicated changes are determined by injury type, these changes are applied to the latest distribution of incurred losses by injury type in order to obtain the estimated change in total indemnity costs. The resultant indicated indemnity change is then weighted with the distribution of indemnity and medical losses to obtain an overall change. The NYCIRB analysis then includes a utilization factor of 1.10 that contemplates the additional utilization of the workers compensation system as a result of the significantly higher benefit level. This effect must be taken into account in order to properly price this part of the reform bill. John W. Ruser of the U.S. Bureau of Economic Analysis in his 2004 paper entitled *Workers Compensation Reforms and Benefit Claiming*, states that "...Benefit claiming is positively associated with the generosity of benefits...". He then goes on to say that "...we then show that the probability of filing a claim increases...with an increase in benefit generosity". Experience in states that have enacted benefit increases has shown that utilization can increase significantly (up to 25% and more) with an increase in statutory benefits. In 2004, the California Workers Compensation Insurance Rating Bureau determined that there was a 26% rise in claims as a result of the latest series of benefit increases. The WCRI in a report by Dr. John Gardner entitled *Benefit Increases and System Utilization: The Connecticut Experience* states that "...Over the past decade, a number of studies have shown that as benefits rise, the duration of claims increases and more claims are filed. This study finds a large increase in utilization – about a 20 percent increase in utilization for every 20 percent increase in benefits – among workers affected by the benefit increase...". Based on the above, and recognizing that the 2007 benefit increase in New York is the first in 15 years, the 1.10 utilization factor can be considered reasonable in relation to the magnitude of the benefit change.

In total, the increase in the maximum weekly benefit is expected to result in a 6.0% increase in workers compensation claim costs, effective October 1, 2007.

In addition, the legislated benefit increases scheduled for subsequent years, using the above described methodology, are expected to result in the following claim cost changes:

| <u>Effective Date</u> | <u>Maximum Weekly Benefit</u> | <u>Claim Cost Change</u> |
|-----------------------|-------------------------------|--------------------------|
| 7/1/08 | \$550 | +1.9% |
| 7/1/09 | \$660 | +1.5% |
| 7/1/10 | 2/3 AWW | +2.9% * |

* preliminary estimate

Proportional effects of the 7/1/08 and 7/1/09 benefit increases will also affect the October 1, 2007 – October 1, 2008 policy period by approximately 1.3%.

IV. Medical and Other Provisions

This portion of the NYCIRB analysis summarizes the remaining quantifiable portions of the legislation.

a. Incarceration of Injured Workers

Benefits are to be denied to incarcerated injured workers.

Information has been received from the Workers' Compensation Board with respect to a heretofore unknown New York court case, *Biello v. A.J. Eckert Co.*, 43 AD2d 192 (3rd Dept. 1974). This case holds that claimants who are incarcerated in prison under a conviction are not entitled to receive compensation awards. This has been followed and represents well-settled law. Thus, the reform simply codifies existing case law and represents no new savings.

Based on this information, there is no expected savings under this provision.

b. Fee Schedule for Prosthetic Devices, Etc.

Information received from the New York State Insurance Department indicates that the cost of these devices could be reduced approximately 40%, if purchased at other than retail prices. Other information indicates that durable medical goods are approximately 5% of total medical costs. However, carriers on the Rating Board's Actuarial Committee have indicated that discount prices are already being utilized for these devices in many cases. Carrier anecdotal information also indicates that claimant participation in these programs runs at about 75%. Assuming that half of all purchases are currently discounted, the above produces an indicated savings on medical costs of 1.8%.

c. Pharmacy Fee Schedule

A Rating Board study in 2003 had determined that pharmacy costs were approximately 12.5% of New York's WC medical costs, and later data indicates that this figure is now approximately 16%. However, information obtained from the Actuarial Committee indicates that about 75% of the carriers are already utilizing discounted drug pricing programs, averaging about 20% below wholesale prices. These same carriers also indicated that participation in these programs by claimants is close to 80%. However, it is the Rating Board's understanding that the schedule to be implemented will be similar to the reimbursement under Medicaid, which average about 50% below the average wholesale price of drugs. Using this information, the resultant estimated savings on medical costs is 2.6%.

d. Mail Order Prescription Drugs & Generic Substitution

A 2006 NCCI study indicates that over 85% of drug prescriptions are written for generic drugs when these drugs are available. The study also indicates that the possible potential additional savings from generic drugs is 8% of total prescription costs. However, generics are not always prescribed even though available if insisted upon by a doctor. Consequently, if three-quarters of the 8% savings on total New York prescription costs materialize, which affects 16% of medical costs, a potential savings of 0.9% in medical costs could be realized.

e. Prompt (72 hours) Notification of Claims

This provision reduces the required reporting of claims by the employer to the carrier from the current 10 days to 3 days. Carriers have indicated that at least half of all claims are currently being reported to them within 3 days. However, there are no credible statistics available, either in New York or in other jurisdictions, to determine an estimated cost savings from this proposal. Consequently, any savings will flow through the ratemaking data and be reflected in future manual rates.

f. Networks for Laboratory, X-ray, or Imaging Services.

According to a Workers Compensation Research Institute study, approximately 3% of medical costs are attributable to radiological or similar diagnostic tests. However, many carriers are already utilizing discount arrangements for these tests and procedures. These same carriers also indicate that participation in these programs by claimants is close to 75%. If 50% of the carriers already have discount arrangements for these services, assuming a 30% price reduction, an estimated savings on medical costs as a result of implementing diagnostic treatment networks is 1.3%.

g. Utilization of Health Insurance for Controverted Cases

According to the data from the State Workers' Compensation Board, there are over 20,000 cases that are challenged annually. However, it is the NYCIRB's understanding that, once a controverted case is determined to be a legitimate WC case, the common practice in the industry is for the carrier, if not already paying some medical costs, to reimburse, at the WC fee schedule rates, any other insurer or the claimant for medical costs expended

during the period in which the case was being challenged. Consequently, this provision appears to be a codifying of current industry practice and would not have any identifiable or quantifiable cost impacts.

h. Total Estimated Effect on Medical Costs

The total estimated effect on medical costs from the provisions discussed in (a) through (g) above is -6.6%.

V. Permanent Partial Disability Claims to the Aggregate Trust Fund

This provision of the legislation requires that every claim that is established by the WCB as a PPD must be placed into the Aggregate Trust Fund (ATF) by the private insurance carriers. While alleged to be a safety net for these cases by its proponents, it is a provision that will most likely result in an increase in costs.

A key element to the cost impact of this provision will be the manner in which these new ATF cases are treated by the claimants, claimants' attorneys and the ATF. Under the new law, a carrier will be at a disadvantage when attempting to negotiate a settlement with the claimant since the claimant will be aware of the ATF required claim value and now knows that the carrier must offer a settlement within a specific timeframe. This can lead to a claimant holding out for a settlement that is greater than what would have been settled prior to the reform. Furthermore, if the negotiation process does not result in a settlement, the carrier must then deposit the indemnity portion of the claim, at a discounted amount, into the ATF. If the ATF is eventually able to settle, any resultant savings does not get returned to the carrier. In addition, by retaining the medical portion of the claim, the carrier incurs the additional medical costs that could have been eliminated by virtue of a settlement prior to the reform (currently, carriers settle almost exclusively on a combined indemnity and medical basis).

In addition, for purposes of the ATF under the new law, when the payment into the ATF is made, all dependent children are assumed to be entitled to benefits up to age 23. Even though the ATF will eventually return payments on these children if it is found that they did not attend an accredited educational institution, the initial payment for about half the cases with dependent children will be considerably greater under the new law.

It should be especially noted that the required use of discounted PPD loss amounts relative to undiscounted loss values is not a real "cost savings" in the sense of the other reforms. Instead, this is more in the nature of a shifting of part of the investment income portion of the profit and contingency load in the rates to the expected indemnity loss cost portion of the rates. At some ideal level, the discount rate mandated by the Superintendent of Insurance would have a neutral economic impact on carriers' underwriting results. The net effect is forcing the promulgated rates to reflect a portion of the indemnity losses on an essentially discounted basis. The difference in the interest rate used by the carriers relative to the discount rate mandated by the Superintendent of Insurance could have either a positive or negative impact on the overall carrier results.

In addition, there is an administrative cost associated with all ATF claims. The ATF currently charges 3% of the claim value it receives as an administrative fee. Whether or not the ATF charges the same 3% or another percentage for the PPD cases, this fee is nevertheless a new cost to be borne by the private carriers.

VI. Medical Guidelines

Medical guidelines, composed of both Impairment and Treatment guidelines, are currently in the process of being developed by the Insurance Department. The impairment guidelines will help in the decision of whether or not an employee has suffered a compensable permanent partial disability. The treatment guidelines, which creates a system for evaluating and treating common occupational injuries, is intended to help reduce disputes and provide appropriate medical care. These guidelines should also impact the recovery of an injured employee and help to promote both a safe and timely return to work. According to the Insurance Superintendent, it is expected that such guidelines will be available by December 1, 2007. Once these guidelines have been implemented, it is expected that system cost savings will be attained.

VII. Fraud

Several sections of the law attempt to provide stiffer penalties for the perpetration of fraud and assure the proper reporting of payroll and premiums within the workers compensation system. The Department has, in the past, underscored the importance of fraud initiatives undertaken by the carrier community and has pointed specifically to the work of the State Insurance Fund in combating this problem. Information from the Department has indicated that the Fund has saved in the neighborhood of \$20 million annually due to efforts in this area. The additional fraud reform is also expected to result in system savings.

VIII. Effect of V, VI and VII on Rate Level

Due to the many varied aspects of the law change associated with the Aggregate Trust Fund, as well as the unknown behavioral impact of claimants, their attorneys and WCB law judges, an actuarial basis for estimating a cost impact cannot be developed with certainty at this time.

Also, given the fact that actual medical impairment and treatment guidelines for New York have not as yet been finalized, as well as the fact that information regarding such regulations is not readily available, an actuarial basis for any proposed rate reduction is not determinable.

Finally, while the 2007 additional fraud provisions may have a positive effect on the overall system costs, there is, once again, no actuarial basis for a calculation at this time.

As a result, due to both the positive and negative impacts that these provisions could have on rate level, we are proposing an overall no change in rates at this time due to these reform elements.

IX. Total Effect of 2007 Reforms

As a result of the above-described methodologies, an overall rate level effect of -13.3% has been determined. A summary of the components underlying this reduction is attached as Exhibit F, Sheet 1. In this exhibit, the resultant effects of the SDF, PPD caps, 7/1/07 benefit increase, the pro-rate portion of the 7/1/08 and 7/1/09 benefit changes and medical savings are shown for their respective injury types and then combined into an estimated 17.1% reduction in loss costs. Since many of the expenses underlying typical manual rates are not expected to flow in relation to the change in loss costs, the expense ratios, other taxes and commission, were considered to be 75% fixed and 25% to be variable for use in determining the overall rate level impact. Based on this assumption,

an overall 13.3% reduction in manual rates has been determined for the measurable portions of the reform legislation.

7. Catastrophe Provision

As a result of the terrorism attack of September 11, 2001, the Rating Board introduced a loading in the manual rates for foreign terrorism in conjunction with its October 1, 2002 rate revision. In February 2003, this loading was replaced by a stand-alone premium charge of \$.034 per \$100 of payroll (2.5% of manual premium for non-payroll classes). This charge remains in effect today.

In 2002, the Terrorism Risk Insurance Act (TRIA) was enacted that provided a federal backstop to the terrorism exposure through December 31, 2005. The Terrorism Risk Insurance Extension Act (TRIEA) subsequently became effective January 1, 2006 and extended the federal backstop until December 31, 2007. Currently, the U.S. Congress is debating whether or not the federal protection will be extended beyond December 31, 2007.

Since, at this time, there are ongoing debates and sensitive discussions regarding the future role of the federal government in providing a backstop to the insurance industry for the terrorism exposure, no changes to the current New York terrorism rates are being proposed at this time.

8. Industry Group Differentials

Industry group differentials are used to more equitably distribute the overall rate level change to individual employer classifications. Nine industry groups are used in this analysis and are listed below:

| | |
|---------------------------------|-------------------------------------|
| Food and Beverage Manufacturing | Stores and Dealers-Wholesale/Retail |
| Chemical Manufacturing | Professional and Office |
| All Other Manufacturing | Services |
| Contracting | Miscellaneous |
| Maritime, Admiralty and Federal | |

The industry group methodology entails a compilation of the latest three years of Unit Statistical Plan data into the nine industry groups, and utilizes loss ratios as the basis for calculating a differential for each group relative to the statewide average (Exhibit G, Sheet 1). The underlying premium base is standard premium on current rate level and includes payroll development. Incurred losses have been developed to ultimate and are at the pre-2007 benefit level. The methodology includes trend and utilizes the factors contained in the general rate revision. Credibility for each group is based on the three-year total number of compensable claims, with the total number of lost-time claims for all groups combined as the standard for full credibility. Partial credibility for each group in this revision is determined by the formula $(N/T)^{2/3}$, where N is the three-year total of lost-time claims for the industry group and T is the three-year total of all lost-time claims. The complement of credibility is the loss ratio for all groups combined. Indicated differentials are calculated by relating each credibility weighted industry group's loss ratio to the overall total loss ratio. As in past revisions, an additional refinement to the indicated differential is included which recognizes different wage trends by industry group (Exhibit G, Sheet 2). The final differentials will be applied as part of the process which calculates manual rates from class pure premiums. To ensure overall balance, after the differentials are applied in the determination of class rates, a test of rates will become the final step in the process. The use of relativities by industry group provides a more refined and equitable distribution of rate level to each class.

Manual rate changes for each classification will continue to be limited to $\pm 25\%$ from the calculated industry group change to minimize the swings in rate level by class while still maintaining a proper relativity structure.

9. Minimum Premium

No change in the minimum premium formula is being proposed with this revision. As referenced in Appendix B, the current multiplier of 110, the expense constant of \$200 and the \$875 maximum minimum premium will continue to apply.

10. Small Deductible Premium Credits

Small deductible credits are not being changed in this revision. With the anticipated implementation of a revised Hazard Group structure as of January 1, 2008, it follows that the deductible credits which are dependent on this structure, should be changed at the same time as the new Hazard Group alignment is introduced.

11. Large Deductible Experience

Appendix D contains the experience reported by the Rating Board's member companies for policies written under independently filed large deductible programs. Both policy year and accident year data is being provided in this section of the filing and all loss data is on a first dollar, or gross of deductible, basis.

Consistent with last year's filing, large deductible loss development factors for both policy year and accident year are also included in this Appendix. Since the development factors for this business differ from those of the non-large deductible business, any projection or analysis of ultimate large deductible losses reflects this experience's own development.

12. Construction Classification Territory Off-Balance

In accordance with the Construction Employment Payroll Limitation Law (Chapter 135 of the Laws of 1998), the weekly payroll limitation for construction employments will remain at \$750 effective October 1, 2007.

In recognition of this payroll limitation relative to today's wage levels, revised territory differentials have been developed in accordance with the methodology approved by the Department at the inception of this program in 1999. Updated construction wage data was obtained from the New York Department of Labor and was projected into the prospective policy period. The standard actuarial wage distribution table was then used to estimate the percentage of payroll by territory that would be eliminated by the \$750 weekly cap.

The average statewide differential, proposed for October 1, 2007, is 6.8% which, when calculated by territory, is as follows: Territory 1 (NYC): 8.5%; Territory 2 (surrounding counties): 6.8%; Territory 3 (remainder): 4.0%.

The change in the off-balance represents a 13.1% decrease below the current average differential of 22.9%. However, the estimated overall premium level effect for all construction classes is 0.0% since the differentials merely offset the effect of the capped payrolls on manual premiums.

The derivation of the October 1, 2007 territory differentials can be found in Appendix E.

13. State Insurance Fund Experience

Appendix F contains the experience of the State Insurance Fund, which includes premium development factors for the policy year, and separate indemnity and medical loss development factors on both a policy year and accident year basis. Because of the large volume of State Fund data, it is appropriate that projections of ultimate losses reflect this experience's own development patterns.

14. Classification Pure Premiums

Classification pure premiums are based on the experience of all carriers for the five-policy years 2000 - 2004, excluding the experience of self-rated risks. In addition, losses over \$1,200,000 per claim (State Act) and \$1,800,000 (Federal Act) are excluded from the pure premium development. Consistent with past revisions, five years of experience are used to determine the proposed pure premiums for all classes irrespective of credibility.

Complete details with respect to the classification experience are contained in a separate document which has been provided to the Department under separate cover.

15. Changes in Rate by Classification and Industry Group

A table showing the percentage changes in manual rate level for each classification and industry group and the number of classifications for which rates are to be increased or decreased, as well as those to which no change will be applicable, will be provided upon approval.

16. Total Change

As a result of the above analyses, and including the estimated effects of the measurable 2007 reforms, an overall rate level change, of -14.1% is indicated. When combined with no change in the catastrophe provisions, an overall -13.6% change in premium level is proposed.

17. New York State Assessment

A separate identifiable policy charge, referred to as the New York State Assessment, has been in effect since April 1, 1994 as the mechanism to fund the costs of the Workers' Compensation Board, the Reopened Case Fund, the Special Disability Fund, the Special Funds Conservation Committee and Interdepartmental Expenses. The current percentage charge calculated by the Rating Board, effective October 1, 2006, is 18.6% of standard premium.

Based on the latest available information from the Workers' Compensation Board and Special Funds Conservation Committee, the percentage of standard premium required to fund these costs for policies effective October 1, 2007 is estimated to be 14.9% or a 3.1% decrease from the current level. The derivation of this policy charge is contained in Appendix A and utilizes the identical methodology which underlies the present charge with an additional adjustment to account for the anticipated lower premium base after the effects of the reforms are taken into account.

The overall impact on policyholders resulting from the decrease in the New York State Assessment and the decrease in overall premium level is an average -16.3% change in workers compensation costs.

18. Effective Date

It is proposed that the revised rates and rating values, after approval by the Insurance Department, become effective on October 1, 2007 for new, renewal and outstanding business, observing the established rating anniversary date in accordance with the provisions of Rule I, Section G of the New York Workers Compensation and Employers Liability Manual.